

A bill for an act

relating to state government; making changes to health and human services programs; changing children and family provisions; modifying licensing provisions; amending health care law; modifying continuing care provisions; amending mental health provisions; changing Department of Health provisions; establishing a children's health security program; changing public health provisions; amending MinnesotaCare, medical assistance, and general assistance medical care; instituting health care reform; establishing the Minnesota Health Insurance Exchange; requiring Section 125 Plans; modifying health insurance provisions; regulating anatomical gifts; establishing family supportive services; providing rate increases for certain providers; changing health records information provisions; making technical changes; providing civil and criminal penalties; establishing task forces; requiring reports; making forecast adjustments; appropriating money for human services and health; appropriating money for various state boards and councils; amending Minnesota Statutes 2006, sections 13.3806, by adding a subdivision; 13.46, subdivision 2; 16A.10, by adding a subdivision; 16B.61, by adding a subdivision; 16D.13, subdivision 3; 43A.316; 62A.65, subdivision 3; 62E.141; 62H.02; 62J.04, subdivision 3; 62J.17, subdivisions 2, 4a, 7; 62J.41, subdivision 1; 62J.495; 62J.52, subdivisions 1, 2; 62J.60, subdivisions 2, 3; 62J.692, subdivisions 1, 4, 7a, 8, 10; 62J.81, subdivision 1; 62J.82; 62L.12, subdivisions 2, 4; 62Q.165, subdivisions 1, 2; 62Q.80, subdivisions 3, 4, 13, 14, by adding a subdivision; 103I.101, subdivision 6; 103I.208, subdivisions 1, 2; 103I.235, subdivision 1; 119B.05, subdivision 1; 119B.09, subdivisions 1, 7, by adding subdivisions; 119B.12; 119B.125, subdivision 2; 119B.13, subdivisions 1, 3a, 6, 7; 119B.21, subdivision 5; 144.05, by adding a subdivision; 144.123; 144.125; 144.2215, subdivision 1; 144.3345; 144.565; 144.651, subdivision 26; 144.672, subdivision 1; 144.698, subdivision 1; 144.699, by adding a subdivision; 144.9502, subdivision 3; 144.9504, subdivision 2; 144.9507, by adding a subdivision; 144.9512; 144A.071, subdivision 4c; 144D.03, subdivision 1; 144E.101, subdivision 6; 144E.127; 144E.35, subdivision 1; 145A.17; 145C.05; 145C.07, by adding a subdivision; 148.235, by adding a subdivision; 148.6445, subdivisions 1, 2; 148B.53, subdivision 3; 149A.52, subdivision 3; 149A.97, subdivision 7; 151.37, subdivision 2; 152.11, by adding a subdivision; 156.001, by adding a subdivision; 156.02, subdivisions 1, 2; 156.04; 156.072, subdivision 2; 156.073; 156.12, subdivisions 2, 4, 6; 156.15, subdivision 2; 156.16, subdivisions 3, 10; 156.18, subdivisions 1, 2; 156.19; 157.16, subdivision 1; 179A.03, subdivision 7; 198.075; 245.462, subdivision 20; 245.465, by adding a subdivision; 245.4874; 245.50, subdivision 5; 245.98, subdivisions 2, 5; 245A.035; 245A.10, subdivision

2.1 2; 245A.16, subdivisions 1, 3; 245C.02, by adding a subdivision; 245C.04,
2.2 subdivision 1; 245C.05, subdivisions 1, 4, 5, 7, by adding a subdivision; 245C.08,
2.3 subdivisions 1, 2; 245C.10, by adding a subdivision; 245C.11, subdivisions 1, 2;
2.4 245C.12; 245C.16, subdivision 1; 245C.17, by adding a subdivision; 245C.21, by
2.5 adding a subdivision; 245C.23, subdivision 2; 245C.24, subdivision 2; 246.54,
2.6 subdivision 1; 252.27, subdivision 2a; 252.32, subdivision 3; 252.46, by adding
2.7 a subdivision; 253B.185, subdivision 2; 254A.03, subdivision 3; 254A.16,
2.8 subdivision 2; 254B.02, subdivisions 1, 5; 254B.03, subdivisions 1, 3; 254B.06,
2.9 subdivision 3; 256.01, subdivisions 2, 2b, 4, 18, by adding subdivisions;
2.10 256.015, subdivision 7; 256.017, subdivisions 1, 9; 256.0471, subdivision 1;
2.11 256.476, subdivisions 1, 2, 3, 4, 5, 10; 256.969, subdivisions 3a, 9, by adding
2.12 a subdivision; 256.974; 256.9741, subdivisions 1, 3; 256.9742, subdivisions 3,
2.13 4, 6; 256.9744, subdivision 1; 256.975, subdivision 7; 256.984, subdivision 1;
2.14 256B.04, subdivision 14, by adding a subdivision; 256B.056, subdivisions 1a, 3,
2.15 5c, by adding a subdivision; 256B.057, subdivision 8; 256B.0621, subdivision
2.16 11; 256B.0625, subdivisions 3f, 13c, 13d, 14, 17, 18a, 20, 23, 47, by adding
2.17 subdivisions; 256B.0644; 256B.0911, subdivisions 3a, 3b, 4b, 4c, 6, 7, by
2.18 adding subdivisions; 256B.0913, subdivisions 4, 5, 5a, 8, 9, 10, 11, 12, 13, 14;
2.19 256B.0915; 256B.0917, subdivision 8; 256B.0919, subdivision 3; 256B.0943,
2.20 subdivisions 6, 9, 11, 12; 256B.0945, subdivision 4; 256B.095; 256B.0951,
2.21 subdivision 1; 256B.199; 256B.431, subdivisions 1, 2e, 3f, 17e; 256B.434,
2.22 subdivision 4, by adding subdivisions; 256B.437, by adding a subdivision;
2.23 256B.438, subdivision 3; 256B.439, subdivision 1; 256B.441, subdivisions 1, 2,
2.24 5, 6, 10, 11, 13, 14, 17, 20, 24, 30, 31, 34, 38, by adding subdivisions; 256B.49,
2.25 subdivision 11, by adding a subdivision; 256B.5012, by adding a subdivision;
2.26 256B.69, subdivisions 5g, 5h, 23, 28; 256B.75; 256B.76; 256B.763; 256D.03,
2.27 subdivision 4; 256D.44, subdivisions 2, 5; 256E.35, subdivision 2; 256I.04,
2.28 subdivision 3; 256I.05, by adding subdivisions; 256J.01, by adding a subdivision;
2.29 256J.02, subdivisions 1, 4; 256J.021; 256J.08, subdivision 65; 256J.21,
2.30 subdivision 2; 256J.24, subdivision 10; 256J.42, subdivision 1; 256J.425,
2.31 subdivisions 3, 4; 256J.46, by adding a subdivision; 256J.49, subdivision 13;
2.32 256J.521, subdivisions 1, 2, by adding a subdivision; 256J.53, subdivision
2.33 2; 256J.55, subdivision 1; 256J.626, subdivisions 1, 2, 3, 4, 5, 6; 256J.751,
2.34 subdivisions 2, 5; 256J.95, subdivisions 3, 13; 256K.45, by adding a subdivision;
2.35 256L.01, subdivision 4; 256L.03, subdivisions 1, 5; 256L.035; 256L.04,
2.36 subdivisions 1, 12; 256L.11, subdivision 7; 256L.12, subdivision 9a; 259.20,
2.37 subdivision 2; 259.24, subdivision 3; 259.29, subdivision 1; 259.41; 259.53,
2.38 subdivisions 1, 2; 259.57, subdivisions 1, 2; 259.67, subdivisions 4, 7; 259.75,
2.39 subdivision 8; 260.012; 260.755, subdivisions 12, 20; 260.761, subdivision 7;
2.40 260.765, subdivision 5; 260.771, subdivisions 1, 2; 260B.157, subdivision 1;
2.41 260C.152, subdivision 5; 260C.163, subdivision 1; 260C.201, subdivision 11;
2.42 260C.209; 260C.212, subdivisions 1, 2, 4, 9; 260C.317, subdivision 3; 260C.331,
2.43 subdivision 1; 270B.14, subdivision 1; 609.115, subdivision 9; 626.556,
2.44 subdivisions 2, 3, 10, 10a, 10c, 10f, by adding subdivisions; Laws 2000, chapter
2.45 340, section 19; Laws 2005, chapter 98, article 3, section 25; Laws 2005, First
2.46 Special Session chapter 4, article 9, section 3, subdivision 2; Laws 2006, chapter
2.47 282, article 20, section 37; proposing coding for new law in Minnesota Statutes,
2.48 chapters 16A; 62A; 62J; 62Q; 144; 145; 148; 149A; 152; 156; 245A; 245C;
2.49 254A; 256B; 256C; 256D; 256F; 256J; 260; 325E; proposing coding for new
2.50 law as Minnesota Statutes, chapters 256N; 525A; repealing Minnesota Statutes
2.51 2006, sections 62J.052, subdivision 1; 62J.17, subdivisions 1, 5a, 6a, 8; 119B.08,
2.52 subdivision 4; 144.335; 252.21; 252.22; 252.23; 252.24; 252.25; 252.261;
2.53 252.275, subdivision 5; 254A.02, subdivisions 7, 9, 12, 14, 15, 16; 254A.085;
2.54 254A.086; 254A.12; 254A.14; 254A.15; 254A.16, subdivision 5; 254A.175;
2.55 254A.18; 256.969, subdivision 27; 256.9743; 256B.0913, subdivisions 5b, 5c,
2.56 5d, 5e, 5f, 5g, 5h; 256B.441, subdivisions 12, 16, 21, 26, 28, 42, 45; 256J.29;
2.57 256J.37, subdivisions 3a, 3b; 256J.561, subdivision 1; 256J.62, subdivision 9;
2.58 256J.626, subdivisions 7, 9; 256J.65; 525.921; 525.9211; 525.9212; 525.9213;

3.1 525.9214; 525.9215; 525.9216; 525.9217; 525.9218; 525.9219; 525.9221;
3.2 525.9222; 525.9223; 525.9224; Laws 1997, chapter 8, section 1; Laws 2004,
3.3 chapter 288, article 6, section 27; Minnesota Rules, parts 4610.2800; 9503.0035,
3.4 subpart 2; 9560.0102, subpart 2, item C; 9585.0030.

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

3.6 **ARTICLE 1**
3.7 **CHILDREN AND FAMILY**

3.8 Section 1. Minnesota Statutes 2006, section 13.46, subdivision 2, is amended to read:

3.9 Subd. 2. **General.** (a) Unless the data is summary data or a statute specifically
3.10 provides a different classification, data on individuals collected, maintained, used, or
3.11 disseminated by the welfare system is private data on individuals, and shall not be
3.12 disclosed except:

3.13 (1) according to section 13.05;

3.14 (2) according to court order;

3.15 (3) according to a statute specifically authorizing access to the private data;

3.16 (4) to an agent of the welfare system, including a law enforcement person, attorney,
3.17 or investigator acting for it in the investigation or prosecution of a criminal or civil
3.18 proceeding relating to the administration of a program;

3.19 (5) to personnel of the welfare system who require the data to verify an individual's
3.20 identity; determine eligibility, amount of assistance, and the need to provide services to
3.21 an individual or family across programs; evaluate the effectiveness of programs; and
3.22 investigate suspected fraud;

3.23 (6) to administer federal funds or programs;

3.24 (7) between personnel of the welfare system working in the same program;

3.25 (8) to the Department of Revenue to administer and evaluate tax refund or tax credit
3.26 programs and to identify individuals who may benefit from these programs. The following
3.27 information may be disclosed under this paragraph: an individual's and their dependent's
3.28 names, dates of birth, Social Security numbers, income, addresses, and other data as
3.29 required, upon request by the Department of Revenue. Disclosures by the commissioner
3.30 of revenue to the commissioner of human services for the purposes described in this clause
3.31 are governed by section 270B.14, subdivision 1. Tax refund or tax credit programs include,
3.32 but are not limited to, the dependent care credit under section 290.067, the Minnesota
3.33 working family credit under section 290.0671, the property tax refund and rental credit
3.34 under section 290A.04, and the Minnesota education credit under section 290.0674;

3.35 (9) between the Department of Human Services, the Department of Education, and
3.36 the Department of Employment and Economic Development for the purpose of monitoring

the eligibility of the data subject for unemployment benefits, for any employment or training program administered, supervised, or certified by that agency, for the purpose of administering any rehabilitation program or child care assistance program, whether alone or in conjunction with the welfare system, or to monitor and evaluate the Minnesota family investment program or the child care assistance program by exchanging data on recipients and former recipients of food support, cash assistance under chapter 256, 256D, 256J, or 256K, child care assistance under chapter 119B, or medical programs under chapter 256B, 256D, or 256L;

(10) to appropriate parties in connection with an emergency if knowledge of the information is necessary to protect the health or safety of the individual or other individuals or persons;

(11) data maintained by residential programs as defined in section 245A.02 may be disclosed to the protection and advocacy system established in this state according to Part C of Public Law 98-527 to protect the legal and human rights of persons with developmental disabilities or other related conditions who live in residential facilities for these persons if the protection and advocacy system receives a complaint by or on behalf of that person and the person does not have a legal guardian or the state or a designee of the state is the legal guardian of the person;

(12) to the county medical examiner or the county coroner for identifying or locating relatives or friends of a deceased person;

(13) data on a child support obligor who makes payments to the public agency may be disclosed to the Minnesota Office of Higher Education to the extent necessary to determine eligibility under section 136A.121, subdivision 2, clause (5);

(14) participant Social Security numbers and names collected by the telephone assistance program may be disclosed to the Department of Revenue to conduct an electronic data match with the property tax refund database to determine eligibility under section 237.70, subdivision 4a;

(15) the current address of a Minnesota family investment program participant may be disclosed to law enforcement officers who provide the name of the participant and notify the agency that:

(i) the participant:

(A) is a fugitive felon fleeing to avoid prosecution, or custody or confinement after conviction, for a crime or attempt to commit a crime that is a felony under the laws of the jurisdiction from which the individual is fleeing; or

(B) is violating a condition of probation or parole imposed under state or federal law;

(ii) the location or apprehension of the felon is within the law enforcement officer's official duties; and

(iii) the request is made in writing and in the proper exercise of those duties;

(16) the current address of a recipient of general assistance or general assistance medical care may be disclosed to probation officers and corrections agents who are supervising the recipient and to law enforcement officers who are investigating the recipient in connection with a felony level offense;

(17) information obtained from food support applicant or recipient households may be disclosed to local, state, or federal law enforcement officials, upon their written request, for the purpose of investigating an alleged violation of the Food Stamp Act, according to Code of Federal Regulations, title 7, section 272.1(c);

(18) the address, Social Security number, and, if available, photograph of any member of a household receiving food support shall be made available, on request, to a local, state, or federal law enforcement officer if the officer furnishes the agency with the name of the member and notifies the agency that:

(i) the member:

(A) is fleeing to avoid prosecution, or custody or confinement after conviction, for a crime or attempt to commit a crime that is a felony in the jurisdiction the member is fleeing;

(B) is violating a condition of probation or parole imposed under state or federal law; or

(C) has information that is necessary for the officer to conduct an official duty related to conduct described in subitem (A) or (B);

(ii) locating or apprehending the member is within the officer's official duties; and

(iii) the request is made in writing and in the proper exercise of the officer's official duty;

(19) the current address of a recipient of Minnesota family investment program, general assistance, general assistance medical care, or food support may be disclosed to law enforcement officers who, in writing, provide the name of the recipient and notify the agency that the recipient is a person required to register under section 243.166, but is not residing at the address at which the recipient is registered under section 243.166;

(20) certain information regarding child support obligors who are in arrears may be made public according to section 518A.74;

(21) data on child support payments made by a child support obligor and data on the distribution of those payments excluding identifying information on obligees may be disclosed to all obligees to whom the obligor owes support, and data on the enforcement

actions undertaken by the public authority, the status of those actions, and data on the income of the obligor or obligee may be disclosed to the other party;

(22) data in the work reporting system may be disclosed under section 256.998, subdivision 7;

(23) to the Department of Education for the purpose of matching Department of Education student data with public assistance data to determine students eligible for free and reduced price meals, meal supplements, and free milk according to United States Code, title 42, sections 1758, 1761, 1766, 1766a, 1772, and 1773; to allocate federal and state funds that are distributed based on income of the student's family; and to verify receipt of energy assistance for the telephone assistance plan;

(24) the current address and telephone number of program recipients and emergency contacts may be released to the commissioner of health or a local board of health as defined in section 145A.02, subdivision 2, when the commissioner or local board of health has reason to believe that a program recipient is a disease case, carrier, suspect case, or at risk of illness, and the data are necessary to locate the person;

(25) to other state agencies, statewide systems, and political subdivisions of this state, including the attorney general, and agencies of other states, interstate information networks, federal agencies, and other entities as required by federal regulation or law for the administration of the child support enforcement program;

(26) to personnel of public assistance programs as defined in section 256.741, for access to the child support system database for the purpose of administration, including monitoring and evaluation of those public assistance programs;

(27) to monitor and evaluate the Minnesota family investment program by exchanging data between the Departments of Human Services and Education, on recipients and former recipients of food support, cash assistance under chapter 256, 256D, 256J, or 256K, child care assistance under chapter 119B, or medical programs under chapter 256B, 256D, or 256L;

(28) to evaluate child support program performance and to identify and prevent fraud in the child support program by exchanging data between the Department of Human Services, Department of Revenue under section 270B.14, subdivision 1, paragraphs (a) and (b), without regard to the limitation of use in paragraph (c), Department of Health, Department of Employment and Economic Development, and other state agencies as is reasonably necessary to perform these functions; or

(29) counties operating child care assistance programs under chapter 119B may disseminate data on program participants, applicants, and providers to the commissioner of education.

(b) Information on persons who have been treated for drug or alcohol abuse may only be disclosed according to the requirements of Code of Federal Regulations, title 42, sections 2.1 to 2.67.

(c) Data provided to law enforcement agencies under paragraph (a), clause (15), (16), (17), or (18), or paragraph (b), are investigative data and are confidential or protected nonpublic while the investigation is active. The data are private after the investigation becomes inactive under section 13.82, subdivision 5, paragraph (a) or (b).

(d) Mental health data shall be treated as provided in subdivisions 7, 8, and 9, but is not subject to the access provisions of subdivision 10, paragraph (b).

For the purposes of this subdivision, a request will be deemed to be made in writing if made through a computer interface system.

Sec. 2. Minnesota Statutes 2006, section 16D.13, subdivision 3, is amended to read:

Subd. 3. **Exclusion.** A state agency may not charge interest under this section on overpayments of assistance benefits under the programs formerly codified in sections 256.031 to 256.0361, 256.72 to 256.87, and under chapters 119B, 256D, and 256I, or the federal food stamp program. Notwithstanding this prohibition, any debts that have been reduced to judgment under these programs are subject to the interest charges provided under section 549.09.

Sec. 3. Minnesota Statutes 2006, section 119B.05, subdivision 1, is amended to read:

Subdivision 1. **Eligible participants.** Families eligible for child care assistance under the MFIP child care program are:

(1) MFIP participants who are employed or in job search and meet the requirements of section 119B.10;

(2) persons who are members of transition year families under section 119B.011, subdivision 20, and meet the requirements of section 119B.10;

(3) families who are participating in employment orientation or job search, or other employment or training activities that are included in an approved employability development plan under ~~section~~ sections 256J.09 and 256J.95;

(4) MFIP families who are participating in work job search, job support, employment, or training activities as required in their employment plan, or in appeals, hearings, assessments, or orientations according to chapter 256J;

(5) MFIP families who are participating in social services activities under chapter 256J as required in their employment plan approved according to chapter 256J;

(6) families who are participating in programs as required in tribal contracts under section 119B.02, subdivision 2, or 256.01, subdivision 2; and

(7) families who are participating in the transition year extension under section 119B.011, subdivision 20a.

Sec. 4. Minnesota Statutes 2006, section 119B.09, subdivision 1, is amended to read:

Subdivision 1. **General Eligibility requirements for all applicants for child care assistance.** (a) Child care services must be available to families who need child care to find or keep employment or to obtain the training or education necessary to find employment and who:

(1) have household income less than or equal to 250 percent of the federal poverty guidelines, adjusted for family size, and meet the requirements of section 119B.05; ~~receive MFHP assistance; and are participating in employment and training services under chapter 256J or 256K; or~~

(2) have household income less than or equal to 175 percent of the federal poverty guidelines, adjusted for family size, at program entry and less than 250 percent of the federal poverty guidelines, adjusted for family size, at program exit; or

(3) have household income less than or equal to 250 percent of the federal poverty guidelines, adjusted for family size, and were a family whose child care assistance was terminated due to insufficient funds under Minnesota Rules, part 3400.0183.

(b) Child care services must be made available as in-kind services.

(c) All applicants for child care assistance and families currently receiving child care assistance must be assisted and required to cooperate in establishment of paternity and enforcement of child support obligations for all children in the family as a condition of program eligibility. For purposes of this section, a family is considered to meet the requirement for cooperation when the family complies with the requirements of section 256.741.

EFFECTIVE DATE. This section is effective July 1, 2008.

Sec. 5. Minnesota Statutes 2006, section 119B.09, subdivision 7, is amended to read:

Subd. 7. **Date of eligibility for assistance.** (a) The date of eligibility for child care assistance under this chapter is the later of the date the application was signed; the beginning date of employment, education, or training; the date the infant is born for applicants to the at-home infant care program; or the date a determination has been made that the applicant is a participant in employment and training services under Minnesota Rules, part 3400.0080, ~~subpart 2a,~~ or chapter 256J.

(b) Payment ceases for a family under the at-home infant child care program when a family has used a total of 12 months of assistance as specified under section 119B.035. Payment of child care assistance for employed persons on MFIP is effective the date of employment or the date of MFIP eligibility, whichever is later. Payment of child care assistance for MFIP or DWP participants in employment and training services is effective the date of commencement of the services or the date of MFIP or DWP eligibility, whichever is later. Payment of child care assistance for transition year child care must be made retroactive to the date of eligibility for transition year child care.

(c) Notwithstanding paragraph (b), payment of child care assistance for participants eligible under section 119B.05, may only be made retroactively for a maximum of six months from the date of application for child care assistance.

EFFECTIVE DATE. This section is effective July 1, 2008.

Sec. 6. Minnesota Statutes 2006, section 119B.09, is amended by adding a subdivision to read:

Subd. 11. **Payment of other child care expenses.** Payment by a source other than the family, of part or all of a family's child care expenses not payable under this chapter, does not affect the family's eligibility for child care assistance, and the amount paid is excluded from the family's income, if the funds are paid directly to the family's child care provider on behalf of the family. Child care providers who accept third-party payments must maintain family-specific documentation of payment source, amount, type of expenses, and time period covered by the payment.

Sec. 7. Minnesota Statutes 2006, section 119B.09, is amended by adding a subdivision to read:

Subd. 12. **Sliding fee.** Child care services to families must be made available on a sliding fee basis.

The commissioner shall convert eligibility requirements in section 119B.09 and parent fee schedules in 119B.12 to state median income, based on a family size of three, adjusted for family size, by July 1, 2008. The commissioner shall report to the 2008 legislature with the necessary statutory changes to codify this conversion to state median income.

Sec. 8. Minnesota Statutes 2006, section 119B.12, is amended to read:

119B.12 SLIDING FEE SCALE.

Subdivision 1. **Fee schedule.** In setting the sliding fee schedule, the commissioner shall exclude from the amount of income used to determine eligibility an amount for federal and state income and Social Security taxes attributable to that income level according to federal and state standardized tax tables. The commissioner shall base the parent fee on the ability of the family to pay for child care. The fee schedule must be designed to use any available tax credits.

PARENT FEE SCHEDULE. The parent fee schedule is as follows:

<u>Income Range (as a percent of the federal poverty guidelines)</u>	<u>Co-payment (as a percentage of adjusted gross income)</u>
<u>0-74.99%</u>	<u>\$0/month</u>
<u>75.00-99.99%</u>	<u>\$5/month</u>
<u>100.00-104.99%</u>	<u>2.61%</u>
<u>105.00-109.99%</u>	<u>2.61%</u>
<u>110.00-114.99%</u>	<u>2.61%</u>
<u>115.00-119.99%</u>	<u>2.61%</u>
<u>120.00-124.99%</u>	<u>2.91%</u>
<u>125.00-129.99%</u>	<u>2.91%</u>
<u>130.00-134.99%</u>	<u>2.91%</u>
<u>135.00-139.99%</u>	<u>2.91%</u>
<u>140.00-144.99%</u>	<u>3.21%</u>
<u>145.00-149.99%</u>	<u>3.21%</u>
<u>150.00-154.99%</u>	<u>3.21%</u>
<u>155.00-159.99%</u>	<u>3.84%</u>
<u>160.00-164.99%</u>	<u>3.84%</u>
<u>165.00-169.99%</u>	<u>4.46%</u>
<u>170.00-174.99%</u>	<u>4.76%</u>
<u>175.00-179.99%</u>	<u>5.05%</u>
<u>180.00-184.99%</u>	<u>5.65%</u>
<u>185.00-189.99%</u>	<u>5.95%</u>
<u>190.00-194.99%</u>	<u>6.24%</u>
<u>195.00-199.99%</u>	<u>6.84%</u>
<u>200.00-204.99%</u>	<u>7.58%</u>
<u>205.00-209.99%</u>	<u>8.33%</u>
<u>210.00-214.99%</u>	<u>9.20%</u>
<u>215.00-219.99%</u>	<u>10.07%</u>
<u>220.00-224.99%</u>	<u>10.94%</u>
<u>225.00-229.99%</u>	<u>11.55%</u>
<u>230.00-234.99%</u>	<u>12.16%</u>
<u>235.00-239.99%</u>	<u>12.77%</u>
<u>240.00-244.99%</u>	<u>13.38%</u>
<u>245.00-249.99%</u>	<u>14.00%</u>
<u>250%</u>	<u>ineligible</u>

A family's monthly co-payment fee is the fixed percentage established for the income range multiplied by the highest possible income within that income range.

Subd. 2. **Parent fee.** A family must be assessed a parent fee for each service period. A family's parent fee must be a fixed percentage of its annual gross income. Parent fees must apply to families eligible for child care assistance under sections 119B.03 and 119B.05. Income must be as defined in section 119B.011, subdivision 15. The fixed percent is based on the relationship of the family's annual gross income to 100 percent of the annual federal poverty guidelines. Parent fees must begin at 75 percent of the poverty level. The minimum parent fees for families between 75 percent and 100 percent of poverty level must be ~~\$10~~ \$5 per month. Parent fees must provide for graduated movement to full payment. Payment of part or all of a family's parent fee directly to the family's child care provider on behalf of the family by a source other than the family shall not affect the family's eligibility for child care assistance, and the amount paid shall be excluded from the family's income. Child care providers who accept third-party payments must maintain family specific documentation of payment source, amount, and time period covered by the payment.

EFFECTIVE DATE. (a) This section is effective July 1, 2007.

(b) Effective July 1, 2008, the parent fee scale for families with incomes greater than or equal to 100 percent of FPG shall be converted to state median income for a family size of three, adjusted for family size, as directed in section 119B.09, subdivision 12.

Sec. 9. Minnesota Statutes 2006, section 119B.125, subdivision 2, is amended to read:

Subd. 2. **Persons who cannot be authorized.** (a) A person who meets any of the conditions under paragraphs (b) to (n) must not be authorized as a legal nonlicensed family child care provider. To determine whether any of the listed conditions exist, the county must request information about the provider from the Bureau of Criminal Apprehension, the juvenile courts, and social service agencies. When one of the listed entities does not maintain information on a statewide basis, the county must contact the entity in the county where the provider resides and any other county in which the provider previously resided in the past year. For purposes of this subdivision, a finding that a delinquency petition is proven in juvenile court must be considered a conviction in state district court. If a county has determined that a provider is able to be authorized in that county, and a family in another county later selects that provider, the provider is able to be authorized in the second county without undergoing a new background investigation unless one of the following conditions exists:

(1) two years have passed since the first authorization;

(2) another person age 13 or older has joined the provider's household since the last authorization;

(3) a current household member has turned 13 since the last authorization; or

(4) there is reason to believe that a household member has a factor that prevents authorization.

(b) The person has been convicted of one of the following offenses or has admitted to committing or a preponderance of the evidence indicates that the person has committed an act that meets the definition of one of the following offenses: sections 609.185 to 609.195, murder in the first, second, or third degree; 609.2661 to 609.2663, murder of an unborn child in the first, second, or third degree; 609.322, solicitation, inducement, promotion of prostitution, or receiving profit from prostitution; 609.342 to 609.345, criminal sexual conduct in the first, second, third, or fourth degree; 609.352, solicitation of children to engage in sexual conduct; 609.365, incest; 609.377, felony malicious punishment of a child; 617.246, use of minors in sexual performance; 617.247, possession of pictorial representation of a minor; 609.2242 to 609.2243, felony domestic assault; a felony offense of spousal abuse; a felony offense of child abuse or neglect; a felony offense of a crime against children; or an attempt or conspiracy to commit any of these offenses as defined in Minnesota Statutes; or an offense in any other state or country where the elements are substantially similar to any of the offenses listed in this paragraph.

(c) Less than 15 years have passed since the discharge of the sentence imposed for the offense and the person has received a felony conviction for one of the following offenses, or the person has admitted to committing or a preponderance of the evidence indicates that the person has committed an act that meets the definition of a felony conviction for one of the following offenses: sections 609.20 to 609.205, manslaughter in the first or second degree; 609.21, criminal vehicular homicide; 609.215, aiding suicide or aiding attempted suicide; 609.221 to 609.2231, assault in the first, second, third, or fourth degree; 609.224, repeat offenses of fifth degree assault; 609.228, great bodily harm caused by distribution of drugs; 609.2325, criminal abuse of a vulnerable adult; 609.2335, financial exploitation of a vulnerable adult; 609.235, use of drugs to injure or facilitate a crime; 609.24, simple robbery; 617.241, repeat offenses of obscene materials and performances; 609.245, aggravated robbery; 609.25, kidnapping; 609.255, false imprisonment; 609.2664 to 609.2665, manslaughter of an unborn child in the first or second degree; 609.267 to 609.2672, assault of an unborn child in the first, second, or third degree; 609.268, injury or death of an unborn child in the commission of a crime; 609.27, coercion; 609.275, attempt to coerce; 609.324, subdivision 1, other prohibited acts, minor engaged in prostitution; 609.3451, repeat offenses of criminal sexual conduct in the fifth

13.1 degree; 609.378, neglect or endangerment of a child; 609.52, theft; 609.521, possession of
13.2 shoplifting gear; 609.561 to 609.563, arson in the first, second, or third degree; 609.582,
13.3 burglary in the first, second, third, or fourth degree; 609.625, aggravated forgery; 609.63,
13.4 forgery; 609.631, check forgery, offering a forged check; 609.635, obtaining signature
13.5 by false pretenses; 609.66, dangerous weapon; 609.665, setting a spring gun; 609.67,
13.6 unlawfully owning, possessing, or operating a machine gun; 609.687, adulteration; 609.71,
13.7 riot; 609.713, terrorist threats; 609.749, harassment, stalking; 260C.301, termination of
13.8 parental rights; 152.021 to 152.022 and 152.0262, controlled substance crime in the first
13.9 or second degree; 152.023, subdivision 1, clause (3) or (4), or 152.023, subdivision 2,
13.10 clause (4), controlled substance crime in third degree; 152.024, subdivision 1, clause
13.11 (2), (3), or (4), controlled substance crime in fourth degree; 617.23, repeat offenses of
13.12 indecent exposure; an attempt or conspiracy to commit any of these offenses as defined in
13.13 Minnesota Statutes; or an offense in any other state or country where the elements are
13.14 substantially similar to any of the offenses listed in this paragraph.

13.15 (d) Less than ten years have passed since the discharge of the sentence imposed for
13.16 the offense and the person has received a gross misdemeanor conviction for one of the
13.17 following offenses or the person has admitted to committing or a preponderance of the
13.18 evidence indicates that the person has committed an act that meets the definition of a gross
13.19 misdemeanor conviction for one of the following offenses: sections 609.224, fifth degree
13.20 assault; 609.2242 to 609.2243, domestic assault; 518B.01, subdivision 14, violation of
13.21 an order for protection; 609.3451, fifth degree criminal sexual conduct; 609.746, repeat
13.22 offenses of interference with privacy; 617.23, repeat offenses of indecent exposure;
13.23 617.241, obscene materials and performances; 617.243, indecent literature, distribution;
13.24 617.293, disseminating or displaying harmful material to minors; 609.71, riot; 609.66,
13.25 dangerous weapons; 609.749, harassment, stalking; 609.224, subdivision 2, paragraph
13.26 (c), fifth degree assault against a vulnerable adult by a caregiver; 609.23, mistreatment
13.27 of persons confined; 609.231, mistreatment of residents or patients; 609.2325, criminal
13.28 abuse of a vulnerable adult; 609.2335, financial exploitation of a vulnerable adult;
13.29 609.233, criminal neglect of a vulnerable adult; 609.234, failure to report maltreatment of
13.30 a vulnerable adult; 609.72, subdivision 3, disorderly conduct against a vulnerable adult;
13.31 609.265, abduction; 609.378, neglect or endangerment of a child; 609.377, malicious
13.32 punishment of a child; 609.324, subdivision 1a, other prohibited acts, minor engaged
13.33 in prostitution; 609.33, disorderly house; 609.52, theft; 609.582, burglary in the first,
13.34 second, third, or fourth degree; 609.631, check forgery, offering a forged check; 609.275,
13.35 attempt to coerce; an attempt or conspiracy to commit any of these offenses as defined in

14.1 Minnesota Statutes; or an offense in any other state or country where the elements are
14.2 substantially similar to any of the offenses listed in this paragraph.

14.3 (e) Less than seven years have passed since the discharge of the sentence imposed
14.4 for the offense and the person has received a misdemeanor conviction for one of the
14.5 following offenses or the person has admitted to committing or a preponderance of
14.6 the evidence indicates that the person has committed an act that meets the definition
14.7 of a misdemeanor conviction for one of the following offenses: sections 609.224, fifth
14.8 degree assault; 609.2242, domestic assault; 518B.01, violation of an order for protection;
14.9 609.3232, violation of an order for protection; 609.746, interference with privacy; 609.79,
14.10 obscene or harassing telephone calls; 609.795, letter, telegram, or package opening,
14.11 harassment; 617.23, indecent exposure; 609.2672, assault of an unborn child, third degree;
14.12 617.293, dissemination and display of harmful materials to minors; 609.66, dangerous
14.13 weapons; 609.665, spring guns; an attempt or conspiracy to commit any of these offenses
14.14 as defined in Minnesota Statutes; or an offense in any other state or country where the
14.15 elements are substantially similar to any of the offenses listed in this paragraph.

14.16 (f) The person has been identified by the child protection agency in the county where
14.17 the provider resides or a county where the provider has resided or by the statewide child
14.18 protection database as a person found by a preponderance of evidence under section
14.19 626.556 to be responsible for physical or sexual abuse of a child within the last seven years.

14.20 (g) The person has been identified by the adult protection agency in the county
14.21 where the provider resides or a county where the provider has resided or by the statewide
14.22 adult protection database as the person responsible for abuse or neglect of a vulnerable
14.23 adult within the last seven years.

14.24 (h) The person has refused to give written consent for disclosure of criminal history
14.25 records.

14.26 (i) The person has been denied a family child care license or has received a fine or a
14.27 sanction as a licensed child care provider that has not been reversed on appeal.

14.28 (j) The person has a family child care licensing disqualification that has not been
14.29 set aside.

14.30 (k) The person has admitted or a county has found that there is a preponderance of
14.31 evidence that fraudulent information was given to the county for child care assistance
14.32 application purposes or was used in submitting child care assistance bills for payment.

14.33 (l) The person has been convicted of the crime of theft by wrongfully obtaining
14.34 public assistance or has been found guilty of wrongfully obtaining public assistance by a
14.35 federal court, state court, or an administrative hearing determination or waiver, through a

15.1 disqualification consent agreement, as part of an approved diversion plan under section
15.2 401.065, or a court-ordered stay with probationary or other conditions.

15.3 (m) The person has a household member age 13 or older who has access to children
15.4 during the hours that care is provided and who meets one of the conditions listed in
15.5 paragraphs (b) to (l).

15.6 (n) The person has a household member ages ten to 12 who has access to children
15.7 during the hours that care is provided; information or circumstances exist which provide
15.8 the county with articulable suspicion that further pertinent information may exist showing
15.9 the household member meets one of the conditions listed in paragraphs (b) to (l); and the
15.10 household member actually meets one of the conditions listed in paragraphs (b) to (l).

15.11 Sec. 10. Minnesota Statutes 2006, section 119B.13, subdivision 1, is amended to read:

15.12 Subdivision 1. **Subsidy restrictions.** (a) Beginning July 1, ~~2006~~ 2007, the
15.13 maximum rate paid for child care assistance in any county or multicounty region under the
15.14 child care fund shall be the rate for like-care arrangements in the county effective ~~January~~
15.15 July 1, 2006, increased by ~~six~~ two percent.

15.16 (b) Rate changes shall be implemented for services provided in September ~~2006~~
15.17 2007 unless a participant eligibility redetermination or a new provider agreement is
15.18 completed between July 1, ~~2006~~ 2007, and August 31, ~~2006~~ 2007.

15.19 As necessary, appropriate notice of adverse action must be made according to
15.20 Minnesota Rules, part 3400.0185, subparts 3 and 4.

15.21 New cases approved on or after July 1, ~~2006~~ 2007, shall have the maximum rates
15.22 under paragraph (a), implemented immediately.

15.23 (c) Not less than ~~once~~ every ~~two years~~ year, the commissioner shall survey rates
15.24 charged by child care providers in Minnesota to determine the 75th percentile for
15.25 like-care arrangements in counties. When the commissioner determines that, using the
15.26 commissioner's established protocol, the number of providers responding to the survey is
15.27 too small to determine the 75th percentile rate for like-care arrangements in a county or
15.28 multicounty region, the commissioner may establish the 75th percentile maximum rate
15.29 based on like-care arrangements in a county, region, or category that the commissioner
15.30 deems to be similar.

15.31 (d) A rate which includes a special needs rate paid under subdivision 3 or under
15.32 a school readiness service agreement paid under section 30 may be in excess of the
15.33 maximum rate allowed under this subdivision.

15.34 (e) The department shall monitor the effect of this paragraph on provider rates. The
15.35 county shall pay the provider's full charges for every child in care up to the maximum

established. The commissioner shall determine the maximum rate for each type of care on an hourly, full-day, and weekly basis, including special needs and disability care. The half-day rates are effective beginning July 1, 2008.

(f) When the provider charge is greater than the maximum provider rate allowed, the parent is responsible for payment of the difference in the rates in addition to any family co-payment fee.

(g) All maximum provider rate changes shall be implemented on the Monday following the effective date of the maximum provider rate.

Sec. 11. Minnesota Statutes 2006, section 119B.13, subdivision 3a, is amended to read:

Subd. 3a. **Provider rate differential for accreditation.** A family child care provider or child care center shall be paid a 15 percent differential above the maximum rate established in subdivision 1, up to the actual provider rate, if the provider or center holds a current early childhood development credential or is accredited. For a family child care provider, early childhood development credential and accreditation includes an individual who has earned a child development associate degree, a child development associate credential, a diploma in child development from a Minnesota state technical college, or a bachelor's or post baccalaureate degree in early childhood education from an accredited college or university, or who is accredited by the National Association for Family Child Care or the Competency Based Training and Assessment Program. For a child care center, accreditation includes accreditation by the National Association for the Education of Young Children, the Council on Accreditation, the National Early Childhood Program Accreditation, the National School-Age Care Association, or the National Head Start Association Program of Excellence. For Montessori programs, accreditation includes the American Montessori Society, Association of Montessori International-USA, or the National Center for Montessori Education.

Sec. 12. Minnesota Statutes 2006, section 119B.13, subdivision 6, is amended to read:

Subd. 6. **Provider payments.** (a) Counties or the state shall make vendor payments to the child care provider or pay the parent directly for eligible child care expenses.

(b) If payments for child care assistance are made to providers, the provider shall bill the county for services provided within ten days of the end of the service period. If bills are submitted within ten days of the end of the service period, a county or the state shall issue payment to the provider of child care under the child care fund within 30 days of receiving a bill from the provider. Counties or the state may establish policies that make payments on a more frequent basis.

(c) ~~All bills~~ If a provider has received an authorization of care and has been issued a billing form for an eligible family, the bill must be submitted within 60 days of the last date of service on the bill. A county may pay a bill submitted more than 60 days after the last date of service if the provider shows good cause why the bill was not submitted within 60 days. Good cause must be defined in the county's child care fund plan under section 119B.08, subdivision 3, and the definition of good cause must include county error. A county may not pay any bill submitted more than a year after the last date of service on the bill.

(d) If a provider provided care for a time period without receiving an authorization of care and a billing form for an eligible family, payment of child care assistance may only be made retroactively for a maximum of six months from the date the provider is issued an authorization of care and a billing form.

~~(d)~~ (e) A county may stop payment issued to a provider or may refuse to pay a bill submitted by a provider if:

(1) the provider admits to intentionally giving the county materially false information on the provider's billing forms; or

(2) a county finds by a preponderance of the evidence that the provider intentionally gave the county materially false information on the provider's billing forms.

~~(e)~~ (f) A county's payment policies must be included in the county's child care plan under section 119B.08, subdivision 3. If payments are made by the state, in addition to being in compliance with this subdivision, the payments must be made in compliance with section 16A.124.

Sec. 13. Minnesota Statutes 2006, section 119B.13, subdivision 7, is amended to read:

Subd. 7. **Absent days.** (a) Child care providers may not be reimbursed for more than 25 full-day absent days per child, excluding holidays, in a fiscal year, or for more than ten consecutive full-day absent days, unless the child has a documented medical condition that causes more frequent absences. Absences due to a documented medical condition of a parent or sibling who lives in the same residence as the child receiving child care assistance do not count against the 25-day absent day limit in a fiscal year. Documentation of medical conditions must be on the forms and submitted according to the timelines established by the commissioner. A public health nurse or school nurse may verify the illness in lieu of a medical practitioner. If a provider sends a child home early due to a medical reason including, but not limited to, fever or contagious illness, the child care center director or lead teacher may verify the illness in lieu of a medical practitioner. If a child attends for part of the time authorized to be in care in a day, but is

absent for part of the time authorized to be in care in that same day, the absent time will be reimbursed but the time will not count toward the ten consecutive or 25 cumulative absent day limits. Children in families where at least one parent is under the age of 21, does not have a high school or general education development (GED) diploma, and is a student in a school district or another similar program that provides or arranges for child care, as well as parenting, social services, career and employment supports, and academic support to achieve high school graduation, may be exempt from the absent day limits upon request of the program and approval of the county. If a child attends part of an authorized day, payment to the provider must be for the full amount of care authorized for that day. Child care providers may only be reimbursed for absent days if the provider has a written policy for child absences and charges all other families in care for similar absences.

(b) Child care providers must be reimbursed for up to ten federal or state holidays or designated holidays per year when the provider charges all families for these days and the holiday or designated holiday falls on a day when the child is authorized to be in attendance. Parents may substitute other cultural or religious holidays for the ten recognized state and federal holidays. Holidays do not count toward the ten consecutive or 25 cumulative absent day limits.

(c) A family or child care provider may not be assessed an overpayment for an absent day payment unless (1) there was an error in the amount of care authorized for the family, (2) all of the allowed full-day absent payments for the child have been paid, or (3) the family or provider did not timely report a change as required under law.

(d) The provider and family must receive notification of the number of absent days used upon initial provider authorization for a family and when the family has used 15 cumulative absent days. Upon statewide implementation of the Minnesota Electronic Child Care System, the provider and family authorization for a family and ongoing notification of the number of absent days used as of the date of the notification.

(e) A county may pay for more absent days than the statewide absent day policy established under this subdivision, if current market practice in the county justifies payment for those additional days. County policies for payment of absent days in excess of the statewide absent day policy and justification for these county policies must be included in the county's child care fund plan under section 119B.08, subdivision 3. This paragraph may be implemented by counties on or after July 1, 2008.

Sec. 14. Minnesota Statutes 2006, section 119B.21, subdivision 5, is amended to read:

Subd. 5. **Child care services grants.** (a) A child care resource and referral program designated under section 119B.19, subdivision 1a, may award child care services grants for:

(1) creating new licensed child care facilities and expanding existing facilities, including, but not limited to, supplies, equipment, facility renovation, and remodeling;

(2) improving licensed child care facility programs;

(3) staff training and development services including, but not limited to, in-service training, curriculum development, accreditation, certification, consulting, resource centers, ~~and~~ program and resource materials, supporting effective teacher-child interactions, child-focused teaching, and content-driven classroom instruction;

(4) interim financing;

(5) capacity building through the purchase of appropriate technology to create, enhance, and maintain business management systems;

(6) emergency assistance for child care programs;

(7) new programs or projects for the creation, expansion, or improvement of programs that serve ethnic immigrant and refugee communities; and

(8) targeted recruitment initiatives to expand and build the capacity of the child care system and to improve the quality of care provided by legal nonlicensed child care providers.

(b) A child care resource and referral program designated under section 119B.19, subdivision 1a, may award child care services grants to:

(1) licensed providers;

(2) providers in the process of being licensed;

(3) corporations or public agencies that develop or provide child care services;

(4) school-age care programs; or

(5) any combination of clauses (1) to (4).

Unlicensed providers are only eligible for grants under paragraph (a), clause (7).

(c) A recipient of a child care services grant for facility improvements, interim financing, or staff training and development must provide a 25 percent local match.

Sec. 15. Minnesota Statutes 2006, section 256.01, subdivision 2, is amended to read:

Subd. 2. **Specific powers.** Subject to the provisions of section 241.021, subdivision 2, the commissioner of human services shall carry out the specific duties in paragraphs (a) through (cc):

(a) Administer and supervise all forms of public assistance provided for by state law and other welfare activities or services as are vested in the commissioner. Administration

and supervision of human services activities or services includes, but is not limited to, assuring timely and accurate distribution of benefits, completeness of service, and quality program management. In addition to administering and supervising human services activities vested by law in the department, the commissioner shall have the authority to:

(1) require county agency participation in training and technical assistance programs to promote compliance with statutes, rules, federal laws, regulations, and policies governing human services;

(2) monitor, on an ongoing basis, the performance of county agencies in the operation and administration of human services, enforce compliance with statutes, rules, federal laws, regulations, and policies governing welfare services and promote excellence of administration and program operation;

(3) develop a quality control program or other monitoring program to review county performance and accuracy of benefit determinations;

(4) require county agencies to make an adjustment to the public assistance benefits issued to any individual consistent with federal law and regulation and state law and rule and to issue or recover benefits as appropriate;

(5) delay or deny payment of all or part of the state and federal share of benefits and administrative reimbursement according to the procedures set forth in section 256.017;

(6) make contracts with and grants to public and private agencies and organizations, both profit and nonprofit, and individuals, using appropriated funds; and

(7) enter into contractual agreements with federally recognized Indian tribes with a reservation in Minnesota to the extent necessary for the tribe to operate a federally approved family assistance program or any other program under the supervision of the commissioner. The commissioner shall consult with the affected county or counties in the contractual agreement negotiations, if the county or counties wish to be included, in order to avoid the duplication of county and tribal assistance program services. The commissioner may establish necessary accounts for the purposes of receiving and disbursing funds as necessary for the operation of the programs.

(b) Inform county agencies, on a timely basis, of changes in statute, rule, federal law, regulation, and policy necessary to county agency administration of the programs.

(c) Administer and supervise all child welfare activities; promote the enforcement of laws protecting disabled, dependent, neglected and delinquent children, and children born to mothers who were not married to the children's fathers at the times of the conception nor at the births of the children; license and supervise child-caring and child-placing agencies and institutions; supervise the care of children in boarding and foster homes or

in private institutions; and generally perform all functions relating to the field of child welfare now vested in the State Board of Control.

(d) Administer and supervise all noninstitutional service to disabled persons, including those who are visually impaired, hearing impaired, or physically impaired or otherwise disabled. The commissioner may provide and contract for the care and treatment of qualified indigent children in facilities other than those located and available at state hospitals when it is not feasible to provide the service in state hospitals.

(e) Assist and actively cooperate with other departments, agencies and institutions, local, state, and federal, by performing services in conformity with the purposes of Laws 1939, chapter 431.

(f) Act as the agent of and cooperate with the federal government in matters of mutual concern relative to and in conformity with the provisions of Laws 1939, chapter 431, including the administration of any federal funds granted to the state to aid in the performance of any functions of the commissioner as specified in Laws 1939, chapter 431, and including the promulgation of rules making uniformly available medical care benefits to all recipients of public assistance, at such times as the federal government increases its participation in assistance expenditures for medical care to recipients of public assistance, the cost thereof to be borne in the same proportion as are grants of aid to said recipients.

(g) Establish and maintain any administrative units reasonably necessary for the performance of administrative functions common to all divisions of the department.

(h) Act as designated guardian of both the estate and the person of all the wards of the state of Minnesota, whether by operation of law or by an order of court, without any further act or proceeding whatever, except as to persons committed as developmentally disabled. For children under the guardianship of the commissioner or a tribe in Minnesota recognized by the Secretary of the Interior whose interests would be best served by adoptive placement, the commissioner may contract with a licensed child-placing agency or a Minnesota tribal social services agency to provide adoption services. A contract with a licensed child-placing agency must be designed to supplement existing county efforts and may not replace existing county programs or tribal social services, unless the replacement is agreed to by the county board and the appropriate exclusive bargaining representative, tribal governing body, or the commissioner has evidence that child placements of the county continue to be substantially below that of other counties. Funds encumbered and obligated under an agreement for a specific child shall remain available until the terms of the agreement are fulfilled or the agreement is terminated.

(i) Act as coordinating referral and informational center on requests for service for newly arrived immigrants coming to Minnesota.

22.1 (j) The specific enumeration of powers and duties as hereinabove set forth shall in no
22.2 way be construed to be a limitation upon the general transfer of powers herein contained.

22.3 (k) Establish county, regional, or statewide schedules of maximum fees and charges
22.4 which may be paid by county agencies for medical, dental, surgical, hospital, nursing and
22.5 nursing home care and medicine and medical supplies under all programs of medical
22.6 care provided by the state and for congregate living care under the income maintenance
22.7 programs.

22.8 (l) Have the authority to conduct and administer experimental projects to test
22.9 methods and procedures of administering assistance and services to recipients or potential
22.10 recipients of public welfare. To carry out such experimental projects, it is further provided
22.11 that the commissioner of human services is authorized to waive the enforcement of
22.12 existing specific statutory program requirements, rules, and standards in one or more
22.13 counties. The order establishing the waiver shall provide alternative methods and
22.14 procedures of administration, shall not be in conflict with the basic purposes, coverage, or
22.15 benefits provided by law, and in no event shall the duration of a project exceed four years.
22.16 It is further provided that no order establishing an experimental project as authorized by
22.17 the provisions of this section shall become effective until the following conditions have
22.18 been met:

22.19 (1) the secretary of health and human services of the United States has agreed, for
22.20 the same project, to waive state plan requirements relative to statewide uniformity; and

22.21 (2) a comprehensive plan, including estimated project costs, shall be approved by
22.22 the Legislative Advisory Commission and filed with the commissioner of administration.

22.23 (m) According to federal requirements, establish procedures to be followed by
22.24 local welfare boards in creating citizen advisory committees, including procedures for
22.25 selection of committee members.

22.26 (n) Allocate federal fiscal disallowances or sanctions which are based on quality
22.27 control error rates for the aid to families with dependent children program formerly
22.28 codified in sections 256.72 to 256.87, medical assistance, or food stamp program in the
22.29 following manner:

22.30 (1) one-half of the total amount of the disallowance shall be borne by the county
22.31 boards responsible for administering the programs. For the medical assistance and the
22.32 AFDC program formerly codified in sections 256.72 to 256.87, disallowances shall be
22.33 shared by each county board in the same proportion as that county's expenditures for the
22.34 sanctioned program are to the total of all counties' expenditures for the AFDC program
22.35 formerly codified in sections 256.72 to 256.87, and medical assistance programs. For the
22.36 food stamp program, sanctions shall be shared by each county board, with 50 percent of

the sanction being distributed to each county in the same proportion as that county's administrative costs for food stamps are to the total of all food stamp administrative costs for all counties, and 50 percent of the sanctions being distributed to each county in the same proportion as that county's value of food stamp benefits issued are to the total of all benefits issued for all counties. Each county shall pay its share of the disallowance to the state of Minnesota. When a county fails to pay the amount due hereunder, the commissioner may deduct the amount from reimbursement otherwise due the county, or the attorney general, upon the request of the commissioner, may institute civil action to recover the amount due; and

(2) notwithstanding the provisions of clause (1), if the disallowance results from knowing noncompliance by one or more counties with a specific program instruction, and that knowing noncompliance is a matter of official county board record, the commissioner may require payment or recover from the county or counties, in the manner prescribed in clause (1), an amount equal to the portion of the total disallowance which resulted from the noncompliance, and may distribute the balance of the disallowance according to clause (1).

(o) Develop and implement special projects that maximize reimbursements and result in the recovery of money to the state. For the purpose of recovering state money, the commissioner may enter into contracts with third parties. Any recoveries that result from projects or contracts entered into under this paragraph shall be deposited in the state treasury and credited to a special account until the balance in the account reaches \$1,000,000. When the balance in the account exceeds \$1,000,000, the excess shall be transferred and credited to the general fund. All money in the account is appropriated to the commissioner for the purposes of this paragraph.

(p) Have the authority to make direct payments to facilities providing shelter to women and their children according to section 256D.05, subdivision 3. Upon the written request of a shelter facility that has been denied payments under section 256D.05, subdivision 3, the commissioner shall review all relevant evidence and make a determination within 30 days of the request for review regarding issuance of direct payments to the shelter facility. Failure to act within 30 days shall be considered a determination not to issue direct payments.

(q) Have the authority to establish and enforce the following county reporting requirements:

(1) the commissioner shall establish fiscal and statistical reporting requirements necessary to account for the expenditure of funds allocated to counties for human services programs. When establishing financial and statistical reporting requirements, the

24.1 commissioner shall evaluate all reports, in consultation with the counties, to determine if
24.2 the reports can be simplified or the number of reports can be reduced;

24.3 (2) the county board shall submit monthly or quarterly reports to the department
24.4 as required by the commissioner. Monthly reports are due no later than 15 working days
24.5 after the end of the month. Quarterly reports are due no later than 30 calendar days after
24.6 the end of the quarter, unless the commissioner determines that the deadline must be
24.7 shortened to 20 calendar days to avoid jeopardizing compliance with federal deadlines
24.8 or risking a loss of federal funding. Only reports that are complete, legible, and in the
24.9 required format shall be accepted by the commissioner;

24.10 (3) if the required reports are not received by the deadlines established in clause (2),
24.11 the commissioner may delay payments and withhold funds from the county board until
24.12 the next reporting period. When the report is needed to account for the use of federal
24.13 funds and the late report results in a reduction in federal funding, the commissioner shall
24.14 withhold from the county boards with late reports an amount equal to the reduction in
24.15 federal funding until full federal funding is received;

24.16 (4) a county board that submits reports that are late, illegible, incomplete, or not
24.17 in the required format for two out of three consecutive reporting periods is considered
24.18 noncompliant. When a county board is found to be noncompliant, the commissioner
24.19 shall notify the county board of the reason the county board is considered noncompliant
24.20 and request that the county board develop a corrective action plan stating how the
24.21 county board plans to correct the problem. The corrective action plan must be submitted
24.22 to the commissioner within 45 days after the date the county board received notice
24.23 of noncompliance;

24.24 (5) the final deadline for fiscal reports or amendments to fiscal reports is one year
24.25 after the date the report was originally due. If the commissioner does not receive a report
24.26 by the final deadline, the county board forfeits the funding associated with the report for
24.27 that reporting period and the county board must repay any funds associated with the
24.28 report received for that reporting period;

24.29 (6) the commissioner may not delay payments, withhold funds, or require repayment
24.30 under clause (3) or (5) if the county demonstrates that the commissioner failed to
24.31 provide appropriate forms, guidelines, and technical assistance to enable the county to
24.32 comply with the requirements. If the county board disagrees with an action taken by the
24.33 commissioner under clause (3) or (5), the county board may appeal the action according
24.34 to sections 14.57 to 14.69; and

24.35 (7) counties subject to withholding of funds under clause (3) or forfeiture or
24.36 repayment of funds under clause (5) shall not reduce or withhold benefits or services to

clients to cover costs incurred due to actions taken by the commissioner under clause (3) or (5).

(r) Allocate federal fiscal disallowances or sanctions for audit exceptions when federal fiscal disallowances or sanctions are based on a statewide random sample for the foster care program under title IV-E of the Social Security Act, United States Code, title 42, in direct proportion to each county's title IV-E foster care maintenance claim for that period.

(s) Be responsible for ensuring the detection, prevention, investigation, and resolution of fraudulent activities or behavior by applicants, recipients, and other participants in the human services programs administered by the department.

(t) Require county agencies to identify overpayments, establish claims, and utilize all available and cost-beneficial methodologies to collect and recover these overpayments in the human services programs administered by the department.

(u) Have the authority to administer a drug rebate program for drugs purchased pursuant to the prescription drug program established under section 256.955 after the beneficiary's satisfaction of any deductible established in the program. The commissioner shall require a rebate agreement from all manufacturers of covered drugs as defined in section 256B.0625, subdivision 13. Rebate agreements for prescription drugs delivered on or after July 1, 2002, must include rebates for individuals covered under the prescription drug program who are under 65 years of age. For each drug, the amount of the rebate shall be equal to the rebate as defined for purposes of the federal rebate program in United States Code, title 42, section 1396r-8. The manufacturers must provide full payment within 30 days of receipt of the state invoice for the rebate within the terms and conditions used for the federal rebate program established pursuant to section 1927 of title XIX of the Social Security Act. The manufacturers must provide the commissioner with any information necessary to verify the rebate determined per drug. The rebate program shall utilize the terms and conditions used for the federal rebate program established pursuant to section 1927 of title XIX of the Social Security Act.

(v) Have the authority to administer the federal drug rebate program for drugs purchased under the medical assistance program as allowed by section 1927 of title XIX of the Social Security Act and according to the terms and conditions of section 1927. Rebates shall be collected for all drugs that have been dispensed or administered in an outpatient setting and that are from manufacturers who have signed a rebate agreement with the United States Department of Health and Human Services.

(w) Have the authority to administer a supplemental drug rebate program for drugs purchased under the medical assistance program. The commissioner may enter into

supplemental rebate contracts with pharmaceutical manufacturers and may require prior authorization for drugs that are from manufacturers that have not signed a supplemental rebate contract. Prior authorization of drugs shall be subject to the provisions of section 256B.0625, subdivision 13.

(x) Operate the department's communication systems account established in Laws 1993, First Special Session chapter 1, article 1, section 2, subdivision 2, to manage shared communication costs necessary for the operation of the programs the commissioner supervises. A communications account may also be established for each regional treatment center which operates communications systems. Each account must be used to manage shared communication costs necessary for the operations of the programs the commissioner supervises. The commissioner may distribute the costs of operating and maintaining communication systems to participants in a manner that reflects actual usage. Costs may include acquisition, licensing, insurance, maintenance, repair, staff time and other costs as determined by the commissioner. Nonprofit organizations and state, county, and local government agencies involved in the operation of programs the commissioner supervises may participate in the use of the department's communications technology and share in the cost of operation. The commissioner may accept on behalf of the state any gift, bequest, devise or personal property of any kind, or money tendered to the state for any lawful purpose pertaining to the communication activities of the department. Any money received for this purpose must be deposited in the department's communication systems accounts. Money collected by the commissioner for the use of communication systems must be deposited in the state communication systems account and is appropriated to the commissioner for purposes of this section.

(y) Receive any federal matching money that is made available through the medical assistance program for the consumer satisfaction survey. Any federal money received for the survey is appropriated to the commissioner for this purpose. The commissioner may expend the federal money received for the consumer satisfaction survey in either year of the biennium.

(z) Designate community information and referral call centers and incorporate cost reimbursement claims from the designated community information and referral call centers into the federal cost reimbursement claiming processes of the department according to federal law, rule, and regulations. Existing information and referral centers provided by Greater Twin Cities United Way or existing call centers for which Greater Twin Cities United Way has legal authority to represent, shall be included in these designations upon review by the commissioner and assurance that these services are accredited and in compliance with national standards. Any reimbursement is appropriated

to the commissioner and all designated information and referral centers shall receive payments according to normal department schedules established by the commissioner upon final approval of allocation methodologies from the United States Department of Health and Human Services Division of Cost Allocation or other appropriate authorities.

(aa) Develop recommended standards for foster care homes that address the components of specialized therapeutic services to be provided by foster care homes with those services.

(bb) Authorize the method of payment to or from the department as part of the human services programs administered by the department. This authorization includes the receipt or disbursement of funds held by the department in a fiduciary capacity as part of the human services programs administered by the department.

(cc) Have the authority to administer a drug rebate program for drugs purchased for persons eligible for general assistance medical care under section 256D.03, subdivision 3. For manufacturers that agree to participate in the general assistance medical care rebate program, the commissioner shall enter into a rebate agreement for covered drugs as defined in section 256B.0625, subdivisions 13 and 13d. For each drug, the amount of the rebate shall be equal to the rebate as defined for purposes of the federal rebate program in United States Code, title 42, section 1396r-8. The manufacturers must provide payment within the terms and conditions used for the federal rebate program established under section 1927 of title XIX of the Social Security Act. The rebate program shall utilize the terms and conditions used for the federal rebate program established under section 1927 of title XIX of the Social Security Act.

Effective January 1, 2006, drug coverage under general assistance medical care shall be limited to those prescription drugs that:

(1) are covered under the medical assistance program as described in section 256B.0625, subdivisions 13 and 13d; and

(2) are provided by manufacturers that have fully executed general assistance medical care rebate agreements with the commissioner and comply with such agreements. Prescription drug coverage under general assistance medical care shall conform to coverage under the medical assistance program according to section 256B.0625, subdivisions 13 to 13g.

The rebate revenues collected under the drug rebate program are deposited in the general fund.

Sec. 16. Minnesota Statutes 2006, section 256.01, subdivision 4, is amended to read:

Subd. 4. **Duties as state agency.** (a) The state agency shall:

(1) supervise the administration of assistance to dependent children under Laws 1937, chapter 438, by the county agencies in an integrated program with other service for dependent children maintained under the direction of the state agency;

~~(2) may subpoena witnesses and administer oaths, make rules, and take such action as may be necessary, or desirable for carrying out the provisions of Laws 1937, chapter 438. All rules made by the state agency shall be binding on the counties and shall be complied with by the respective county agencies;~~

~~(3)~~ (2) establish adequate standards for personnel employed by the counties and the state agency in the administration of Laws 1937, chapter 438, and make the necessary rules to maintain such standards;

~~(4)~~ (3) prescribe the form of and print and supply to the county agencies blanks for applications, reports, affidavits, and such other forms as it may deem necessary and advisable;

~~(5)~~ (4) cooperate with the federal government and its public welfare agencies in any reasonable manner as may be necessary to qualify for federal aid for temporary assistance for needy families and in conformity with title I of Public Law 104-193, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 and successor amendments, including the making of such reports and such forms and containing such information as the Federal Social Security Board may from time to time require, and comply with such provisions as such board may from time to time find necessary to assure the correctness and verification of such reports;

~~(6) may cooperate with other state agencies in establishing reciprocal agreements in instances where a child receiving Minnesota family investment program assistance moves or contemplates moving into or out of the state, in order that such child may continue to receive supervised aid from the state moved from until the child shall have resided for one year in the state moved to;~~

~~(7)~~ (5) on or before October 1 in each even-numbered year make a biennial report to the governor concerning the activities of the agency;

~~(8)~~ (6) enter into agreements with other departments of the state as necessary to meet all requirements of the federal government; and

~~(9)~~ (7) cooperate with the commissioner of education to enforce the requirements for program integrity and fraud prevention for investigation for child care assistance under chapter 119B.

(b) The state agency may:

(1) subpoena witnesses and administer oaths, make rules, and take such action as may be necessary or desirable for carrying out the provisions of Laws 1937, chapter 438.

29.1 All rules made by the state agency shall be binding on the counties and shall be complied
29.2 with by the respective county agencies;

29.3 (2) cooperate with other state agencies in establishing reciprocal agreements in
29.4 instances where a child receiving Minnesota family investment program assistance moves
29.5 or contemplates moving into or out of the state, in order that the child may continue
29.6 to receive supervised aid from the state moved from until the child has resided for one
29.7 year in the state moved to; and

29.8 (3) administer oaths and affirmations, take depositions, certify to official acts, and
29.9 issue subpoenas to compel the attendance of individuals and the production of documents
29.10 and other personal property necessary in connection with the administration of programs
29.11 administered by the Department of Human Services.

29.12 (c) The fees for service of a subpoena in paragraph (b), clause (3), must be paid in
29.13 the same manner as prescribed by law for a service of process issued by a district court.
29.14 Witnesses must receive the same fees and mileage as in civil actions.

29.15 (d) The subpoena in paragraph (b), clause (3), shall be enforceable through the
29.16 district court in the district where the subpoena is issued.

29.17 Sec. 17. Minnesota Statutes 2006, section 256.01, subdivision 18, is amended to read:

29.18 Subd. 18. **Immigration status verifications.** (a) Notwithstanding any waiver of
29.19 this requirement by the secretary of the United States Department of Health and Human
29.20 Services, effective July 1, 2001, the commissioner shall utilize the Systematic Alien
29.21 Verification for Entitlements (SAVE) program to conduct immigration status verifications:

29.22 (1) as required under United States Code, title 8, section 1642;

29.23 (2) for all applicants and recipients at recertification for food assistance benefits,
29.24 whether under the federal food stamp program, the MFIP ~~or work first program~~, or the
29.25 Minnesota food assistance program;

29.26 (3) for all applicants and recipients at recertification for general assistance medical
29.27 care, except assistance for an emergency medical condition, for immunization with respect
29.28 to an immunizable disease, or for testing and treatment of symptoms of a communicable
29.29 disease; and

29.30 (4) for all applicants and recipients at recertification for general assistance,
29.31 Minnesota supplemental aid, MinnesotaCare, or group residential housing, when the
29.32 benefits provided by these programs would fall under the definition of "federal public
29.33 benefit" under United States Code, title 8, section 1642, if federal funds were used to
29.34 pay for all or part of the benefits.

(b) The commissioner shall comply with the reporting requirements under United States Code, title 42, section 611a, and any federal regulation or guidance adopted under that law.

Sec. 18. Minnesota Statutes 2006, section 256.01, is amended by adding a subdivision to read:

Subd. 23. **Administrative simplification; county cost study.** (a) The commissioner shall establish and convene the first meeting of an advisory committee to identify ways to simplify and streamline human services laws and administrative requirements. The advisory committee shall select its chair from its membership at the first meeting.

(b) The committee shall consist of three senators appointed by the senate Committee on Rules and Administration, three state representatives appointed by the speaker of the house of representatives, four department staff, and five county representatives appointed by the Association of Minnesota Counties after consultation with other relevant county organizations.

(c) The committee shall annually select up to two topics for review. The goals of the reviews are to discuss opportunities for administrative improvements and increased simplification and streamlining to improve consistency, efficiency, fairness, and to reduce the risk of recipient noncompliance. In reviewing the topics selected, consideration shall be given to:

(1) current challenges in administrative complexity and service delivery and whether the sharing of responsibilities between the state and the county should be altered in any way, including transferring responsibilities from one entity to the other;

(2) methods of reducing inconsistency with similar programs; and

(3) the current funding mechanism, whether funding formulas should be adjusted for special demographic or geographic factors that influence program costs, differences in county property tax contributions and maintenance of effort obligations, and whether the mix of state and county obligations for financial support of this service should be changed.

(d) The committee members shall assume responsibility for reporting progress to the appropriate leadership of the groups they represent. The commissioner, in partnership with the advisory committee, shall report to the legislative committees and divisions with jurisdiction over the Department of Human Services on the findings and recommendations of the advisory committee by December 15 of each year.

(e) This section expires June 30, 2012.

Sec. 19. Minnesota Statutes 2006, section 256.015, subdivision 7, is amended to read:

Subd. 7. **Cooperation required.** Upon the request of the Department of Human Services, any state agency or third party payer shall cooperate with the department in furnishing information to help establish a third party liability. Upon the request of the Department of Human Services or county child support or human service agencies, any employer or third party payer shall cooperate in furnishing information about group health insurance plans or medical benefit plans available to its employees. For purposes of section 176.191, subdivision 4, the Department of Labor and Industry may allow the Department of Human Services and county agencies direct access and data matching on information relating to workers' compensation claims in order to determine whether the claimant has reported the fact of a pending claim and the amount paid to or on behalf of the claimant to the Department of Human Services. The Department of Human Services and county agencies shall limit its use of information gained from agencies, third party payers, and employers to purposes directly connected with the administration of its public assistance and child support programs. The provision of information by agencies, third party payers, and employers to the department under this subdivision is not a violation of any right of confidentiality or data privacy.

Sec. 20. Minnesota Statutes 2006, section 256.017, subdivision 1, is amended to read:

Subdivision 1. **Authority and purpose.** The commissioner shall administer a compliance system for the Minnesota family investment program, the food stamp or food support program, emergency assistance, general assistance, medical assistance, general assistance medical care, emergency general assistance, Minnesota supplemental assistance, preadmission screening, ~~and~~ alternative care grants, and the child care assistance program under the powers and authorities named in section 256.01, subdivision 2. The purpose of the compliance system is to permit the commissioner to supervise the administration of public assistance programs and to enforce timely and accurate distribution of benefits, completeness of service and efficient and effective program management and operations, to increase uniformity and consistency in the administration and delivery of public assistance programs throughout the state, and to reduce the possibility of sanctions and fiscal disallowances for noncompliance with federal regulations and state statutes.

The commissioner shall utilize training, technical assistance, and monitoring activities, as specified in section 256.01, subdivision 2, to encourage county agency compliance with written policies and procedures.

Sec. 21. Minnesota Statutes 2006, section 256.017, subdivision 9, is amended to read:

Subd. 9. **Timing and disposition of penalty and case disallowance funds.** Quality control case penalty and administrative penalty amounts shall be disallowed or withheld from the next regular reimbursement made to the county agency for state and federal benefit reimbursements and federal administrative reimbursements for all programs covered in this section, according to procedures established in statute, but shall not be imposed sooner than 30 calendar days from the date of written notice of such penalties. Except for penalties withheld under the child care assistance program, all penalties must be deposited in the county incentive fund provided in section 256.018. Penalties withheld under the child care assistance program shall be reallocated to counties using the allocation formula under section 119B.03, subdivision 5. All penalties must be imposed according to this provision until a decision is made regarding the status of a written exception. Penalties must be returned to county agencies when a review of a written exception results in a decision in their favor.

Sec. 22. Minnesota Statutes 2006, section 256.0471, subdivision 1, is amended to read:

Subdivision 1. **Qualifying overpayment.** Any overpayment for assistance granted under chapter 119B, the MFIP program formerly codified under sections 256.031 to 256.0361, and the AFDC program formerly codified under sections 256.72 to 256.871; chapters 256B, 256D, 256I, 256J, ~~and 256K,~~ and 256L; and the food stamp or food support program, except agency error claims, become a judgment by operation of law 90 days after the notice of overpayment is personally served upon the recipient in a manner that is sufficient under rule 4.03(a) of the Rules of Civil Procedure for district courts, or by certified mail, return receipt requested. This judgment shall be entitled to full faith and credit in this and any other state.

Sec. 23. Minnesota Statutes 2006, section 256.984, subdivision 1, is amended to read:

Subdivision 1. **Declaration.** Every application for public assistance under this chapter or chapters 256B, 256D, 256J, and 256L; child care programs under chapter 119B; and food stamps or food support under chapter 393 shall be in writing or reduced to writing as prescribed by the state agency and shall contain the following declaration which shall be signed by the applicant:

"I declare under the penalties of perjury that this application has been examined by me and to the best of my knowledge is a true and correct statement of every material point. I understand that a person convicted of perjury may be sentenced to imprisonment of not more than five years or to payment of a fine of not more than \$10,000, or both."

Sec. 24. **[256D.0516] EXPIRATION OF FOOD SUPPORT BENEFITS AND REPORTING REQUIREMENTS.**

Subdivision 1. Expiration of food support benefits. Food support benefits shall not be stored off line or expunged from a recipient's account unless the benefits have not been accessed for 12 months after the month they were issued.

Subd. 2. Food support reporting requirements. The Department of Human Services shall implement simplified reporting as permitted under the Food Stamp Act of 1977, as amended, and the food stamp regulations in Code of Federal Regulations, title 7, part 273. Food support recipient households required to report periodically shall not be required to report more often than one time every six months. This provision shall not apply to households receiving food benefits under the Minnesota family investment program waiver.

EFFECTIVE DATE. Subdivision 1 is effective February 1, 2008, and subdivision 2 is effective May 1, 2008.

Sec. 25. **[256F.15] GRANT PROGRAM FOR CRISIS NURSERIES.**

Subdivision 1. Crisis nurseries. The commissioner of human services shall establish a grant program to assist private and public agencies and organizations to provide crisis nurseries to offer services and temporary care to families experiencing crisis situations including children who are at high risk of abuse and neglect, children who have been abused and neglected, and children who are in families receiving child protective services. This service shall be provided without a fee for a maximum of 30 days in any year. Crisis nurseries shall provide short-term case management, family support services, parent education, crisis intervention, referrals, and resources, as needed.

(a) The crisis nurseries must provide a spectrum of services that may include, but are not limited to:

(1) being available 24 hours a day, seven days a week;

(2) providing services for children up to 72 hours at any one time;

(3) providing short-term case management to bridge the gap between crisis and successful living;

(4) making referrals for parents to counseling services and other community resources to help alleviate the underlying cause of the precipitating stress or crisis;

(5) providing services without a fee for a maximum of 30 days in any year;

(6) providing services to families with children from birth through 12 years of age, as services are available;

(7) providing an immediate response to family needs and strengths with an initial assessment and intake interview, making referrals to appropriate agencies or programs, and providing temporary care of children, as needed;

(8) maintaining the clients' confidentiality to the extent required by law, and also complying with statutory reporting requirements which may mandate a report to child protective services;

(9) providing a volunteer component and support for volunteers;

(10) providing preservice training and ongoing training to providers and volunteers;

(11) evaluating the services provided by documenting use of services, the result of family referrals made to community resources, and how the services reduced the risk of maltreatment;

(12) providing developmental assessments;

(13) providing medical assessments as determined by using a risk screening tool;

(14) providing parent education classes or programs that include parent-child interaction either on site or in collaboration with other community agencies; and

(15) having a multidisciplinary advisory board which may include one or more parents who have used the crisis nursery services.

(b) The crisis nurseries are encouraged to provide opportunities for parents to volunteer, if appropriate.

(c) Parents shall retain custody of their children during placement in a crisis facility.

Subd. 2. Fund distribution. In distributing funds, the commissioner shall give priority consideration to agencies and organizations with experience in working with abused or neglected children and their families, and with children at high risk of abuse and neglect and their families, and serve communities which demonstrate the greatest need for these services. Funds shall be distributed to crisis nurseries according to a formula developed by the commissioner in consultation with the Minnesota Crisis Nursery Association. The formula shall include funding for all existing crisis nursery programs that have been previously funded through the Department of Human Services and that meet program requirements as specified in subdivision 1, paragraph (a), and consideration of factors reflecting the need for services in each service area, including but not limited to the number of children 18 years of age and under living in the service area, the percent of children 18 years of age and under living in poverty in the service area, and factors reflecting the cost of providing services, including but not limited to the number of hours of service provided in the previous year.

Sec. 26. Minnesota Statutes 2006, section 256J.01, is amended by adding a subdivision to read:

Subd. 6. **Legislative approval to move programs or activities.** The commissioner shall not move programs or activities funded with MFIP or TANF maintenance of effort funds to other funding sources without legislative approval.

Sec. 27. Minnesota Statutes 2006, section 256J.02, subdivision 1, is amended to read:

Subdivision 1. **Commissioner's authority to administer block grant funds.** The commissioner of human services is authorized to receive, administer, and expend funds available under the TANF block grant authorized under title I of Public Law 104-193, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, and under Public Law 109-171, the Deficit Reduction Act of 2005.

Sec. 28. Minnesota Statutes 2006, section 256J.02, subdivision 4, is amended to read:

Subd. 4. **Authority to transfer.** Subject to limitations of title I of Public Law 104-193, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, as amended, and under Public Law 109-171, the Deficit Reduction Act of 2005, the legislature may transfer money from the TANF block grant to the child care fund under chapter 119B, or the Title XX block grant.

Sec. 29. Minnesota Statutes 2006, section 256J.021, is amended to read:

256J.021 SEPARATE STATE PROGRAM FOR USE OF STATE MONEY.

Families receiving assistance under this section must comply with all applicable requirements in this chapter.

~~(a) Until October 1, 2006, the commissioner of human services must treat MFIP expenditures made to or on behalf of any minor child under section 256J.02, subdivision 2, clause (1), who is a resident of this state under section 256J.12, and who is part of a two-parent eligible household as expenditures under a separately funded state program and report those expenditures to the federal Department of Health and Human Services as separate state program expenditures under Code of Federal Regulations, title 45, section 263.5.~~

~~(b) Beginning October 1, 2006, and each year thereafter, the commissioner of human services must treat MFIP expenditures made to or on behalf of any minor child under section 256J.02, subdivision 2, clause (1), who is a resident of this state under section 256J.12, and who is part of a two-parent eligible household, as expenditures under a separately funded state program. These expenditures shall not count toward the state's~~

~~maintenance of effort (MOE) requirements under the federal Temporary Assistance to Needy Families (TANF) program except if counting certain families would allow the commissioner to avoid a federal penalty. Families receiving assistance under this section must comply with all applicable requirements in this chapter.~~

Sec. 30. Minnesota Statutes 2006, section 256J.08, subdivision 65, is amended to read:

Subd. 65. **Participant.** (a) "Participant" means includes any of the following:

(1) a person who is currently receiving cash assistance or the food portion available through MFIP. A person who fails to withdraw or access electronically any portion of the person's cash and food assistance payment by the end of the payment month, who makes a written request for closure before the first of a payment month and repays cash and food assistance electronically issued for that payment month within that payment month, or who returns any uncashed assistance check and food coupons and withdraws from the program is not a participant.

(2) a person who withdraws a cash or food assistance payment by electronic transfer or receives and cashes an MFIP assistance check or food coupons and is subsequently determined to be ineligible for assistance for that period of time is a participant, regardless whether that assistance is repaid. The term "participant" includes;

(3) the caregiver relative and the minor child whose needs are included in the assistance payment;

(4) a person in an assistance unit who does not receive a cash and food assistance payment because the case has been suspended from MFIP is a participant;

(5) a person who receives cash payments under the diversionary work program under section 256J.95 is a participant; and

(6) a person who receives cash payments under the family stabilization services program under section 256J.575.

(b) "Participant" does not include a person who fails to withdraw or access electronically any portion of the person's cash and food assistance payment by the end of the payment month, who makes a written request for closure before the first of a payment month and repays cash and food assistance electronically issued for that payment month within that payment month, or who returns any uncashed assistance check and food coupons and withdraws from the program.

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

Sec. 31. Minnesota Statutes 2006, section 256J.21, subdivision 2, is amended to read:

Subd. 2. **Income exclusions.** The following must be excluded in determining a family's available income:

(1) payments for basic care, difficulty of care, and clothing allowances received for providing family foster care to children or adults under Minnesota Rules, parts 9555.5050 to 9555.6265, 9560.0521, and 9560.0650 to 9560.0655, and payments received and used for care and maintenance of a third-party beneficiary who is not a household member;

(2) reimbursements for employment training received through the Workforce Investment Act of 1998, United States Code, title 20, chapter 73, section 9201;

(3) reimbursement for out-of-pocket expenses incurred while performing volunteer services, jury duty, employment, or informal carpooling arrangements directly related to employment;

(4) all educational assistance, except the county agency must count graduate student teaching assistantships, fellowships, and other similar paid work as earned income and, after allowing deductions for any unmet and necessary educational expenses, shall count scholarships or grants awarded to graduate students that do not require teaching or research as unearned income;

(5) loans, regardless of purpose, from public or private lending institutions, governmental lending institutions, or governmental agencies;

(6) loans from private individuals, regardless of purpose, provided an applicant or participant documents that the lender expects repayment;

(7)(i) state income tax refunds; and

(ii) federal income tax refunds;

(8)(i) federal earned income credits;

(ii) Minnesota working family credits;

(iii) state homeowners and renters credits under chapter 290A; and

(iv) federal or state tax rebates;

(9) funds received for reimbursement, replacement, or rebate of personal or real property when these payments are made by public agencies, awarded by a court, solicited through public appeal, or made as a grant by a federal agency, state or local government, or disaster assistance organizations, subsequent to a presidential declaration of disaster;

(10) the portion of an insurance settlement that is used to pay medical, funeral, and burial expenses, or to repair or replace insured property;

(11) reimbursements for medical expenses that cannot be paid by medical assistance;

(12) payments by a vocational rehabilitation program administered by the state under chapter 268A, except those payments that are for current living expenses;

- 38.1 (13) in-kind income, including any payments directly made by a third party to a
38.2 provider of goods and services;
- 38.3 (14) assistance payments to correct underpayments, but only for the month in which
38.4 the payment is received;
- 38.5 (15) payments for short-term emergency needs under section 256J.626, subdivision
38.6 2;
- 38.7 (16) funeral and cemetery payments as provided by section 256.935;
- 38.8 (17) nonrecurring cash gifts of \$30 or less, not exceeding \$30 per participant in
38.9 a calendar month;
- 38.10 (18) any form of energy assistance payment made through Public Law 97-35,
38.11 Low-Income Home Energy Assistance Act of 1981, payments made directly to energy
38.12 providers by other public and private agencies, and any form of credit or rebate payment
38.13 issued by energy providers;
- 38.14 (19) Supplemental Security Income (SSI), including retroactive SSI payments and
38.15 other income of an SSI recipient, except as described in section 256J.37, subdivision 3b;
- 38.16 (20) Minnesota supplemental aid, including retroactive payments;
- 38.17 (21) proceeds from the sale of real or personal property;
- 38.18 (22) state adoption assistance payments under section 259.67, and up to an equal
38.19 amount of county adoption assistance payments;
- 38.20 (23) state-funded family subsidy program payments made under section 252.32
38.21 to help families care for children with developmental disabilities, consumer support
38.22 grant funds under section 256.476, and resources and services for a disabled household
38.23 member under one of the home and community-based waiver services programs under
38.24 chapter 256B;
- 38.25 (24) interest payments and dividends from property that is not excluded from and
38.26 that does not exceed the asset limit;
- 38.27 (25) rent rebates;
- 38.28 (26) income earned by a minor caregiver, minor child through age 6, or a minor
38.29 child who is at least a half-time student in an approved elementary or secondary education
38.30 program;
- 38.31 (27) income earned by a caregiver under age 20 who is at least a half-time student in
38.32 an approved elementary or secondary education program;
- 38.33 (28) MFIP child care payments under section 119B.05;
- 38.34 (29) all other payments made through MFIP to support a caregiver's pursuit of
38.35 greater economic stability;
- 38.36 (30) income a participant receives related to shared living expenses;

- 39.1 (31) reverse mortgages;
- 39.2 (32) benefits provided by the Child Nutrition Act of 1966, United States Code, title
39.3 42, chapter 13A, sections 1771 to 1790;
- 39.4 (33) benefits provided by the women, infants, and children (WIC) nutrition program,
39.5 United States Code, title 42, chapter 13A, section 1786;
- 39.6 (34) benefits from the National School Lunch Act, United States Code, title 42,
39.7 chapter 13, sections 1751 to 1769e;
- 39.8 (35) relocation assistance for displaced persons under the Uniform Relocation
39.9 Assistance and Real Property Acquisition Policies Act of 1970, United States Code, title
39.10 42, chapter 61, subchapter II, section 4636, or the National Housing Act, United States
39.11 Code, title 12, chapter 13, sections 1701 to 1750jj;
- 39.12 (36) benefits from the Trade Act of 1974, United States Code, title 19, chapter
39.13 12, part 2, sections 2271 to 2322;
- 39.14 (37) war reparations payments to Japanese Americans and Aleuts under United
39.15 States Code, title 50, sections 1989 to 1989d;
- 39.16 (38) payments to veterans or their dependents as a result of legal settlements
39.17 regarding Agent Orange or other chemical exposure under Public Law 101-239, section
39.18 10405, paragraph (a)(2)(E);
- 39.19 (39) income that is otherwise specifically excluded from MFIP consideration in
39.20 federal law, state law, or federal regulation;
- 39.21 (40) security and utility deposit refunds;
- 39.22 (41) American Indian tribal land settlements excluded under Public Laws 98-123,
39.23 98-124, and 99-377 to the Mississippi Band Chippewa Indians of White Earth, Leech
39.24 Lake, and Mille Lacs reservations and payments to members of the White Earth Band,
39.25 under United States Code, title 25, chapter 9, section 331, and chapter 16, section 1407;
- 39.26 (42) all income of the minor parent's parents and stepparents when determining the
39.27 grant for the minor parent in households that include a minor parent living with parents or
39.28 stepparents on MFIP with other children;
- 39.29 (43) income of the minor parent's parents and stepparents equal to 200 percent of the
39.30 federal poverty guideline for a family size not including the minor parent and the minor
39.31 parent's child in households that include a minor parent living with parents or stepparents
39.32 not on MFIP when determining the grant for the minor parent. The remainder of income is
39.33 deemed as specified in section 256J.37, subdivision 1b;
- 39.34 (44) payments made to children eligible for relative custody assistance under section
39.35 257.85;

(45) vendor payments for goods and services made on behalf of a client unless the client has the option of receiving the payment in cash; ~~and~~

(46) the principal portion of a contract for deed payment; and

(47) cash payments to individuals enrolled for full-time service as a volunteer under AmeriCorps programs including AmeriCorps VISTA, AmeriCorps State, AmeriCorps National, and AmeriCorps NCCC.

Sec. 32. Minnesota Statutes 2006, section 256J.24, subdivision 10, is amended to read:

Subd. 10. **MFIP exit level.** The commissioner shall adjust the MFIP earned income disregard to ensure that most participants do not lose eligibility for MFIP until their income reaches at least ~~115~~ 140 percent of the federal poverty guidelines in effect in October of each fiscal year. The adjustment to the disregard shall be based on a household size of three, and the resulting earned income disregard percentage must be applied to all household sizes. The adjustment under this subdivision must be implemented at the same time as the October food stamp or food support cost-of-living adjustment is reflected in the food portion of MFIP transitional standard as required under subdivision 5a.

Sec. 33. Minnesota Statutes 2006, section 256J.42, subdivision 1, is amended to read:

Subdivision 1. **Time limit.** (a) Except as otherwise provided for in this section, an assistance unit in which any adult caregiver has received 60 months of cash assistance funded in whole or in part by the TANF block grant in this or any other state or United States territory, or from a tribal TANF program, MFIP, the AFDC program formerly codified in sections 256.72 to 256.87, or the family general assistance program formerly codified in sections 256D.01 to 256D.23, funded in whole or in part by state appropriations, is ineligible to receive MFIP. Any cash assistance funded with TANF dollars in this or any other state or United States territory, or from a tribal TANF program, or MFIP assistance funded in whole or in part by state appropriations, that was received by the unit on or after the date TANF was implemented, including any assistance received in states or United States territories of prior residence, counts toward the 60-month limitation. Months during which any cash assistance is received by an assistance unit with a mandatory member who is disqualified for wrongfully obtaining public assistance under section 256.98, subdivision 8, counts toward the time limit for the disqualified member. The 60-month limit applies to a minor caregiver except under subdivision 5. The 60-month time period does not need to be consecutive months for this provision to apply.

41.1 (b) The months before July 1998 in which individuals received assistance as part of
41.2 the field trials as an MFIP, MFIP-R, or MFIP or MFIP-R comparison group family are
41.3 not included in the 60-month time limit.

41.4 **EFFECTIVE DATE.** This section is effective October 1, 2007.

41.5 Sec. 34. Minnesota Statutes 2006, section 256J.425, subdivision 3, is amended to read:

41.6 Subd. 3. **Hard-to-employ participants.** An assistance unit subject to the time
41.7 limit in section 256J.42, subdivision 1, is eligible to receive months of assistance under
41.8 a hardship extension if the participant who reached the time limit belongs to any of the
41.9 following groups:

41.10 (1) a person who is diagnosed by a licensed physician, psychological practitioner,
41.11 or other qualified professional, as developmentally disabled or mentally ill, and that
41.12 condition prevents the person from obtaining or retaining unsubsidized employment;

41.13 (2) a person who:

41.14 (i) has been assessed by a vocational specialist or the county agency to be
41.15 unemployable for purposes of this subdivision; or

41.16 (ii) has an IQ below 80 who has been assessed by a vocational specialist or a county
41.17 agency to be employable, but not at a level that makes the participant eligible for an
41.18 extension under subdivision 4. The determination of IQ level must be made by a qualified
41.19 professional. In the case of a non-English-speaking person: (A) the determination must
41.20 be made by a qualified professional with experience conducting culturally appropriate
41.21 assessments, whenever possible; (B) the county may accept reports that identify an
41.22 IQ range as opposed to a specific score; (C) these reports must include a statement of
41.23 confidence in the results;

41.24 (3) a person who is determined by a qualified professional to be learning disabled,
41.25 and the disability severely limits the person's ability to obtain, perform, or maintain
41.26 suitable employment. For purposes of the initial approval of a learning disability
41.27 extension, the determination must have been made or confirmed within the previous 12
41.28 months. In the case of a non-English-speaking person: (i) the determination must be made
41.29 by a qualified professional with experience conducting culturally appropriate assessments,
41.30 whenever possible; and (ii) these reports must include a statement of confidence in the
41.31 results. If a rehabilitation plan for a participant extended as learning disabled is developed
41.32 or approved by the county agency, the plan must be incorporated into the employment
41.33 plan. However, a rehabilitation plan does not replace the requirement to develop and
41.34 comply with an employment plan under section 256J.521; ~~or~~

(4) a person who has been granted a family violence waiver, and who is complying with an employment plan under section 256J.521, subdivision 3; or

(5) a participant under section 256J.561, subdivision 2, paragraph (d), who is complying with an employment plan tailored to recognize the special circumstances of the caregivers and family, including limitations due to illness or disability, and caregiving needs.

Sec. 35. Minnesota Statutes 2006, section 256J.425, subdivision 4, is amended to read:

Subd. 4. **Employed participants.** (a) An assistance unit subject to the time limit under section 256J.42, subdivision 1, is eligible to receive assistance under a hardship extension if the participant who reached the time limit belongs to:

(1) a one-parent assistance unit in which the participant is participating in work activities for at least 30 hours per week, ~~of which an average of at least 25 hours per week every month are spent participating in employment;~~

(2) a two-parent assistance unit in which the participants are participating in work activities for at least 55 hours per week, ~~of which an average of at least 45 hours per week every month are spent participating in employment;~~ or

(3) an assistance unit in which a participant is participating in employment for fewer hours than those specified in clause (1) or (2), and the participant submits verification from a qualified professional, in a form acceptable to the commissioner, stating that the number of hours the participant may work is limited due to illness or disability, as long as the participant is participating in employment for at least the number of hours specified by the qualified professional. The participant must be following the treatment recommendations of the qualified professional providing the verification. The commissioner shall develop a form to be completed and signed by the qualified professional, documenting the diagnosis and any additional information necessary to document the functional limitations of the participant that limit work hours. If the participant is part of a two-parent assistance unit, the other parent must be treated as a one-parent assistance unit for purposes of meeting the work requirements under this subdivision.

~~(b) For purposes of this section, employment means:~~

~~(1) unsubsidized employment under section 256J.49, subdivision 13, clause (1);~~

~~(2) subsidized employment under section 256J.49, subdivision 13, clause (2);~~

~~(3) on-the-job training under section 256J.49, subdivision 13, clause (2);~~

~~(4) an apprenticeship under section 256J.49, subdivision 13, clause (1);~~

~~(5) supported work under section 256J.49, subdivision 13, clause (2);~~

~~(6) a combination of clauses (1) to (5); or~~

~~(7) child care under section 256J.49, subdivision 13, clause (7), if it is in combination with paid employment.~~

~~(e)~~ If a participant is complying with a child protection plan under chapter 260C, the number of hours required under the child protection plan count toward the number of hours required under this subdivision.

~~(d)~~ (c) The county shall provide the opportunity for subsidized employment to participants needing that type of employment within available appropriations.

~~(e)~~ (d) To be eligible for a hardship extension for employed participants under this subdivision, a participant must be in compliance for at least ten out of the 12 months the participant received MFIP immediately preceding the participant's 61st month on assistance. If ten or fewer months of eligibility for TANF assistance remain at the time the participant from another state applies for assistance, the participant must be in compliance every month.

~~(f)~~ (e) The employment plan developed under section 256J.521, subdivision 2, for participants under this subdivision must contain at least the minimum number of hours specified in paragraph (a) for the purpose of meeting the requirements for an extension under this subdivision. The job counselor and the participant must sign the employment plan to indicate agreement between the job counselor and the participant on the contents of the plan.

~~(g)~~ (f) Participants who fail to meet the requirements in paragraph (a), without good cause under section 256J.57, shall be sanctioned or permanently disqualified under subdivision 6. Good cause may only be granted for that portion of the month for which the good cause reason applies. Participants must meet all remaining requirements in the approved employment plan or be subject to sanction or permanent disqualification.

~~(h)~~ (g) If the noncompliance with an employment plan is due to the involuntary loss of employment, the participant is exempt from the hourly employment requirement under this subdivision for one month. Participants must meet all remaining requirements in the approved employment plan or be subject to sanction or permanent disqualification. This exemption is available to each participant two times in a 12-month period.

Sec. 36. Minnesota Statutes 2006, section 256J.46, is amended by adding a subdivision to read:

Subd. 3. **Restrictions on sanctions.** A participant shall not be sanctioned for failure to meet the agreed upon hours in a participant's employment plan under section 256J.521, subdivision 2, when the participant:

(1) fails to meet the agreed upon hours of participation in paid employment because the participant is not eligible for holiday pay and the participant's place of employment is closed for a holiday; or

(2) is otherwise meeting or exceeding the federal TANF work participation rate hourly requirements.

Sec. 37. Minnesota Statutes 2006, section 256J.49, subdivision 13, is amended to read:

Subd. 13. **Work activity.** "Work activity" means any activity in a participant's approved employment plan that leads to employment. For purposes of the MFIP program, this includes activities that meet the definition of work activity under the participation requirements of TANF. Work activity includes:

(1) unsubsidized employment, including work study and paid apprenticeships or internships;

(2) subsidized private sector or public sector employment, including grant diversion as specified in section 256J.69, on-the-job training as specified in section 256J.66, the self-employment investment demonstration program (SEID) as specified in section 256J.65, paid work experience, and supported work when a wage subsidy is provided;

(3) unpaid work experience, including community service, volunteer work, the community work experience program as specified in section 256J.67, unpaid apprenticeships or internships, and supported work when a wage subsidy is not provided.

Unpaid work performed in return for cash assistance is prohibited and does not count as a work activity, unless the participant voluntarily agrees, in writing, to engage in unpaid work in return for cash assistance. The participant may terminate the unpaid work arrangement, in writing, at any time;

(4) job search including job readiness assistance, job clubs, job placement, job-related counseling, and job retention services;

(5) job readiness education, including English as a second language (ESL) or functional work literacy classes as limited by the provisions of section 256J.531, subdivision 2, general educational development (GED) course work, high school completion, and adult basic education as limited by the provisions of section 256J.531, subdivision 1;

(6) job skills training directly related to employment, including education and training that can reasonably be expected to lead to employment, as limited by the provisions of section 256J.53;

(7) providing child care services to a participant who is working in a community service program;

(8) activities included in the employment plan that is developed under section 256J.521, subdivision 3; and

(9) preemployment activities including chemical and mental health assessments, treatment, and services; learning disabilities services; child protective services; family stabilization services; or other programs designed to enhance employability.

Sec. 38. Minnesota Statutes 2006, section 256J.521, subdivision 1, is amended to read:

Subdivision 1. **Assessments.** (a) For purposes of MFIP employment services, assessment is a continuing process of gathering information related to employability for the purpose of identifying both participant's strengths and strategies for coping with issues that interfere with employment. The job counselor must use information from the assessment process to develop and update the employment plan under subdivision 2 or 3, as appropriate, ~~and~~ to determine whether the participant qualifies for a family violence waiver including an employment plan under subdivision 3, and to determine whether the participant should be referred to the family stabilization services program under section 256J.575.

(b) The scope of assessment must cover at least the following areas:

(1) basic information about the participant's ability to obtain and retain employment, including: a review of the participant's education level; interests, skills, and abilities; prior employment or work experience; transferable work skills; child care and transportation needs;

(2) identification of personal and family circumstances that impact the participant's ability to obtain and retain employment, including: any special needs of the children, the level of English proficiency, family violence issues, and any involvement with social services or the legal system;

(3) the results of a mental and chemical health screening tool designed by the commissioner and results of the brief screening tool for special learning needs. Screening tools for mental and chemical health and special learning needs must be approved by the commissioner and may only be administered by job counselors or county staff trained in using such screening tools. The commissioner shall work with county agencies to develop protocols for referrals and follow-up actions after screens are administered to participants, including guidance on how employment plans may be modified based upon outcomes of certain screens. Participants must be told of the purpose of the screens and how the information will be used to assist the participant in identifying and overcoming barriers to employment. Screening for mental and chemical health and special learning needs must be completed by participants who are unable to find suitable employment after six weeks

of job search under subdivision 2, paragraph (b), and participants who are determined to have barriers to employment under subdivision 2, paragraph (d). Failure to complete the screens will result in sanction under section 256J.46; and

(4) a comprehensive review of participation and progress for participants who have received MFIP assistance and have not worked in unsubsidized employment during the past 12 months. The purpose of the review is to determine the need for additional services and supports, including placement in subsidized employment or unpaid work experience under section 256J.49, subdivision 13, or referral to the family stabilization services program under section 256J.575.

(c) Information gathered during a caregiver's participation in the diversionary work program under section 256J.95 must be incorporated into the assessment process.

(d) The job counselor may require the participant to complete a professional chemical use assessment to be performed according to the rules adopted under section 254A.03, subdivision 3, including provisions in the administrative rules which recognize the cultural background of the participant, or a professional psychological assessment as a component of the assessment process, when the job counselor has a reasonable belief, based on objective evidence, that a participant's ability to obtain and retain suitable employment is impaired by a medical condition. The job counselor may assist the participant with arranging services, including child care assistance and transportation, necessary to meet needs identified by the assessment. Data gathered as part of a professional assessment must be classified and disclosed according to the provisions in section 13.46.

Sec. 39. Minnesota Statutes 2006, section 256J.521, subdivision 2, is amended to read:

Subd. 2. Employment plan; contents. (a) Based on the assessment under subdivision 1, the job counselor and the participant must develop an employment plan that includes participation in activities and hours that meet the requirements of section 256J.55, subdivision 1. The purpose of the employment plan is to identify for each participant the most direct path to unsubsidized employment and any subsequent steps that support long-term economic stability. The employment plan should be developed using the highest level of activity appropriate for the participant. Activities must be chosen from clauses (1) to (6), which are listed in order of preference. Notwithstanding this order of preference for activities, priority must be given for activities related to a family violence waiver when developing the employment plan. The employment plan must also list the specific steps the participant will take to obtain employment, including steps necessary for the participant to progress from one level of activity to another, and a timetable for completion of each step. Levels of activity include:

- (1) unsubsidized employment;
- (2) job search;
- (3) subsidized employment or unpaid work experience;
- (4) unsubsidized employment and job readiness education or job skills training;
- (5) unsubsidized employment or unpaid work experience and activities related to a family violence waiver or preemployment needs; and
- (6) activities related to a family violence waiver or preemployment needs.
- (b) Participants who are determined to possess sufficient skills such that the participant is likely to succeed in obtaining unsubsidized employment must job search at least 30 hours per week for up to six weeks and accept any offer of suitable employment. The remaining hours necessary to meet the requirements of section 256J.55, subdivision 1, may be met through participation in other work activities under section 256J.49, subdivision 13. The participant's employment plan must specify, at a minimum: (1) whether the job search is supervised or unsupervised; (2) support services that will be provided; and (3) how frequently the participant must report to the job counselor. Participants who are unable to find suitable employment after six weeks must meet with the job counselor to determine whether other activities in paragraph (a) should be incorporated into the employment plan. Job search activities which are continued after six weeks must be structured and supervised.
- (c) Beginning July 1, 2004, activities and hourly requirements in the employment plan may be adjusted as necessary to accommodate the personal and family circumstances of participants identified under section 256J.561, subdivision 2, paragraph (d). Participants who no longer meet the provisions of section 256J.561, subdivision 2, paragraph (d), must meet with the job counselor within ten days of the determination to revise the employment plan.
- (d) Participants who are determined to have barriers to obtaining or retaining employment that will not be overcome during six weeks of job search under paragraph (b) must work with the job counselor to develop an employment plan that addresses those barriers by incorporating appropriate activities from paragraph (a), clauses (1) to (6). The employment plan must include enough hours to meet the participation requirements in section 256J.55, subdivision 1, unless a compelling reason to require fewer hours is noted in the participant's file.
- (e) The job counselor and the participant must sign the employment plan to indicate agreement on the contents.
- (f) Except as provided under paragraphs (g) and (h), failure to develop or comply with activities in the plan, or voluntarily quitting suitable employment without good

cause, will result in the imposition of a sanction under section 256J.46. The job counselor is encouraged to allow participants who are participating in at least 20 hours of work activities to also participate in employment and training activities in order to meet the federal hourly participation rates.

(g) When a participant fails to meet the agreed upon hours of participation in paid employment because the participant is not eligible for holiday pay and the participant's place of employment is closed for a holiday, the job counselor shall not impose a sanction or increase the hours of participation in any other activity, including paid employment, to offset the hours that were missed due to the holiday.

(h) The job counselor shall not impose a sanction for failure to meet the agreed upon hours in a participant's employment plan under this subdivision when the participant is otherwise meeting or exceeding the federal TANF work participation rate hourly requirements.

(i) Employment plans must be reviewed at least every three months to determine whether activities and hourly requirements should be revised.

Sec. 40. Minnesota Statutes 2006, section 256J.521, is amended by adding a subdivision to read:

Subd. 7. Employment plan; nonmaintenance of effort; single caregivers. (a) When a single caregiver is moved to the nonmaintenance of effort state-funded program under section 256J.021, paragraphs (a) and (b), the single caregiver shall develop or revise the employment plan as specified in this subdivision with a job counselor or county. The plan must address issues interfering with employment, including physical and mental health, substance use, and social service issues of the caregiver and the caregiver's family. Job search and employment must also be included in the plan to the extent possible.

(b) Counties must coordinate services by ensuring that all workers involved with the family communicate on a regular basis, and that expectations for the family across service areas lead to common goals.

(c) Activities and hourly requirements in the employment plan may be adjusted as necessary to accommodate the personal and family circumstances of the participant. Participants who no longer meet the criteria for the nonmaintenance of effort state-funded program shall meet with the job counselor or county within ten days of the determination to revise the employment plan.

Sec. 41. Minnesota Statutes 2006, section 256J.53, subdivision 2, is amended to read:

Subd. 2. **Approval of postsecondary education or training.** ~~(a) In order for a postsecondary education or training program to be an approved activity in an employment plan, the participant must be working in unsubsidized employment at least 20 hours per week.~~

~~(b)~~ Participants seeking approval of a postsecondary education or training plan must provide documentation that:

(1) the employment goal can only be met with the additional education or training;

(2) there are suitable employment opportunities that require the specific education or training in the area in which the participant resides or is willing to reside;

(3) the education or training will result in significantly higher wages for the participant than the participant could earn without the education or training;

(4) the participant can meet the requirements for admission into the program; and

(5) there is a reasonable expectation that the participant will complete the training program based on such factors as the participant's MFIP assessment, previous education, training, and work history; current motivation; and changes in previous circumstances.

~~(c) The hourly unsubsidized employment requirement does not apply for intensive education or training programs lasting 12 weeks or less when full-time attendance is required.~~

~~(d)~~ (b) Participants with an approved employment plan in place on July 1, 2003, which includes more than 12 months of postsecondary education or training shall be allowed to complete that plan provided that hourly requirements in section 256J.55, subdivision 1, and conditions specified in paragraph ~~(b)~~ (a), and subdivisions 3 and 5 are met. A participant whose case is subsequently closed for three months or less for reasons other than noncompliance with program requirements and who returns to MFIP shall be allowed to complete that plan provided that hourly requirements in section 256J.55, subdivision 1, and conditions specified in paragraph ~~(b)~~ (a) and subdivisions 3 and 5 are met.

Sec. 42. Minnesota Statutes 2006, section 256J.55, subdivision 1, is amended to read:

Subdivision 1. **Participation requirements.** (a) All caregivers must participate in employment services under sections 256J.515 to 256J.57 concurrent with receipt of MFIP assistance.

(b) Until July 1, 2004, participants who meet the requirements of section 256J.56 are exempt from participation requirements.

(c) Participants under paragraph (a) must develop and comply with an employment plan under section 256J.521 or section 256J.54 in the case of a participant under the age of 20 who has not obtained a high school diploma or its equivalent.

(d) With the exception of participants under the age of 20 who must meet the education requirements of section 256J.54, all participants must meet the hourly participation requirements of TANF or the hourly requirements listed in clauses (1) to (3), whichever is higher.

(1) In single-parent families with no children under six years of age, the job counselor and the caregiver must develop an employment plan that includes ~~30 to 35 hours per week of work activities~~ 130 hours per month of work activities.

(2) In single-parent families with a child under six years of age, the job counselor and the caregiver must develop an employment plan that includes ~~20 to 35 hours per week of work activities~~ 87 hours per month of work activities.

(3) In two-parent families, the job counselor and the caregivers must develop employment plans which result in a combined total of at least 55 hours per week of work activities.

(e) Failure to participate in employment services, including the requirement to develop and comply with an employment plan, including hourly requirements, without good cause under section 256J.57, shall result in the imposition of a sanction under section 256J.46.

Sec. 43. **[256J.575] FAMILY STABILIZATION SERVICES.**

Subdivision 1. Purpose. (a) The family stabilization services serve families who are not making significant progress within the Minnesota family investment program (MFIP) due to a variety of barriers to employment.

(b) The goal of the services is to stabilize and improve the lives of families at risk of long-term welfare dependency or family instability due to employment barriers such as physical disability, mental disability, age, or providing care for a disabled household member. These services promote and support families to achieve the greatest possible degree of self-sufficiency.

Subd. 2. Definitions. The terms used in this section have the meanings given them in paragraphs (a) to (d).

(a) "Case management" means the services provided by or through the county agency or through the employment services agency to participating families, including assessment, information, referrals, and assistance in the preparation and implementation of a family stabilization plan under subdivision 5.

51.1 (b) "Family stabilization plan" means a plan developed by a case manager and
51.2 the participant, which identifies the participant's most appropriate path to unsubsidized
51.3 employment, family stability, and barrier reduction, taking into account the family's
51.4 circumstances.

51.5 (c) "Family stabilization services" means programs, activities, and services in this
51.6 section that provide participants and their family members with assistance regarding,
51.7 but not limited to:

51.8 (1) obtaining and retaining unsubsidized employment;

51.9 (2) family stability;

51.10 (3) economic stability; and

51.11 (4) barrier reduction.

51.12 The goal of the services is to achieve the greatest degree of economic self-sufficiency
51.13 and family well-being possible for the family under the circumstances.

51.14 (d) "Case manager" means the county-designated staff person or employment
51.15 services counselor.

51.16 Subd. 3. **Eligibility.** (a) The following MFIP or diversionary work program (DWP)
51.17 participants are eligible for the services under this section:

51.18 (1) a participant identified under section 256J.561, subdivision 2, paragraph (d), who
51.19 has or is eligible for an employment plan developed under section 256J.521, subdivision
51.20 2, paragraph (c);

51.21 (2) a participant identified under section 256J.95, subdivision 12, paragraph (b), as
51.22 unlikely to benefit from the DWP;

51.23 (3) a participant who meets the requirements for or has been granted a hardship
51.24 extension under section 256J.425, subdivision 2 or 3;

51.25 (4) a participant who is applying for supplemental security income or Social Security
51.26 disability insurance;

51.27 (5) a participant who is a noncitizen who has been in the United States for 12 or
51.28 fewer months; and

51.29 (6) a new MFIP participant, for the first 30 days the participant receives assistance or
51.30 when the participant's employment plan is completed, whichever is sooner.

51.31 (b) Families must meet all other eligibility requirements for MFIP established in
51.32 this chapter. Families are eligible for financial assistance to the same extent as if they
51.33 were participating in MFIP.

51.34 (c) A participant under paragraph (a), clause (5), must be provided with English as a
51.35 second language opportunities and skills training for up to 12 months. After 12 months,
51.36 the case manager and participant must determine whether the participant should continue

with English as a second language classes or skills training, or both, or if the participant should become an MFIP participant.

Subd. 4. **Universal participation.** All caregivers must participate in family stabilization services as defined in subdivision 2.

Subd. 5. **Case management; family stabilization plans; coordinated services.** (a) The county agency shall provide family stabilization services to families through a case management model. A case manager shall be assigned to each participating family within 30 days after the family begins to receive financial assistance as a participant of the family stabilization services. The case manager, with the full involvement of the participant, shall recommend, and the county agency shall establish and modify as necessary, a family stabilization plan for each participating family. If a participant is already assigned to a county case manager or a county-designated case manager in social services, disability services, or housing services that case manager already assigned may be the case manager for purposes of these services.

(b) The family stabilization plan must include:

(1) each participant's plan for long-term self-sufficiency, including an employment goal where applicable;

(2) an assessment of each participant's strengths and barriers, and any special circumstances of the participant's family that impact, or are likely to impact, the participant's progress towards the goals in the plan; and

(3) an identification of the services, supports, education, training, and accommodations needed to reduce or overcome any barriers to enable the family to achieve self-sufficiency and to fulfill each caregiver's personal and family responsibilities.

(c) The case manager and the participant shall meet within 30 days of the family's referral to the case manager. The initial family stabilization plan must be completed within 30 days of the first meeting with the case manager. The case manager shall establish a schedule for periodic review of the family stabilization plan that includes personal contact with the participant at least once per month. In addition, the case manager shall review and, if necessary, modify the plan under the following circumstances:

(1) there is a lack of satisfactory progress in achieving the goals of the plan;

(2) the participant has lost unsubsidized or subsidized employment;

(3) a family member has failed or is unable to comply with a family stabilization plan requirement;

(4) services, supports, or other activities required by the plan are unavailable;

(5) changes to the plan are needed to promote the well-being of the children; or

53.1 (6) the participant and case manager determine that the plan is no longer appropriate
53.2 for any other reason.

53.3 Subd. 6. Cooperation with services requirements. (a) To be eligible, a participant
53.4 shall comply with paragraphs (b) to (e).

53.5 (b) Participants shall engage in family stabilization plan services for the appropriate
53.6 number of hours per week that the activities are scheduled and available, unless good
53.7 cause exists for not doing so, as defined in section 256J.57, subdivision 1. The appropriate
53.8 number of hours must be based on the participant's plan.

53.9 (c) The case manager shall review the participant's progress toward the goals in the
53.10 family stabilization plan every six months to determine whether conditions have changed,
53.11 including whether revisions to the plan are needed.

53.12 (d) When the participant has increased participation in work-related activities
53.13 sufficient to meet the federal participation requirements of TANF, the county agency shall
53.14 refer the participant to the MFIP program and assign the participant to a job counselor.
53.15 The participant and the job counselor shall meet within 15 days of referral to the MFIP
53.16 program to develop an employment plan under section 256J.521. No reapplication is
53.17 necessary and financial assistance continues without interruption.

53.18 (e) A participant's requirement to comply with any or all family stabilization plan
53.19 requirements under this subdivision is excused when the case management services,
53.20 training and educational services, and family support services identified in the participant's
53.21 family stabilization plan are unavailable for reasons beyond the control of the participant,
53.22 including when money appropriated is not sufficient to provide the services.

53.23 Subd. 7. Sanctions. (a) The financial assistance grant of a participating family is
53.24 reduced according to section 256J.46, if a participating adult fails without good cause to
53.25 comply or continue to comply with the family stabilization plan requirements in this
53.26 subdivision, unless compliance has been excused under subdivision 6, paragraph (e).

53.27 (b) Given the purpose of the family stabilization services in this section and the
53.28 nature of the underlying family circumstances that act as barriers to both employment and
53.29 full compliance with program requirements, sanctions are appropriate only when it is clear
53.30 that there is both the ability to comply and willful noncompliance by the participant, as
53.31 confirmed by a behavioral health or medical professional.

53.32 (c) Prior to the imposition of a sanction, the county agency shall review the
53.33 participant's case to determine if the family stabilization plan is still appropriate and
53.34 meet with the participant face-to-face. The participant may bring an advocate to the
53.35 face-to-face meeting.

53.36 During the face-to-face meeting, the county agency must:

(1) determine whether the continued noncompliance can be explained and mitigated by providing a needed family stabilization service, as defined in subdivision 2, paragraph (d);

(2) determine whether the participant qualifies for a good cause exemption under section 256J.57, or if the sanction is for noncooperation with child support requirements, determine if the participant qualifies for a good cause exemption under section 256.741, subdivision 10;

(3) determine whether activities in the family stabilization plan are appropriate based on the family's circumstances;

(4) explain the consequences of continuing noncompliance;

(5) identify other resources that may be available to the participant to meet the needs of the family; and

(6) inform the participant of the right to appeal under section 256J.40.

If the lack of an identified activity or service can explain the noncompliance, the county shall work with the participant to provide the identified activity.

(d) If the participant fails to come to the face-to-face meeting, the case manager or a designee shall attempt at least one home visit. If a face-to-face meeting is not conducted, the county agency shall send the participant a written notice that includes the information under paragraph (c).

(e) After the requirements of paragraphs (c) and (d) are met and prior to imposition of a sanction, the county agency shall provide a notice of intent to sanction under section 256J.57, subdivision 2, and, when applicable, a notice of adverse action under section 256J.31.

(f) Section 256J.57 applies to this section except to the extent that it is modified by this subdivision.

Subd. 8. **Funding.** (a) The commissioner of human services must treat MFIP expenditures made to or on behalf of any minor child under this section, who is part of a household that meets criteria in subdivision 3, as expenditures under a separately funded state program. These expenditures shall not count toward the state's maintenance of effort requirements under the federal TANF program.

(b) A family is no longer part of a separately funded program under this section, if the caregiver no longer meets the criteria for family stabilization services in subdivision 3 or if it is determined at recertification that the caregiver is meeting the federal work participation rate, whichever occurs sooner.

Sec. 44. Minnesota Statutes 2006, section 256J.626, subdivision 1, is amended to read:

Subdivision 1. **Consolidated fund.** The consolidated fund is established to support counties and tribes in meeting their duties under this chapter. Counties and tribes must use funds from the consolidated fund to develop programs and services that are designed to improve participant outcomes as measured in section 256J.751, subdivision 2. Counties may use the funds for any allowable expenditures under subdivision 2, and to provide case management services to participants of the family stabilization services program. Tribes may use the funds for any allowable expenditures under subdivision 2, except those in subdivision 2, paragraph (a), clauses (1) and (6).

Sec. 45. Minnesota Statutes 2006, section 256J.626, subdivision 2, is amended to read:

Subd. 2. **Allowable expenditures.** (a) The commissioner must restrict expenditures under the consolidated fund to benefits and services allowed under title IV-A of the federal Social Security Act. Allowable expenditures under the consolidated fund may include, but are not limited to:

(1) short-term, nonrecurring shelter and utility needs that are excluded from the definition of assistance under Code of Federal Regulations, title 45, section 260.31, for families who meet the residency requirement in section 256J.12, subdivisions 1 and 1a. Payments under this subdivision are not considered TANF cash assistance and are not counted towards the 60-month time limit;

(2) transportation needed to obtain or retain employment or to participate in other approved work activities or activities under a family stabilization plan;

(3) direct and administrative costs of staff to deliver employment services for MFIP ~~or~~ the diversionary work program, or the family stabilization services program; to administer financial assistance; and to provide specialized services intended to assist hard-to-employ participants to transition to work or transition from the family stabilization services program to MFIP;

(4) costs of education and training including functional work literacy and English as a second language;

(5) cost of work supports including tools, clothing, boots, telephone service, and other work-related expenses;

(6) county administrative expenses as defined in Code of Federal Regulations, title 45, section 260(b);

(7) services to parenting and pregnant teens;

(8) supported work;

(9) wage subsidies;

(10) child care needed for MFIP ~~or~~, the diversionary work program, or the family stabilization services program participants to participate in social services;

(11) child care to ensure that families leaving MFIP or diversionary work program will continue to receive child care assistance from the time the family no longer qualifies for transition year child care until an opening occurs under the basic sliding fee child care program; ~~and~~

(12) services to help noncustodial parents who live in Minnesota and have minor children receiving MFIP or DWP assistance, but do not live in the same household as the child, obtain or retain employment; and

(13) services to help families participating in the family stabilization services program achieve the greatest possible degree of self-sufficiency.

(b) Administrative costs that are not matched with county funds as provided in subdivision 8 may not exceed 7.5 percent of a county's or 15 percent of a tribe's allocation under this section. The commissioner shall define administrative costs for purposes of this subdivision.

(c) The commissioner may waive the cap on administrative costs for a county or tribe that elects to provide an approved supported employment, unpaid work, or community work experience program for a major segment of the county's or tribe's MFIP population. The county or tribe must apply for the waiver on forms provided by the commissioner. In no case shall total administrative costs exceed the TANF limits.

Sec. 46. Minnesota Statutes 2006, section 256J.626, subdivision 3, is amended to read:

Subd. 3. **Eligibility for services.** Families with a minor child, a pregnant woman, or a noncustodial parent of a minor child receiving assistance, with incomes below 200 percent of the federal poverty guideline for a family of the applicable size, are eligible for services funded under the consolidated fund. Counties and tribes must give priority to families currently receiving MFIP ~~or~~, the diversionary work program, or the family stabilization services program, and families at risk of receiving MFIP or diversionary work program.

Sec. 47. Minnesota Statutes 2006, section 256J.626, subdivision 4, is amended to read:

Subd. 4. **County and tribal biennial service agreements.** (a) Effective January 1, 2004, and each two-year period thereafter, each county and tribe must have in place an approved biennial service agreement related to the services and programs in this chapter. In counties with a city of the first class with a population over 300,000, the county must consider a service agreement that includes a jointly developed plan for the delivery of

57.1 employment services with the city. Counties may collaborate to develop multicounty,
57.2 multitribal, or regional service agreements.

57.3 (b) The service agreements will be completed in a form prescribed by the
57.4 commissioner. The agreement must include:

57.5 (1) a statement of the needs of the service population and strengths and resources
57.6 in the community;

57.7 (2) numerical goals for participant outcomes measures to be accomplished during
57.8 the biennial period. The commissioner may identify outcomes from section 256J.751,
57.9 subdivision 2, as core outcomes for all counties and tribes;

57.10 (3) strategies the county or tribe will pursue to achieve the outcome targets.
57.11 Strategies must include specification of how funds under this section will be used and may
57.12 include community partnerships that will be established or strengthened; ~~and~~

57.13 (4) strategies the county or tribe will pursue under the family stabilization services
57.14 program; and

57.15 (5) other items prescribed by the commissioner in consultation with counties and
57.16 tribes.

57.17 (c) The commissioner shall provide each county and tribe with information needed
57.18 to complete an agreement, including: (1) information on MFIP cases in the county or
57.19 tribe; (2) comparisons with the rest of the state; (3) baseline performance on outcome
57.20 measures; and (4) promising program practices.

57.21 (d) The service agreement must be submitted to the commissioner by October 15,
57.22 2003, and October 15 of each second year thereafter. The county or tribe must allow
57.23 a period of not less than 30 days prior to the submission of the agreement to solicit
57.24 comments from the public on the contents of the agreement.

57.25 (e) The commissioner must, within 60 days of receiving each county or tribal service
57.26 agreement, inform the county or tribe if the service agreement is approved. If the service
57.27 agreement is not approved, the commissioner must inform the county or tribe of any
57.28 revisions needed prior to approval.

57.29 (f) The service agreement in this subdivision supersedes the plan requirements
57.30 of section 116L.88.

57.31 Sec. 48. Minnesota Statutes 2006, section 256J.626, subdivision 5, is amended to read:

57.32 Subd. 5. **Innovation projects.** Beginning January 1, 2005, no more than \$3,000,000
57.33 of the funds annually appropriated to the commissioner for use in the consolidated
57.34 fund shall be available to the commissioner for projects testing innovative approaches
57.35 to improving outcomes for MFIP participants, family stabilization services program

58.1 participants, and persons at risk of receiving MFIP as detailed in subdivision 3, and
58.2 for providing incentives to counties and tribes that exceed performance. Projects shall
58.3 be targeted to geographic areas with poor outcomes as specified in section 256J.751,
58.4 subdivision 5, or to subgroups within the MFIP case load who are experiencing poor
58.5 outcomes. For purposes of an incentive, a county or tribe exceeds performance if the
58.6 county or tribe is above the top of the county's or tribe's annualized range of expected
58.7 performance on the three-year self-support index under section 256J.751, subdivision 2,
58.8 clause (7), and achieves a 50 percent TANF participation rate under section 256J.751,
58.9 subdivision 2, clause (7), as averaged across the four quarterly measurements for the most
58.10 recent year for which the measurements are available.

58.11 Sec. 49. Minnesota Statutes 2006, section 256J.626, subdivision 6, is amended to read:

58.12 Subd. 6. **Base allocation to counties and tribes; definitions.** (a) For purposes of
58.13 this section, the following terms have the meanings given.

58.14 (1) "2002 historic spending base" means the commissioner's determination of
58.15 the sum of the reimbursement related to fiscal year 2002 of county or tribal agency
58.16 expenditures for the base programs listed in clause (6), items (i) through (iv), and earnings
58.17 related to calendar year 2002 in the base program listed in clause (6), item (v), and the
58.18 amount of spending in fiscal year 2002 in the base program listed in clause (6), item (vi),
58.19 issued to or on behalf of persons residing in the county or tribal service delivery area.

58.20 (2) "Adjusted caseload factor" means a factor weighted:

58.21 (i) 47 percent on the MFIP cases in each county at four points in time in the most
58.22 recent 12-month period for which data is available multiplied by the county's caseload
58.23 difficulty factor; and

58.24 (ii) 53 percent on the count of adults on MFIP in each county and tribe at four points
58.25 in time in the most recent 12-month period for which data is available multiplied by the
58.26 county or tribe's caseload difficulty factor.

58.27 (3) "Caseload difficulty factor" means a factor determined by the commissioner for
58.28 each county and tribe based upon the self-support index described in section 256J.751,
58.29 subdivision 2, clause (7).

58.30 (4) "Initial allocation" means the amount potentially available to each county or tribe
58.31 based on the formula in paragraphs (b) through (h).

58.32 (5) "Final allocation" means the amount available to each county or tribe based on
58.33 the formula in paragraphs (b) through (h), ~~after adjustment by subdivision 7.~~

58.34 (6) "Base programs" means the:

(i) MFIP employment and training services under Minnesota Statutes 2002, section 256J.62, subdivision 1, in effect June 30, 2002;

(ii) bilingual employment and training services to refugees under Minnesota Statutes 2002, section 256J.62, subdivision 6, in effect June 30, 2002;

(iii) work literacy language programs under Minnesota Statutes 2002, section 256J.62, subdivision 7, in effect June 30, 2002;

(iv) supported work program authorized in Laws 2001, First Special Session chapter 9, article 17, section 2, in effect June 30, 2002;

(v) administrative aid program under section 256J.76 in effect December 31, 2002; and

(vi) emergency assistance program under Minnesota Statutes 2002, section 256J.48, in effect June 30, 2002.

(b) The commissioner shall:

(1) beginning July 1, 2003, determine the initial allocation of funds available under this section according to clause (2);

(2) allocate all of the funds available for the period beginning July 1, 2003, and ending December 31, 2004, to each county or tribe in proportion to the county's or tribe's share of the statewide 2002 historic spending base;

(3) determine for calendar year 2005 the initial allocation of funds to be made available under this section in proportion to the county or tribe's initial allocation for the period of July 1, 2003, to December 31, 2004;

(4) determine for calendar year 2006 the initial allocation of funds to be made available under this section based 90 percent on the proportion of the county or tribe's share of the statewide 2002 historic spending base and ten percent on the proportion of the county or tribe's share of the adjusted caseload factor;

(5) determine for calendar year 2007 the initial allocation of funds to be made available under this section based 70 percent on the proportion of the county or tribe's share of the statewide 2002 historic spending base and 30 percent on the proportion of the county or tribe's share of the adjusted caseload factor; and

(6) determine for calendar year 2008 and subsequent years the initial allocation of funds to be made available under this section based 50 percent on the proportion of the county or tribe's share of the statewide 2002 historic spending base and 50 percent on the proportion of the county or tribe's share of the adjusted caseload factor.

(c) With the commencement of a new or expanded tribal TANF program or an agreement under section 256.01, subdivision 2, paragraph (g), in which some or all of

the responsibilities of particular counties under this section are transferred to a tribe, the commissioner shall:

(1) in the case where all responsibilities under this section are transferred to a tribal program, determine the percentage of the county's current caseload that is transferring to a tribal program and adjust the affected county's allocation accordingly; and

(2) in the case where a portion of the responsibilities under this section are transferred to a tribal program, the commissioner shall consult with the affected county or counties to determine an appropriate adjustment to the allocation.

~~(d) Effective January 1, 2005, counties and tribes will have their final allocations adjusted based on the performance provisions of subdivision 7.~~

Sec. 50. Minnesota Statutes 2006, section 256J.751, subdivision 2, is amended to read:

Subd. 2. **Quarterly comparison report.** The commissioner shall report quarterly to all counties on each county's performance on the following measures:

(1) percent of MFIP caseload working in paid employment;

(2) percent of MFIP caseload receiving only the food portion of assistance;

(3) number of MFIP cases that have left assistance;

(4) median placement wage rate;

(5) caseload by months of TANF assistance;

(6) percent of MFIP and diversionary work program (DWP) cases off cash assistance or working 30 or more hours per week at one-year, two-year, and three-year follow-up points from a baseline quarter. This measure is called the self-support index. The commissioner shall report quarterly an expected range of performance for each county, county grouping, and tribe on the self-support index. The expected range shall be derived by a statistical methodology developed by the commissioner in consultation with the counties and tribes. The statistical methodology shall control differences across counties in economic conditions and demographics of the MFIP and DWP case load; and

(7) ~~the MFIP TANF~~ work participation rate, defined as the participation requirements specified in ~~title 1 of Public Law 104-193 applied to all MFIP cases except child only cases~~ under Public Law 109-171, the Deficit Reduction Act of 2005.

Sec. 51. Minnesota Statutes 2006, section 256J.751, subdivision 5, is amended to read:

Subd. 5. **Failure to meet federal performance standards.** (a) If sanctions occur for failure to meet the performance standards specified in title 1 of Public Law 104-193 of the Personal Responsibility and Work Opportunity Act of 1996, and under Public Law 109-171, the Deficit Reduction Act of 2005, the state shall pay 88 percent of the

sanction. The remaining 12 percent of the sanction will be paid by the counties. The county portion of the sanction will be distributed across all counties in proportion to each county's percentage of the MFIP average monthly caseload during the period for which the sanction was applied.

(b) If a county fails to meet the performance standards specified in title 1 of Public Law 104-193 of the Personal Responsibility and Work Opportunity Act of 1996, and Public Law 109-171, the Deficit Reduction Act of 2005, for any year, the commissioner shall work with counties to organize a joint state-county technical assistance team to work with the county. The commissioner shall coordinate any technical assistance with other departments and agencies including the Departments of Employment and Economic Development and Education as necessary to achieve the purpose of this paragraph.

(c) For state performance measures, a low-performing county is one that:

(1) performs below the bottom of their expected range for the measure in subdivision 2, clause ~~(7)~~ (6), in an annualized measurement reported in October of each year; or

(2) performs below 40 percent for the measure in subdivision 2, clause ~~(8)~~ (7), as averaged across the four quarterly measurements for the year, or the ten counties with the lowest rates if more than ten are below 40 percent.

(d) Low-performing counties under paragraph (c) must engage in corrective action planning as defined by the commissioner. The commissioner may coordinate technical assistance as specified in paragraph (b) for low-performing counties under paragraph (c).

Sec. 52. Minnesota Statutes 2006, section 256J.95, subdivision 3, is amended to read:

Subd. 3. **Eligibility for diversionary work program.** (a) Except for the categories of family units listed below, all family units who apply for cash benefits and who meet MFIP eligibility as required in sections 256J.11 to 256J.15 are eligible and must participate in the diversionary work program. Family units that are not eligible for the diversionary work program include:

(1) child only cases;

(2) a single-parent family unit that includes a child under 12 weeks of age. A parent is eligible for this exception once in a parent's lifetime and is not eligible if the parent has already used the previously allowed child under age one exemption from MFIP employment services;

(3) a minor parent without a high school diploma or its equivalent;

(4) an 18- or 19-year-old caregiver without a high school diploma or its equivalent who chooses to have an employment plan with an education option;

(5) a caregiver age 60 or over;

(6) family units with a caregiver who received DWP benefits in the 12 months prior to the month the family applied for DWP, except as provided in paragraph (c);

(7) family units with a caregiver who received MFIP within the 12 months prior to the month the family unit applied for DWP;

(8) a family unit with a caregiver who received 60 or more months of TANF assistance; ~~and~~

(9) a family unit with a caregiver who is disqualified from DWP or MFIP due to fraud; and

(10) refugees as defined in Code of Federal Regulations, title 45, chapter IV, section 444.43, who arrived in the United States in the 12 months prior to the date of application for family cash assistance.

(b) A two-parent family must participate in DWP unless both caregivers meet the criteria for an exception under paragraph (a), clauses (1) through (5), or the family unit includes a parent who meets the criteria in paragraph (a), clause (6), (7), (8), or (9).

(c) Once DWP eligibility is determined, the four months run consecutively. If a participant leaves the program for any reason and reapplies during the four-month period, the county must redetermine eligibility for DWP.

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

Sec. 53. Minnesota Statutes 2006, section 256J.95, subdivision 13, is amended to read:

Subd. 13. **Immediate referral to employment services.** Within one working day of determination that the applicant is eligible for the diversionary work program, but before benefits are issued to or on behalf of the family unit, the county shall refer all caregivers to employment services. The referral to the DWP employment services must be in writing and must contain the following information:

(1) notification that, as part of the application process, applicants are required to develop an employment plan or the DWP application will be denied;

(2) the employment services provider name and phone number;

~~(3) the date, time, and location of the scheduled employment services interview;~~

~~(4)~~ (3) the immediate availability of supportive services, including, but not limited to, child care, transportation, and other work-related aid; and

~~(5)~~ (4) the rights, responsibilities, and obligations of participants in the program, including, but not limited to, the grounds for good cause, the consequences of refusing or failing to participate fully with program requirements, and the appeal process.

Sec. 54. Minnesota Statutes 2006, section 256K.45, is amended by adding a subdivision to read:

Subd. 6. **Funding.** Any funds appropriated for this section may be expended on programs described under subdivisions 3 to 5, technical assistance, and capacity building. In addition, up to five percent of funds appropriated may be used for program administration and up to eight percent of funds appropriated may be used for the purpose of monitoring and evaluating runaway and homeless youth programs receiving funding under this section. Funding shall be directed to meet the greatest need, with a significant share of the funding focused on homeless youth providers in greater Minnesota.

Sec. 55. Minnesota Statutes 2006, section 259.24, subdivision 3, is amended to read:

Subd. 3. **Child.** When the child to be adopted is over 14 years of age, the child's written consent to adoption by a particular person is also ~~shall be~~ necessary. A child of any age who is under the guardianship of the commissioner and is legally available for adoption may not refuse or waive the commissioner's agent's exhaustive efforts to recruit, identify, and place the child in an adoptive home required under section 260C.317, subdivision 3, paragraph (b), or sign a document relieving county social services agencies of all recruitment efforts on the child's behalf.

Sec. 56. Minnesota Statutes 2006, section 259.53, subdivision 1, is amended to read:

Subdivision 1. **Notice to commissioner; referral for postplacement assessment.**

(a) Upon the filing of a petition for adoption of a child who is:

(1) under the guardianship of the commissioner or a licensed child-placing agency according to section 260C.201, subdivision 11, or 260C.317;

(2) placed by the commissioner, commissioner's agent, or licensed child-placing agency after a consent to adopt according to section 259.24 or under an agreement conferring authority to place for adoption according to section 259.25; or

(3) placed by preadoptive custody order for a direct adoptive placement ordered by the district court under section 259.47,

the court administrator shall immediately transmit a copy of the petition to the commissioner of human services.

(b) The court shall immediately refer the petition to the agency specified below for completion of a postplacement assessment and report as required by subdivision 2.

(1) If the child to be adopted has been committed to the guardianship of the commissioner or an agency under section 260C.317 or an agency has been given authority to place the child under section 259.25, the court shall refer the petition to that agency,

unless another agency is supervising the placement, in which case the court shall refer the petition to the supervising agency.

(2) If the child to be adopted has been placed in the petitioner's home by a direct adoptive placement, the court shall refer the petition to the agency supervising the placement under section 259.47, subdivision 3, paragraph (a), clause (6).

(3) If the child is to be adopted by an individual who is related to the child as defined by section 245A.02, subdivision 13, and in all other instances not described in clause (1) or (2), the court shall refer the petition to the local social services agency of the county in which the prospective adoptive parent lives.

Sec. 57. Minnesota Statutes 2006, section 259.57, subdivision 1, is amended to read:

Subdivision 1. **Findings; orders.** Upon the hearing,

(a) if the court finds that it is in the best interests of the child that the petition be granted, a decree of adoption shall be made and recorded in the office of the court administrator, ordering that henceforth the child shall be the child of the petitioner. In the decree the court may change the name of the child if desired. After the decree is granted for a child who is:

(1) under the guardianship of the commissioner or a licensed child-placing agency according to section 260C.201, subdivision 11, or 260C.317;

(2) placed by the commissioner, commissioner's agent, or licensed child-placing agency after a consent to adopt according to section 259.24 or under an agreement conferring authority to place for adoption according to section 259.25; or

(3) adopted after a direct adoptive placement ordered by the district court under section 259.47,

the court administrator shall immediately mail a copy of the recorded decree to the commissioner of human services;

(b) if the court is not satisfied that the proposed adoption is in the best interests of the child, the court shall deny the petition, and shall order the child returned to the custody of the person or agency legally vested with permanent custody or certify the case for appropriate action and disposition to the court having jurisdiction to determine the custody and guardianship of the child.

Sec. 58. Minnesota Statutes 2006, section 259.67, subdivision 4, is amended to read:

Subd. 4. **Eligibility conditions.** (a) The placing agency shall use the AFDC requirements as specified in federal law as of July 16, 1996, when determining the child's eligibility for adoption assistance under title IV-E of the Social Security Act. If the child

does not qualify, the placing agency shall certify a child as eligible for state funded adoption assistance only if the following criteria are met:

(1) Due to the child's characteristics or circumstances it would be difficult to provide the child an adoptive home without adoption assistance.

(2)(i) A placement agency has made reasonable efforts to place the child for adoption without adoption assistance, but has been unsuccessful; or

(ii) the child's licensed foster parents desire to adopt the child and it is determined by the placing agency that the adoption is in the best interest of the child.

(3)(i) The child has been a ward of the commissioner, a Minnesota-licensed child-placing agency, or a tribal social service agency of Minnesota recognized by the Secretary of the Interior; or (ii) the child will be adopted according to tribal law without a termination of parental rights or relinquishment, provided that the tribe has documented the valid reason why the child cannot or should not be returned to the home of the child's parent. The placing agency shall not certify a child who remains under the jurisdiction of the sending agency pursuant to section 260.851, article 5, for state-funded adoption assistance when Minnesota is the receiving state.

(b) For purposes of this subdivision, the characteristics or circumstances that may be considered in determining whether a child is a child with special needs under United States Code, title 42, chapter 7, subchapter IV, part E, or meets the requirements of paragraph (a), clause (1), are the following:

(1) The child is a member of a sibling group to be placed as one unit in which at least one sibling is older than 15 months of age or is described in clause (2) or (3).

(2) The child has documented physical, mental, emotional, or behavioral disabilities.

(3) The child has a high risk of developing physical, mental, emotional, or behavioral disabilities.

~~(4) The child is adopted according to tribal law without a termination of parental rights or relinquishment, provided that the tribe has documented the valid reason why the child cannot or should not be returned to the home of the child's parent.~~

(4) The child is five years of age or older.

(c) When a child's eligibility for adoption assistance is based upon the high risk of developing physical, mental, emotional, or behavioral disabilities, payments shall not be made under the adoption assistance agreement unless and until the potential disability manifests itself as documented by an appropriate health care professional.

Sec. 59. Minnesota Statutes 2006, section 259.67, subdivision 7, is amended to read:

Subd. 7. **Reimbursement of costs.** (a) Subject to rules of the commissioner, and the provisions of this subdivision a child-placing agency licensed in Minnesota or any other state, or local or tribal social services agency shall receive a reimbursement from the commissioner equal to 100 percent of the reasonable and appropriate cost of providing adoption services ~~for a child certified as eligible for adoption assistance under subdivision 4. Such assistance.~~ Adoption services under this subdivision may include adoptive family recruitment, counseling, and special training when needed.

(b) An eligible child must have a goal of adoption, which may include an adoption in accordance with tribal law, and meet one of the following criteria:

(1) is a ward of the commissioner of human services or a ward of tribal court pursuant to section 260.755, subdivision 20, who meets one of the criteria in subdivision 4, paragraph (b), clause (1), (2), or (3); or

(2) is under the guardianship of a Minnesota-licensed child-placing agency who meets one of the criteria in subdivision 4, paragraph (b), clause (1) or (2).

(c) A child-placing agency licensed in Minnesota or any other state shall receive reimbursement for adoption services it purchases for or directly provides to an eligible child. Tribal social services shall receive reimbursement for adoption services it purchases for or directly provides to an eligible child. A local or tribal social services agency shall receive such reimbursement only for adoption services it purchases for an eligible child.

~~(b) A child-placing agency licensed in Minnesota or any other state or local or tribal social services agency seeking reimbursement under this subdivision shall enter into~~
Before providing adoption services for which reimbursement will be sought under this subdivision, a reimbursement agreement, on the designated format, must be entered into
with the commissioner before providing adoption services for which reimbursement is sought. No reimbursement under this subdivision shall be made to an agency for services provided prior to entering a reimbursement agreement. Separate reimbursement agreements shall be made for each child and separate records shall be kept on each child for whom a reimbursement agreement is made. The commissioner of human services shall agree that the reimbursement costs are reasonable and appropriate. The commissioner may spend up to \$16,000 for each purchase of service agreement. Only one agreement per child is allowed, unless an exception is granted by the commissioner. Funds encumbered and obligated under such an agreement for the child remain available until the terms of the agreement are fulfilled or the agreement is terminated.

~~(c) When a local or tribal social services agency uses a purchase of service agreement to provide services reimbursable under a reimbursement agreement, The commissioner may shall~~ make reimbursement payments directly to the agency providing the service if

67.1 direct reimbursement is specified by the purchase of service agreement, and if the request
67.2 for reimbursement is submitted by the local or tribal social services agency along with a
67.3 verification that the service was provided.

67.4 Sec. 60. Minnesota Statutes 2006, section 259.75, subdivision 8, is amended to read:

67.5 Subd. 8. **Reasons for deferral.** Deferral of the listing of a child with the state
67.6 adoption exchange shall be only for one or more of the following reasons:

67.7 (a) the child is in an adoptive placement but is not legally adopted;

67.8 (b) the child's foster parents or other individuals are now considering adoption;

67.9 (c) diagnostic study or testing is required to clarify the child's problem and provide
67.10 an adequate description; or

67.11 (d) the child is currently in a hospital and continuing need for daily professional care
67.12 will not permit placement in a family setting; ~~or,~~

67.13 ~~(e) the child is 14 years of age or older and will not consent to an adoption plan.~~

67.14 Approval of a request to defer listing for any of the reasons specified in paragraph (b) or
67.15 (c) shall be valid for a period not to exceed 90 days, with no subsequent deferrals for
67.16 those reasons.

67.17 Sec. 61. Minnesota Statutes 2006, section 260.012, is amended to read:

67.18 **260.012 DUTY TO ENSURE PLACEMENT PREVENTION AND FAMILY**
67.19 **REUNIFICATION; REASONABLE EFFORTS.**

67.20 (a) Once a child alleged to be in need of protection or services is under the court's
67.21 jurisdiction, the court shall ensure that reasonable efforts, including culturally appropriate
67.22 services, by the social services agency are made to prevent placement or to eliminate the
67.23 need for removal and to reunite the child with the child's family at the earliest possible
67.24 time, and ~~when a child cannot be reunified with the parent or guardian from whom the~~
67.25 ~~child was removed,~~ the court must ensure that the responsible social services agency
67.26 makes reasonable efforts to finalize an alternative permanent plan for the child as provided
67.27 in paragraph (e). In determining reasonable efforts to be made with respect to a child and
67.28 in making those reasonable efforts, the child's best interests, health, and safety must be of
67.29 paramount concern. Reasonable efforts to prevent placement and for rehabilitation and
67.30 reunification are always required except upon a determination by the court that a petition
67.31 has been filed stating a prima facie case that:

67.32 (1) the parent has subjected a child to egregious harm as defined in section
67.33 260C.007, subdivision 14;

68.1 (2) the parental rights of the parent to another child have been terminated
68.2 involuntarily;

68.3 (3) the child is an abandoned infant under section 260C.301, subdivision 2,
68.4 paragraph (a), clause (2);

68.5 (4) the parent's custodial rights to another child have been involuntarily transferred
68.6 to a relative under section 260C.201, subdivision 11, paragraph (e), clause (1), or a similar
68.7 law of another jurisdiction; or

68.8 (5) the provision of services or further services for the purpose of reunification is
68.9 futile and therefore unreasonable under the circumstances.

68.10 (b) When the court makes one of the prima facie determinations under paragraph (a),
68.11 either permanency pleadings under section 260C.201, subdivision 11, or a termination
68.12 of parental rights petition under sections 260C.141 and 260C.301 must be filed. A
68.13 permanency hearing under section 260C.201, subdivision 11, must be held within 30
68.14 days of this determination.

68.15 (c) In the case of an Indian child, in proceedings under sections 260B.178 or
68.16 260C.178, 260C.201, and 260C.301 the juvenile court must make findings and conclusions
68.17 consistent with the Indian Child Welfare Act of 1978, United States Code, title 25, section
68.18 1901 et seq., as to the provision of active efforts. In cases governed by the Indian Child
68.19 Welfare Act of 1978, United States Code, title 25, section 1901, the responsible social
68.20 services agency must provide active efforts as required under United States Code, title
68.21 25, section 1911(d).

68.22 (d) "Reasonable efforts to prevent placement" means:

68.23 (1) the agency has made reasonable efforts to prevent the placement of the child in
68.24 foster care; or

68.25 (2) given the particular circumstances of the child and family at the time of the
68.26 child's removal, there are no services or efforts available which could allow the child to
68.27 safely remain in the home.

68.28 (e) "Reasonable efforts to finalize a permanent plan for the child" means due
68.29 diligence by the responsible social services agency to:

68.30 (1) reunify the child with the parent or guardian from whom the child was removed;

68.31 (2) assess a noncustodial parent's ability to provide day-to-day care for the child and,
68.32 where appropriate, provide services necessary to enable the noncustodial parent to safely
68.33 provide the care, as required by section 260C.212, subdivision 4;

68.34 (3) conduct a relative search as required under section 260C.212, subdivision 5; and

68.35 (4) when the child cannot return to the parent or guardian from whom the child was
68.36 removed, to plan for and finalize a safe and legally permanent alternative home for the

child, and considers permanent alternative homes for the child inside or outside of the state, preferably through adoption or transfer of permanent legal and physical custody of the child.

(f) Reasonable efforts are made upon the exercise of due diligence by the responsible social services agency to use culturally appropriate and available services to meet the needs of the child and the child's family. Services may include those provided by the responsible social services agency and other culturally appropriate services available in the community. At each stage of the proceedings where the court is required to review the appropriateness of the responsible social services agency's reasonable efforts as described in paragraphs (a), (d), and (e), the social services agency has the burden of demonstrating that:

(1) it has made reasonable efforts to prevent placement of the child in foster care;

(2) it has made reasonable efforts to eliminate the need for removal of the child from the child's home and to reunify the child with the child's family at the earliest possible time;

(3) it has made reasonable efforts to finalize an alternative permanent home for the child, and considers permanent alternative homes for the child inside or outside of the state; or

(4) reasonable efforts to prevent placement and to reunify the child with the parent or guardian are not required. The agency may meet this burden by stating facts in a sworn petition filed under section 260C.141, by filing an affidavit summarizing the agency's reasonable efforts or facts the agency believes demonstrate there is no need for reasonable efforts to reunify the parent and child, or through testimony or a certified report required under juvenile court rules.

(g) Once the court determines that reasonable efforts for reunification are not required because the court has made one of the prima facie determinations under paragraph (a), the court may only require reasonable efforts for reunification after a hearing according to section 260C.163, where the court finds there is not clear and convincing evidence of the facts upon which the court based its prima facie determination. In this case when there is clear and convincing evidence that the child is in need of protection or services, the court may find the child in need of protection or services and order any of the dispositions available under section 260C.201, subdivision 1. Reunification of a surviving child with a parent is not required if the parent has been convicted of:

(1) a violation of, or an attempt or conspiracy to commit a violation of, sections 609.185 to 609.20; 609.222, subdivision 2; or 609.223 in regard to another child of the parent;

(2) a violation of section 609.222, subdivision 2; or 609.223, in regard to the surviving child; or

(3) a violation of, or an attempt or conspiracy to commit a violation of, United States Code, title 18, section 1111(a) or 1112(a), in regard to another child of the parent.

(h) The juvenile court, in proceedings under sections 260B.178 or 260C.178, 260C.201, and 260C.301 shall make findings and conclusions as to the provision of reasonable efforts. When determining whether reasonable efforts have been made, the court shall consider whether services to the child and family were:

(1) relevant to the safety and protection of the child;

(2) adequate to meet the needs of the child and family;

(3) culturally appropriate;

(4) available and accessible;

(5) consistent and timely; and

(6) realistic under the circumstances.

In the alternative, the court may determine that provision of services or further services for the purpose of rehabilitation is futile and therefore unreasonable under the circumstances or that reasonable efforts are not required as provided in paragraph (a).

(i) This section does not prevent out-of-home placement for treatment of a child with a mental disability when the child's diagnostic assessment or individual treatment plan indicates that appropriate and necessary treatment cannot be effectively provided outside of a residential or inpatient treatment program.

(j) If continuation of reasonable efforts to prevent placement or reunify the child with the parent or guardian from whom the child was removed is determined by the court to be inconsistent with the permanent plan for the child or upon the court making one of the prima facie determinations under paragraph (a), reasonable efforts must be made to place the child in a timely manner in a safe and permanent home and to complete whatever steps are necessary to legally finalize the permanent placement of the child.

(k) Reasonable efforts to place a child for adoption or in another permanent placement may be made concurrently with reasonable efforts to prevent placement or to reunify the child with the parent or guardian from whom the child was removed. When the responsible social services agency decides to concurrently make reasonable efforts for both reunification and permanent placement away from the parent under paragraph (a), the agency shall disclose its decision and both plans for concurrent reasonable efforts to all parties and the court. When the agency discloses its decision to proceed on both plans for reunification and permanent placement away from the parent, the court's review of the agency's reasonable efforts shall include the agency's efforts under both plans.

71.1 Sec. 62. Minnesota Statutes 2006, section 260.755, subdivision 12, is amended to read:

71.2 Subd. 12. **Indian tribe.** "Indian tribe" means an Indian tribe, band, nation, or
71.3 other organized group or community of Indians recognized as eligible for the services
71.4 provided to Indians by the secretary because of their status as Indians, including any ~~band~~
71.5 Native group under the Alaska Native Claims Settlement Act, United States Code, title 43,
71.6 section 1602, ~~and exercising tribal governmental powers.~~

71.7 Sec. 63. Minnesota Statutes 2006, section 260.755, subdivision 20, is amended to read:

71.8 Subd. 20. **Tribal court.** "Tribal court" means a court with ~~federally recognized~~
71.9 jurisdiction over child custody proceedings and which is either a court of Indian offenses,
71.10 or a court established and operated under the code or custom of an Indian tribe, or ~~the~~
71.11 any other administrative body of a tribe which is vested with authority over child custody
71.12 proceedings. Except as provided in section 260.771, subdivision 5, nothing in this chapter
71.13 shall be construed as conferring jurisdiction on an Indian tribe.

71.14 Sec. 64. Minnesota Statutes 2006, section 260.761, subdivision 7, is amended to read:

71.15 Subd. 7. **Identification of extended family members.** Any agency considering
71.16 placement of an Indian child shall make ~~reasonable~~ active efforts to identify and locate
71.17 extended family members.

71.18 Sec. 65. Minnesota Statutes 2006, section 260.765, subdivision 5, is amended to read:

71.19 Subd. 5. **Identification of extended family members.** Any agency considering
71.20 placement of an Indian child shall make ~~reasonable~~ active efforts to identify and locate
71.21 extended family members.

71.22 Sec. 66. Minnesota Statutes 2006, section 260.771, subdivision 1, is amended to read:

71.23 Subdivision 1. **Indian tribe jurisdiction.** An Indian tribe ~~with a tribal court~~ has
71.24 exclusive jurisdiction over a child placement proceeding involving an Indian child who
71.25 resides or is domiciled within the reservation of ~~such the~~ tribe ~~at the commencement of~~
71.26 ~~the proceedings, except where jurisdiction is otherwise vested in the state by existing~~
71.27 federal law. When an Indian child is ~~in the legal custody of a person or agency pursuant~~
71.28 ~~to an order of a~~ ward of the tribal court, the Indian tribe retains exclusive jurisdiction,
71.29 notwithstanding the residence or domicile of the child.

71.30 Sec. 67. Minnesota Statutes 2006, section 260.771, subdivision 2, is amended to read:

Subd. 2. **Court determination of tribal affiliation of child.** In any child placement proceeding, the court shall establish whether an Indian child is involved and the identity of the Indian child's tribe. This chapter and the federal Indian Child Welfare Act are applicable without exception in any child custody proceeding, as defined in the federal act, involving an Indian child. This chapter applies to child custody proceedings involving an Indian child whether the child is in the physical or legal custody of an Indian parent, Indian custodian, Indian extended family member, or other person at the commencement of the proceedings. A court shall not determine the applicability of this chapter or the federal Indian Child Welfare Act to a child custody proceeding based upon whether an Indian child is part of an existing Indian family or based upon the level of contact a child has with the child's Indian tribe, reservation, society, or off-reservation community.

Sec. 68. **[260.852] PLACEMENT PROCEDURES.**

Subdivision 1. **Home study.** The state must have procedures for the orderly and timely interstate placement of children that are implemented in accordance with an interstate compact and that, within 60 days after the state receives from another state a request to conduct a study of a home environment for purposes of assessing the safety and suitability of placing a child in the home, the state shall, directly or by contract, conduct and complete a home study and return to the other state a report on the results of the study, which shall address the extent to which placement in the home would meet the needs of the child; except in the case of a home study begun before October 1, 2008, if the state fails to comply with conducting and completing the home study within the 60-day period and this is as a result of circumstances beyond the control of the state, the state has 75 days to comply if the state documents the circumstances involved and certifies that completing the home study is in the best interests of the child.

This subdivision does not require the completion within the applicable period of the parts of the home study involving the education and training of the prospective foster or adoptive parents.

Subd. 2. **Effect of received report.** The state shall treat any report described in subdivision 1 that is received from another state, an Indian tribe, or a private agency under contract with another state or Indian tribe as meeting any requirements imposed by the state for the completion of a home study before placing a child in the home, unless, within 14 days after receipt of the report, the state determines, based on grounds that are specific to the content of the report, that making a decision in reliance on the report would be contrary to the welfare of the child.

73.1 Subd. 3. **Resources.** The state shall make effective use of cross-jurisdictional
73.2 resources, including through contract for the purchase of services, and shall eliminate
73.3 legal barriers to facilitate timely adoptive or permanent placements for waiting children.
73.4 The state shall not impose any restriction on the use of private agencies for the purpose of
73.5 conducting a home study to meet the 60-day requirement.

73.6 Subd. 4. **Incentive eligibility.** Minnesota is an incentive-eligible state and must:
73.7 (1) have an approved plan as required by the United States Secretary of Health
73.8 and Human Services;

73.9 (2) be in compliance with the data requirements of the United States Department of
73.10 Health and Human Services; and

73.11 (3) have data that verify that a home study is completed within 30 days.

73.12 Subd. 5. **Data requirements.** The state shall provide to the United States Secretary
73.13 of Health and Human Services a written report, covering the preceding fiscal year, that
73.14 specifies:

73.15 (1) the total number of interstate home studies requested by the state with respect
73.16 to children in foster care under the responsibility of the state, and with respect to each
73.17 study, the identity of the other state involved;

73.18 (2) the total number of timely interstate home studies completed by the state with
73.19 respect to children in foster care under the responsibility of other states and, with respect
73.20 to each study, the identity of the other state involved; and

73.21 (3) other information the United States Secretary of Health and Human Services
73.22 requires in order to determine whether Minnesota is a home study incentive-eligible state.

73.23 Subd. 6. **Definitions.** (a) The definitions in this subdivision apply to this section.

73.24 (b) "Home study" means an evaluation of a home environment conducted in
73.25 accordance with applicable requirements of the state in which the home is located, to
73.26 determine whether a proposed placement of a child would meet the individual needs of the
73.27 child, including the child's safety; permanency; health; well-being; and mental, emotional,
73.28 and physical development.

73.29 (c) "Interstate home study" means a home study conducted by a state at the request
73.30 of another state to facilitate an adoptive or foster placement in the state of a child in foster
73.31 care under the responsibility of the state.

73.32 (d) "Timely interstate home study" means an interstate home study completed by a
73.33 state if the state provides to the state that requested the study, within 30 days after receipt
73.34 of the request, a report on the results of the study, except that there is no requirement
73.35 for completion within the 30-day period of the parts of the home study involving the
73.36 education and training of the prospective foster or adoptive parents.

Subd. 7. **Background study requirements for adoption and foster care.** (a)

Background study requirements for an adoption home study must be completed consistent with section 259.41, subdivisions 1, 2, and 3.

(b) Background study requirements for a foster care license must be completed consistent with section 245C.08.

Subd. 8. **Home visits.** If a child has been placed in foster care outside the state in which the home of the parents of the child is located, periodically, but at least every six months, a caseworker on the staff of the agency of the state in which the home of the parents of the child is located or the state in which the child has been placed, or a private agency under contract with either state, must visit the child in the home or institution and submit a report on each visit to the agency of the state in which the home of the parents of the child is located.

Sec. 69. Minnesota Statutes 2006, section 260B.157, subdivision 1, is amended to read:

Subdivision 1. **Investigation.** Upon request of the court the local social services agency or probation officer shall investigate the personal and family history and environment of any minor coming within the jurisdiction of the court under section 260B.101 and shall report its findings to the court. The court may order any minor coming within its jurisdiction to be examined by a duly qualified physician, psychiatrist, or psychologist appointed by the court.

The court shall ~~have~~ order a chemical use assessment conducted when a child is (1) found to be delinquent for violating a provision of chapter 152, or for committing a felony-level violation of a provision of chapter 609 if the probation officer determines that alcohol or drug use was a contributing factor in the commission of the offense, or (2) alleged to be delinquent for violating a provision of chapter 152, if the child is being held in custody under a detention order. The assessor's qualifications and the assessment criteria shall comply with Minnesota Rules, parts 9530.6600 to 9530.6655. If funds under chapter 254B are to be used to pay for the recommended treatment, the assessment and placement must comply with all provisions of Minnesota Rules, parts 9530.6600 to 9530.6655 and 9530.7000 to 9530.7030. The commissioner of human services shall reimburse the court for the cost of the chemical use assessment, up to a maximum of \$100.

The court shall ~~have~~ order a children's mental health screening conducted when a child is found to be delinquent. The screening shall be conducted with a screening instrument approved by the commissioner of human services and shall be conducted by a mental health practitioner as defined in section 245.4871, subdivision 26, or a probation officer who is trained in the use of the screening instrument. If the screening indicates

a need for assessment, the local social services agency, in consultation with the child's family, shall have a diagnostic assessment conducted, including a functional assessment, as defined in section 245.4871.

With the consent of the commissioner of corrections and agreement of the county to pay the costs thereof, the court may, by order, place a minor coming within its jurisdiction in an institution maintained by the commissioner for the detention, diagnosis, custody and treatment of persons adjudicated to be delinquent, in order that the condition of the minor be given due consideration in the disposition of the case. Any funds received under the provisions of this subdivision shall not cancel until the end of the fiscal year immediately following the fiscal year in which the funds were received. The funds are available for use by the commissioner of corrections during that period and are hereby appropriated annually to the commissioner of corrections as reimbursement of the costs of providing these services to the juvenile courts.

Sec. 70. Minnesota Statutes 2006, section 260C.152, subdivision 5, is amended to read:

Subd. 5. **Notice to foster parents and preadoptive parents and relatives.** The foster parents, if any, of a child and any preadoptive parent or relative providing care for the child must be provided notice of and ~~an opportunity~~ a right to be heard in any review or hearing to be held with respect to the child. Any other relative may also request, and must be granted, a notice and the opportunity to be heard under this section. This subdivision does not require that a foster parent, preadoptive parent, or relative providing care for the child be made a party to a review or hearing solely on the basis of the notice and ~~opportunity~~ right to be heard.

Sec. 71. Minnesota Statutes 2006, section 260C.163, subdivision 1, is amended to read:

Subdivision 1. **General.** (a) Except for hearings arising under section 260C.425, hearings on any matter shall be without a jury and may be conducted in an informal manner. In all adjudicatory proceedings involving a child alleged to be in need of protection or services, the court shall admit only evidence that would be admissible in a civil trial. To be proved at trial, allegations of a petition alleging a child to be in need of protection or services must be proved by clear and convincing evidence.

(b) Except for proceedings involving a child alleged to be in need of protection or services and petitions for the termination of parental rights, hearings may be continued or adjourned from time to time. In proceedings involving a child alleged to be in need of protection or services and petitions for the termination of parental rights, hearings may not be continued or adjourned for more than one week unless the court makes specific findings

that the continuance or adjournment is in the best interests of the child. If a hearing is held on a petition involving physical or sexual abuse of a child who is alleged to be in need of protection or services or neglected and in foster care, the court shall file the decision with the court administrator as soon as possible but no later than 15 days after the matter is submitted to the court. When a continuance or adjournment is ordered in any proceeding, the court may make any interim orders as it deems in the best interests of the minor in accordance with the provisions of sections 260C.001 to 260C.421.

(c) Except as otherwise provided in this paragraph, the court shall exclude the general public from hearings under this chapter and shall admit only those persons who, in the discretion of the court, have a direct interest in the case or in the work of the court.

(d) Adoption hearings shall be conducted in accordance with the provisions of laws relating to adoptions.

(e) In any permanency hearing, including the transition of a child from foster care to independent living, the court shall ensure that any consult with the child is in an age-appropriate manner.

Sec. 72. Minnesota Statutes 2006, section 260C.201, subdivision 11, is amended to read:

Subd. 11. **Review of court-ordered placements; permanent placement determination.** (a) This subdivision and subdivision 11a do not apply in cases where the child is in placement due solely to the child's developmental disability or emotional disturbance, where legal custody has not been transferred to the responsible social services agency, and where the court finds compelling reasons under section 260C.007, subdivision 8, to continue the child in foster care past the time periods specified in this subdivision. Foster care placements of children due solely to their disability are governed by section 260C.141, subdivision 2a. In all other cases where the child is in foster care or in the care of a noncustodial parent under subdivision 1, the court shall commence proceedings to determine the permanent status of a child not later than 12 months after the child is placed in foster care or in the care of a noncustodial parent. At the admit-deny hearing commencing such proceedings, the court shall determine whether there is a prima facie basis for finding that the agency made reasonable efforts, or in the case of an Indian child active efforts, required under section 260.012 and proceed according to the rules of juvenile court.

For purposes of this subdivision, the date of the child's placement in foster care is the earlier of the first court-ordered placement or 60 days after the date on which the child has been voluntarily placed in foster care by the child's parent or guardian. For

purposes of this subdivision, time spent by a child under the protective supervision of the responsible social services agency in the home of a noncustodial parent pursuant to an order under subdivision 1 counts towards the requirement of a permanency hearing under this subdivision or subdivision 11a. Time spent on a trial home visit ~~does not count~~ counts towards the requirement of a permanency hearing under this subdivision ~~or~~ and a permanency review for a child under eight years of age under subdivision 11a.

For purposes of this subdivision, 12 months is calculated as follows:

(1) during the pendency of a petition alleging that a child is in need of protection or services, all time periods when a child is placed in foster care or in the home of a noncustodial parent are cumulated;

(2) if a child has been placed in foster care within the previous five years under one or more previous petitions, the lengths of all prior time periods when the child was placed in foster care within the previous five years are cumulated. If a child under this clause has been in foster care for 12 months or more, the court, if it is in the best interests of the child and for compelling reasons, may extend the total time the child may continue out of the home under the current petition up to an additional six months before making a permanency determination.

(b) Unless the responsible social services agency recommends return of the child to the custodial parent or parents, not later than 30 days prior to the admit-deny hearing required under paragraph (a) and the rules of juvenile court, the responsible social services agency shall file pleadings in juvenile court to establish the basis for the juvenile court to order permanent placement of the child, including a termination of parental rights petition, according to paragraph (d). Notice of the hearing and copies of the pleadings must be provided pursuant to section 260C.152.

(c) The permanency proceedings shall be conducted in a timely fashion including that any trial required under section 260C.163 shall be commenced within 60 days of the admit-deny hearing required under paragraph (a). At the conclusion of the permanency proceedings, the court shall:

(1) order the child returned to the care of the parent or guardian from whom the child was removed; or

(2) order a permanent placement or termination of parental rights if permanent placement or termination of parental rights is in the child's best interests. The "best interests of the child" means all relevant factors to be considered and evaluated. Transfer of permanent legal and physical custody, termination of parental rights, or guardianship and legal custody to the commissioner through a consent to adopt are preferred permanency options for a child who cannot return home.

78.1 (d) If the child is not returned to the home, the court must order one of the following
78.2 dispositions:

78.3 (1) permanent legal and physical custody to a relative in the best interests of the
78.4 child according to the following conditions:

78.5 (i) an order for transfer of permanent legal and physical custody to a relative shall
78.6 only be made after the court has reviewed the suitability of the prospective legal and
78.7 physical custodian;

78.8 (ii) in transferring permanent legal and physical custody to a relative, the juvenile
78.9 court shall follow the standards applicable under this chapter and chapter 260, and the
78.10 procedures set out in the juvenile court rules;

78.11 (iii) an order establishing permanent legal and physical custody under this
78.12 subdivision must be filed with the family court;

78.13 (iv) a transfer of legal and physical custody includes responsibility for the protection,
78.14 education, care, and control of the child and decision making on behalf of the child;

78.15 (v) the social services agency may bring a petition or motion naming a fit and
78.16 willing relative as a proposed permanent legal and physical custodian. The commissioner
78.17 of human services shall annually prepare for counties information that must be given to
78.18 proposed custodians about their legal rights and obligations as custodians together with
78.19 information on financial and medical benefits for which the child is eligible; and

78.20 (vi) the juvenile court may maintain jurisdiction over the responsible social services
78.21 agency, the parents or guardian of the child, the child, and the permanent legal and
78.22 physical custodian for purposes of ensuring appropriate services are delivered to the child
78.23 and permanent legal custodian or for the purpose of ensuring conditions ordered by the
78.24 court related to the care and custody of the child are met;

78.25 (2) termination of parental rights when the requirements of sections 260C.301 to
78.26 260C.328 are met or according to the following conditions:

78.27 (i) order the social services agency to file a petition for termination of parental
78.28 rights in which case all the requirements of sections 260C.301 to 260C.328 remain
78.29 applicable; and

78.30 (ii) an adoption completed subsequent to a determination under this subdivision may
78.31 include an agreement for communication or contact under section 259.58;

78.32 (3) long-term foster care according to the following conditions:

78.33 (i) the court may order a child into long-term foster care only if it approves the
78.34 responsible social service agency's compelling reasons that neither an award of permanent
78.35 legal and physical custody to a relative, nor termination of parental rights is in the child's
78.36 best interests;

(ii) further, the court may only order long-term foster care for the child under this section if it finds the following:

(A) the child has reached age 12 and the responsible social services agency has made reasonable efforts to locate and place the child with an adoptive family or with a fit and willing relative who will agree to a transfer of permanent legal and physical custody of the child, but such efforts have not proven successful; or

(B) the child is a sibling of a child described in subitem (A) and the siblings have a significant positive relationship and are ordered into the same long-term foster care home; and

(iii) at least annually, the responsible social services agency reconsiders its provision of services to the child and the child's placement in long-term foster care to ensure that:

(A) long-term foster care continues to be the most appropriate legal arrangement for meeting the child's need for permanency and stability, including whether there is another permanent placement option under this chapter that would better serve the child's needs and best interests;

(B) whenever possible, there is an identified long-term foster care family that is committed to being the foster family for the child as long as the child is a minor or under the jurisdiction of the court;

(C) the child is receiving appropriate services or assistance to maintain or build connections with the child's family and community;

(D) the child's physical and mental health needs are being appropriately provided for; and

(E) the child's educational needs are being met;

(4) foster care for a specified period of time according to the following conditions:

(i) foster care for a specified period of time may be ordered only if:

(A) the sole basis for an adjudication that the child is in need of protection or services is the child's behavior;

(B) the court finds that foster care for a specified period of time is in the best interests of the child; and

(C) the court approves the responsible social services agency's compelling reasons that neither an award of permanent legal and physical custody to a relative, nor termination of parental rights is in the child's best interests;

(ii) the order does not specify that the child continue in foster care for any period exceeding one year; or

(5) guardianship and legal custody to the commissioner of human services under the following procedures and conditions:

(i) there is an identified prospective adoptive home agreed to by the responsible social services agency having legal custody of the child pursuant to court order under this section that has agreed to adopt the child and the court accepts the parent's voluntary consent to adopt under section 259.24, except that such consent executed by a parent under this item, following proper notice that consent given under this provision is irrevocable upon acceptance by the court, shall be irrevocable unless fraud is established and an order issues permitting revocation as stated in item (vii);

(ii) if the court accepts a consent to adopt in lieu of ordering one of the other enumerated permanency dispositions, the court must review the matter at least every 90 days. The review will address the reasonable efforts of the agency to achieve a finalized adoption;

(iii) a consent to adopt under this clause vests all legal authority regarding the child, including guardianship and legal custody of the child, with the commissioner of human services as if the child were a state ward after termination of parental rights;

(iv) the court must forward a copy of the consent to adopt, together with a certified copy of the order transferring guardianship and legal custody to the commissioner, to the commissioner;

(v) if an adoption is not finalized by the identified prospective adoptive parent within 12 months of the execution of the consent to adopt under this clause, the commissioner of human services or the commissioner's delegate shall pursue adoptive placement in another home unless the commissioner certifies that the failure to finalize is not due to either an action or a failure to act by the prospective adoptive parent;

(vi) notwithstanding item (v), the commissioner of human services or the commissioner's designee must pursue adoptive placement in another home as soon as the commissioner or commissioner's designee determines that finalization of the adoption with the identified prospective adoptive parent is not possible, that the identified prospective adoptive parent is not willing to adopt the child, that the identified prospective adoptive parent is not cooperative in completing the steps necessary to finalize the adoption, or upon the commissioner's determination to withhold consent to the adoption.

(vii) unless otherwise required by the Indian Child Welfare Act, United States Code, title 25, section 1913, a consent to adopt executed under this section, following proper notice that consent given under this provision is irrevocable upon acceptance by the court, shall be irrevocable upon acceptance by the court except upon order permitting revocation issued by the same court after written findings that consent was obtained by fraud.

(e) In ordering a permanent placement of a child, the court must be governed by the best interests of the child, including a review of the relationship between the child and

81.1 relatives and the child and other important persons with whom the child has resided or
81.2 had significant contact. When the court has determined that permanent placement of the
81.3 child away from the parent is necessary, the court shall consider permanent alternative
81.4 homes that are available both inside and outside the state.

81.5 (f) Once a permanent placement determination has been made and permanent
81.6 placement has been established, further court reviews are necessary if:

81.7 (1) the placement is long-term foster care or foster care for a specified period of time;

81.8 (2) the court orders further hearings because it has retained jurisdiction of a transfer
81.9 of permanent legal and physical custody matter;

81.10 (3) an adoption has not yet been finalized; or

81.11 (4) there is a disruption of the permanent or long-term placement.

81.12 (g) Court reviews of an order for long-term foster care, whether under this section
81.13 or section 260C.317, subdivision 3, paragraph (d), must be conducted at least yearly and
81.14 must review the child's out-of-home placement plan and the reasonable efforts of the
81.15 agency to finalize the permanent plan for the child including the agency's efforts to:

81.16 (1) ensure that long-term foster care continues to be the most appropriate legal
81.17 arrangement for meeting the child's need for permanency and stability or, if not, to identify
81.18 and attempt to finalize another permanent placement option under this chapter that would
81.19 better serve the child's needs and best interests;

81.20 (2) identify a specific long-term foster home for the child, if one has not already
81.21 been identified;

81.22 (3) support continued placement of the child in the identified home, if one has been
81.23 identified;

81.24 (4) ensure appropriate services are provided to address the physical health, mental
81.25 health, and educational needs of the child during the period of long-term foster care and
81.26 also ensure appropriate services or assistance to maintain relationships with appropriate
81.27 family members and the child's community; and

81.28 (5) plan for the child's independence upon the child's leaving long-term foster care
81.29 living as required under section 260C.212, subdivision 1.

81.30 (h) In the event it is necessary for a child that has been ordered into foster care for a
81.31 specified period of time to be in foster care longer than one year after the permanency
81.32 hearing held under this section, not later than 12 months after the time the child was
81.33 ordered into foster care for a specified period of time, the matter must be returned to
81.34 court for a review of the appropriateness of continuing the child in foster care and of the
81.35 responsible social services agency's reasonable efforts to finalize a permanent plan for
81.36 the child; if it is in the child's best interests to continue the order for foster care for a

specified period of time past a total of 12 months, the court shall set objectives for the child's continuation in foster care, specify any further amount of time the child may be in foster care, and review the plan for the safe return of the child to the parent.

(i) An order permanently placing a child out of the home of the parent or guardian must include the following detailed findings:

(1) how the child's best interests are served by the order;

(2) the nature and extent of the responsible social service agency's reasonable efforts, or, in the case of an Indian child, active efforts to reunify the child with the parent or guardian where reasonable efforts are required;

(3) the parent's or parents' efforts and ability to use services to correct the conditions which led to the out-of-home placement; and

(4) that the conditions which led to the out-of-home placement have not been corrected so that the child can safely return home.

(j) An order for permanent legal and physical custody of a child may be modified under sections 518.18 and 518.185. The social services agency is a party to the proceeding and must receive notice. A parent may only seek modification of an order for long-term foster care upon motion and a showing by the parent of a substantial change in the parent's circumstances such that the parent could provide appropriate care for the child and that removal of the child from the child's permanent placement and the return to the parent's care would be in the best interest of the child. The responsible social services agency may ask the court to vacate an order for long-term foster care upon a prima facie showing that there is a factual basis for the court to order another permanency option under this chapter and that such an option is in the child's best interests. Upon a hearing where the court determines that there is a factual basis for vacating the order for long-term foster care and that another permanent order regarding the placement of the child is in the child's best interests, the court may vacate the order for long-term foster care and enter a different order for permanent placement that is in the child's best interests. The court shall not require further reasonable efforts to reunify the child with the parent or guardian as a basis for vacating the order for long-term foster care and ordering a different permanent placement in the child's best interests. The county attorney must file pleadings and give notice as required under the rules of juvenile court in order to modify an order for long-term foster care under this paragraph.

(k) The court shall issue an order required under this section within 15 days of the close of the proceedings. The court may extend issuing the order an additional 15 days when necessary in the interests of justice and the best interests of the child.

(1) This paragraph applies to proceedings required under this subdivision when the child is on a trial home visit:

(1) if the child is on a trial home visit 12 months after the child was placed in foster care or in the care of a noncustodial parent as calculated in this subdivision, the responsible social services agency may file a report with the court regarding the child's and parent's progress on the trial home visit and its reasonable efforts to finalize the child's safe and permanent return to the care of the parent in lieu of filing the pleadings required under paragraph (b). The court shall make findings regarding reasonableness of the responsible social services efforts to finalize the child's return home as the permanent order in the best interests of the child. The court may continue the trial home visit to a total time not to exceed six months as provided in subdivision 1. If the court finds the responsible social services agency has not made reasonable efforts to finalize the child's return home as the permanent order in the best interests of the child, the court may order other or additional efforts to support the child remaining in the care of the parent; and

(2) if a trial home visit ordered or continued at proceedings under this subdivision terminates, the court shall re-commence proceedings under this subdivision to determine the permanent status of the child not later than 30 days after the child is returned to foster care.

Sec. 73. Minnesota Statutes 2006, section 260C.212, subdivision 1, is amended to read:

Subdivision 1. **Out-of-home placement; plan.** (a) An out-of-home placement plan shall be prepared within 30 days after any child is placed in a residential facility by court order or by the voluntary release of the child by the parent or parents.

For purposes of this section, a residential facility means any group home, family foster home or other publicly supported out-of-home residential facility, including any out-of-home residential facility under contract with the state, county or other political subdivision, or any agency thereof, to provide those services or foster care as defined in section 260C.007, subdivision 18.

(b) An out-of-home placement plan means a written document which is prepared by the responsible social services agency jointly with the parent or parents or guardian of the child and in consultation with the child's guardian ad litem, the child's tribe, if the child is an Indian child, the child's foster parent or representative of the residential facility, and, where appropriate, the child. For a child in placement due solely or in part to the child's emotional disturbance, preparation of the out-of-home placement plan shall additionally include the child's mental health treatment provider. As appropriate, the plan shall be:

(1) submitted to the court for approval under section 260C.178, subdivision 7;

84.1 (2) ordered by the court, either as presented or modified after hearing, under section
84.2 260C.178, subdivision 7, or 260C.201, subdivision 6; and

84.3 (3) signed by the parent or parents or guardian of the child, the child's guardian ad
84.4 litem, a representative of the child's tribe, the responsible social services agency, and, if
84.5 possible, the child.

84.6 (c) The out-of-home placement plan shall be explained to all persons involved in its
84.7 implementation, including the child who has signed the plan, and shall set forth:

84.8 (1) a description of the residential facility including how the out-of-home placement
84.9 plan is designed to achieve a safe placement for the child in the least restrictive, most
84.10 family-like, setting available which is in close proximity to the home of the parent or
84.11 parents or guardian of the child when the case plan goal is reunification, and how the
84.12 placement is consistent with the best interests and special needs of the child according to
84.13 the factors under subdivision 2, paragraph (b);

84.14 (2) the specific reasons for the placement of the child in a residential facility, and
84.15 when reunification is the plan, a description of the problems or conditions in the home of
84.16 the parent or parents which necessitated removal of the child from home and the changes
84.17 the parent or parents must make in order for the child to safely return home;

84.18 (3) a description of the services offered and provided to prevent removal of the child
84.19 from the home and to reunify the family including:

84.20 (i) the specific actions to be taken by the parent or parents of the child to eliminate
84.21 or correct the problems or conditions identified in clause (2), and the time period during
84.22 which the actions are to be taken; and

84.23 (ii) the reasonable efforts, or in the case of an Indian child, active efforts to be made
84.24 to achieve a safe and stable home for the child including social and other supportive
84.25 services to be provided or offered to the parent or parents or guardian of the child, the
84.26 child, and the residential facility during the period the child is in the residential facility;

84.27 (4) a description of any services or resources that were requested by the child or the
84.28 child's parent, guardian, foster parent, or custodian since the date of the child's placement
84.29 in the residential facility, and whether those services or resources were provided and if
84.30 not, the basis for the denial of the services or resources;

84.31 (5) the visitation plan for the parent or parents or guardian, other relatives as defined
84.32 in section 260C.007, subdivision 27, and siblings of the child if the siblings are not placed
84.33 together in the residential facility, and whether visitation is consistent with the best interest
84.34 of the child, during the period the child is in the residential facility;

84.35 (6) documentation of steps to finalize the adoption or legal guardianship of the child
84.36 if the court has issued an order terminating the rights of both parents of the child or of

the only known, living parent of the child, ~~and~~. At a minimum, the documentation must include child-specific recruitment efforts such as relative search and the use of state, regional, and national adoption exchanges to facilitate orderly and timely placements in and outside of the state. A copy of this documentation shall be provided to the court in the review required under section 260C.317, subdivision 3, paragraph (b);

~~(7) to the extent available and accessible;~~ the health and educational records of the child including the most recent information available regarding:

(i) the names and addresses of the child's health and educational providers;
(ii) the child's grade level performance;
(iii) the child's school record;
(iv) assurances that the child's placement in foster care takes into account proximity to the school in which the child is enrolled at the time of placement;

(v) a record of the child's immunizations;
(vi) the child's known medical problems, including any known communicable diseases, as defined in section 144.4172, subdivision 2;

(vii) the child's medications; and
(viii) any other relevant health and education information;

(8) an independent living plan for a child age 16 or older who is in placement as a result of a permanency disposition. The plan should include, but not be limited to, the following objectives:

(i) educational, vocational, or employment planning;
(ii) health care planning and medical coverage;
(iii) transportation including, where appropriate, assisting the child in obtaining a driver's license;

(iv) money management;
(v) planning for housing;
(vi) social and recreational skills; and
(vii) establishing and maintaining connections with the child's family and community; and

(9) for a child in placement due solely or in part to the child's emotional disturbance, diagnostic and assessment information, specific services relating to meeting the mental health care needs of the child, and treatment outcomes.

(d) The parent or parents or guardian and the child each shall have the right to legal counsel in the preparation of the case plan and shall be informed of the right at the time of placement of the child. The child shall also have the right to a guardian ad litem. If unable to employ counsel from their own resources, the court shall appoint counsel

upon the request of the parent or parents or the child or the child's legal guardian. The parent or parents may also receive assistance from any person or social services agency in preparation of the case plan.

After the plan has been agreed upon by the parties involved or approved or ordered by the court, the foster parents shall be fully informed of the provisions of the case plan and shall be provided a copy of the plan.

Upon discharge from foster care, the parent, adoptive parent, or permanent legal and physical custodian, as appropriate, and the child, if appropriate, must be provided with a current copy of the child's health and education record.

Sec. 74. Minnesota Statutes 2006, section 260C.212, subdivision 4, is amended to read:

Subd. 4. **Responsible social service agency's duties for children in placement.** (a) When a child is in placement, the responsible social services agency shall make diligent efforts to identify, locate, and, where appropriate, offer services to both parents of the child.

(1) The responsible social services agency shall assess whether a noncustodial or nonadjudicated parent is willing and capable of providing for the day-to-day care of the child temporarily or permanently. An assessment under this clause may include, but is not limited to, obtaining information under section 260C.209. If after assessment, the responsible social services agency determines that a noncustodial or nonadjudicated parent is willing and capable of providing day-to-day care of the child, the responsible social services agency may seek authority from the custodial parent or the court to have that parent assume day-to-day care of the child. If a parent is not an adjudicated parent, the responsible social services agency shall require the nonadjudicated parent to cooperate with paternity establishment procedures as part of the case plan.

(2) If, after assessment, the responsible social services agency determines that the child cannot be in the day-to-day care of either parent, the agency shall:

(i) prepare an out-of-home placement plan addressing the conditions that each parent must meet before the child can be in that parent's day-to-day care; and

(ii) provide a parent who is the subject of a background study under section 260C.209 15 days' notice that it intends to use the study to recommend against putting the child with that parent, as well as the notice provided in section 260C.209, subdivision 4, and the court shall afford the parent an opportunity to be heard concerning the study.

The results of a background study of a noncustodial parent shall not be used by the agency to determine that the parent is incapable of providing day-to-day care of the child unless the agency reasonably believes that placement of the child into the home of that parent would endanger the child's health, safety, or welfare.

(3) If, after the provision of services following an out-of-home placement plan under this section, the child cannot return to the care of the parent from whom the child was removed or who had legal custody at the time the child was placed in foster care, the agency may petition on behalf of a noncustodial parent to establish legal custody with that parent under section 260C.201, subdivision 11. If paternity has not already been established, it may be established in the same proceeding in the manner provided for under chapter 257.

(4) The responsible social services agency may be relieved of the requirement to locate and offer services to both parents by the juvenile court upon a finding of good cause after the filing of a petition under section 260C.141.

(b) The responsible social services agency shall give notice to the parent or parents or guardian of each child in a residential facility, other than a child in placement due solely to that child's developmental disability or emotional disturbance, of the following information:

(1) that residential care of the child may result in termination of parental rights or an order permanently placing the child out of the custody of the parent, but only after notice and a hearing as required under chapter 260C and the juvenile court rules;

(2) time limits on the length of placement and of reunification services, including the date on which the child is expected to be returned to and safely maintained in the home of the parent or parents or placed for adoption or otherwise permanently removed from the care of the parent by court order;

(3) the nature of the services available to the parent;

(4) the consequences to the parent and the child if the parent fails or is unable to use services to correct the circumstances that led to the child's placement;

(5) the first consideration for placement with relatives;

(6) the benefit to the child in getting the child out of residential care as soon as possible, preferably by returning the child home, but if that is not possible, through a permanent legal placement of the child away from the parent;

(7) when safe for the child, the benefits to the child and the parent of maintaining visitation with the child as soon as possible in the course of the case and, in any event, according to the visitation plan under this section; and

(8) the financial responsibilities and obligations, if any, of the parent or parents for the support of the child during the period the child is in the residential facility.

(c) The responsible social services agency shall inform a parent considering voluntary placement of a child who is not developmentally disabled or emotionally disturbed of the following information:

(1) the parent and the child each has a right to separate legal counsel before signing a voluntary placement agreement, but not to counsel appointed at public expense;

(2) the parent is not required to agree to the voluntary placement, and a parent who enters a voluntary placement agreement may at any time request that the agency return the child. If the parent so requests, the child must be returned within 24 hours of the receipt of the request;

(3) evidence gathered during the time the child is voluntarily placed may be used at a later time as the basis for a petition alleging that the child is in need of protection or services or as the basis for a petition seeking termination of parental rights or other permanent placement of the child away from the parent;

(4) if the responsible social services agency files a petition alleging that the child is in need of protection or services or a petition seeking the termination of parental rights or other permanent placement of the child away from the parent, the parent would have the right to appointment of separate legal counsel and the child would have a right to the appointment of counsel and a guardian ad litem as provided by law, and that counsel will be appointed at public expense if they are unable to afford counsel; and

(5) the timelines and procedures for review of voluntary placements under subdivision 3, and the effect the time spent in voluntary placement on the scheduling of a permanent placement determination hearing under section 260C.201, subdivision 11.

(d) When an agency accepts a child for placement, the agency shall determine whether the child has had a physical examination by or under the direction of a licensed physician within the 12 months immediately preceding the date when the child came into the agency's care. If there is documentation that the child has had an examination within the last 12 months, the agency is responsible for seeing that the child has another physical examination within one year of the documented examination and annually in subsequent years. If the agency determines that the child has not had a physical examination within the 12 months immediately preceding placement, the agency shall ensure that the child has an examination within 30 days of coming into the agency's care and once a year in subsequent years.

(e) If a child leaves foster care by reason of having attained the age of majority under state law, the child must be given at no cost a copy of the child's health and education report.

Sec. 75. Minnesota Statutes 2006, section 260C.212, subdivision 9, is amended to read:

Subd. 9. **Review of certain child placements.** (a) When a developmentally disabled child or emotionally disturbed child needs placement in a residential facility for

the sole reason of accessing services or a level of skilled care that cannot be provided in the parent's home, the child must be placed pursuant to a voluntary placement agreement between the responsible social services agency and the child's parent. The voluntary placement agreement must give the responsible social services agency legal responsibility for the child's physical care, custody, and control, but must not transfer legal custody of the child to the agency. The voluntary placement agreement must be executed in a form developed and promulgated by the commissioner of human services. The responsible social services agency shall report to the commissioner the number of children who are the subject of a voluntary placement agreement under this subdivision and other information regarding these children as the commissioner may require.

(b) If a developmentally disabled child or a child diagnosed as emotionally disturbed has been placed in a residential facility pursuant to a voluntary release by the child's parent or parents because of the child's disabling conditions or need for long-term residential treatment or supervision, the social services agency responsible for the placement shall report to the court and bring a petition for review of the child's foster care status as required in section 260C.141, subdivision 2a.

~~(b)~~ (c) If a child is in placement due solely to the child's developmental disability or emotional disturbance, ~~and~~ the court finds compelling reasons not to proceed under section 260C.201, subdivision 11, and custody of the child is not transferred to the responsible social services agency under section 260C.201, subdivision 1, paragraph (a), clause (2), ~~and~~ no petition is required by section 260C.201, subdivision 11.

~~(c)~~ (d) Whenever a petition for review is brought pursuant to this subdivision, a guardian ad litem shall be appointed for the child.

Sec. 76. Minnesota Statutes 2006, section 260C.317, subdivision 3, is amended to read:

Subd. 3. **Order; retention of jurisdiction.** (a) A certified copy of the findings and the order terminating parental rights, and a summary of the court's information concerning the child shall be furnished by the court to the commissioner or the agency to which guardianship is transferred. The orders shall be on a document separate from the findings. The court shall furnish the individual to whom guardianship is transferred a copy of the order terminating parental rights.

(b) The court shall retain jurisdiction in a case where adoption is the intended permanent placement disposition until the child's adoption is finalized, the child is 18 years of age, or the child is otherwise ordered discharged from the jurisdiction of the court. The guardian ad litem and counsel for the child shall continue on the case until an adoption decree is entered. A hearing must be held every 90 days following termination of parental

rights for the court to review progress toward an adoptive placement and the specific recruitment efforts the agency has taken to find an adoptive family or other placement living arrangement for the child and to finalize the adoption or other permanency plan.

(c) The responsible social services agency may make a determination of compelling reasons for a child to be in long-term foster care when the agency has made exhaustive efforts to recruit, identify, and place the child in an adoptive home, and the child continues in foster care for at least 24 months after the court has issued the order terminating parental rights. A child of any age who is under the guardianship of the commissioner of the Department of Human Services and is legally available for adoption may not refuse or waive the commissioner's agent's exhaustive efforts to recruit, identify, and place the child in an adoptive home required under paragraph (b) or sign a document relieving county social services agencies of all recruitment efforts on the child's behalf. Upon approving the agency's determination of compelling reasons, the court may order the child placed in long-term foster care. At least every 12 months thereafter as long as the child continues in out-of-home placement, the court shall conduct a permanency review hearing to determine the future status of the child using the review requirements of section 260C.201, subdivision 11, paragraph (g).

(d) The court shall retain jurisdiction through the child's minority in a case where long-term foster care is the permanent disposition whether under paragraph (c) or section 260C.201, subdivision 11.

Sec. 77. Minnesota Statutes 2006, section 260C.331, subdivision 1, is amended to read:

Subdivision 1. **Care, examination, or treatment.** (a) Except where parental rights are terminated,

(1) whenever legal custody of a child is transferred by the court to a responsible social services agency,

(2) whenever legal custody is transferred to a person other than the responsible social services agency, but under the supervision of the responsible social services agency, or

(3) whenever a child is given physical or mental examinations or treatment under order of the court, and no provision is otherwise made by law for payment for the care, examination, or treatment of the child, these costs are a charge upon the welfare funds of the county in which proceedings are held upon certification of the judge of juvenile court.

(b) The court shall order, and the responsible social services agency shall require, the parents or custodian of a child, while the child is under the age of 18, to use the total income and resources attributable to the child for the period of care, examination, or treatment, except for clothing and personal needs allowance as provided in section

256B.35, to reimburse the county for the cost of care, examination, or treatment. Income and resources attributable to the child include, but are not limited to, Social Security benefits, supplemental security income (SSI), veterans benefits, railroad retirement benefits and child support. When the child is over the age of 18, and continues to receive care, examination, or treatment, the court shall order, and the responsible social services agency shall require, reimbursement from the child for the cost of care, examination, or treatment from the income and resources attributable to the child less the clothing and personal needs allowance. Income does not include earnings from a child over the age of 18 who is working as part of a plan under section 260C.212, subdivision 1, paragraph (c), clause (8), to transition from foster care.

(c) If the income and resources attributable to the child are not enough to reimburse the county for the full cost of the care, examination, or treatment, the court shall inquire into the ability of the parents to support the child and, after giving the parents a reasonable opportunity to be heard, the court shall order, and the responsible social services agency shall require, the parents to contribute to the cost of care, examination, or treatment of the child. When determining the amount to be contributed by the parents, the court shall use a fee schedule based upon ability to pay that is established by the responsible social services agency and approved by the commissioner of human services. The income of a stepparent who has not adopted a child shall be excluded in calculating the parental contribution under this section.

(d) The court shall order the amount of reimbursement attributable to the parents or custodian, or attributable to the child, or attributable to both sources, withheld under chapter 518A from the income of the parents or the custodian of the child. A parent or custodian who fails to pay without good reason may be proceeded against for contempt, or the court may inform the county attorney, who shall proceed to collect the unpaid sums, or both procedures may be used.

(e) If the court orders a physical or mental examination for a child, the examination is a medically necessary service for purposes of determining whether the service is covered by a health insurance policy, health maintenance contract, or other health coverage plan. Court-ordered treatment shall be subject to policy, contract, or plan requirements for medical necessity. Nothing in this paragraph changes or eliminates benefit limits, conditions of coverage, co-payments or deductibles, provider restrictions, or other requirements in the policy, contract, or plan that relate to coverage of other medically necessary services.

Sec. 78. Minnesota Statutes 2006, section 270B.14, subdivision 1, is amended to read:

Subdivision 1. **Disclosure to commissioner of human services.** (a) On the request of the commissioner of human services, the commissioner shall disclose return information regarding taxes imposed by chapter 290, and claims for refunds under chapter 290A, to the extent provided in paragraph (b) and for the purposes set forth in paragraph (c).

(b) Data that may be disclosed are limited to data relating to the identity, whereabouts, employment, income, and property of a person owing or alleged to be owing an obligation of child support.

(c) The commissioner of human services may request data only for the purposes of carrying out the child support enforcement program and to assist in the location of parents who have, or appear to have, deserted their children. Data received may be used only as set forth in section 256.978.

(d) The commissioner shall provide the records and information necessary to administer the supplemental housing allowance to the commissioner of human services.

(e) At the request of the commissioner of human services, the commissioner of revenue shall electronically match the Social Security numbers and names of participants in the telephone assistance plan operated under sections 237.69 to 237.711, with those of property tax refund filers, and determine whether each participant's household income is within the eligibility standards for the telephone assistance plan.

(f) The commissioner may provide records and information collected under sections 295.50 to 295.59 to the commissioner of human services for purposes of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, Public Law 102-234. Upon the written agreement by the United States Department of Health and Human Services to maintain the confidentiality of the data, the commissioner may provide records and information collected under sections 295.50 to 295.59 to the Centers for Medicare and Medicaid Services section of the United States Department of Health and Human Services for purposes of meeting federal reporting requirements.

(g) The commissioner may provide records and information to the commissioner of human services as necessary to administer the early refund of refundable tax credits.

(h) The commissioner may disclose information to the commissioner of human services necessary to verify income for eligibility and premium payment under the MinnesotaCare program, under section 256L.05, subdivision 2.

(i) The commissioner may disclose information to the commissioner of human services necessary to verify whether applicants or recipients for the Minnesota family investment program, general assistance, food support, ~~and~~ Minnesota supplemental aid program, and child care assistance have claimed refundable tax credits under chapter 290 and the property tax refund under chapter 290A, and the amounts of the credits.

93.1 Sec. 79. Minnesota Statutes 2006, section 626.556, subdivision 2, is amended to read:

93.2 Subd. 2. **Definitions.** As used in this section, the following terms have the meanings
93.3 given them unless the specific content indicates otherwise:

93.4 (a) "Family assessment" means a comprehensive assessment of child safety, risk
93.5 of subsequent child maltreatment, and family strengths and needs that is applied to a
93.6 child maltreatment report that does not allege substantial child endangerment. Family
93.7 assessment does not include a determination as to whether child maltreatment occurred
93.8 but does determine the need for services to address the safety of family members and the
93.9 risk of subsequent maltreatment.

93.10 (b) "Investigation" means fact gathering related to the current safety of a child
93.11 and the risk of subsequent maltreatment that determines whether child maltreatment
93.12 occurred and whether child protective services are needed. An investigation must be used
93.13 when reports involve substantial child endangerment, and for reports of maltreatment in
93.14 facilities required to be licensed under chapter 245A or 245B; under sections 144.50 to
93.15 144.58 and 241.021; in a school as defined in sections 120A.05, subdivisions 9, 11, and
93.16 13, and 124D.10; or in a nonlicensed personal care provider association as defined in
93.17 sections 256B.04, subdivision 16, and 256B.0625, subdivision 19a.

93.18 (c) "Substantial child endangerment" means a person responsible for a child's care,
93.19 and in the case of sexual abuse includes a person who has a significant relationship to the
93.20 child as defined in section 609.341, or a person in a position of authority as defined in
93.21 section 609.341, who by act or omission commits or attempts to commit an act against a
93.22 child under their care that constitutes any of the following:

93.23 (1) egregious harm as defined in section 260C.007, subdivision 14;

93.24 (2) sexual abuse as defined in paragraph (d);

93.25 (3) abandonment under section 260C.301, subdivision 2;

93.26 (4) neglect as defined in paragraph (f), clause (2), that substantially endangers the
93.27 child's physical or mental health, including a growth delay, which may be referred to as
93.28 failure to thrive, that has been diagnosed by a physician and is due to parental neglect;

93.29 (5) murder in the first, second, or third degree under section 609.185, 609.19, or
93.30 609.195;

93.31 (6) manslaughter in the first or second degree under section 609.20 or 609.205;

93.32 (7) assault in the first, second, or third degree under section 609.221, 609.222, or
93.33 609.223;

93.34 (8) solicitation, inducement, and promotion of prostitution under section 609.322;

93.35 (9) criminal sexual conduct under sections 609.342 to 609.3451;

93.36 (10) solicitation of children to engage in sexual conduct under section 609.352;

94.1 (11) malicious punishment or neglect or endangerment of a child under section
94.2 609.377 or 609.378;

94.3 (12) use of a minor in sexual performance under section 617.246; or

94.4 (13) parental behavior, status, or condition which mandates that the county attorney
94.5 file a termination of parental rights petition under section 260C.301, subdivision 3,
94.6 paragraph (a).

94.7 (d) "Sexual abuse" means the subjection of a child by a person responsible for the
94.8 child's care, by a person who has a significant relationship to the child, as defined in
94.9 section 609.341, or by a person in a position of authority, as defined in section 609.341,
94.10 subdivision 10, to any act which constitutes a violation of section 609.342 (criminal sexual
94.11 conduct in the first degree), 609.343 (criminal sexual conduct in the second degree),
94.12 609.344 (criminal sexual conduct in the third degree), 609.345 (criminal sexual conduct
94.13 in the fourth degree), or 609.3451 (criminal sexual conduct in the fifth degree). Sexual
94.14 abuse also includes any act which involves a minor which constitutes a violation of
94.15 prostitution offenses under sections 609.321 to 609.324 or 617.246. Sexual abuse includes
94.16 threatened sexual abuse.

94.17 (e) "Person responsible for the child's care" means (1) an individual functioning
94.18 within the family unit and having responsibilities for the care of the child such as a
94.19 parent, guardian, or other person having similar care responsibilities, or (2) an individual
94.20 functioning outside the family unit and having responsibilities for the care of the child
94.21 such as a teacher, school administrator, other school employees or agents, or other lawful
94.22 custodian of a child having either full-time or short-term care responsibilities including,
94.23 but not limited to, day care, babysitting whether paid or unpaid, counseling, teaching,
94.24 and coaching.

94.25 (f) "Neglect" means:

94.26 (1) failure by a person responsible for a child's care to supply a child with necessary
94.27 food, clothing, shelter, health, medical, or other care required for the child's physical or
94.28 mental health when reasonably able to do so;

94.29 (2) failure to protect a child from conditions or actions that seriously endanger the
94.30 child's physical or mental health when reasonably able to do so, including a growth delay,
94.31 which may be referred to as a failure to thrive, that has been diagnosed by a physician and
94.32 is due to parental neglect;

94.33 (3) failure to provide for necessary supervision or child care arrangements
94.34 appropriate for a child after considering factors as the child's age, mental ability, physical
94.35 condition, length of absence, or environment, when the child is unable to care for the
94.36 child's own basic needs or safety, or the basic needs or safety of another child in their care;

(4) failure to ensure that the child is educated as defined in sections 120A.22 and 260C.163, subdivision 11, which does not include a parent's refusal to provide the parent's child with sympathomimetic medications, consistent with section 125A.091, subdivision 5;

(5) nothing in this section shall be construed to mean that a child is neglected solely because the child's parent, guardian, or other person responsible for the child's care in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the child in lieu of medical care; except that a parent, guardian, or caretaker, or a person mandated to report pursuant to subdivision 3, has a duty to report if a lack of medical care may cause serious danger to the child's health. This section does not impose upon persons, not otherwise legally responsible for providing a child with necessary food, clothing, shelter, education, or medical care, a duty to provide that care;

(6) prenatal exposure to a controlled substance, as defined in section 253B.02, subdivision 2, used by the mother for a nonmedical purpose, as evidenced by withdrawal symptoms in the child at birth, results of a toxicology test performed on the mother at delivery or the child at birth, or medical effects or developmental delays during the child's first year of life that medically indicate prenatal exposure to a controlled substance;

(7) "medical neglect" as defined in section 260C.007, subdivision 6, clause (5);

(8) chronic and severe use of alcohol or a controlled substance by a parent or person responsible for the care of the child that adversely affects the child's basic needs and safety; or

(9) emotional harm from a pattern of behavior which contributes to impaired emotional functioning of the child which may be demonstrated by a substantial and observable effect in the child's behavior, emotional response, or cognition that is not within the normal range for the child's age and stage of development, with due regard to the child's culture.

(g) "Physical abuse" means any physical injury, mental injury, or threatened injury, inflicted by a person responsible for the child's care on a child other than by accidental means, or any physical or mental injury that cannot reasonably be explained by the child's history of injuries, or any aversive or deprivation procedures, or regulated interventions, that have not been authorized under section 121A.67 or 245.825. Abuse does not include reasonable and moderate physical discipline of a child administered by a parent or legal guardian which does not result in an injury. Abuse does not include the use of reasonable force by a teacher, principal, or school employee as allowed by section 121A.582. Actions which are not reasonable and moderate include, but are not limited to, any of the following that are done in anger or without regard to the safety of the child:

(1) throwing, kicking, burning, biting, or cutting a child;

- 96.1 (2) striking a child with a closed fist;
- 96.2 (3) shaking a child under age three;
- 96.3 (4) striking or other actions which result in any nonaccidental injury to a child
- 96.4 under 18 months of age;
- 96.5 (5) unreasonable interference with a child's breathing;
- 96.6 (6) threatening a child with a weapon, as defined in section 609.02, subdivision 6;
- 96.7 (7) striking a child under age one on the face or head;
- 96.8 (8) purposely giving a child poison, alcohol, or dangerous, harmful, or controlled
- 96.9 substances which were not prescribed for the child by a practitioner, in order to control or
- 96.10 punish the child; or other substances that substantially affect the child's behavior, motor
- 96.11 coordination, or judgment or that results in sickness or internal injury, or subjects the
- 96.12 child to medical procedures that would be unnecessary if the child were not exposed
- 96.13 to the substances;
- 96.14 (9) unreasonable physical confinement or restraint not permitted under section
- 96.15 609.379, including but not limited to tying, caging, or chaining; or
- 96.16 (10) in a school facility or school zone, an act by a person responsible for the child's
- 96.17 care that is a violation under section 121A.58.
- 96.18 (h) "Report" means any report received by the local welfare agency, police
- 96.19 department, county sheriff, or agency responsible for assessing or investigating
- 96.20 maltreatment pursuant to this section.
- 96.21 (i) "Facility" means:
- 96.22 (1) a licensed or unlicensed day care facility, residential facility, agency, hospital,
- 96.23 sanitarium, or other facility or institution required to be licensed under sections 144.50 to
- 96.24 144.58, 241.021, or 245A.01 to 245A.16, or chapter 245B;
- 96.25 (2) a school as defined in sections 120A.05, subdivisions 9, 11, and 13; and
- 96.26 124D.10; or
- 96.27 (3) a nonlicensed personal care provider organization as defined in sections 256B.04,
- 96.28 subdivision 16, and 256B.0625, subdivision 19a.
- 96.29 (j) "Operator" means an operator or agency as defined in section 245A.02.
- 96.30 (k) "Commissioner" means the commissioner of human services.
- 96.31 (l) "Practice of social services," for the purposes of subdivision 3, includes but is
- 96.32 not limited to employee assistance counseling and the provision of guardian ad litem and
- 96.33 parenting time expeditor services.
- 96.34 (m) "Mental injury" means an injury to the psychological capacity or emotional
- 96.35 stability of a child as evidenced by an observable or substantial impairment in the child's

97.1 ability to function within a normal range of performance and behavior with due regard to
97.2 the child's culture.

97.3 (n) "Threatened injury" means a statement, overt act, condition, or status that
97.4 represents a substantial risk of physical or sexual abuse or mental injury. Threatened
97.5 injury includes, but is not limited to, exposing a child to a person responsible for the
97.6 child's care, as defined in paragraph (e), clause (1), who has:

97.7 (1) subjected a child to, or failed to protect a child from, an overt act or condition
97.8 that constitutes egregious harm, as defined in section 260C.007, subdivision 14, or a
97.9 similar law of another jurisdiction;

97.10 (2) been found to be palpably unfit under section 260C.301, paragraph (b), clause
97.11 (4), or a similar law of another jurisdiction;

97.12 (3) committed an act that has resulted in an involuntary termination of parental rights
97.13 under section 260C.301, or a similar law of another jurisdiction; or

97.14 (4) committed an act that has resulted in the involuntary transfer of permanent legal
97.15 and physical custody of a child to a relative under section 260C.201, subdivision 11,
97.16 paragraph (d), clause (1), or a similar law of another jurisdiction.

97.17 (o) Persons who conduct assessments or investigations under this section shall take
97.18 into account accepted child-rearing practices of the culture in which a child participates
97.19 and accepted teacher discipline practices, which are not injurious to the child's health,
97.20 welfare, and safety.

97.21 Sec. 80. Minnesota Statutes 2006, section 626.556, subdivision 3, is amended to read:

97.22 Subd. 3. **Persons mandated to report.** (a) A person who knows or has reason
97.23 to believe a child is being neglected or physically or sexually abused, as defined in
97.24 subdivision 2, or has been neglected or physically or sexually abused within the preceding
97.25 three years, shall immediately report the information to the local welfare agency, agency
97.26 responsible for assessing or investigating the report, police department, or the county
97.27 sheriff if the person is:

97.28 (1) a professional or professional's delegate who is engaged in the practice of
97.29 the healing arts, social services, hospital administration, psychological or psychiatric
97.30 treatment, child care, education, correctional supervision, probation and correctional
97.31 services, or law enforcement; or

97.32 (2) employed as a member of the clergy and received the information while
97.33 engaged in ministerial duties, provided that a member of the clergy is not required by
97.34 this subdivision to report information that is otherwise privileged under section 595.02,
97.35 subdivision 1, paragraph (c).

98.1 The police department or the county sheriff, upon receiving a report, shall
98.2 immediately notify the local welfare agency or agency responsible for assessing or
98.3 investigating the report, orally and in writing. The local welfare agency, or agency
98.4 responsible for assessing or investigating the report, upon receiving a report, shall
98.5 immediately notify the local police department or the county sheriff orally and in writing.
98.6 The county sheriff and the head of every local welfare agency, agency responsible
98.7 for assessing or investigating reports, and police department shall each designate a
98.8 person within their agency, department, or office who is responsible for ensuring that
98.9 the notification duties of this paragraph and paragraph (b) are carried out. Nothing in
98.10 this subdivision shall be construed to require more than one report from any institution,
98.11 facility, school, or agency.

98.12 (b) Any person may voluntarily report to the local welfare agency, agency
98.13 responsible for assessing or investigating the report, police department, or the county
98.14 sheriff if the person knows, has reason to believe, or suspects a child is being or has been
98.15 neglected or subjected to physical or sexual abuse. The police department or the county
98.16 sheriff, upon receiving a report, shall immediately notify the local welfare agency or
98.17 agency responsible for assessing or investigating the report, orally and in writing. The
98.18 local welfare agency or agency responsible for assessing or investigating the report, upon
98.19 receiving a report, shall immediately notify the local police department or the county
98.20 sheriff orally and in writing.

98.21 (c) A person mandated to report physical or sexual child abuse or neglect occurring
98.22 within a licensed facility shall report the information to the agency responsible for
98.23 licensing the facility under sections 144.50 to 144.58; 241.021; 245A.01 to 245A.16; or
98.24 chapter 245B; or a nonlicensed personal care provider organization as defined in sections
98.25 256B.04, subdivision 16; and 256B.0625, subdivision 19. A health or corrections agency
98.26 receiving a report may request the local welfare agency to provide assistance pursuant
98.27 to subdivisions 10, 10a, and 10b. A board or other entity whose licensees perform work
98.28 within a school facility, upon receiving a complaint of alleged maltreatment, shall provide
98.29 information about the circumstances of the alleged maltreatment to the commissioner of
98.30 education. Section 13.03, subdivision 4, applies to data received by the commissioner of
98.31 education from a licensing entity.

98.32 (d) Any person mandated to report shall receive a summary of the disposition of
98.33 any report made by that reporter, including whether the case has been opened for child
98.34 protection or other services, or if a referral has been made to a community organization,
98.35 unless release would be detrimental to the best interests of the child. Any person who is
98.36 not mandated to report shall, upon request to the local welfare agency, receive a concise

99.1 summary of the disposition of any report made by that reporter, unless release would be
99.2 detrimental to the best interests of the child.

99.3 (e) For purposes of this ~~subdivision~~ section, "immediately" means as soon as
99.4 possible but in no event longer than 24 hours.

99.5 Sec. 81. Minnesota Statutes 2006, section 626.556, is amended by adding a subdivision
99.6 to read:

99.7 Subd. 3e. **Agency responsibility for assessing or investigating reports of sexual**
99.8 **abuse.** The local welfare agency is the agency responsible for investigating allegations
99.9 of sexual abuse if the alleged offender is the parent, guardian, sibling, or an individual
99.10 functioning within the family unit as a person responsible for the child's care, or a person
99.11 with a significant relationship to the child if that person resides in the child's household.

99.12 Sec. 82. Minnesota Statutes 2006, section 626.556, is amended by adding a subdivision
99.13 to read:

99.14 Subd. 3f. **Law enforcement agency responsibility for investigating**
99.15 **maltreatment.** The local law enforcement agency has responsibility for investigating any
99.16 report of child maltreatment if a violation of a criminal statute is alleged. Law enforcement
99.17 and the responsible agency must coordinate their investigations or assessments as required
99.18 under subdivision 10.

99.19 Sec. 83. Minnesota Statutes 2006, section 626.556, subdivision 10, is amended to read:

99.20 Subd. 10. **Duties of local welfare agency and local law enforcement agency upon**
99.21 **receipt of a report.** (a) Upon receipt of a report, the local welfare agency shall determine
99.22 whether to conduct a family assessment or an investigation as appropriate to prevent or
99.23 provide a remedy for child maltreatment. The local welfare agency:

99.24 (1) shall conduct an investigation on reports involving substantial child
99.25 endangerment;

99.26 (2) shall begin an immediate investigation if, at any time when it is using a family
99.27 assessment response, it determines that there is reason to believe that substantial child
99.28 endangerment or a serious threat to the child's safety exists;

99.29 (3) may conduct a family assessment for reports that do not allege substantial child
99.30 endangerment. In determining that a family assessment is appropriate, the local welfare
99.31 agency may consider issues of child safety, parental cooperation, and the need for an
99.32 immediate response; and

(4) may conduct a family assessment on a report that was initially screened and assigned for an investigation. In determining that a complete investigation is not required, the local welfare agency must document the reason for terminating the investigation and notify the local law enforcement agency if the local law enforcement agency is conducting a joint investigation.

If the report alleges neglect, physical abuse, or sexual abuse by a parent, guardian, or individual functioning within the family unit as a person responsible for the child's care, or sexual abuse by a person with a significant relationship to the child when that person resides in the child's household or by a sibling, the local welfare agency shall immediately conduct a family assessment or investigation as identified in clauses (1) to (4). In conducting a family assessment or investigation, the local welfare agency shall gather information on the existence of substance abuse and domestic violence and offer services for purposes of preventing future child maltreatment, safeguarding and enhancing the welfare of the abused or neglected minor, and supporting and preserving family life whenever possible. If the report alleges a violation of a criminal statute involving sexual abuse, physical abuse, or neglect or endangerment, under section 609.378, the local law enforcement agency and local welfare agency shall coordinate the planning and execution of their respective investigation and assessment efforts to avoid a duplication of fact-finding efforts and multiple interviews. Each agency shall prepare a separate report of the results of its investigation. In cases of alleged child maltreatment resulting in death, the local agency may rely on the fact-finding efforts of a law enforcement investigation to make a determination of whether or not maltreatment occurred. When necessary the local welfare agency shall seek authority to remove the child from the custody of a parent, guardian, or adult with whom the child is living. In performing any of these duties, the local welfare agency shall maintain appropriate records.

If the family assessment or investigation indicates there is a potential for abuse of alcohol or other drugs by the parent, guardian, or person responsible for the child's care, the local welfare agency shall conduct a chemical use assessment pursuant to Minnesota Rules, part 9530.6615. The local welfare agency shall report the determination of the chemical use assessment, and the recommendations and referrals for alcohol and other drug treatment services to the state authority on alcohol and drug abuse.

(b) When a local agency receives a report or otherwise has information indicating that a child who is a client, as defined in section 245.91, has been the subject of physical abuse, sexual abuse, or neglect at an agency, facility, or program as defined in section 245.91, it shall, in addition to its other duties under this section, immediately inform the ombudsman established under sections 245.91 to 245.97. The commissioner of education

shall inform the ombudsman established under sections 245.91 to 245.97 of reports regarding a child defined as a client in section 245.91 that maltreatment occurred at a school as defined in sections 120A.05, subdivisions 9, 11, and 13, and 124D.10.

(c) Authority of the local welfare agency responsible for assessing or investigating the child abuse or neglect report, the agency responsible for assessing or investigating the report, and of the local law enforcement agency for investigating the alleged abuse or neglect includes, but is not limited to, authority to interview, without parental consent, the alleged victim and any other minors who currently reside with or who have resided with the alleged offender. The interview may take place at school or at any facility or other place where the alleged victim or other minors might be found or the child may be transported to, and the interview conducted at, a place appropriate for the interview of a child designated by the local welfare agency or law enforcement agency. The interview may take place outside the presence of the alleged offender or parent, legal custodian, guardian, or school official. For family assessments, it is the preferred practice to request a parent or guardian's permission to interview the child prior to conducting the child interview, unless doing so would compromise the safety assessment. Except as provided in this paragraph, the parent, legal custodian, or guardian shall be notified by the responsible local welfare or law enforcement agency no later than the conclusion of the investigation or assessment that this interview has occurred. Notwithstanding rule ~~49.02~~ 32 of the Minnesota Rules of Procedure for Juvenile Courts, the juvenile court may, after hearing on an ex parte motion by the local welfare agency, order that, where reasonable cause exists, the agency withhold notification of this interview from the parent, legal custodian, or guardian. If the interview took place or is to take place on school property, the order shall specify that school officials may not disclose to the parent, legal custodian, or guardian the contents of the notification of intent to interview the child on school property, as provided under this paragraph, and any other related information regarding the interview that may be a part of the child's school record. A copy of the order shall be sent by the local welfare or law enforcement agency to the appropriate school official.

(d) When the local welfare, local law enforcement agency, or the agency responsible for assessing or investigating a report of maltreatment determines that an interview should take place on school property, written notification of intent to interview the child on school property must be received by school officials prior to the interview. The notification shall include the name of the child to be interviewed, the purpose of the interview, and a reference to the statutory authority to conduct an interview on school property. For interviews conducted by the local welfare agency, the notification shall be signed by the chair of the local social services agency or the chair's designee. The notification shall be

102.1 private data on individuals subject to the provisions of this paragraph. School officials
102.2 may not disclose to the parent, legal custodian, or guardian the contents of the notification
102.3 or any other related information regarding the interview until notified in writing by the
102.4 local welfare or law enforcement agency that the investigation or assessment has been
102.5 concluded, unless a school employee or agent is alleged to have maltreated the child.
102.6 Until that time, the local welfare or law enforcement agency or the agency responsible
102.7 for assessing or investigating a report of maltreatment shall be solely responsible for any
102.8 disclosures regarding the nature of the assessment or investigation.

102.9 Except where the alleged offender is believed to be a school official or employee,
102.10 the time and place, and manner of the interview on school premises shall be within the
102.11 discretion of school officials, but the local welfare or law enforcement agency shall have
102.12 the exclusive authority to determine who may attend the interview. The conditions as to
102.13 time, place, and manner of the interview set by the school officials shall be reasonable and
102.14 the interview shall be conducted not more than 24 hours after the receipt of the notification
102.15 unless another time is considered necessary by agreement between the school officials and
102.16 the local welfare or law enforcement agency. Where the school fails to comply with the
102.17 provisions of this paragraph, the juvenile court may order the school to comply. Every
102.18 effort must be made to reduce the disruption of the educational program of the child, other
102.19 students, or school staff when an interview is conducted on school premises.

102.20 (e) Where the alleged offender or a person responsible for the care of the alleged
102.21 victim or other minor prevents access to the victim or other minor by the local welfare
102.22 agency, the juvenile court may order the parents, legal custodian, or guardian to produce
102.23 the alleged victim or other minor for questioning by the local welfare agency or the local
102.24 law enforcement agency outside the presence of the alleged offender or any person
102.25 responsible for the child's care at reasonable places and times as specified by court order.

102.26 (f) Before making an order under paragraph (e), the court shall issue an order to
102.27 show cause, either upon its own motion or upon a verified petition, specifying the basis for
102.28 the requested interviews and fixing the time and place of the hearing. The order to show
102.29 cause shall be served personally and shall be heard in the same manner as provided in
102.30 other cases in the juvenile court. The court shall consider the need for appointment of a
102.31 guardian ad litem to protect the best interests of the child. If appointed, the guardian ad
102.32 litem shall be present at the hearing on the order to show cause.

102.33 (g) The commissioner of human services, the ombudsman for mental health and
102.34 developmental disabilities, the local welfare agencies responsible for investigating reports,
102.35 the commissioner of education, and the local law enforcement agencies have the right to
102.36 enter facilities as defined in subdivision 2 and to inspect and copy the facility's records,

including medical records, as part of the investigation. Notwithstanding the provisions of chapter 13, they also have the right to inform the facility under investigation that they are conducting an investigation, to disclose to the facility the names of the individuals under investigation for abusing or neglecting a child, and to provide the facility with a copy of the report and the investigative findings.

(h) The local welfare agency responsible for conducting a family assessment or investigation shall collect available and relevant information to determine child safety, risk of subsequent child maltreatment, and family strengths and needs and share not public information with an Indian's tribal social services agency without violating any law of the state that may otherwise impose duties of confidentiality on the local welfare agency in order to implement the tribal state agreement. The local welfare agency or the agency responsible for investigating the report shall collect available and relevant information to ascertain whether maltreatment occurred and whether protective services are needed. Information collected includes, when relevant, information with regard to the person reporting the alleged maltreatment, including the nature of the reporter's relationship to the child and to the alleged offender, and the basis of the reporter's knowledge for the report; the child allegedly being maltreated; the alleged offender; the child's caretaker; and other collateral sources having relevant information related to the alleged maltreatment. The local welfare agency or the agency responsible for assessing or investigating the report may make a determination of no maltreatment early in an assessment, and close the case and retain immunity, if the collected information shows no basis for a full assessment or investigation.

Information relevant to the assessment or investigation must be asked for, and may include:

(1) the child's sex and age, prior reports of maltreatment, information relating to developmental functioning, credibility of the child's statement, and whether the information provided under this clause is consistent with other information collected during the course of the assessment or investigation;

(2) the alleged offender's age, a record check for prior reports of maltreatment, and criminal charges and convictions. The local welfare agency or the agency responsible for assessing or investigating the report must provide the alleged offender with an opportunity to make a statement. The alleged offender may submit supporting documentation relevant to the assessment or investigation;

(3) collateral source information regarding the alleged maltreatment and care of the child. Collateral information includes, when relevant: (i) a medical examination of the child; (ii) prior medical records relating to the alleged maltreatment or the care of the

child maintained by any facility, clinic, or health care professional and an interview with the treating professionals; and (iii) interviews with the child's caretakers, including the child's parent, guardian, foster parent, child care provider, teachers, counselors, family members, relatives, and other persons who may have knowledge regarding the alleged maltreatment and the care of the child; and

(4) information on the existence of domestic abuse and violence in the home of the child, and substance abuse.

Nothing in this paragraph precludes the local welfare agency, the local law enforcement agency, or the agency responsible for assessing or investigating the report from collecting other relevant information necessary to conduct the assessment or investigation. Notwithstanding section 13.384 or 144.335, the local welfare agency has access to medical data and records for purposes of clause (3). Notwithstanding the data's classification in the possession of any other agency, data acquired by the local welfare agency or the agency responsible for assessing or investigating the report during the course of the assessment or investigation are private data on individuals and must be maintained in accordance with subdivision 11. Data of the commissioner of education collected or maintained during and for the purpose of an investigation of alleged maltreatment in a school are governed by this section, notwithstanding the data's classification as educational, licensing, or personnel data under chapter 13.

In conducting an assessment or investigation involving a school facility as defined in subdivision 2, paragraph (i), the commissioner of education shall collect investigative reports and data that are relevant to a report of maltreatment and are from local law enforcement and the school facility.

(i) Upon receipt of a report, the local welfare agency shall conduct a face-to-face contact with the child reported to be maltreated and with the child's primary caregiver sufficient to complete a safety assessment and ensure the immediate safety of the child. The face-to-face contact with the child and primary caregiver shall occur immediately if substantial child endangerment is alleged and within five calendar days for all other reports. If the alleged offender was not already interviewed as the primary caregiver, the local welfare agency shall also conduct a face-to-face interview with the alleged offender in the early stages of the assessment or investigation. At the initial contact, the local child welfare agency or the agency responsible for assessing or investigating the report must inform the alleged offender of the complaints or allegations made against the individual in a manner consistent with laws protecting the rights of the person who made the report. The interview with the alleged offender may be postponed if it would jeopardize an active law enforcement investigation.

(j) When conducting an investigation, the local welfare agency shall use a question and answer interviewing format with questioning as nondirective as possible to elicit spontaneous responses. For investigations only, the following interviewing methods and procedures must be used whenever possible when collecting information:

(1) audio recordings of all interviews with witnesses and collateral sources; and

(2) in cases of alleged sexual abuse, audio-video recordings of each interview with the alleged victim and child witnesses.

(k) In conducting an assessment or investigation involving a school facility as defined in subdivision 2, paragraph (i), the commissioner of education shall collect available and relevant information and use the procedures in paragraphs (i), (k), and subdivision 3d, except that the requirement for face-to-face observation of the child and face-to-face interview of the alleged offender is to occur in the initial stages of the assessment or investigation provided that the commissioner may also base the assessment or investigation on investigative reports and data received from the school facility and local law enforcement, to the extent those investigations satisfy the requirements of paragraphs (i) and (k), and subdivision 3d.

Sec. 84. Minnesota Statutes 2006, section 626.556, subdivision 10a, is amended to read:

Subd. 10a. ~~Abuse outside family unit~~ **Law enforcement agency responsibility for investigation; welfare agency reliance on law enforcement fact-finding; welfare agency offer of services.** (a) If the report alleges neglect, physical abuse, or sexual abuse by a person who is not a parent, guardian, sibling, person responsible for the child's care functioning outside within the family unit, or a person who lives in the child's household and who has a significant relationship to the child, in a setting other than a facility as defined in subdivision 2, the local welfare agency shall immediately notify the appropriate law enforcement agency, which shall conduct an investigation of the alleged abuse or neglect if a violation of a criminal statute is alleged.

(b) The local agency may rely on the fact-finding efforts of the law enforcement investigation conducted under this subdivision to make a determination whether or not threatened harm or other maltreatment has occurred under subdivision 2 if an alleged offender has minor children or lives with minors.

(c) The local welfare agency shall offer appropriate social services for the purpose of safeguarding and enhancing the welfare of the abused or neglected minor.

106.1 Sec. 85. Minnesota Statutes 2006, section 626.556, subdivision 10c, is amended to
106.2 read:

106.3 Subd. 10c. **Duties of local social service agency upon receipt of a report of**
106.4 **medical neglect.** If the report alleges medical neglect as defined in section 260C.007,
106.5 subdivision ~~4~~ 6, clause (5), the local welfare agency shall, in addition to its other duties
106.6 under this section, immediately consult with designated hospital staff and with the parents
106.7 of the infant to verify that appropriate nutrition, hydration, and medication are being
106.8 provided; and shall immediately secure an independent medical review of the infant's
106.9 medical charts and records and, if necessary, seek a court order for an independent medical
106.10 examination of the infant. If the review or examination leads to a conclusion of medical
106.11 neglect, the agency shall intervene on behalf of the infant by initiating legal proceedings
106.12 under section 260C.141 and by filing an expedited motion to prevent the withholding
106.13 of medically indicated treatment.

106.14 Sec. 86. Minnesota Statutes 2006, section 626.556, subdivision 10f, is amended to read:

106.15 Subd. 10f. **Notice of determinations.** Within ten working days of the conclusion
106.16 of a family assessment, the local welfare agency shall notify the parent or guardian of
106.17 the child of the need for services to address child safety concerns or significant risk of
106.18 subsequent child maltreatment. The local welfare agency and the family may also jointly
106.19 agree that family support and family preservation services are needed. Within ten working
106.20 days of the conclusion of an investigation, the local welfare agency or agency responsible
106.21 for assessing or investigating the report shall notify the parent or guardian of the child, the
106.22 person determined to be maltreating the child, and if applicable, the director of the facility,
106.23 of the determination and a summary of the specific reasons for the determination. The
106.24 notice must also include a certification that the information collection procedures under
106.25 subdivision 10, paragraphs (h), (i), and (j), were followed and a notice of the right of a
106.26 data subject to obtain access to other private data on the subject collected, created, or
106.27 maintained under this section. In addition, the notice shall include the length of time that
106.28 the records will be kept under subdivision 11c. The investigating agency shall notify the
106.29 parent or guardian of the child who is the subject of the report, and any person or facility
106.30 determined to have maltreated a child, of their appeal or review rights under this section
106.31 or section 256.022. The notice must also state that a finding of maltreatment may result
106.32 in denial of a license application or background study disqualification under chapter
106.33 245C related to employment or services that are licensed by the Department of Human
106.34 Services under chapter 245A, the Department of Health under chapter 144 or 144A, the

107.1 Department of Corrections under section 241.021, and from providing services related to
107.2 an unlicensed personal care provider organization under chapter 256B.

107.3 Sec. 87. **KINSHIP NAVIGATOR PROGRAM; DEMONSTRATION GRANT.**

107.4 (a) The commissioner of human services shall fund a two-year demonstration grant
107.5 to be transferred to a nonprofit organization experienced in kinship advocacy and policy
107.6 that has:

107.7 (1) experience working with grandparents and relatives who are raising kinship
107.8 children;

107.9 (2) an established statewide outreach network;

107.10 (3) established kinship support groups;

107.11 (4) an intergenerational approach to programming; and

107.12 (5) a board of directors consisting of 50 percent grandparents and relatives raising
107.13 kinship children.

107.14 (b) The purpose of the grant is to provide support to grandparents or relatives raising
107.15 kinship children. One site must be in the metropolitan area, and the other in the Bemidji
107.16 region. One-stop services may include, but are not limited to, legal services, education,
107.17 information, family activities, support groups, mental health access, advocacy, mentors,
107.18 and information related to foster care licensing. Funds may also be used for a media
107.19 campaign to inform kinship families about available information and services, support
107.20 sites, and other program development.

107.21 Sec. 88. **MFIP PILOT PROGRAM; WORKFORCE U.**

107.22 Subdivision 1. **Establishment.** A pilot program is established in Stearns and
107.23 Benton Counties to expand the Workforce U program administered by the Stearns-Benton
107.24 Employment and Training Council.

107.25 Subd. 2. **Evaluation.** The Workforce U pilot program must be evaluated by a
107.26 research and evaluation organization with experience evaluating welfare programs. The
107.27 evaluation must include information on the total number of persons served, percentage
107.28 of participants exiting the program, percentage of former participants reentering the
107.29 program, average wages of program participants, and recommendations to the legislature
107.30 for possible statewide implementation of the program. The evaluation must be presented
107.31 to the legislature by February 15, 2011.

107.32 Subd. 3. **Expiration.** The Workforce U pilot program expires on June 30, 2011.

107.33 Sec. 89. **LEECH LAKE YOUTH TREATMENT CENTER PROPOSAL.**

108.1 (a) The commissioner of human services shall provide a planning grant to address
108.2 the unmet need for local, effective, culturally relevant alcohol and drug treatment for
108.3 American Indian youth, and develop a plan for a family-based youth treatment center in
108.4 the Leech Lake area. The planning grant must be provided to a volunteer board consisting
108.5 of at least four members appointed by the commissioner, to include at least the following:

- 108.6 (1) two members of the Leech Lake Tribal Council or their designees;
108.7 (2) one member appointed by the Cass County Social Services administrator; and
108.8 (3) one member appointed by the Cass Lake-Bena Public School superintendent.

108.9 (b) The plan must include:

- 108.10 (1) an interest, feasibility, and suitability of location study;
108.11 (2) defining scope of programs and services to be offered;
108.12 (3) defining site use limitations and restrictions, including physical and capacity;
108.13 (4) defining facilities required for programs and services offered;
108.14 (5) identifying partners, partnership roles, and partner resources;
108.15 (6) developing proposed operating and maintenance budgets;
108.16 (7) identifying funding sources;
108.17 (8) developing a long-term funding plan; and
108.18 (9) developing a formal steering committee, structure, and bylaws.

108.19 (c) The plan is due to the legislative committees having jurisdiction over chemical
108.20 health issues no later than September 2008 in order to provide the 12 months necessary to
108.21 complete the plan.

108.22 Sec. 90. **MINNESOTA FOOD SUPPORT PROGRAM SIMPLIFIED**
108.23 **APPLICATION.**

108.24 The Department of Human Services shall create a simplified application for the
108.25 Minnesota food support program for persons over the age of 60 and persons with
108.26 disabilities. The application must be no longer than three pages in length.

108.27 **EFFECTIVE DATE.** This section is effective January 1, 2008.

108.28 Sec. 91. **INSPECTION OF LEGAL UNLICENSED CHILD CARE PROVIDERS.**

108.29 The commissioner of human services, in consultation with the commissioners of
108.30 health and education and the counties, shall develop and present recommendations to
108.31 the legislature in January 2008 in order for each legally unlicensed child care provider
108.32 receiving child care assistance funds to receive a onetime home visit to receive information
108.33 on health and safety, and school readiness.

Sec. 92. COMMISSIONER OF HUMAN SERVICES DUTIES; EARLY
CHILDHOOD AND SCHOOL-AGE PROFESSIONAL DEVELOPMENT
TRAINING.

Subdivision 1. Development and implementation of an early childhood and school-age professional development system. (a) The commissioner of human services, in cooperation with the commissioners of education and health, shall develop and phase-in the implementation of a professional development system for practitioners serving children in early childhood and school-age programs. The system shall provide training options and supports for practitioners to voluntarily choose, as they complete or exceed existing licensing requirements.

The system must, at a minimum, include the following features:

(1) a continuum of training content based on the early childhood and school-age care practitioner core competencies that translates knowledge into improved practice to support children's school success;

(2) training strategies that provide direct feedback about practice to practitioners through ongoing consultation, mentoring, or coaching with special emphasis on early literacy and early mathematics;

(3) an approval process for trainers;

(4) a professional development registry for early childhood and school-age care practitioners that will provide tracking and recognition of practitioner training/career development progress;

(5) a career lattice that includes a range of professional development and educational opportunities that provide appropriate coursework and degree pathways;

(6) development of a plan with public higher education institutions for an articulated system of education, training, and professional development that includes credit for prior learning and development of equivalences to two- and four-year degrees;

(7) incentives and supports for early childhood and school-age care practitioners to seek additional training and education, including TEACH, other scholarships, and career guidance; and

(8) coordinated and accessible delivery of training to early childhood and school-age care practitioners.

(b) By January 1, 2008, the commissioner, in consultation with the organizations named in subdivision 2 shall develop additional opportunities in order to qualify more licensed family child care providers under section 119B.13, subdivision 3a.

(c) The commissioner of human services must evaluate the professional development system and make continuous improvements.

110.1 (d) Beginning July 1, 2007, as appropriations permit, the commissioner shall
110.2 phase-in the professional development system.

110.3 Subd. 2. **Two-hour early childhood training.** By January 15, 2008, the
110.4 commissioner of human services, with input from the Minnesota Licensed Family Child
110.5 Care Association and the Minnesota Professional Development Council, shall identify
110.6 trainings that qualify for the two-hour early childhood development training requirement
110.7 for new child care practitioners under Minnesota Statutes, section 245A.14, subdivision
110.8 9a, paragraphs (a) and (b). For licensed family child care, the commissioner shall also
110.9 seek the input of labor unions that serve licensed family child care providers, if the union
110.10 has been recognized by a county to serve licensed family child care providers.

110.11 Sec. 93. **SCHOOL READINESS SERVICE AGREEMENTS.**

110.12 Subdivision 1. **Overview.** (a) Effective July 1, 2007, funds must be made available
110.13 to allow the commissioner to pay higher rates to up to 50 child care providers who are
110.14 deemed by the commissioner to meet the requirements of a school readiness service
110.15 agreement (SRSA) provider and perform services that support school readiness for
110.16 children and economic stability for parents.

110.17 (b) A provider may be paid a rate above that currently allowed under Minnesota
110.18 Statutes, section 119B.13, if:

110.19 (1) the provider has entered into an SRSA with the commissioner;

110.20 (2) a family using that provider receives child care assistance under any provision in
110.21 Minnesota Statutes, chapter 119B, except Minnesota Statutes, section 119B.035;

110.22 (3) the family using that provider meets the criteria in this section; and

110.23 (4) funding is available under this section.

110.24 Subd. 2. **Provider eligibility.** (a) To be considered for an SRSA, a provider shall
110.25 apply to the commissioner. To be eligible to apply for an SRSA, a provider shall:

110.26 (1) be eligible for child care assistance payments under Minnesota Statutes, chapter
110.27 119B;

110.28 (2) have at least 25 percent of the children enrolled with the provider subsidized
110.29 through the child care assistance program;

110.30 (3) provide full-time, full-year child care services; and

110.31 (4) serve at least one child who is subsidized through the child care assistance
110.32 program and who is expected to enter kindergarten within the following 30 months.

110.33 (b) The commissioner may waive the 25 percent requirement in paragraph (a), clause
110.34 (2), if necessary to achieve geographic distribution of SRSA providers and diversity of
110.35 types of care provided by SRSA providers.

111.1 (c) An eligible provider who would like to enter into an SRSA with the commissioner
111.2 shall submit an SRSA application. To determine whether to enter into an SRSA with a
111.3 provider, the commissioner shall evaluate the following factors:

- 111.4 (1) the qualifications of the provider and the provider's staff;
111.5 (2) the provider's staff-child ratios;
111.6 (3) the provider's curriculum;
111.7 (4) the provider's current or planned parent education activities;
111.8 (5) the provider's current or planned social service and employment linkages;
111.9 (6) the provider's child development assessment plan;
111.10 (7) the geographic distribution needed for SRSA providers;
111.11 (8) the inclusion of a variety of child care delivery models; and
111.12 (9) other related factors determined by the commissioner.

111.13 Subd. 3. **Family and child eligibility.** (a) A family eligible to choose an SRSA
111.14 provider for their children shall:

111.15 (1) be eligible to receive child care assistance under any provision in Minnesota
111.16 Statutes, chapter 119B, except Minnesota Statutes, section 119B.035;

111.17 (2) be in an authorized activity for an average of at least 35 hours per week when
111.18 initial eligibility is determined; and

111.19 (3) include a child who has not yet entered kindergarten.

111.20 (b) A family who is determined to be eligible to choose an SRSA provider remains
111.21 eligible to be paid at a higher rate through the SRSA provider when the following
111.22 conditions exist:

111.23 (1) the child attends child care with the SRSA provider a minimum of 25 hours per
111.24 week, on average;

111.25 (2) the family has a child who has not yet entered kindergarten; and

111.26 (3) the family maintains eligibility under Minnesota Statutes, chapter 119B, except
111.27 Minnesota Statutes, section 119B.035.

111.28 (c) For the 12 months after initial eligibility has been determined, a decrease in
111.29 the family's authorized activities to an average of less than 35 hours per week does not
111.30 result in ineligibility for the SRSA rate.

111.31 (d) A family that moves between counties but continues to use the same SRSA
111.32 provider shall continue to receive SRSA funding for the increased payments.

111.33 Subd. 4. **Requirements of providers.** An SRSA must include assessment,
111.34 evaluation, and reporting requirements that promote the goals of improved school
111.35 readiness and movement toward appropriate child development milestones. A provider

112.1 who enters into an SRSA shall comply with the assessment, evaluation, and reporting
112.2 requirements in the SRSA.

112.3 Subd. 5. **Relationship to current law.** (a) The following provisions in Minnesota
112.4 Statutes, chapter 119B, must be waived or modified for families receiving services under
112.5 this section.

112.6 (b) Notwithstanding Minnesota Statutes, section 119B.13, subdivisions 1 and 1a,
112.7 maximum weekly rates under this section are 125 percent of the existing maximum
112.8 weekly rate for like-care. Providers eligible for a differential rate under Minnesota
112.9 Statutes, section 119B.13, subdivision 3a, remain eligible for the differential above the
112.10 rate identified in this section. Only care for children who have not yet entered kindergarten
112.11 may be paid at the maximum rate under this section. The provider's charge for service
112.12 provided through an SRSA may not exceed the rate that the provider charges a private-pay
112.13 family for like-care arrangements.

112.14 (c) A family or child care provider may not be assessed an overpayment for care
112.15 provided through an SRSA unless:

112.16 (1) there was an error in the amount of care authorized for the family; or
112.17 (2) the family or provider did not timely report a change as required under the law.

112.18 (d) Care provided through an SRSA is authorized on a weekly basis.

112.19 (e) Funds appropriated under this section to serve families eligible under Minnesota
112.20 Statutes, section 119B.03, are not allocated through the basic sliding fee formula under
112.21 Minnesota Statutes, section 119B.03. Funds appropriated under this section are used to
112.22 offset increased costs when payments are made under SRSA's.

112.23 (f) Notwithstanding Minnesota Statutes, section 119B.09, subdivision 6, the
112.24 maximum amount of child care assistance that may be authorized for a child receiving
112.25 care through an SRSA in a two-week period is 160 hours per child.

112.26 Subd. 6. **Establishment of service agreements.** (a) The commissioner shall
112.27 approve SRSA's for up to 50 providers that represent diverse parts of the state and a
112.28 variety of child care delivery models. Entering into a service agreement does not guarantee
112.29 that a provider will receive payment at a higher rate for families receiving child care
112.30 assistance. A family eligible under this section shall choose a provider participating in an
112.31 SRSA in order for a higher rate to be paid. Payments through SRSA's are also limited by
112.32 the availability of SRSA funds.

112.33 (b) Nothing in this section shall be construed to limit parent choice as defined in
112.34 Minnesota Statutes, section 119B.09, subdivision 5.

113.1 (c) The commissioner may allow for startup time for some providers if failing to
113.2 do so would limit geographic diversity of SRSA providers or a variety of child care
113.3 delivery models.

113.4 Sec. 94. **FAMILY, FRIEND, AND NEIGHBOR GRANT PROGRAM.**

113.5 Subdivision 1. **Establishment.** A family, friend, and neighbor (FFN) grant program
113.6 is established to promote children's early literacy, healthy development, and school
113.7 readiness, and to foster community partnerships to promote children's school readiness.
113.8 The commissioner shall attempt to ensure that grants are made in all areas of the state. The
113.9 commissioner of human services shall make grants available to fund: community-based
113.10 organizations, nonprofit organizations, and Indian tribes working with FFN caregivers
113.11 under subdivision 2, paragraph (a); and community-based partnerships to implement early
113.12 literacy programs under subdivision 2, paragraph (b).

113.13 Subd. 2. **Program components.** (a)(1) Grants that the commissioner awards under
113.14 this section must be used by community-based organizations, nonprofit organizations, and
113.15 Indian tribes working with FFN caregivers in local communities, cultural communities,
113.16 and Indian tribes to:

113.17 (i) provide training, support, and resources to FFN caregivers in order to improve
113.18 and promote children's health, safety, nutrition, and school readiness;

113.19 (ii) connect FFN caregivers and children's families with appropriate community
113.20 resources that support the families' health, mental health, economic, and developmental
113.21 needs;

113.22 (iii) connect FFN caregivers and children's families to early childhood screening
113.23 programs and facilitate referrals where appropriate;

113.24 (iv) provide FFN caregivers and children's families with information about early
113.25 learning guidelines from the Departments of Human Services and Education;

113.26 (v) provide FFN caregivers and children's families with information about becoming
113.27 a licensed family child care provider; and

113.28 (vi) provide FFN caregivers and children's families with information about early
113.29 learning allowances and enrollment opportunities in high quality community-based
113.30 child-care and preschool programs.

113.31 (2) Grants that the commissioner awards under this paragraph also may be used for:

113.32 (i) health and safety and early learning kits for FFN caregivers;

113.33 (ii) play-and-learn groups with FFN caregivers;

113.34 (iii) culturally appropriate early childhood training for FFN caregivers;

114.1 (iv) transportation for FFN caregivers and children's families to school readiness and
114.2 other early childhood training activities;

114.3 (v) other activities that promote school readiness;

114.4 (vi) data collection and evaluation;

114.5 (vii) staff outreach and outreach activities;

114.6 (viii) translation needs; or

114.7 (ix) administrative costs that equal up to 12 percent of the recipient's grant award.

114.8 (b) Grants that the commissioner awards under this section also must be used to fund
114.9 partnerships among Minnesota public and regional library systems, community-based
114.10 organizations, nonprofit organizations, and Indian tribes to implement early literacy
114.11 programs in low-income communities, including tribal communities, to:

114.12 (1) purchase and equip early childhood read-mobiles that provide FFN caregivers
114.13 and children's families with books, training, and early literacy activities;

114.14 (2) provide FFN caregivers and children's families with translations of early
114.15 childhood books, training, and early literacy activities in native languages; or

114.16 (3) provide FFN caregivers and children's families with early literacy activities in
114.17 local libraries.

114.18 Subd. 3. **Grant awards.** Interested entities eligible to receive a grant under
114.19 this section may apply to the commissioner in the form and manner the commissioner
114.20 determines. The commissioner shall awards grants to eligible entities consistent with
114.21 the requirements of this section.

114.22 Subd. 4. **Evaluation.** The commissioner, in consultation with early childhood
114.23 care and education experts at the University of Minnesota, must evaluate the impact of
114.24 the grants under subdivision 2 on children's school readiness and submit a written report
114.25 to the human services and education finance and policy committees of the legislature by
114.26 February 15, 2010.

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

114.28 Sec. 95. **CHILD CARE PROVIDER STUDY.**

114.29 The commissioner of human services is directed to study the implications of
114.30 restricting the use of state subsidies in center-based child care to centers meeting state
114.31 quality standards under Minnesota Statutes, section 124D.175, paragraph (c), and to
114.32 publish the results no later than January 1, 2010. The study must include:

114.33 (1) the likelihood of there being sufficient child care providers meeting the standards;

114.34 (2) the cost to bring providers up to the standards and how this cost would be funded;

requirements of ~~subdivision 2~~ this section are met. As used in this section, the term "relative" has the meaning given it under section 260C.007, subdivision 27.

Subd. 2. **Cooperation with emergency ~~licensing~~ placement process.** (a) A county agency that places a child with a relative who is not licensed to provide foster care must ~~begin the process of securing an emergency license for the relative as soon as possible and must~~ conduct the initial inspection required by subdivision 3, clause (1), whenever possible, prior to placing the child in the relative's home, but no later than three working days after placing the child in the home. A child placed in the home of a relative who is not licensed to provide foster care must be removed from that home if the relative fails to cooperate with the county agency ~~in securing an emergency foster care license. The commissioner may issue an emergency foster care license to a relative with whom the county agency wishes to place or has placed a child for foster care, or to a relative with whom a child has been placed by court order.~~

(b) If a child is to be placed in the home of a relative not licensed to provide foster care, either the placing agency or the county agency in the county in which the relative lives shall conduct the emergency ~~licensing~~ placement process as required in this section.

Subd. 3. **Requirements for emergency ~~license~~ placement.** Before an emergency ~~license~~ placement may be ~~issued~~ made, the following requirements must be met:

(1) the county agency must conduct an initial inspection of the premises where the ~~foster care~~ placement is to be ~~provided~~ made to ensure the health and safety of any child placed in the home. The county agency shall conduct the inspection using a form developed by the commissioner;

(2) at the time of the inspection or placement, whichever is earlier, the county agency must provide the relative being considered for an emergency ~~license~~ placement an application form for a child foster care license;

(3) whenever possible, prior to placing the child in the relative's home, the relative being considered for an emergency ~~license~~ placement shall provide the information required by section 245C.05; and

(4) if the county determines, prior to the ~~issuance of an emergency license~~ placement, that anyone requiring a background study ~~may be~~ prior to licensure of the home is disqualified under ~~section 245C.14 and~~ chapter 245C, and the disqualification is one which the commissioner cannot set aside, an emergency ~~license~~ placement must not be issued made.

Subd. 4. **Applicant study.** When the county agency has received the information required by section 245C.05, the county agency shall ~~begin an applicant study according to the procedures in chapter 245C. The commissioner may issue an emergency license upon~~

~~recommendation of the county agency once the initial inspection has been successfully completed and the information necessary to begin the applicant background study has been provided. If the county agency does not recommend that the emergency license be granted, the agency shall notify the relative in writing that the agency is recommending denial to the commissioner; shall remove any child who has been placed in the home prior to licensure; and shall inform the relative in writing of the procedure to request review pursuant to subdivision 6. An emergency license shall be effective until a child foster care license is granted or denied, but shall in no case remain in effect more than 120 days from the date of placement~~ submit the information to the commissioner according to section 245C.05.

Subd. 5. **Child foster care license application.** (a) The relatives with whom the emergency ~~license holder~~ placement has been made shall complete the child foster care license application and necessary paperwork within ten days of the placement. The county agency shall assist the emergency ~~license holder~~ applicant to complete the application. The granting of a child foster care license to a relative shall be under the procedures in this chapter and according to the standards ~~set forth by foster care rule~~ in Minnesota Rules, chapter 2960. In licensing a relative, the commissioner shall consider the importance of maintaining the child's relationship with relatives as an additional significant factor in determining whether to a background study disqualification should be set aside a licensing disqualifier under section 245C.22, or to grant a variance of licensing requirements should be granted under ~~sections 245C.21 to 245C.27~~ section 245C.30.

(b) When the county or private child-placing agency is processing an application for child foster care licensure of a relative as defined in section 260B.007, subdivision 12, or 260C.007, subdivision 27, the county agency or child-placing agency must explain the licensing process to the prospective licensee, including the background study process and the procedure for reconsideration of an initial disqualification for licensure. The county or private child-placing agency must also provide the prospective relative licensee with information regarding appropriate options for legal representation in the pertinent geographic area. If a relative is initially disqualified under section 245C.14, the ~~county or child-placing agency~~ commissioner must provide written notice of the reasons for the disqualification and the right to request a reconsideration by the commissioner as required under section 245C.17.

(c) The commissioner shall maintain licensing data so that activities related to applications and licensing actions for relative foster care providers may be distinguished from other child foster care settings.

~~Subd. 6. Denial of emergency license. If the commissioner denies an application for an emergency foster care license under this section, that denial must be in writing and~~

118.1 ~~must include reasons for the denial. Denial of an emergency license is not subject to~~
118.2 ~~appeal under chapter 14. The relative may request a review of the denial by submitting~~
118.3 ~~to the commissioner a written statement of the reasons an emergency license should be~~
118.4 ~~granted. The commissioner shall evaluate the request for review and determine whether~~
118.5 ~~to grant the emergency license. The commissioner's review shall be based on a review~~
118.6 ~~of the records submitted by the county agency and the relative. Within 15 working~~
118.7 ~~days of the receipt of the request for review, the commissioner shall notify the relative~~
118.8 ~~requesting review in written form whether the emergency license will be granted. The~~
118.9 ~~commissioner's review shall be based on a review of the records submitted by the county~~
118.10 ~~agency and the relative. A child shall not be placed or remain placed in the relative's home~~
118.11 ~~while the request for review is pending. Denial of an emergency license shall not preclude~~
118.12 ~~an individual from reapplying for an emergency license or from applying for a child foster~~
118.13 ~~care license. The decision of the commissioner is the final administrative agency action.~~

118.14 Sec. 2. Minnesota Statutes 2006, section 245A.10, subdivision 2, is amended to read:

118.15 Subd. 2. **County fees for background studies and licensing inspections.** (a) For
118.16 purposes of family and group family child care licensing under this chapter, a county
118.17 agency may charge a ~~fee to an applicant or license holder to recover the actual cost of~~
118.18 ~~background studies, but in any case not to exceed \$100 annually. A county agency may~~
118.19 ~~also charge a license fee to an applicant or license holder to recover the actual cost of~~
118.20 ~~licensing inspections, but in any case not to exceed \$150 annually~~ \$50 for a one-year
118.21 license or \$100 for a two-year license.

118.22 (b) A county agency may charge a fee to a legal nonlicensed child care provider or
118.23 applicant for authorization to recover the actual cost of background studies completed
118.24 under section 119B.125, but in any case not to exceed \$100 annually.

118.25 (c) Counties may elect to reduce or waive the fees in paragraph (a) or (b):

118.26 (1) in cases of financial hardship;

118.27 (2) if the county has a shortage of providers in the county's area;

118.28 (3) for new providers; or

118.29 (4) for providers who have attained at least 16 hours of training before seeking
118.30 initial licensure.

118.31 (d) Counties may allow providers to pay the applicant fees in paragraph (a) or (b) on
118.32 an installment basis for up to one year. If the provider is receiving child care assistance
118.33 payments from the state, the provider may have the fees under paragraph (a) or (b)
118.34 deducted from the child care assistance payments for up to one year and the state shall
118.35 reimburse the county for the county fees collected in this manner.

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

119.2 Sec. 3. Minnesota Statutes 2006, section 245A.16, subdivision 1, is amended to read:

119.3 Subdivision 1. **Delegation of authority to agencies.** (a) County agencies and
119.4 private agencies that have been designated or licensed by the commissioner to perform
119.5 licensing functions and activities under section 245A.04 ~~and~~ background studies for adult
119.6 foster care, family adult day services, and until December 31, 2007, family child care,
119.7 under chapter 245C; to recommend denial of applicants under section 245A.05; to issue
119.8 correction orders, to issue variances, and recommend a conditional license under section
119.9 245A.06, or to recommend suspending or revoking a license or issuing a fine under section
119.10 245A.07, shall comply with rules and directives of the commissioner governing those
119.11 functions and with this section. The following variances are excluded from the delegation
119.12 of variance authority and may be issued only by the commissioner:

119.13 (1) dual licensure of family child care and child foster care, dual licensure of child
119.14 and adult foster care, and adult foster care and family child care;

119.15 (2) adult foster care maximum capacity;

119.16 (3) adult foster care minimum age requirement;

119.17 (4) child foster care maximum age requirement;

119.18 (5) variances regarding disqualified individuals except that county agencies may
119.19 issue variances under section 245C.30 regarding disqualified individuals when the county
119.20 is responsible for conducting a consolidated reconsideration according to sections 245C.25
119.21 and 245C.27, subdivision 2, clauses (a) and (b), of a county maltreatment determination
119.22 and a disqualification based on serious or recurring maltreatment; and

119.23 (6) the required presence of a caregiver in the adult foster care residence during
119.24 normal sleeping hours.

119.25 (b) County agencies must report:

119.26 ~~(1)~~ information about disqualification reconsiderations under sections 245C.25 and
119.27 245C.27, subdivision 2, ~~clauses~~ paragraphs (a) and (b), and variances granted under
119.28 paragraph (a), clause (5), to the commissioner at least monthly in a format prescribed by
119.29 the commissioner; ~~and.~~

119.30 ~~(2) for relative child foster care applicants and license holders, the number of~~
119.31 ~~relatives, as defined in section 260C.007, subdivision 27, and household members of~~
119.32 ~~relatives who are disqualified under section 245C.14; the disqualifying characteristics~~
119.33 ~~under section 245C.15; the number of these individuals who requested reconsideration~~
119.34 ~~under section 245C.21; the number of set-asides under section 245C.22; and variances~~

120.1 ~~under section 245C.30 issued. This information shall be reported to the commissioner~~
120.2 ~~annually by January 15 of each year in a format prescribed by the commissioner.~~

120.3 (c) For family day care programs, the commissioner may authorize licensing reviews
120.4 every two years after a licensee has had at least one annual review.

120.5 (d) For family adult day services programs, the commissioner may authorize
120.6 licensing reviews every two years after a licensee has had at least one annual review.

120.7 (e) A license issued under this section may be issued for up to two years.

120.8 Sec. 4. Minnesota Statutes 2006, section 245A.16, subdivision 3, is amended to read:

120.9 Subd. 3. **Recommendations to the commissioner.** The county or private agency
120.10 shall not make recommendations to the commissioner regarding licensure without
120.11 first conducting an inspection, and for adult foster care, family adult day services, and
120.12 until December 31, 2007, family child care, a background study of the applicant, and
120.13 ~~evaluation pursuant to~~ under chapter 245C. The county or private agency must forward its
120.14 recommendation to the commissioner regarding the appropriate licensing action within 20
120.15 working days of receipt of a completed application.

120.16 **EFFECTIVE DATE.** This section is effective January 1, 2008.

120.17 Sec. 5. Minnesota Statutes 2006, section 245C.02, is amended by adding a subdivision
120.18 to read:

120.19 Subd. 14a. **Private agency.** "Private agency" has the meaning given in section
120.20 245A.02, subdivision 12.

120.21 Sec. 6. Minnesota Statutes 2006, section 245C.04, subdivision 1, is amended to read:

120.22 Subdivision 1. **Licensed programs.** (a) The commissioner shall conduct a
120.23 background study of an individual required to be studied under section 245C.03,
120.24 subdivision 1, at least upon application for initial license for all license types.

120.25 (b) The commissioner shall conduct a background study of an individual required
120.26 to be studied under section 245C.03, subdivision 1, at reapplication for a license for
120.27 family child care, ~~child foster care, and adult foster care,~~ family adult day services, and
120.28 until January 1, 2008, family child care.

120.29 (c) The commissioner is not required to conduct a study of an individual at the time
120.30 of reapplication for a license if the individual's background study was completed by the
120.31 commissioner of human services for an adult foster care license holder that is also:

120.32 (1) registered under chapter 144D; or

121.1 (2) licensed to provide home and community-based services to people with
121.2 disabilities at the foster care location and the license holder does not reside in the foster
121.3 care residence; and

121.4 (3) the following conditions are met:

121.5 (i) a study of the individual was conducted either at the time of initial licensure or
121.6 when the individual became affiliated with the license holder;

121.7 (ii) the individual has been continuously affiliated with the license holder since
121.8 the last study was conducted; and

121.9 (iii) the last study of the individual was conducted on or after October 1, 1995.

121.10 (d) From July 1, 2007, to June 30, 2009, the commissioner of human services
121.11 shall conduct a study of an individual required to be studied under section 245C.03, at
121.12 the time of reapplication for a child foster care license. The county or private agency
121.13 shall collect and forward to the commissioner the information required under section
121.14 245C.05, subdivisions 1, paragraphs (a) and (b), and 5, paragraphs (a) and (b). The
121.15 background study conducted by the commissioner of human services under this paragraph
121.16 must include a review of the information required under section 245C.08, subdivisions
121.17 1, paragraph (a), clauses (1) to (4), and 3.

121.18 (e) From January 1, 2008, to December 31, 2009, the commissioner shall conduct
121.19 a study of an individual required to be studied under section 245C.03, at the time of
121.20 reapplication for a family child care license. The county shall collect and forward to the
121.21 commissioner the information required under section 245C.05, subdivisions 1 and 5. The
121.22 background study conducted by the commissioner under this paragraph must include a
121.23 review of the information required under section 245C.08, subdivisions 1, paragraph
121.24 (a), and 3.

121.25 (f) The commissioner of human services shall conduct a background study of an
121.26 individual specified under section 245C.03, subdivision 1, paragraph (a), clauses (2)
121.27 to (6), who is newly affiliated with a child foster care license holder. The county or
121.28 private agency shall collect and forward to the commissioner the information required
121.29 under section 245C.05, subdivisions 1 and 5. The background study conducted by the
121.30 commissioner of human services under this paragraph must include a review of the
121.31 information required under section 245C.08, subdivisions 1, paragraph (a), and 3.

121.32 (g) Applicants for licensure, license holders, and other entities as provided in this
121.33 chapter must submit completed background study forms to the commissioner before
121.34 individuals specified in section 245C.03, subdivision 1, begin positions allowing direct
121.35 contact in any licensed program.

122.1 ~~(e)~~ (h) For purposes of this section, a physician licensed under chapter 147 is
122.2 considered to be continuously affiliated upon the license holder's receipt from the
122.3 commissioner of health or human services of the physician's background study results.

122.4 Sec. 7. Minnesota Statutes 2006, section 245C.05, subdivision 1, is amended to read:

122.5 Subdivision 1. **Individual studied.** (a) The individual who is the subject of the
122.6 background study must provide the applicant, license holder, or other entity under section
122.7 245C.04 with sufficient information to ensure an accurate study, including:

122.8 (1) the individual's first, middle, and last name and all other names by which the
122.9 individual has been known;

122.10 (2) home address, city, and state of residence;

122.11 (3) zip code;

122.12 (4) sex;

122.13 (5) date of birth; and

122.14 (6) Minnesota driver's license number or state identification number.

122.15 (b) Every subject of a background study conducted or initiated by counties or private
122.16 agencies under this chapter must also provide the home address, city, county, and state of
122.17 residence for the past five years.

122.18 (c) Every subject of a background study related to child foster care licensed through
122.19 a private agency shall also provide the commissioner a signed consent for the release of
122.20 any information received from national crime information databases to the private agency
122.21 that initiated the background study.

122.22 (d) The subject of a background study shall provide fingerprints as required in
122.23 subdivision 5, paragraph (c).

122.24 Sec. 8. Minnesota Statutes 2006, section 245C.05, is amended by adding a subdivision
122.25 to read:

122.26 Subd. 2a. **County or private agency.** For background studies related to child
122.27 foster care, and beginning January 1, 2008, for studies related to family child care, county
122.28 and private agencies must collect the information under subdivision 1 and forward it to
122.29 the commissioner.

122.30 Sec. 9. Minnesota Statutes 2006, section 245C.05, subdivision 4, is amended to read:

122.31 Subd. 4. **Electronic transmission.** For background studies conducted by the
122.32 Department of Human Services, the commissioner shall implement a system for the
122.33 electronic transmission of:

123.1 (1) background study information to the commissioner; ~~and~~
123.2 (2) background study results to the license holder; and
123.3 (3) background study results to county and private agencies for background studies
123.4 conducted by the commissioner for child foster care, and beginning January 1, 2008,
123.5 also for family child care.

123.6 **EFFECTIVE DATE.** This section is effective January 1, 2008.

123.7 Sec. 10. Minnesota Statutes 2006, section 245C.05, subdivision 5, is amended to read:

123.8 Subd. 5. **Fingerprints.** (a) Except as provided in paragraph (c), for any background
123.9 study completed under this chapter, when the commissioner has reasonable cause to
123.10 believe that further pertinent information may exist on the subject of the background
123.11 study, the subject shall provide the commissioner with a set of classifiable fingerprints
123.12 obtained from an authorized ~~law enforcement~~ agency.

123.13 (b) For purposes of requiring fingerprints, the commissioner has reasonable cause
123.14 when, but not limited to, the:

123.15 (1) information from the Bureau of Criminal Apprehension indicates that the subject
123.16 is a multistate offender;

123.17 (2) information from the Bureau of Criminal Apprehension indicates that multistate
123.18 offender status is undetermined; or

123.19 (3) commissioner has received a report from the subject or a third party indicating
123.20 that the subject has a criminal history in a jurisdiction other than Minnesota.

123.21 (c) Except as specified under section 245C.04, subdivision 1, paragraph (d), for
123.22 background studies conducted by the commissioner for child foster care, the subject of the
123.23 background study shall provide the commissioner with a set of classifiable fingerprints
123.24 obtained from an authorized agency.

123.25 Sec. 11. Minnesota Statutes 2006, section 245C.05, subdivision 7, is amended to read:

123.26 Subd. 7. **Probation officer and corrections agent.** (a) A probation officer or
123.27 corrections agent shall notify the commissioner of an individual's conviction if the
123.28 individual is:

123.29 (1) affiliated with a program or facility regulated by the Department of Human
123.30 Services or Department of Health, a facility serving children or youth licensed by the
123.31 Department of Corrections, or any type of home care agency or provider of personal care
123.32 assistance services; and

123.33 (2) convicted of a crime constituting a disqualification under section 245C.14.

124.1 (b) For the purpose of this subdivision, "conviction" has the meaning given it
124.2 in section 609.02, subdivision 5.

124.3 (c) The commissioner, in consultation with the commissioner of corrections, shall
124.4 develop forms and information necessary to implement this subdivision and shall provide
124.5 the forms and information to the commissioner of corrections for distribution to local
124.6 probation officers and corrections agents.

124.7 (d) The commissioner shall inform individuals subject to a background study that
124.8 criminal convictions for disqualifying crimes will be reported to the commissioner by the
124.9 corrections system.

124.10 (e) A probation officer, corrections agent, or corrections agency is not civilly or
124.11 criminally liable for disclosing or failing to disclose the information required by this
124.12 subdivision.

124.13 (f) Upon receipt of disqualifying information, the commissioner shall provide the
124.14 notice required under section 245C.17, as appropriate, to agencies on record as having
124.15 initiated a background study or making a request for documentation of the background
124.16 study status of the individual.

124.17 (g) This subdivision does not apply to family child care ~~and child foster care~~
124.18 programs until January 1, 2008.

124.19 Sec. 12. Minnesota Statutes 2006, section 245C.08, subdivision 1, is amended to read:

124.20 Subdivision 1. **Background studies conducted by commissioner of human**
124.21 **services.** (a) For a background study conducted by the commissioner, the commissioner
124.22 shall review:

124.23 (1) information related to names of substantiated perpetrators of maltreatment of
124.24 vulnerable adults that has been received by the commissioner as required under section
124.25 626.557, subdivision 9c, paragraph (i);

124.26 (2) the commissioner's records relating to the maltreatment of minors in licensed
124.27 programs, and from ~~county agency~~ findings of maltreatment of minors as indicated
124.28 through the social service information system;

124.29 (3) information from juvenile courts as required in subdivision 4 for individuals
124.30 listed in section 245C.03, subdivision 1, clauses (2), (5), and (6); ~~and~~

124.31 (4) information from the Bureau of Criminal Apprehension; ₂

124.32 (5) except as provided in clause (6), information from the national crime information
124.33 system when the commissioner has reasonable cause as defined under section 245C.05,
124.34 subdivision 5; and

125.1 (6) for a background study related to a child foster care application for licensure, the
125.2 commissioner shall also review:

125.3 (i) information from the child abuse and neglect registry for any state in which the
125.4 background study subject has resided in for the past five years; and

125.5 (ii) information from national crime information databases.

125.6 (b) Notwithstanding expungement by a court, the commissioner may consider
125.7 information obtained under paragraph (a), clauses (3) and (4), unless the commissioner
125.8 received notice of the petition for expungement and the court order for expungement is
125.9 directed specifically to the commissioner.

125.10 Sec. 13. Minnesota Statutes 2006, section 245C.08, subdivision 2, is amended to read:

125.11 Subd. 2. **Background studies conducted by a county ~~or private~~ agency.** (a) For
125.12 a background study conducted by a county ~~or private~~ agency for ~~child foster care~~, adult
125.13 foster care, family adult day services, and until January 1, 2008, family child care homes
125.14 services, the commissioner shall review:

125.15 (1) information from the county agency's record of substantiated maltreatment
125.16 of adults and the maltreatment of minors;

125.17 (2) information from juvenile courts as required in subdivision 4 for individuals
125.18 listed in section 245C.03, subdivision 1, clauses (2), (5), and (6);

125.19 (3) information from the Bureau of Criminal Apprehension; and

125.20 (4) arrest and investigative records maintained by the Bureau of Criminal
125.21 Apprehension, county attorneys, county sheriffs, courts, county agencies, local police, the
125.22 National Criminal Records Repository, and criminal records from other states.

125.23 (b) If the individual has resided in the county for less than five years, the study shall
125.24 include the records specified under paragraph (a) for the previous county or counties of
125.25 residence for the past five years.

125.26 (c) Notwithstanding expungement by a court, the county ~~or private~~ agency may
125.27 consider information obtained under paragraph (a), clauses (3) and (4), unless the
125.28 commissioner received notice of the petition for expungement and the court order for
125.29 expungement is directed specifically to the commissioner.

125.30 Sec. 14. Minnesota Statutes 2006, section 245C.10, is amended by adding a
125.31 subdivision to read:

125.32 Subd. 4. **Temporary personnel agencies, educational programs, and professional**
125.33 **services agencies.** The commissioner shall recover the cost of the background studies
125.34 initiated by temporary personnel agencies, educational programs, and professional

126.1 services agencies that initiate background studies under section 245C.03, subdivision 4,
126.2 through a fee of no more than \$20 per study charged to the agency. In fiscal years 2008
126.3 and 2009, the fees collected under this subdivision are appropriated to the commissioner
126.4 for the purpose of conducting background studies.

126.5 Sec. 15. Minnesota Statutes 2006, section 245C.11, subdivision 1, is amended to read:

126.6 Subdivision 1. **Adult foster care; criminal conviction data.** For individuals who
126.7 are required to have background studies under section 245C.03, subdivisions 1 and 2, and
126.8 who have been continuously affiliated with ~~a~~ an adult foster care provider that is licensed
126.9 in more than one county, criminal conviction data may be shared among those counties in
126.10 which the adult foster care programs are licensed. A county agency's receipt of criminal
126.11 conviction data from another county agency shall meet the criminal data background
126.12 study requirements of this chapter.

126.13 Sec. 16. Minnesota Statutes 2006, section 245C.11, subdivision 2, is amended to read:

126.14 Subd. 2. **Jointly licensed programs.** A county agency may accept a background
126.15 study completed by the commissioner under this chapter in place of the background study
126.16 required under section 245A.16, subdivision 3, in programs with joint licensure as home
126.17 and community-based services and adult foster care for people with developmental
126.18 disabilities when the license holder does not reside in the adult foster care residence and
126.19 the subject of the study has been continuously affiliated with the license holder since the
126.20 date of the commissioner's study.

126.21 Sec. 17. Minnesota Statutes 2006, section 245C.12, is amended to read:

126.22 **245C.12 BACKGROUND STUDY; TRIBAL ORGANIZATIONS.**

126.23 (a) For the purposes of background studies completed by tribal organizations
126.24 performing licensing activities otherwise required of the commissioner under this chapter,
126.25 after obtaining consent from the background study subject, tribal licensing agencies shall
126.26 have access to criminal history data in the same manner as county licensing agencies and
126.27 private licensing agencies under this chapter.

126.28 (b) Tribal organizations may contract with the commissioner to obtain background
126.29 study data on individuals under tribal jurisdiction related to adoptions according to
126.30 section 245C.34. Tribal organizations may also contract with the commissioner to obtain
126.31 background study data on individuals under tribal jurisdiction related to child foster care
126.32 according to section 245C.34.

127.1 Sec. 18. Minnesota Statutes 2006, section 245C.16, subdivision 1, is amended to read:

127.2 Subdivision 1. **Determining immediate risk of harm.** (a) If the commissioner
127.3 determines that the individual studied has a disqualifying characteristic, the commissioner
127.4 shall review the information immediately available and make a determination as to the
127.5 subject's immediate risk of harm to persons served by the program where the individual
127.6 studied will have direct contact.

127.7 (b) The commissioner shall consider all relevant information available, including the
127.8 following factors in determining the immediate risk of harm:

- 127.9 (1) the recency of the disqualifying characteristic;
127.10 (2) the recency of discharge from probation for the crimes;
127.11 (3) the number of disqualifying characteristics;
127.12 (4) the intrusiveness or violence of the disqualifying characteristic;
127.13 (5) the vulnerability of the victim involved in the disqualifying characteristic;
127.14 (6) the similarity of the victim to the persons served by the program where the
127.15 individual studied will have direct contact; and
127.16 (7) whether the individual has a disqualification from a previous background study
127.17 that has not been set aside.

127.18 (c) This section does not apply when the subject of a background study is regulated
127.19 by a health-related licensing board as defined in chapter 214, and the subject is determined
127.20 to be responsible for substantiated maltreatment under section 626.556 or 626.557.

127.21 (d) This section does not apply to a background study related to an initial application
127.22 for a child foster care license.

127.23 (e) If the commissioner has reason to believe, based on arrest information or an
127.24 active maltreatment investigation, that an individual poses an imminent risk of harm to
127.25 persons receiving services, the commissioner may order that the person be continuously
127.26 supervised or immediately removed pending the conclusion of the maltreatment
127.27 investigation or criminal proceedings.

127.28 Sec. 19. Minnesota Statutes 2006, section 245C.17, is amended by adding a
127.29 subdivision to read:

127.30 Subd. 5. **Notice to county or private agency.** For studies on individuals related
127.31 to a license to provide child foster care, and beginning January 1, 2008, for family child
127.32 care, the commissioner shall also provide a notice of the background study results to the
127.33 county or private agency that initiated the background study.

128.1 Sec. 20. Minnesota Statutes 2006, section 245C.21, is amended by adding a
128.2 subdivision to read:

128.3 Subd. 1a. **Submission of reconsideration request to county or private agency.**

128.4 (a) For disqualifications related to studies conducted by county agencies, and for
128.5 disqualifications related to studies conducted by the commissioner for child foster care, and
128.6 beginning January 1, 2008, for family child care, the individual shall submit the request
128.7 for reconsideration to the county or private agency that initiated the background study.

128.8 (b) A reconsideration request shall be submitted within the time frames specified in
128.9 subdivision 2.

128.10 (c) The county or private agency shall forward the individual's request for
128.11 reconsideration and provide the commissioner with a recommendation whether to set aside
128.12 the individual's disqualification.

128.13 Sec. 21. Minnesota Statutes 2006, section 245C.23, subdivision 2, is amended to read:

128.14 Subd. 2. **Commissioner's notice of disqualification that is not set aside.** (a) The
128.15 commissioner shall notify the license holder of the disqualification and order the license
128.16 holder to immediately remove the individual from any position allowing direct contact
128.17 with persons receiving services from the license holder if:

128.18 (1) the individual studied does not submit a timely request for reconsideration
128.19 under section 245C.21;

128.20 (2) the individual submits a timely request for reconsideration, but the commissioner
128.21 does not set aside the disqualification for that license holder under section 245C.22;

128.22 (3) an individual who has a right to request a hearing under sections 245C.27 and
128.23 256.045, or 245C.28 and chapter 14 for a disqualification that has not been set aside, does
128.24 not request a hearing within the specified time; or

128.25 (4) an individual submitted a timely request for a hearing under sections 245C.27
128.26 and 256.045, or 245C.28 and chapter 14, but the commissioner does not set aside the
128.27 disqualification under section 245A.08, subdivision 5, or 256.045.

128.28 (b) If the commissioner does not set aside the disqualification under section 245C.22,
128.29 and the license holder was previously ordered under section 245C.17 to immediately
128.30 remove the disqualified individual from direct contact with persons receiving services or
128.31 to ensure that the individual is under continuous, direct supervision when providing direct
128.32 contact services, the order remains in effect pending the outcome of a hearing under
128.33 sections 245C.27 and 256.045, or 245C.28 and chapter 14.

129.1 (c) For background studies related to child foster care, and beginning January
129.2 1, 2008, for family child care, the commissioner shall also notify the county or private
129.3 agency that initiated the study of the results of the reconsideration.

129.4 Sec. 22. Minnesota Statutes 2006, section 245C.24, subdivision 2, is amended to read:

129.5 Subd. 2. **Permanent bar to set aside a disqualification.** (a) Except as provided in
129.6 paragraph (b), the commissioner may not set aside the disqualification of any individual
129.7 disqualified pursuant to this chapter, in connection with a license to provide family child
129.8 care for children, foster care for children in the provider's home, or foster care or day care
129.9 services for adults in the provider's home regardless of how much time has passed, if the
129.10 individual was disqualified for a crime or conduct listed in section 245C.15, subdivision 1.

129.11 (b) For an individual in the chemical dependency field who was disqualified for a
129.12 crime or conduct listed under section 245C.15, subdivision 1, and whose disqualification
129.13 was set aside prior to July 1, 2005, the commissioner must consider granting a variance
129.14 pursuant to section 245C.30 for the license holder for a program dealing primarily with
129.15 adults. A request for reconsideration evaluated under this paragraph must include a
129.16 letter of recommendation from the license holder that was subject to the prior set-aside
129.17 decision addressing the individual's quality of care to children or vulnerable adults and the
129.18 circumstances of the individual's departure from that service.

129.19 Sec. 23. **[245C.33] ADOPTION BACKGROUND STUDY REQUIREMENTS.**

129.20 Subdivision 1. Background studies conducted by commissioner. Before
129.21 placement of a child for purposes of adoption, the commissioner shall conduct a
129.22 background study on individuals listed in section 259.41, subdivision 3, for county
129.23 agencies and private agencies licensed to place children for adoption.

129.24 Subd. 2. Information and data provided to county or private agency. The
129.25 subject of the background study shall provide the following information to the county
129.26 or private agency:

129.27 (1) the information specified in section 245C.05;

129.28 (2) a set of classifiable fingerprints obtained from an authorized agency; and

129.29 (3) for studies initiated by a private agency, a signed consent for the release of
129.30 information received from national crime information databases to the private agency.

129.31 Subd. 3. Information and data provided to commissioner. The county or private
129.32 agency shall forward the data collected under subdivision 2 to the commissioner.

129.33 Subd. 4. Information commissioner reviews. (a) The commissioner shall review
129.34 the following information regarding the background study subject:

130.1 (1) the information under section 245C.08, subdivisions 1, 3, and 4;

130.2 (2) information from the child abuse and neglect registry for any state in which the
130.3 subject has resided for the past five years; and

130.4 (3) information from national crime information databases.

130.5 (b) The commissioner shall provide any information collected under this subdivision
130.6 to the county or private agency that initiated the background study. The commissioner
130.7 shall indicate if the information collected shows that the subject of the background study
130.8 has a conviction listed in United States Code, title 42, section 671(a)(20)(A).

130.9 Sec. 24. **[245C.34] ADOPTION AND CHILD FOSTER CARE BACKGROUND**
130.10 **STUDIES; TRIBAL ORGANIZATIONS.**

130.11 Subdivision 1. **Background studies may be conducted by commissioner.** (a)
130.12 Tribal organizations may contract with the commissioner under section 245C.12 to obtain
130.13 background study data on individuals under tribal jurisdiction related to adoptions.

130.14 (b) Tribal organizations may contract with the commissioner under section 245C.12
130.15 to obtain background study data on individuals under tribal jurisdiction related to child
130.16 foster care.

130.17 (c) Background studies initiated by tribal organizations under paragraphs (a) and (b)
130.18 must be conducted as provided in subdivisions 2 and 3.

130.19 Subd. 2. **Information and data provided to tribal organization.** The background
130.20 study subject must provide the following information to the tribal organization:

130.21 (1) for background studies related to adoptions, the information under section
130.22 245C.05;

130.23 (2) for background studies related to child foster care, the information under section
130.24 245C.05;

130.25 (3) a set of classifiable fingerprints obtained from an authorized agency; and

130.26 (4) a signed consent for the release of information received from national crime
130.27 information databases to the tribal organization.

130.28 Subd. 3. **Information and data provided to commissioner.** The tribal organization
130.29 shall forward the data collected under subdivision 2 to the commissioner.

130.30 Subd. 4. **Information commissioner reviews.** (a) The commissioner shall review
130.31 the following information regarding the background study subject:

130.32 (1) the information under section 245C.08, subdivisions 1, 3, and 4;

130.33 (2) information from the child abuse and neglect registry for any state in which the
130.34 subject has resided for the past five years; and

130.35 (3) information from national crime information databases.

131.1 (b) The commissioner shall provide any information collected under this subdivision
131.2 to the tribal organization that initiated the background study. The commissioner shall
131.3 indicate if the information collected shows that the subject of the background study has a
131.4 conviction listed in United States Code, title 42, section 671(a)(20)(A).

131.5 Sec. 25. Minnesota Statutes 2006, section 259.20, subdivision 2, is amended to read:

131.6 Subd. 2. **Other applicable law.** (a) Portions of chapters 245A, 245C, 257, 260, and
131.7 317A may also affect the adoption of a particular child.

131.8 (b) Provisions of the Indian Child Welfare Act, United States Code, title 25, chapter
131.9 21, sections 1901-1923, may also apply in the adoption of an Indian child, and may
131.10 preempt specific provisions of this chapter.

131.11 (c) Consistent with section 245C.33 and Public Law 109-248, a completed
131.12 background study is required before the approval of any foster or adoptive placement in
131.13 a related or an unrelated home.

131.14 Sec. 26. Minnesota Statutes 2006, section 259.29, subdivision 1, is amended to read:

131.15 Subdivision 1. **Best interests of the child.** (a) The policy of the state of Minnesota
131.16 is to ensure that the best interests of the child are met by requiring individualized
131.17 determination of the needs of the child and of how the adoptive placement will serve the
131.18 needs of the child.

131.19 (b) Among the factors the agency shall consider in determining the needs of the child
131.20 are those specified under section 260C.193, subdivision 3, paragraph (b).

131.21 (c) Except for emergency placements provided for in section 245A.035, a completed
131.22 background study is required under section 245C.33 before the approval of an adoptive
131.23 placement in a home.

131.24 Sec. 27. Minnesota Statutes 2006, section 259.41, is amended to read:

131.25 **259.41 ADOPTION STUDY.**

131.26 Subdivision 1. **Study required before placement; certain relatives excepted.** (a)
131.27 An approved adoption study; completed background study, as required under section
131.28 245C.33; and written report must be completed before the child is placed in a prospective
131.29 adoptive home under this chapter, except as allowed by section 259.47, subdivision 6.

131.30 In an agency placement, the report must be filed with the court at the time the adoption
131.31 petition is filed. In a direct adoptive placement, the report must be filed with the court in
131.32 support of a motion for temporary preadoptive custody under section 259.47, subdivision
131.33 3, or, if the study and report are complete, in support of an emergency order under section

259.47, subdivision 6. The study and report shall be completed by a licensed child-placing agency and must be thorough and comprehensive. The study and report shall be paid for by the prospective adoptive parent, except as otherwise required under section 259.67 or 259.73.

(b) A placement for adoption with an individual who is related to the child, as defined by section 245A.02, subdivision 13, is not subject to this section except as required by ~~section~~ sections 245C.33 and 259.53, subdivision 2, paragraph (c).

(c) In the case of a licensed foster parent seeking to adopt a child who is in the foster parent's care, any portions of the foster care licensing process that duplicate requirements of the home study may be submitted in satisfaction of the relevant requirements of this section.

Subd. 2. **Form of study.** (a) The adoption study must include at least one in-home visit with the prospective adoptive parent. At a minimum, the study must ~~include~~ document the following information about the prospective adoptive parent:

(1) a background ~~check~~ study as required by subdivision 3 and section 245C.33, ~~and~~ including:

(i) ~~an evaluation~~ assessment of the data and information provided by section 245C.33, subdivision 4, to determine if the prospective adoptive parent and any other person over the age of 13 living in the home has a felony conviction consistent with subdivision 3 and section 471(a)(2) of the Social Security Act; and

(ii) an assessment of the effect of a ~~any~~ conviction or finding of substantiated maltreatment on the ~~ability to~~ capacity of the prospective adoptive parent to safely care for and parent a child;

(2) a medical and social history and assessment of current health;

(3) an assessment of potential parenting skills;

(4) an assessment of ability to provide adequate financial support for a child; and

(5) an assessment of the level of knowledge and awareness of adoption issues including, where appropriate, matters relating to interracial, cross-cultural, and special needs adoptions.

(b) The adoption study is the basis for completion of a written report. The report must be in a format specified by the commissioner and must contain recommendations regarding the suitability of the subject of the study to be an adoptive parent.

Subd. 3. **Background ~~check; affidavit of history~~ study.** (a) At the time an adoption study is commenced, each prospective adoptive parent must:

(1) authorize access by the agency to any private data needed to complete the study;

133.1 (2) provide all addresses at which the prospective adoptive parent and anyone in the
133.2 household over the age of 13 has resided in the previous five years; and

133.3 (3) disclose any names used previously other than the name used at the time of
133.4 the study.

133.5 (b) When the requirements of paragraph (a) have been met, the agency shall
133.6 immediately ~~begin~~ initiate a background ~~check~~, study under section 245C.33 to be
133.7 completed by the commissioner on each person over the age of 13 living in the home;
133.8 ~~consisting, at a minimum, of the following.~~ As required under section 245C.33 and Public
133.9 Law 109-248, a completed background study is required before the approval of any foster
133.10 or adoptive placement in a related or an unrelated home. The required background study
133.11 must be completed as part of the home study.

133.12 ~~(1) a check of criminal conviction data with the Bureau of Criminal Apprehension~~
133.13 ~~and local law enforcement authorities;~~

133.14 ~~(2) a check for data on substantiated maltreatment of a child or vulnerable adult~~
133.15 ~~and domestic violence data with local law enforcement and social services agencies and~~
133.16 ~~district courts; and~~

133.17 ~~(3) for those persons under the age of 25, a check of juvenile court records.~~

133.18 ~~Notwithstanding the provisions of section 260B.171 or 260C.171, the Bureau of~~
133.19 ~~Criminal Apprehension, local law enforcement and social services agencies, district courts,~~
133.20 ~~and juvenile courts shall release the requested information to the agency completing~~
133.21 ~~the adoption study.~~

133.22 ~~(c) When paragraph (b) requires checking the data or records of local law~~
133.23 ~~enforcement and social services agencies and district and juvenile courts, the agency~~
133.24 ~~shall check with the law enforcement and social services agencies and courts whose~~
133.25 ~~jurisdictions cover the addresses under paragraph (a), clause (2). In the event that the~~
133.26 ~~agency is unable to complete any of the record checks required by paragraph (b), the~~
133.27 ~~agency shall document the fact and the agency's efforts to obtain the information.~~

133.28 ~~(d) For a study completed under this section, when the agency has reasonable~~
133.29 ~~cause to believe that further information may exist on the prospective adoptive parent or~~
133.30 ~~household member over the age of 13 that may relate to the health, safety, or welfare of~~
133.31 ~~the child, the prospective adoptive parent or household member over the age of 13 shall~~
133.32 ~~provide the agency with a set of classifiable fingerprints obtained from an authorized law~~
133.33 ~~enforcement agency and the agency may obtain criminal history data from the National~~
133.34 ~~Criminal Records Repository by submitting fingerprints to the Bureau of Criminal~~
133.35 ~~Apprehension. The agency has reasonable cause when, but not limited to, the:~~

~~(1) information from the Bureau of Criminal Apprehension indicates that the prospective adoptive parent or household member over the age of 13 is a multistate offender;~~

~~(2) information from the Bureau of Criminal Apprehension indicates that multistate offender status is undetermined;~~

~~(3) the agency has received a report from the prospective adoptive parent or household member over the age of 13 or a third party indicating that the prospective adoptive parent or household member over the age of 13 has a criminal history in a jurisdiction other than Minnesota; or~~

~~(4) the prospective adoptive parent or household member over the age of 13 is or has been a resident of a state other than Minnesota in the prior five years.~~

~~(e) At any time prior to completion of the background check required under paragraph (b), a prospective adoptive parent may submit to the agency conducting the study a sworn affidavit stating whether they or any person residing in the household have been convicted of a crime. The affidavit shall also state whether the adoptive parent or any other person residing in the household is the subject of an open investigation of, or have been the subject of a substantiated allegation of, child or vulnerable-adult maltreatment within the past ten years. A complete description of the crime, open investigation, or substantiated abuse, and a complete description of any sentence, treatment, or disposition must be included. The affidavit must contain an acknowledgment that if, at any time before the adoption is final, a court receives evidence leading to a conclusion that a prospective adoptive parent knowingly gave false information in the affidavit, it shall be determined that the adoption of the child by the prospective adoptive parent is not in the best interests of the child.~~

~~(f) For the purposes of subdivision 1 and section 259.47, subdivisions 3 and 6, an adoption study is complete for placement, even though the background checks required by paragraph (b) have not been completed, if each prospective adoptive parent has completed the affidavit allowed by paragraph (e) and the other requirements of this section have been met. The background checks required by paragraph (b) must be completed before an adoption petition is filed. If an adoption study has been submitted to the court under section 259.47, subdivision 3 or 6, before the background checks required by paragraph (b) were complete, an updated adoption study report which includes the results of the background check must be filed with the adoption petition. In the event that an agency is unable to complete any of the records checks required by paragraph (b), the agency shall submit with the petition to adopt an affidavit documenting the agency's efforts to complete the checks.~~

135.1 (c) A home study under paragraph (b) used to consider placement of any child
135.2 on whose behalf Title IV-E adoption assistance payments are to be made must not be
135.3 approved if a background study reveals a felony conviction at any time for:

- 135.4 (1) child abuse or neglect;
135.5 (2) spousal abuse;
135.6 (3) a crime against children, including child pornography; or
135.7 (4) a crime involving violence, including rape, sexual assault, or homicide, but not
135.8 including other physical assault or battery.

135.9 (d) A home study under paragraph (b) used to consider placement of any child
135.10 on whose behalf Title IV-E adoption assistance payments are to be made must not be
135.11 approved if a background study reveals a felony conviction within the past five years for:

- 135.12 (1) physical assault or battery; or
135.13 (2) a drug-related offense.

135.14 **Subd. 4. Updates to adoption study; period of validity.** An agency may update
135.15 an adoption study and report as needed, regardless of when the original study and report
135.16 or most recent update was completed. An update must be in a format specified by the
135.17 commissioner and must verify the continuing accuracy of the elements of the original
135.18 report and document any changes to elements of the original report. An update to a study
135.19 and report not originally completed under this section must ensure that the study and
135.20 report, as updated, meet the requirements of this section. An adoption study is valid if the
135.21 report has been completed or updated within the previous 12 months.

135.22 Sec. 28. Minnesota Statutes 2006, section 259.53, subdivision 2, is amended to read:

135.23 **Subd. 2. Adoption agencies; postplacement assessment and report.** (a) The
135.24 agency to which the petition has been referred under subdivision 1 shall conduct a
135.25 postplacement assessment and file a report with the court within 90 days of receipt
135.26 of a copy of the adoption petition. The agency shall send a copy of the report to the
135.27 commissioner at the time it files the report with the court. The assessment and report
135.28 must evaluate the environment and antecedents of the child to be adopted, the home of
135.29 the petitioners, whether placement with the petitioners meets the needs of the child as
135.30 described in section 259.57, subdivision 2. The report must include a recommendation to
135.31 the court as to whether the petition should or should not be granted.

135.32 In making evaluations and recommendations, the postplacement assessment and
135.33 report must, at a minimum, address the following:

- 135.34 (1) the level of adaptation by the prospective adoptive parents to parenting the child;
135.35 (2) the health and well-being of the child in the prospective adoptive parents' home;

(3) the level of incorporation by the child into the prospective adoptive parents' home, extended family, and community; and

(4) the level of inclusion of the child's previous history into the prospective adoptive home, such as cultural or ethnic practices, or contact with former foster parents or biological relatives.

(b) A postplacement adoption report is valid for 12 months following its date of completion.

~~(c) If the petitioner is an individual who is related to the child, as defined by section 245A.02, subdivision 13, the agency, as part of its postplacement assessment and report under paragraph (a), shall conduct a background check meeting the requirements of section 259.41, subdivision 3, paragraph (b). The prospective adoptive parent shall cooperate in the completion of the background check by supplying the information and authorizations described in section 259.41, subdivision 3, paragraph (a).~~

~~(d)~~ (c) If the report recommends that the court not grant the petition to adopt the child, the provisions of this paragraph apply. Unless the assessment and report were completed by the local social services agency, the agency completing the report, at the time it files the report with the court under paragraph (a), must provide a copy of the report to the local social services agency in the county where the prospective adoptive parent lives. The agency or local social services agency may recommend that the court dismiss the petition. If the local social services agency determines that continued placement in the home endangers the child's physical or emotional health, the agency shall seek a court order to remove the child from the home.

~~(e)~~ (d) If, through no fault of the petitioner, the agency to whom the petition was referred under subdivision 1, paragraph (b), fails to complete the assessment and file the report within 90 days of the date it received a copy of the adoption petition, the court may hear the petition upon giving the agency and the local social services agency, if different, five days' notice by mail of the time and place of the hearing.

Sec. 29. Minnesota Statutes 2006, section 259.57, subdivision 2, is amended to read:

Subd. 2. **Protection of child's best interests.** (a) The policy of the state of Minnesota is to ensure that the best interests of children are met by requiring an individualized determination of the needs of the child and how the adoptive placement will serve the needs of the child.

(b) Among the factors the court shall consider in determining the needs of the child are those specified under section 260C.193, subdivision 3, paragraph (b). Consistent with

section 245C.33 and Public Law 109-248, a complete background study is required before the approval of an adoptive placement in a home.

(c) In reviewing adoptive placement and in determining appropriate adoption, the court shall consider placement, consistent with the child's best interests and in the following order, with (1) a relative or relatives of the child, or (2) an important friend with whom the child has resided or had significant contact. Placement of a child cannot be delayed or denied based on race, color, or national origin of the adoptive parent or the child. Whenever possible, siblings should be placed together unless it is determined not to be in the best interests of a sibling.

(d) If the child's birth parent or parents explicitly request that relatives and important friends not be considered, the court shall honor that request consistent with the best interests of the child.

If the child's birth parent or parents express a preference for placing the child in an adoptive home of the same or a similar religious background to that of the birth parent or parents, the court shall place the child with a family that also meets the birth parent's religious preference. Only if no family is available as described in clause (a) or (b) may the court give preference to a family described in clause (c) that meets the parent's religious preference.

(e) This subdivision does not affect the Indian Child Welfare Act, United States Code, title 25, sections 1901 to 1923, and the Minnesota Indian Family Preservation Act, sections 260.751 to 260.835.

Sec. 30. Minnesota Statutes 2006, section 260C.209, is amended to read:

260C.209 BACKGROUND CHECKS.

Subdivision 1. **Subjects.** The responsible social services agency must ~~conduct~~ initiate a background check study to be completed by the commissioner under this section of chapter 245C on the following individuals:

(1) a noncustodial parent or nonadjudicated parent who is being assessed for purposes of providing day-to-day care of a child temporarily or permanently under section 260C.212, subdivision 4, and any member of the parent's household who is over the age of 13 when there is a reasonable cause to believe that the parent or household member over age 13 has a criminal history or a history of maltreatment of a child or vulnerable adult which would endanger the child's health, safety, or welfare;

(2) an individual whose suitability for relative placement under section 260C.212, subdivision 5, is being determined and any member of the relative's household who is over the age of 13 when:

138.1 (i) the relative must be licensed for foster care; or
138.2 (ii) ~~the agency must conduct a~~ background study is required under section 259.53,
138.3 subdivision 2; or
138.4 (iii) the agency or the commissioner has reasonable cause to believe the relative
138.5 or household member over the age of 13 has a criminal history which would not make
138.6 transfer of permanent legal and physical custody to the relative under section 260C.201,
138.7 subdivision 11, in the child's best interest; and

138.8 (3) a parent, following an out-of-home placement, when the responsible social
138.9 services agency has reasonable cause to believe that the parent has been convicted of a
138.10 crime directly related to the parent's capacity to maintain the child's health, safety, or
138.11 welfare or the parent is the subject of an open investigation of, or has been the subject
138.12 of a substantiated allegation of, child or vulnerable-adult maltreatment within the past
138.13 ten years.

138.14 "Reasonable cause" means that the agency has received information or a report from the
138.15 subject or a third person that creates an articulable suspicion that the individual has a
138.16 history that may pose a risk to the health, safety, or welfare of the child. The information
138.17 or report must be specific to the potential subject of the background check and shall not
138.18 be based on the race, religion, ethnic background, age, class, or lifestyle of the potential
138.19 subject.

138.20 Subd. 2. **General procedures.** (a) When ~~conducting~~ initiating a background check
138.21 under subdivision 1, the agency ~~may~~ shall require the individual being assessed to provide
138.22 sufficient information to ensure an accurate assessment under this section, including:

138.23 (1) the individual's first, middle, and last name and all other names by which the
138.24 individual has been known;

138.25 (2) home address, zip code, city, county, and state of residence for the past ~~ten~~ five
138.26 years;

138.27 (3) sex;

138.28 (4) date of birth; and

138.29 (5) driver's license number or state identification number.

138.30 (b) When notified by the commissioner or the responsible social services agency that
138.31 it is conducting an assessment under this section, the Bureau of Criminal Apprehension,
138.32 commissioners of health and human services, law enforcement, and county agencies must
138.33 provide the commissioner or the responsible social services agency or county attorney
138.34 with the following information on the individual being assessed: criminal history data,
138.35 reports about the maltreatment of adults substantiated under section 626.557, and reports
138.36 of maltreatment of minors substantiated under section 626.556.

Subd. 3. **Multistate information.** ~~(a) For any assessment~~ every background study completed under this section, ~~if the responsible social services agency has reasonable cause to believe that the individual is a multistate offender, the individual must~~ the subject of the background study shall provide the responsible social services agency ~~or the county attorney~~ with a set of classifiable fingerprints obtained from an authorized ~~law enforcement~~ agency. The responsible social services agency ~~or county attorney may~~ shall provide the fingerprints to the commissioner, and the commissioner shall obtain criminal history data from the National Criminal Records Repository by submitting the fingerprints to the Bureau of Criminal Apprehension.

~~(b) For purposes of this subdivision, the responsible social services agency has reasonable cause when, but not limited to:~~

~~(1) information from the Bureau of Criminal Apprehension indicates that the individual is a multistate offender;~~

~~(2) information from the Bureau of Criminal Apprehension indicates that multistate offender status is undetermined;~~

~~(3) the social services agency has received a report from the individual or a third party indicating that the individual has a criminal history in a jurisdiction other than Minnesota; or~~

~~(4) the individual is or has been a resident of a state other than Minnesota at any time during the prior ten years.~~

Subd. 4. **Notice upon receipt.** ~~The responsible social services agency~~ commissioner must provide the subject of the background study with the results of the study as required under ~~this section within 15 business days of receipt or at least 15 days prior to the hearing at which the results will be presented, whichever comes first. The subject may provide written information to the agency that the results are incorrect and may provide additional or clarifying information to the agency and to the court through a party to the proceeding. This provision does not apply to any background study conducted under chapters 245A and chapter 245C.~~

Sec. 31. Minnesota Statutes 2006, section 260C.212, subdivision 2, is amended to read:

Subd. 2. **Placement decisions based on best interest of the child.** (a) The policy of the state of Minnesota is to ensure that the child's best interests are met by requiring an individualized determination of the needs of the child and of how the selected placement will serve the needs of the child being placed. The authorized child-placing agency shall place a child, released by court order or by voluntary release by the parent or parents, in

a family foster home selected by considering placement with relatives and important friends in the following order:

(1) with an individual who is related to the child by blood, marriage, or adoption; or
(2) with an individual who is an important friend with whom the child has resided or had significant contact.

(b) Among the factors the agency shall consider in determining the needs of the child are the following:

(1) the child's current functioning and behaviors;
(2) the medical, educational, and developmental needs of the child;
(3) the child's history and past experience;
(4) the child's religious and cultural needs;
(5) the child's connection with a community, school, and church;
(6) the child's interests and talents;
(7) the child's relationship to current caretakers, parents, siblings, and relatives; and
(8) the reasonable preference of the child, if the court, or the child-placing agency in the case of a voluntary placement, deems the child to be of sufficient age to express preferences.

(c) Placement of a child cannot be delayed or denied based on race, color, or national origin of the foster parent or the child.

(d) Siblings should be placed together for foster care and adoption at the earliest possible time unless it is determined not to be in the best interests of a sibling or unless it is not possible after appropriate efforts by the responsible social services agency.

(e) Except for emergency placement as provided for in section 245A.035, a completed background study is required under section 245C.08 before the approval of a foster placement in a related or unrelated home.

Sec. 32. EFFECTIVE DATE.

Changes made to sections in this article related to family child care are effective January 1, 2008.

**ARTICLE 3
HEALTH CARE**

Section 1. Minnesota Statutes 2006, section 256.969, subdivision 3a, is amended to read:

Subd. 3a. **Payments.** (a) Acute care hospital billings under the medical assistance program must not be submitted until the recipient is discharged. However,

141.1 the commissioner shall establish monthly interim payments for inpatient hospitals that
141.2 have individual patient lengths of stay over 30 days regardless of diagnostic category.
141.3 Except as provided in section 256.9693, medical assistance reimbursement for treatment
141.4 of mental illness shall be reimbursed based on diagnostic classifications. Individual
141.5 hospital payments established under this section and sections 256.9685, 256.9686, and
141.6 256.9695, in addition to third party and recipient liability, for discharges occurring during
141.7 the rate year shall not exceed, in aggregate, the charges for the medical assistance covered
141.8 inpatient services paid for the same period of time to the hospital. This payment limitation
141.9 shall be calculated separately for medical assistance and general assistance medical
141.10 care services. The limitation on general assistance medical care shall be effective for
141.11 admissions occurring on or after July 1, 1991. Services that have rates established under
141.12 subdivision 11 or 12, must be limited separately from other services. After consulting with
141.13 the affected hospitals, the commissioner may consider related hospitals one entity and
141.14 may merge the payment rates while maintaining separate provider numbers. The operating
141.15 and property base rates per admission or per day shall be derived from the best Medicare
141.16 and claims data available when rates are established. The commissioner shall determine
141.17 the best Medicare and claims data, taking into consideration variables of recency of the
141.18 data, audit disposition, settlement status, and the ability to set rates in a timely manner.
141.19 The commissioner shall notify hospitals of payment rates by December 1 of the year
141.20 preceding the rate year. The rate setting data must reflect the admissions data used to
141.21 establish relative values. Base year changes from 1981 to the base year established for the
141.22 rate year beginning January 1, 1991, and for subsequent rate years, shall not be limited
141.23 to the limits ending June 30, 1987, on the maximum rate of increase under subdivision
141.24 1. The commissioner may adjust base year cost, relative value, and case mix index data
141.25 to exclude the costs of services that have been discontinued by the October 1 of the year
141.26 preceding the rate year or that are paid separately from inpatient services. Inpatient stays
141.27 that encompass portions of two or more rate years shall have payments established based
141.28 on payment rates in effect at the time of admission unless the date of admission preceded
141.29 the rate year in effect by six months or more. In this case, operating payment rates for
141.30 services rendered during the rate year in effect and established based on the date of
141.31 admission shall be adjusted to the rate year in effect by the hospital cost index.

141.32 (b) For fee-for-service admissions occurring on or after July 1, 2002, the total
141.33 payment, before third-party liability and spenddown, made to hospitals for inpatient
141.34 services is reduced by .5 percent from the current statutory rates.

141.35 (c) In addition to the reduction in paragraph (b), the total payment for fee-for-service
141.36 admissions occurring on or after July 1, 2003, made to hospitals for inpatient services

142.1 before third-party liability and spenddown, is reduced five percent from the current
142.2 statutory rates. Mental health services within diagnosis related groups 424 to 432, ~~and~~
142.3 facilities defined under subdivision 16, and, effective for admissions occurring on or after
142.4 July 1, 2007, a long-term hospital as designated by the Medicare program that is located in
142.5 a city of the first class as defined in section 410.01, are excluded from this paragraph.

142.6 (d) In addition to the reduction in paragraphs (b) and (c), the total payment for
142.7 fee-for-service admissions occurring on or after July 1, 2005, made to hospitals for
142.8 inpatient services before third-party liability and spenddown, is reduced 6.0 percent from
142.9 the current statutory rates. Mental health services within diagnosis related groups 424 to
142.10 432 ~~and~~, facilities defined under subdivision 16, and, effective for admissions occurring
142.11 on or after July 1, 2007, a long-term hospital as designated by the Medicare program
142.12 that is located in a city of the first class as defined in section 410.01, are excluded from
142.13 this paragraph. Notwithstanding section 256.9686, subdivision 7, for purposes of this
142.14 paragraph, medical assistance does not include general assistance medical care. Payments
142.15 made to managed care plans shall be reduced for services provided on or after January
142.16 1, 2006, to reflect this reduction.

142.17 Sec. 2. Minnesota Statutes 2006, section 256.969, subdivision 9, is amended to read:

142.18 Subd. 9. **Disproportionate numbers of low-income patients served.** (a) For
142.19 admissions occurring on or after October 1, 1992, through December 31, 1992, the
142.20 medical assistance disproportionate population adjustment shall comply with federal law
142.21 and shall be paid to a hospital, excluding regional treatment centers and facilities of the
142.22 federal Indian Health Service, with a medical assistance inpatient utilization rate in excess
142.23 of the arithmetic mean. The adjustment must be determined as follows:

142.24 (1) for a hospital with a medical assistance inpatient utilization rate above the
142.25 arithmetic mean for all hospitals excluding regional treatment centers and facilities of the
142.26 federal Indian Health Service but less than or equal to one standard deviation above the
142.27 mean, the adjustment must be determined by multiplying the total of the operating and
142.28 property payment rates by the difference between the hospital's actual medical assistance
142.29 inpatient utilization rate and the arithmetic mean for all hospitals excluding regional
142.30 treatment centers and facilities of the federal Indian Health Service; and

142.31 (2) for a hospital with a medical assistance inpatient utilization rate above one
142.32 standard deviation above the mean, the adjustment must be determined by multiplying
142.33 the adjustment that would be determined under clause (1) for that hospital by 1.1. If
142.34 federal matching funds are not available for all adjustments under this subdivision, the
142.35 commissioner shall reduce payments on a pro rata basis so that all adjustments qualify for

143.1 federal match. The commissioner may establish a separate disproportionate population
143.2 operating payment rate adjustment under the general assistance medical care program.
143.3 For purposes of this subdivision medical assistance does not include general assistance
143.4 medical care. The commissioner shall report annually on the number of hospitals likely to
143.5 receive the adjustment authorized by this paragraph. The commissioner shall specifically
143.6 report on the adjustments received by public hospitals and public hospital corporations
143.7 located in cities of the first class.

143.8 (b) For admissions occurring on or after July 1, 1993, the medical assistance
143.9 disproportionate population adjustment shall comply with federal law and shall be paid to
143.10 a hospital, excluding regional treatment centers and facilities of the federal Indian Health
143.11 Service, with a medical assistance inpatient utilization rate in excess of the arithmetic
143.12 mean. The adjustment must be determined as follows:

143.13 (1) for a hospital with a medical assistance inpatient utilization rate above the
143.14 arithmetic mean for all hospitals excluding regional treatment centers and facilities of the
143.15 federal Indian Health Service but less than or equal to one standard deviation above the
143.16 mean, the adjustment must be determined by multiplying the total of the operating and
143.17 property payment rates by the difference between the hospital's actual medical assistance
143.18 inpatient utilization rate and the arithmetic mean for all hospitals excluding regional
143.19 treatment centers and facilities of the federal Indian Health Service;

143.20 (2) for a hospital with a medical assistance inpatient utilization rate above one
143.21 standard deviation above the mean, the adjustment must be determined by multiplying
143.22 the adjustment that would be determined under clause (1) for that hospital by 1.1. The
143.23 commissioner may establish a separate disproportionate population operating payment
143.24 rate adjustment under the general assistance medical care program. For purposes of this
143.25 subdivision, medical assistance does not include general assistance medical care. The
143.26 commissioner shall report annually on the number of hospitals likely to receive the
143.27 adjustment authorized by this paragraph. The commissioner shall specifically report on
143.28 the adjustments received by public hospitals and public hospital corporations located
143.29 in cities of the first class;

143.30 (3) for a hospital that had medical assistance fee-for-service payment volume during
143.31 calendar year 1991 in excess of 13 percent of total medical assistance fee-for-service
143.32 payment volume, a medical assistance disproportionate population adjustment shall be
143.33 paid in addition to any other disproportionate payment due under this subdivision as
143.34 follows: \$1,515,000 due on the 15th of each month after noon, beginning July 15, 1995.
143.35 For a hospital that had medical assistance fee-for-service payment volume during calendar
143.36 year 1991 in excess of eight percent of total medical assistance fee-for-service payment

volume and was the primary hospital affiliated with the University of Minnesota, a medical assistance disproportionate population adjustment shall be paid in addition to any other disproportionate payment due under this subdivision as follows: \$505,000 due on the 15th of each month after noon, beginning July 15, 1995; and

(4) effective August 1, 2005, the payments in paragraph (b), clause (3), shall be reduced to zero.

(c) The commissioner shall adjust rates paid to a health maintenance organization under contract with the commissioner to reflect rate increases provided in paragraph (b), clauses (1) and (2), on a nondiscounted hospital-specific basis but shall not adjust those rates to reflect payments provided in clause (3).

(d) If federal matching funds are not available for all adjustments under paragraph (b), the commissioner shall reduce payments under paragraph (b), clauses (1) and (2), on a pro rata basis so that all adjustments under paragraph (b) qualify for federal match.

(e) For purposes of this subdivision, medical assistance does not include general assistance medical care.

(f) For hospital services occurring on or after July 1, 2005, ~~to June 30, 2007,~~ general assistance medical care expenditures for fee-for-service inpatient and outpatient hospital services made by the department and by prepaid health plans participating in general assistance medical care effective July 1, 2007, payments under section 256B.199 shall be considered Medicaid disproportionate share hospital payments, except as limited ~~below:~~ by clauses (1) to (5);

(1) only the portion of Minnesota's disproportionate share hospital allotment under section 1923(f) of the Social Security Act that is not spent on the disproportionate population adjustments in paragraph (b), clauses (1) and (2), may be used ~~for general assistance medical care expenditures;~~

(2) only those ~~general assistance medical care~~ expenditures made to hospitals that qualify for disproportionate share payments under section 1923 of the Social Security Act and the Medicaid state plan may be considered disproportionate share hospital payments;

(3) only those ~~general assistance medical care~~ expenditures made to an individual hospital that would not cause the hospital to exceed its individual hospital limits under section 1923 of the Social Security Act may be considered; ~~and~~

(4) ~~general assistance medical care~~ expenditures may be considered only to the extent of Minnesota's aggregate allotment under section 1923 of the Social Security Act.

All hospitals and prepaid health plans participating in general assistance medical care must provide any necessary expenditure, cost, and revenue information required by the commissioner as necessary for purposes of obtaining federal Medicaid matching

145.1 funds for ~~general assistance medical care expenditures~~. Medicaid disproportionate share
145.2 payments; and

145.3 (5) expenditures under general assistance medical care shall be used to the fullest
145.4 extent before payments under section 256B.199.

145.5 (g) Upon federal approval of the related state plan amendment, paragraph (f) is
145.6 effective retroactively from July 1, 2005, or the earliest effective date approved by the
145.7 Centers for Medicare and Medicaid Services.

145.8 Sec. 3. Minnesota Statutes 2006, section 256.969, is amended by adding a subdivision
145.9 to read:

145.10 Subd. 28. **Long-term hospital payment adjustment.** For admissions occurring on
145.11 or after July 1, 2009, the commissioner shall increase the medical assistance payments
145.12 to a long-term hospital with a medical assistance inpatient utilization rate of 17.95
145.13 percent of total patient days as of the base year in effect on July 1, 2005, by an amount
145.14 equal to 13 percent of the total of the operating and property payment rates. Payments
145.15 made to managed care plans shall not reflect this payment increase. For purposes of
145.16 this subdivision, medical assistance does not include general assistance medical care.
145.17 Payments to a hospital under this subdivision shall be reduced by the amount of any
145.18 payments made under subdivision 27.

145.19 Sec. 4. Minnesota Statutes 2006, section 256B.04, subdivision 14, is amended to read:

145.20 Subd. 14. **Competitive bidding.** (a) When determined to be effective, economical,
145.21 and feasible, the commissioner may utilize volume purchase through competitive bidding
145.22 and negotiation under the provisions of chapter 16C, to provide items under the medical
145.23 assistance program including but not limited to the following:

145.24 (1) eyeglasses;

145.25 (2) oxygen. The commissioner shall provide for oxygen needed in an emergency
145.26 situation on a short-term basis, until the vendor can obtain the necessary supply from
145.27 the contract dealer;

145.28 (3) hearing aids and supplies; and

145.29 (4) durable medical equipment, including but not limited to:

145.30 (i) hospital beds;

145.31 (ii) commodes;

145.32 (iii) glide-about chairs;

145.33 (iv) patient lift apparatus;

145.34 (v) wheelchairs and accessories;

- 146.1 (vi) oxygen administration equipment;
- 146.2 (vii) respiratory therapy equipment;
- 146.3 (viii) electronic diagnostic, therapeutic and life support systems;
- 146.4 (5) ~~special~~ nonemergency transportation services level of need determinations,
- 146.5 disbursement of public transportation passes and tokens, and volunteer and recipient
- 146.6 mileage and parking reimbursements; and
- 146.7 (6) drugs.
- 146.8 (b) Rate changes under this chapter and chapters 256D and 256L do not affect
- 146.9 contract payments under this subdivision unless specifically identified.

146.10 Sec. 5. Minnesota Statutes 2006, section 256B.04, is amended by adding a subdivision

146.11 to read:

146.12 Subd. 14a. **Level of need determination.** Nonemergency medical transportation

146.13 level of need determinations must be performed by a physician, a registered nurse working

146.14 under direct supervision of a physician, a physician's assistant, a nurse practitioner, a

146.15 licensed practical nurse, or a discharge planner. Nonemergency medical transportation

146.16 level of need determinations must not be performed more than semiannually on any

146.17 individual, unless the individual's circumstances have sufficiently changed so as to

146.18 require a new level of need determination. Individuals residing in licensed nursing

146.19 facilities and individuals requiring stretcher transportation are exempt from a level of need

146.20 determination and are eligible for special transportation services until the individual no

146.21 longer resides in a licensed nursing facility or no longer requires stretcher transportation.

146.22 Sec. 6. Minnesota Statutes 2006, section 256B.056, is amended by adding a

146.23 subdivision to read:

146.24 Subd. 1d. **Treatment of certain monetary gifts.** The commissioner shall disregard

146.25 as income any portion of a monetary gift received by an applicant or enrollee that is

146.26 designated to purchase a prosthetic device not covered by insurance, other third-party

146.27 payers, or medical assistance.

146.28 Sec. 7. Minnesota Statutes 2006, section 256B.0625, subdivision 3f, is amended to

146.29 read:

146.30 Subd. 3f. **Circumcision for newborns.** ~~Newborn~~ Circumcision is not covered,

146.31 unless the procedure is medically necessary ~~or required because of a well-established~~

146.32 ~~religious practice.~~

147.1 Sec. 8. Minnesota Statutes 2006, section 256B.0625, is amended by adding a
147.2 subdivision to read:

147.3 Subd. 8d. **Chiropractic services.** Medical assistance covers the following
147.4 medically necessary chiropractic services: one initial or progress exam per year, manual
147.5 manipulation of the spine, and x-rays.

147.6 **EFFECTIVE DATE.** This section is effective July 1, 2007.

147.7 Sec. 9. Minnesota Statutes 2006, section 256B.0625, subdivision 13c, is amended to
147.8 read:

147.9 Subd. 13c. **Formulary committee.** The commissioner, after receiving
147.10 recommendations from professional medical associations and professional pharmacy
147.11 associations, and consumer groups shall designate a Formulary Committee to carry
147.12 out duties as described in subdivisions 13 to 13g. The Formulary Committee shall be
147.13 comprised of four licensed physicians actively engaged in the practice of medicine in
147.14 Minnesota one of whom must be actively engaged in the treatment of persons with mental
147.15 illness; at least three licensed pharmacists actively engaged in the practice of pharmacy
147.16 in Minnesota; and one consumer representative; the remainder to be made up of health
147.17 care professionals who are licensed in their field and have recognized knowledge in the
147.18 clinically appropriate prescribing, dispensing, and monitoring of covered outpatient drugs.
147.19 Members of the Formulary Committee shall not be employed by the Department of
147.20 Human Services, but the committee shall be staffed by an employee of the department
147.21 who shall serve as an ex officio, nonvoting member of the ~~board~~ committee. The
147.22 department's medical director shall also serve as an ex officio, nonvoting member for the
147.23 committee. Committee members shall serve three-year terms and may be reappointed
147.24 by the commissioner. The Formulary Committee shall meet at least quarterly. The
147.25 commissioner may require more frequent Formulary Committee meetings as needed. An
147.26 honorarium of \$100 per meeting and reimbursement for mileage shall be paid to each
147.27 committee member in attendance.

147.28 Sec. 10. Minnesota Statutes 2006, section 256B.0625, subdivision 13d, is amended to
147.29 read:

147.30 Subd. 13d. **Drug formulary.** (a) The commissioner shall establish a drug
147.31 formulary. Its establishment and publication shall not be subject to the requirements of the
147.32 Administrative Procedure Act, but the Formulary Committee shall review and comment
147.33 on the formulary contents.

147.34 (b) The formulary shall not include:

148.1 (1) drugs or products for which there is no federal funding;
148.2 (2) over-the-counter drugs, except as provided in subdivision 13;
148.3 (3) drugs used for weight loss, except that medically necessary lipase inhibitors may
148.4 be covered for a recipient with type II diabetes;
148.5 (4) drugs when used for the treatment of impotence or erectile dysfunction;
148.6 (5) drugs for which medical value has not been established; and
148.7 (6) drugs from manufacturers who have not signed a rebate agreement with the
148.8 Department of Health and Human Services pursuant to section 1927 of title XIX of the
148.9 Social Security Act.

148.10 (c) If a single-source drug used by at least two percent of the fee-for-service
148.11 medical assistance recipients is removed from the formulary due to the failure of the
148.12 manufacturer to sign a rebate agreement with the Department of Health and Human
148.13 Services, the commissioner shall notify prescribing practitioners within 30 days of
148.14 receiving notification from the Centers for Medicare and Medicaid Services (CMS) that a
148.15 rebate agreement was not signed.

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

148.17 Sec. 11. Minnesota Statutes 2006, section 256B.0625, is amended by adding a
148.18 subdivision to read:

148.19 Subd. 13i. **Medicare Part D.** Notwithstanding subdivision 13, paragraph (d), for
148.20 recipients who are enrolled in a Medicare Part D prescription drug plan or Medicare
148.21 Advantage special needs plan, medical assistance covers co-payments which the recipient
148.22 is responsible for under a Medicare Part D prescription drug plan or Medicare Advantage
148.23 special needs plan, once the recipient has paid \$12 per month in prescription drug
148.24 co-payments, and according to the requirements of the plan.

148.25 Sec. 12. Minnesota Statutes 2006, section 256B.0625, subdivision 17, is amended to
148.26 read:

148.27 Subd. 17. **Transportation costs.** (a) Medical assistance covers transportation costs
148.28 incurred solely for obtaining emergency medical care or transportation costs incurred
148.29 by eligible persons in obtaining emergency or nonemergency medical care when paid
148.30 directly to an ambulance company, common carrier, or other recognized providers of
148.31 transportation services.

148.32 (b) Medical assistance covers special transportation, as defined in Minnesota Rules,
148.33 part 9505.0315, subpart 1, item F, if the recipient has a physical or mental impairment that

149.1 would prohibit the recipient from safely accessing and using a bus, taxi, other commercial
149.2 transportation, or private automobile.

149.3 The commissioner may use an order by the recipient's attending physician to certify that
149.4 the recipient requires special transportation services. Special transportation includes
149.5 driver-assisted service to eligible individuals. Driver-assisted service includes passenger
149.6 pickup at and return to the individual's residence or place of business, assistance with
149.7 admittance of the individual to the medical facility, and assistance in passenger securement
149.8 or in securing of wheelchairs or stretchers in the vehicle. Special transportation providers
149.9 must obtain written documentation from the health care service provider who is serving
149.10 the recipient being transported, identifying the time that the recipient arrived. Special
149.11 transportation providers may not bill for separate base rates for the continuation of a trip
149.12 beyond the original destination. Special transportation providers must take recipients
149.13 to the nearest appropriate health care provider, using the ~~most direct~~ quickest route
149.14 available as determined by a commercially available mileage software program approved
149.15 by the commissioner. The maximum medical assistance reimbursement rates for special
149.16 transportation services are:

149.17 (1) \$17 for the base rate and ~~\$1.35~~ \$1.43 per mile for services to eligible persons
149.18 who need a wheelchair-accessible van;

149.19 (2) \$11.50 for the base rate and \$1.30 per mile for services to eligible persons who
149.20 do not need a wheelchair-accessible van; and

149.21 (3) \$60 for the base rate and \$2.40 per mile, and an attendant rate of \$9 per trip, for
149.22 services to eligible persons who need a stretcher-accessible vehicle.

149.23 Sec. 13. Minnesota Statutes 2006, section 256B.0625, subdivision 18a, is amended to
149.24 read:

149.25 Subd. 18a. **Access to medical services.** (a) Medical assistance reimbursement for
149.26 meals for persons traveling to receive medical care may not exceed \$5.50 for breakfast,
149.27 \$6.50 for lunch, or \$8 for dinner.

149.28 (b) Medical assistance reimbursement for lodging for persons traveling to receive
149.29 medical care may not exceed \$50 per day unless prior authorized by the local agency.

149.30 (c) Medical assistance direct mileage reimbursement to ~~the~~ an eligible person or ~~the~~
149.31 an eligible person's driver may not exceed 20 cents per mile friend, neighbor, or relative
149.32 that is providing direct transportation to a covered service shall be at 15 cents below the
149.33 current Internal Revenue Service mileage reimbursement for business purposes.

(d) Medical assistance covers oral language interpreter services when provided by an enrolled health care provider during the course of providing a direct, person-to-person covered health care service to an enrolled recipient with limited English proficiency.

Sec. 14. Minnesota Statutes 2006, section 256B.0625, is amended by adding a subdivision to read:

Subd. 49. **Community health worker.** (a) Medical assistance covers the care coordination and patient education services provided by a community health worker if the community health worker has:

(1) received a certificate from the Minnesota State Colleges and Universities System approved community health worker curriculum; or

(2) at least five years of supervised experience with an enrolled physician or advanced practice registered nurse.

Community health workers eligible for payment under clause (2) must complete the certification program by January 1, 2010, to continue to be eligible for payment.

(b) Community health workers must work under the supervision of a medical assistance enrolled physician or advanced practice registered nurse.

Sec. 15. Minnesota Statutes 2006, section 256B.0644, is amended to read:

256B.0644 REIMBURSEMENT UNDER OTHER STATE HEALTH CARE PROGRAMS.

(a) A vendor of medical care, as defined in section 256B.02, subdivision 7, and a health maintenance organization, as defined in chapter 62D, must participate as a provider or contractor in the medical assistance program, general assistance medical care program, and MinnesotaCare as a condition of participating as a provider in health insurance plans and programs or contractor for state employees established under section 43A.18, the public employees insurance program under section 43A.316, for health insurance plans offered to local statutory or home rule charter city, county, and school district employees, the workers' compensation system under section 176.135, and insurance plans provided through the Minnesota Comprehensive Health Association under sections 62E.01 to 62E.19. The limitations on insurance plans offered to local government employees shall not be applicable in geographic areas where provider participation is limited by managed care contracts with the Department of Human Services.

(b) For providers other than health maintenance organizations, participation in the medical assistance program means that:

151.1 (1) the provider accepts new medical assistance, general assistance medical care,
151.2 and MinnesotaCare patients ~~or~~;

151.3 (2) for providers other than dental service providers, at least 20 percent of the
151.4 provider's patients are covered by medical assistance, general assistance medical care, and
151.5 MinnesotaCare as their primary source of coverage, ~~or~~, or

151.6 (3) for dental service providers, at least ten percent of the provider's patients are
151.7 covered by medical assistance, general assistance medical care, and MinnesotaCare as
151.8 their primary source of coverage, or the provider accepts new medical assistance and
151.9 MinnesotaCare patients who are children with special health care needs. For purposes
151.10 of this section, "children with special health care needs" means children up to age 18
151.11 who: (i) require health and related services beyond that required by children generally;
151.12 and (ii) have or are at risk for a chronic physical, developmental, behavioral, or emotional
151.13 condition, including: bleeding and coagulation disorders; immunodeficiency disorders;
151.14 cancer; endocrinopathy; developmental disabilities; epilepsy, cerebral palsy, and other
151.15 neurological diseases; visual impairment or deafness; Down syndrome and other genetic
151.16 disorders; autism; fetal alcohol syndrome; and other conditions designated by the
151.17 commissioner after consultation with representatives of pediatric dental providers and
151.18 consumers.

151.19 (c) Patients seen on a volunteer basis by the provider at a location other than the
151.20 provider's usual place of practice may be considered in meeting ~~this~~ the participation
151.21 requirement in this section. The commissioner shall establish participation requirements
151.22 for health maintenance organizations. The commissioner shall provide lists of
151.23 participating medical assistance providers on a quarterly basis to the commissioner of
151.24 employee relations, the commissioner of labor and industry, and the commissioner of
151.25 commerce. Each of the commissioners shall develop and implement procedures to exclude
151.26 as participating providers in the program or programs under their jurisdiction those
151.27 providers who do not participate in the medical assistance program. The commissioner
151.28 of employee relations shall implement this section through contracts with participating
151.29 health and dental carriers.

151.30 Sec. 16. **[256B.0751] CARE COORDINATION FOR CHILDREN WITH**
151.31 **HIGH-COST MEDICAL CONDITIONS.**

151.32 **Subdivision 1. Care coordination required.** (a) The commissioner of human
151.33 services shall contract with the U special kids program to provide care coordination,
151.34 beginning October 1, 2007, for medical assistance enrollees who are children with
151.35 high-cost medical conditions, and to perform the other duties specified in this section.

152.1 (b) For purposes of this section, "care coordination" means collaboration with
152.2 primary care physicians and specialists to manage care, development of medical
152.3 management plans for recurrent acute illnesses, oversight and coordination of all aspects
152.4 of care in partnership with families, organization of medical information into a summary
152.5 of critical information, coordination and appropriate sequencing of tests and multiple
152.6 appointments, information and assistance with accessing resources, and telephone triage
152.7 for acute illnesses or problems.

152.8 Subd. 2. **Referrals.** The commissioner shall develop a mechanism to refer
152.9 children to the U special kids program for care coordination. Beginning October 1, 2007,
152.10 and subject to the limits on total program enrollment specified in subdivision 3, the
152.11 commissioner shall refer to the U special kids program children who:

152.12 (1) incur medical expenses that exceed the qualifying level specified in subdivision 3;

152.13 (2) have medical conditions that involve four or more major systems; require
152.14 multiple specialists; require use of technology such as G-tube, trach, central line, or
152.15 oxygen; and require multiple medications;

152.16 (3) do not have a medical case manager for cancer, organ transplantation, epilepsy,
152.17 or bone marrow replacement; and

152.18 (4) voluntarily agree to participate in the program.

152.19 Subd. 3. **Qualifying level of medical expenses.** (a) For the period October 1, 2007,
152.20 through September 30, 2008, the commissioner shall refer children for care coordination
152.21 under this section if they incurred medical expenses of \$500,000 or more during the
152.22 fiscal year ending June 30, 2007.

152.23 (b) For the period October 1, 2008, through September 30, 2009, the commissioner
152.24 shall refer children for care coordination under this section if they incurred medical
152.25 expenses of \$400,000 or more during the fiscal year ending June 30, 2008.

152.26 (c) For the period October 1, 2009, through September 30, 2010, the commissioner
152.27 shall refer children for care coordination under this section if they incurred medical
152.28 expenses of \$300,000 or more during the fiscal year ending June 30, 2009.

152.29 (d) Beginning October 1, 2010, the commissioner shall refer children for care
152.30 coordination under this section if they incurred medical expenses of \$250,000 or more
152.31 during the previous fiscal year.

152.32 (e) The commissioner shall limit referrals to the extent necessary to ensure that
152.33 total enrollment in the U special kids program does not exceed 100 children for the
152.34 period October 1, 2007, through September 30, 2008, and does not exceed 150 children
152.35 beginning October 1, 2008.

153.1 Subd. 4. **Case management.** Beginning October 1, 2007, the U special kids
153.2 program shall coordinate all nonmedical case management services provided to children
153.3 who are required to receive care coordination under this section. The program may
153.4 require all nonmedical case managers, including, but not limited to, county case managers
153.5 and case managers for children served under a home and community-based waiver,
153.6 to submit care plans for approval, and to document client compliance with the care
153.7 plans. The U special kids program, beginning October 1, 2008, may employ or contract
153.8 with nonmedical case managers to provide all nonmedical case management services to
153.9 children required to receive care coordination under this section. The commissioner shall
153.10 reimburse the U special kids program for case management services through the medical
153.11 assistance program.

153.12 Subd. 5. **Statewide availability of care coordination.** The U special kids program
153.13 may contract with other entities to provide care coordination services as defined in
153.14 subdivision 1, in order to ensure the availability of these services in all regions of the state.

153.15 Subd. 6. **Advance practice nurse telephone triage system.** The U special kids
153.16 program shall establish and operate an advance practice nurse telephone triage system that
153.17 is available statewide, 24 hours a day, seven days per week. The system must provide
153.18 advance practice nurses with access to a Web-based information system to appropriately
153.19 triage medical problems, manage care, and reduce unnecessary hospitalizations.

153.20 Subd. 7. **Monitoring and evaluation.** The commissioner shall monitor program
153.21 outcomes and evaluate the extent to which referrals to the U special kids program have
153.22 improved the quality and coordination of care and provided financial savings to the
153.23 medical assistance program. The U special kids program shall submit to the commissioner,
153.24 in the form and manner specified by the commissioner, all data and information necessary
153.25 to monitor program outcomes and evaluate the program. The commissioner shall present a
153.26 preliminary evaluation to the legislature by January 15, 2008, and a final evaluation to the
153.27 legislature by January 15, 2010.

153.28 **EFFECTIVE DATE.** This section is effective October 1, 2007, or upon federal
153.29 approval, whichever is later.

153.30 Sec. 17. **[256B.0752] CARE COORDINATION FOR CHILDREN WITH**
153.31 **HIGH-COST MENTAL HEALTH CONDITIONS.**

153.32 Subdivision 1. **Care coordination required.** (a) The commissioner of human
153.33 services shall contract with the U special kids program to provide care coordination,
153.34 beginning October 1, 2007, for medical assistance enrollees who are children with

154.1 high-cost mental health conditions and behavioral problems, and to perform the other
154.2 duties specified in this section.

154.3 (b) For purposes of this section, "care coordination" means: collaboration with
154.4 primary care physicians and specialists to manage care; development of mental health
154.5 management plans for recurrent mental health issues; oversight and coordination of all
154.6 aspects of care in partnership with families; organization of medical, treatment, and
154.7 therapy information into a summary of critical information; coordination and appropriate
154.8 sequencing of evaluations and multiple appointments; information and assistance with
154.9 accessing resources; and telephone triage for behavior or other problems.

154.10 Subd. 2. **Referrals.** The commissioner shall develop a mechanism to refer children
154.11 to the program for care coordination. Beginning October 1, 2007, and subject to the limits
154.12 on total program enrollment specified in subdivision 3, the commissioner shall refer to
154.13 the U special kids program children who:

154.14 (1) incur mental health expenses that exceed the qualifying level specified in
154.15 subdivision 3;

154.16 (2) are currently receiving or at risk of needing inpatient mental health treatment,
154.17 foster home care, or both; and

154.18 (3) voluntarily agree to participate in the program.

154.19 Subd. 3. **Qualifying level of medical expenses.** (a) Beginning October 1, 2007, the
154.20 commissioner shall refer children for care coordination under this section if they incurred
154.21 medical and mental health expenses of \$250,000 or more in the previous fiscal year.

154.22 (b) The commissioner shall limit referrals to the extent necessary to ensure that total
154.23 enrollment in the U special kids program does not exceed 25 children for the period
154.24 October 1, 2007, through September 30, 2008; does not exceed 75 children for the
154.25 period October 1, 2008, through September 30, 2009; and does not exceed 125 children
154.26 beginning October 1, 2009.

154.27 Subd. 4. **Case management.** The U special kids program, beginning October 1,
154.28 2007, shall coordinate all nonmedical case management services provided to children who
154.29 are required to receive care coordination under this section. The program may require all
154.30 nonmedical case managers, including but not limited to county case managers and case
154.31 managers for children served under a home and community-based waiver, to submit care
154.32 plans for approval, and to document client compliance with the care plans. The U special
154.33 kids program, beginning October 1, 2008, may employ or contract with nonmedical case
154.34 managers to provide all nonmedical case management services to children required to
154.35 receive care coordination under this section. The commissioner shall reimburse the

155.1 U special kids program for case management services through the medical assistance
155.2 program.

155.3 Subd. 5. **Statewide availability of care coordination.** The program may contract
155.4 with other entities to provide care coordination services as defined in subdivision 1, in
155.5 order to ensure the availability of these services in all regions of the state.

155.6 Subd. 6. **Monitoring and evaluation.** The commissioner shall monitor program
155.7 outcomes and shall evaluate the extent to which referrals to the U special kids program
155.8 have improved the quality and coordination of care and provided financial savings to the
155.9 medical assistance program. The U special kids program shall submit to the commissioner,
155.10 in the form and manner specified by the commissioner, all data and information necessary
155.11 to monitor program outcomes and evaluate the program. The commissioner shall present a
155.12 preliminary evaluation to the legislature by January 15, 2008, and a final evaluation to the
155.13 legislature by January 15, 2010.

155.14 **EFFECTIVE DATE.** This section is effective October 1, 2007, or upon federal
155.15 approval, whichever is later. The commissioner shall notify the Office of the Revisor of
155.16 Statutes when federal approval is obtained.

155.17 Sec. 18. **[256B.194] FEDERAL PAYMENTS.**

155.18 Subdivision 1. **Payments at actual cost.** If the Centers for Medicare & Medicaid
155.19 Services (CMS) promulgates a final rule consistent with its stated intent in the proposed
155.20 rule published at 72 Federal Register, No. 11, January 18, 2007, regarding limiting
155.21 payments to units of government, and notwithstanding Minnesota Statutes or Minnesota
155.22 Rules to the contrary, for providers that are units of government, the commissioner may
155.23 limit medical assistance and MinnesotaCare payments to a provider's actual cost of
155.24 providing services, in accordance with the CMS final rule. If a final rule is promulgated,
155.25 the commissioner may also require medical assistance and MinnesotaCare providers to
155.26 provide any information necessary to determine Medicaid-related costs, and require the
155.27 cooperation of providers in any audit or review necessary to ensure payments are limited
155.28 to cost. This section does not apply to providers who are exempt from the provisions of
155.29 the CMS final rule.

155.30 Subd. 2. **Loss of federal financial participation.** For all transfers, certified
155.31 expenditures, and medical assistance payments listed below, if the commissioner
155.32 determines that federal financial participation is no longer available for the medical
155.33 assistance payments listed, then related obligations for the nonfederal share of payments
155.34 and the medical assistance payments shall terminate. The commissioner shall notify all
155.35 affected parties of the loss of federal financial participation, and the resulting payments

156.1 and obligations that are terminated. If the commissioner determines that federal financial
156.2 participation is no longer available for any medical assistance payments or contributions
156.3 to the nonfederal share of medical assistance payments that have already been made, the
156.4 commissioner may collect the medical assistance payments from providers and return
156.5 contributions of the nonfederal share to its source. The transfers, certified expenditures,
156.6 and medical assistance payments subject to this section are those specified in: sections
156.7 62J.692, subdivision 7, paragraphs (b) and (c); 256B.19, subdivisions 1c and 1d;
156.8 256B.195; 256B.431, subdivision 23; and 256B.69, subdivision 5c, paragraph (a), clauses
156.9 (2), (3), and (4); Laws 2002, chapter 220, article 17, section 2, subdivision 3; and Laws
156.10 2005, First Special Session chapter 4, article 9, section 2, subdivision 1.

156.11 Sec. 19. Minnesota Statutes 2006, section 256B.199, is amended to read:

156.12 **256B.199 PAYMENTS REPORTED BY GOVERNMENTAL ENTITIES.**

156.13 (a) ~~Hennepin County; and Hennepin County Medical Center, Ramsey County,~~
156.14 ~~Regions Hospital, the University of Minnesota, and Fairview-University Medical Center~~
156.15 shall report quarterly to the commissioner beginning June 1, 2007, payments made during
156.16 the second previous quarter that may qualify for reimbursement under federal law.

156.17 (b) Based on these reports, the commissioner shall apply for federal matching funds.
156.18 These funds are appropriated to the commissioner for ~~the payments under section 256.969,~~
156.19 ~~subdivision 27~~ to Hennepin County Medical Center.

156.20 (c) By May 1 of each year, beginning May 1, 2007, the commissioner shall inform
156.21 the nonstate entities listed in paragraph (a) of the amount of federal disproportionate share
156.22 hospital payment money expected to be available in the current federal fiscal year.

156.23 ~~(d) This section sunsets on June 30, 2009. The commissioner shall report to~~
156.24 ~~the legislature by December 15, 2008, with recommendations for maximizing federal~~
156.25 ~~disproportionate share hospital payments after June 30, 2009.~~

156.26 Sec. 20. Minnesota Statutes 2006, section 256B.75, is amended to read:

156.27 **256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.**

156.28 (a) For outpatient hospital facility fee payments for services rendered on or after
156.29 October 1, 1992, the commissioner of human services shall pay the lower of (1) submitted
156.30 charge, or (2) 32 percent above the rate in effect on June 30, 1992, except for those
156.31 services for which there is a federal maximum allowable payment. Effective for services
156.32 rendered on or after January 1, 2000, payment rates for nonsurgical outpatient hospital
156.33 facility fees and emergency room facility fees shall be increased by eight percent over the
156.34 rates in effect on December 31, 1999, except for those services for which there is a federal

maximum allowable payment. Services for which there is a federal maximum allowable payment shall be paid at the lower of (1) submitted charge, or (2) the federal maximum allowable payment. Total aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare upper limit. If it is determined that a provision of this section conflicts with existing or future requirements of the United States government with respect to federal financial participation in medical assistance, the federal requirements prevail. The commissioner may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial participation resulting from rates that are in excess of the Medicare upper limitations.

(b) Notwithstanding paragraph (a), payment for outpatient, emergency, and ambulatory surgery hospital facility fee services for critical access hospitals designated under section 144.1483, clause (10), shall be paid on a cost-based payment system that is based on the cost-finding methods and allowable costs of the Medicare program. All hospital outpatient services provided by any hospital exclusively devoted to the care of pediatric patients under age 21 that is located in a Minnesota metropolitan statistical area must be paid for using the methodology established for critical access hospitals at a rate equal to fee-for-service rates plus 46 percent, as limited by allowable costs.

(c) Effective for services provided on or after July 1, 2003, rates that are based on the Medicare outpatient prospective payment system shall be replaced by a budget neutral prospective payment system that is derived using medical assistance data. The commissioner shall provide a proposal to the 2003 legislature to define and implement this provision.

(d) For fee-for-service services provided on or after July 1, 2002, the total payment, before third-party liability and spenddown, made to hospitals for outpatient hospital facility services is reduced by .5 percent from the current statutory rate.

(e) In addition to the reduction in paragraph (d), the total payment for fee-for-service services provided on or after July 1, 2003, made to hospitals for outpatient hospital facility services before third-party liability and spenddown, is reduced five percent from the current statutory rates. Facilities defined under section 256.969, subdivision 16, are excluded from this paragraph.

EFFECTIVE DATE. This section is effective July 1, 2007, and applies to services provided on or after that date.

Sec. 21. Minnesota Statutes 2006, section 256B.76, is amended to read:

256B.76 PHYSICIAN AND DENTAL REIMBURSEMENT.

(a) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for physician services as follows:

(1) payment for level one Centers for Medicare and Medicaid Services' common procedural coding system codes titled "office and other outpatient services," "preventive medicine new and established patient," "delivery, antepartum, and postpartum care," "critical care," cesarean delivery and pharmacologic management provided to psychiatric patients, and level three codes for enhanced services for prenatal high risk, shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992. If the rate on any procedure code within these categories is different than the rate that would have been paid under the methodology in section 256B.74, subdivision 2, then the larger rate shall be paid;

(2) payments for all other services shall be paid at the lower of (i) submitted charges, or (ii) 15.4 percent above the rate in effect on June 30, 1992;

(3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases except that payment rates for home health agency services shall be the rates in effect on September 30, 1992;

(4) effective for services rendered on or after January 1, 2000, payment rates for physician and professional services shall be increased by three percent over the rates in effect on December 31, 1999, except for home health agency and family planning agency services; and

(5) the increases in clause (4) shall be implemented January 1, 2000, for managed care.

(b) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for dental services as follows:

(1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992;

(2) dental rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases;

(3) effective for services rendered on or after January 1, 2000, payment rates for dental services shall be increased by three percent over the rates in effect on December 31, 1999;

(4) the commissioner shall award grants to community clinics or other nonprofit community organizations, political subdivisions, professional associations, or other organizations that demonstrate the ability to provide dental services effectively to public program recipients. Grants may be used to fund the costs related to coordinating access for

159.1 recipients, developing and implementing patient care criteria, upgrading or establishing
159.2 new facilities, acquiring furnishings or equipment, recruiting new providers, or other
159.3 development costs that will improve access to dental care in a region. In awarding grants,
159.4 the commissioner shall give priority to applicants that plan to serve areas of the state in
159.5 which the number of dental providers is not currently sufficient to meet the needs of
159.6 recipients of public programs or uninsured individuals. The commissioner shall consider
159.7 the following in awarding the grants:

- 159.8 (i) potential to successfully increase access to an underserved population;
- 159.9 (ii) the ability to raise matching funds;
- 159.10 (iii) the long-term viability of the project to improve access beyond the period
159.11 of initial funding;
- 159.12 (iv) the efficiency in the use of the funding; and
- 159.13 (v) the experience of the proposers in providing services to the target population.

159.14 The commissioner shall monitor the grants and may terminate a grant if the grantee
159.15 does not increase dental access for public program recipients. The commissioner shall
159.16 consider grants for the following:

- 159.17 (i) implementation of new programs or continued expansion of current access
159.18 programs that have demonstrated success in providing dental services in underserved
159.19 areas;
- 159.20 (ii) a pilot program for utilizing hygienists outside of a traditional dental office to
159.21 provide dental hygiene services; and
- 159.22 (iii) a program that organizes a network of volunteer dentists, establishes a system to
159.23 refer eligible individuals to volunteer dentists, and through that network provides donated
159.24 dental care services to public program recipients or uninsured individuals;

159.25 (5) beginning October 1, 1999, the payment for tooth sealants and fluoride treatments
159.26 shall be the lower of (i) submitted charge, or (ii) 80 percent of median 1997 charges;

159.27 (6) the increases listed in clauses (3) and (5) shall be implemented January 1, 2000,
159.28 for managed care; and

159.29 (7) effective for services provided on or after January 1, 2002, payment for
159.30 diagnostic examinations and dental x-rays provided to children under age 21 shall be the
159.31 lower of (i) the submitted charge, or (ii) 85 percent of median 1999 charges.

159.32 (c) Effective for dental services rendered on or after January 1, 2002, the
159.33 commissioner may, ~~within the limits of available appropriation,~~ increase reimbursements
159.34 to dentists and dental clinics deemed by the commissioner to be critical access dental
159.35 providers. ~~Reimbursement to a critical access dental provider may be increased by not~~
159.36 ~~more than 50 percent above the reimbursement rate that would otherwise be paid to the~~

160.1 ~~provider. Payments to~~ For dental services rendered after June 30, 2007, the commissioner
160.2 shall increase reimbursement by 33 percent above the reimbursement rate that would
160.3 otherwise be paid to the provider. The commissioner shall pay the health plan companies
160.4 ~~shall be adjusted~~ in amounts sufficient to reflect increased reimbursements to critical
160.5 access dental providers as approved by the commissioner. In determining which dentists
160.6 and dental clinics shall be deemed critical access dental providers, the commissioner
160.7 shall review:

160.8 (1) the utilization rate in the service area in which the dentist or dental clinic operates
160.9 for dental services to patients covered by medical assistance, general assistance medical
160.10 care, or MinnesotaCare as their primary source of coverage;

160.11 (2) the level of services provided by the dentist or dental clinic to patients covered
160.12 by medical assistance, general assistance medical care, or MinnesotaCare as their primary
160.13 source of coverage; and

160.14 (3) whether the level of services provided by the dentist or dental clinic is critical to
160.15 maintaining adequate levels of patient access within the service area.

160.16 In the absence of a critical access dental provider in a service area, the commissioner may
160.17 designate a dentist or dental clinic as a critical access dental provider if the dentist or
160.18 dental clinic is willing to provide care to patients covered by medical assistance, general
160.19 assistance medical care, or MinnesotaCare at a level which significantly increases access
160.20 to dental care in the service area.

160.21 ~~The commissioner shall annually establish a reimbursement schedule for critical~~
160.22 ~~access dental providers and provider-specific limits on total reimbursement received~~
160.23 ~~under the reimbursement schedule, and shall notify each critical access dental provider~~
160.24 ~~of the schedule and limit.~~

160.25 (d) An entity that operates both a Medicare certified comprehensive outpatient
160.26 rehabilitation facility and a facility which was certified prior to January 1, 1993, that is
160.27 licensed under Minnesota Rules, parts 9570.2000 to 9570.3600, and for whom at least 33
160.28 percent of the clients receiving rehabilitation services in the most recent calendar year are
160.29 medical assistance recipients, shall be reimbursed by the commissioner for rehabilitation
160.30 services at rates that are 38 percent greater than the maximum reimbursement rate
160.31 allowed under paragraph (a), clause (2), when those services are (1) provided within the
160.32 comprehensive outpatient rehabilitation facility and (2) provided to residents of nursing
160.33 facilities owned by the entity.

160.34 (e) Effective for services rendered on or after January 1, 2007, the commissioner
160.35 shall make payments for physician and professional services based on the Medicare

161.1 relative value units (RVU's). This change shall be budget neutral and the cost of
161.2 implementing RVU's will be incorporated in the established conversion factor.

161.3 Sec. 22. Minnesota Statutes 2006, section 256D.03, subdivision 4, is amended to read:

161.4 Subd. 4. **General assistance medical care; services.** (a)(i) For a person who is
161.5 eligible under subdivision 3, paragraph (a), clause (2), item (i), general assistance medical
161.6 care covers, except as provided in paragraph (c):

161.7 (1) inpatient hospital services;

161.8 (2) outpatient hospital services;

161.9 (3) services provided by Medicare certified rehabilitation agencies;

161.10 (4) prescription drugs and other products recommended through the process
161.11 established in section 256B.0625, subdivision 13;

161.12 (5) equipment necessary to administer insulin and diagnostic supplies and equipment
161.13 for diabetics to monitor blood sugar level;

161.14 (6) eyeglasses and eye examinations provided by a physician or optometrist;

161.15 (7) hearing aids;

161.16 (8) prosthetic devices;

161.17 (9) laboratory and X-ray services;

161.18 (10) physician's services;

161.19 (11) medical transportation except special transportation;

161.20 (12) chiropractic services as covered under the medical assistance program;

161.21 (13) podiatric services;

161.22 (14) dental services as covered under the medical assistance program;

161.23 (15) outpatient services provided by a mental health center or clinic that is under
161.24 contract with the county board and is established under section 245.62;

161.25 (16) day treatment services for mental illness provided under contract with the
161.26 county board;

161.27 (17) prescribed medications for persons who have been diagnosed as mentally ill as
161.28 necessary to prevent more restrictive institutionalization;

161.29 (18) psychological services, medical supplies and equipment, and Medicare
161.30 premiums, coinsurance and deductible payments;

161.31 (19) medical equipment not specifically listed in this paragraph when the use of
161.32 the equipment will prevent the need for costlier services that are reimbursable under
161.33 this subdivision;

161.34 (20) services performed by a certified pediatric nurse practitioner, a certified family
161.35 nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological

162.1 nurse practitioner, a certified neonatal nurse practitioner, or a certified geriatric nurse
162.2 practitioner in independent practice, if (1) the service is otherwise covered under this
162.3 chapter as a physician service, (2) the service provided on an inpatient basis is not included
162.4 as part of the cost for inpatient services included in the operating payment rate, and (3) the
162.5 service is within the scope of practice of the nurse practitioner's license as a registered
162.6 nurse, as defined in section 148.171;

162.7 (21) services of a certified public health nurse or a registered nurse practicing in
162.8 a public health nursing clinic that is a department of, or that operates under the direct
162.9 authority of, a unit of government, if the service is within the scope of practice of the
162.10 public health nurse's license as a registered nurse, as defined in section 148.171;

162.11 (22) telemedicine consultations, to the extent they are covered under section
162.12 256B.0625, subdivision 3b; ~~and~~

162.13 (23) mental health telemedicine and psychiatric consultation as covered under
162.14 section 256B.0625, subdivisions 46 and 48;

162.15 (24) care coordination and patient education services provided by a community
162.16 health worker according to section 256B.0625, subdivision 49; and

162.17 (25) regardless of the number of employees that an enrolled health care provider
162.18 may have, sign language interpreter services when provided by an enrolled health care
162.19 provider during the course of providing a direct, person-to-person covered health care
162.20 service to an enrolled recipient who has a hearing loss and uses interpreting services.

162.21 (ii) Effective October 1, 2003, for a person who is eligible under subdivision 3,
162.22 paragraph (a), clause (2), item (ii), general assistance medical care coverage is limited
162.23 to inpatient hospital services, including physician services provided during the inpatient
162.24 hospital stay. A \$1,000 deductible is required for each inpatient hospitalization.

162.25 (b) Effective August 1, 2005, sex reassignment surgery is not covered under this
162.26 subdivision.

162.27 (c) In order to contain costs, the commissioner of human services shall select
162.28 vendors of medical care who can provide the most economical care consistent with high
162.29 medical standards and shall where possible contract with organizations on a prepaid
162.30 capitation basis to provide these services. The commissioner shall consider proposals by
162.31 counties and vendors for prepaid health plans, competitive bidding programs, block grants,
162.32 or other vendor payment mechanisms designed to provide services in an economical
162.33 manner or to control utilization, with safeguards to ensure that necessary services are
162.34 provided. Before implementing prepaid programs in counties with a county operated or
162.35 affiliated public teaching hospital or a hospital or clinic operated by the University of
162.36 Minnesota, the commissioner shall consider the risks the prepaid program creates for the

163.1 hospital and allow the county or hospital the opportunity to participate in the program in a
163.2 manner that reflects the risk of adverse selection and the nature of the patients served by
163.3 the hospital, provided the terms of participation in the program are competitive with the
163.4 terms of other participants considering the nature of the population served. Payment for
163.5 services provided pursuant to this subdivision shall be as provided to medical assistance
163.6 vendors of these services under sections 256B.02, subdivision 8, and 256B.0625. For
163.7 payments made during fiscal year 1990 and later years, the commissioner shall consult
163.8 with an independent actuary in establishing prepayment rates, but shall retain final control
163.9 over the rate methodology.

163.10 (d) Effective January 1, 2008, drug coverage under general assistance medical care
163.11 is limited to prescription drugs that:

163.12 (i) are covered under the medical assistance program as described in section
163.13 256B.0625, subdivisions 13 and 13d; and

163.14 (ii) are provided by manufacturers that have fully executed general assistance
163.15 medical care rebate agreements with the commissioner and comply with the agreements.

163.16 Prescription drug coverage under general assistance medical care must conform to
163.17 coverage under the medical assistance program according to section 256B.0625,
163.18 subdivisions 13 to 13g.

163.19 ~~(d)~~ (e) Recipients eligible under subdivision 3, paragraph (a), shall pay the following
163.20 co-payments for services provided on or after October 1, 2003:

163.21 (1) \$25 for eyeglasses;

163.22 (2) \$25 for nonemergency visits to a hospital-based emergency room;

163.23 (3) \$3 per brand-name drug prescription and \$1 per generic drug prescription,
163.24 subject to a \$12 per month maximum for prescription drug co-payments. No co-payments
163.25 shall apply to antipsychotic drugs when used for the treatment of mental illness; and

163.26 (4) 50 percent coinsurance on restorative dental services.

163.27 ~~(e)~~ (f) Co-payments shall be limited to one per day per provider for nonpreventive
163.28 visits, eyeglasses, and nonemergency visits to a hospital-based emergency room.

163.29 Recipients of general assistance medical care are responsible for all co-payments in this
163.30 subdivision. The general assistance medical care reimbursement to the provider shall be
163.31 reduced by the amount of the co-payment, except that reimbursement for prescription
163.32 drugs shall not be reduced once a recipient has reached the \$12 per month maximum for
163.33 prescription drug co-payments. The provider collects the co-payment from the recipient.
163.34 Providers may not deny services to recipients who are unable to pay the co-payment,
163.35 except as provided in paragraph (f).

164.1 ~~(f)~~ (g) If it is the routine business practice of a provider to refuse service to an
164.2 individual with uncollected debt, the provider may include uncollected co-payments
164.3 under this section. A provider must give advance notice to a recipient with uncollected
164.4 debt before services can be denied.

164.5 ~~(g)~~ (h) Any county may, from its own resources, provide medical payments for
164.6 which state payments are not made.

164.7 ~~(h)~~ (i) Chemical dependency services that are reimbursed under chapter 254B must
164.8 not be reimbursed under general assistance medical care.

164.9 ~~(i)~~ (j) The maximum payment for new vendors enrolled in the general assistance
164.10 medical care program after the base year shall be determined from the average usual and
164.11 customary charge of the same vendor type enrolled in the base year.

164.12 ~~(j)~~ (k) The conditions of payment for services under this subdivision are the same
164.13 as the conditions specified in rules adopted under chapter 256B governing the medical
164.14 assistance program, unless otherwise provided by statute or rule.

164.15 ~~(k)~~ (l) Inpatient and outpatient payments shall be reduced by five percent, effective
164.16 July 1, 2003. This reduction is in addition to the five percent reduction effective July 1,
164.17 2003, and incorporated by reference in paragraph (i).

164.18 ~~(l)~~ (m) Payments for all other health services except inpatient, outpatient, and
164.19 pharmacy services shall be reduced by five percent, effective July 1, 2003.

164.20 ~~(m)~~ (n) Payments to managed care plans shall be reduced by five percent for services
164.21 provided on or after October 1, 2003.

164.22 ~~(n)~~ (o) A hospital receiving a reduced payment as a result of this section may apply
164.23 the unpaid balance toward satisfaction of the hospital's bad debts.

164.24 ~~(o)~~ (p) Fee-for-service payments for nonpreventive visits shall be reduced by \$3
164.25 for services provided on or after January 1, 2006. For purposes of this subdivision, a
164.26 visit means an episode of service which is required because of a recipient's symptoms,
164.27 diagnosis, or established illness, and which is delivered in an ambulatory setting by
164.28 a physician or physician ancillary, chiropractor, podiatrist, advance practice nurse,
164.29 audiologist, optician, or optometrist.

164.30 ~~(p)~~ (q) Payments to managed care plans shall not be increased as a result of the
164.31 removal of the \$3 nonpreventive visit co-payment effective January 1, 2006.

164.32 Sec. 23. Minnesota Statutes 2006, section 256L.01, subdivision 4, is amended to read:

164.33 Subd. 4. **Gross individual or gross family income.** (a) "Gross individual or gross
164.34 family income" for nonfarm self-employed means income calculated for the six-month
164.35 period of eligibility using the net profit or loss reported on the applicant's federal income

165.1 tax form for the previous year and using the medical assistance families with children
165.2 methodology for determining allowable and nonallowable self-employment expenses and
165.3 countable income.

165.4 (b) "Gross individual or gross family income" for farm self-employed means income
165.5 calculated for the six-month period of eligibility using as the baseline the adjusted gross
165.6 income reported on the applicant's federal income tax form for the previous year ~~and~~
165.7 ~~adding back in reported depreciation amounts that apply to the business in which the~~
165.8 ~~family is currently engaged.~~

165.9 (c) "Gross individual or gross family income" means the total income for all family
165.10 members, calculated for the six-month period of eligibility.

165.11 **EFFECTIVE DATE.** This section is effective July 1, 2007, or upon federal
165.12 approval, whichever is later.

165.13 Sec. 24. Minnesota Statutes 2006, section 256L.03, subdivision 5, is amended to read:

165.14 Subd. 5. **Co-payments and coinsurance.** (a) Except as provided in paragraphs (b)
165.15 and (c), the MinnesotaCare benefit plan shall include the following co-payments and
165.16 coinsurance requirements for all enrollees:

165.17 (1) ten percent of the paid charges for inpatient hospital services for adult enrollees,
165.18 subject to an annual inpatient out-of-pocket maximum of \$1,000 per individual and
165.19 \$3,000 per family;

165.20 (2) \$3 per prescription for adult enrollees;

165.21 (3) \$25 for eyeglasses for adult enrollees;

165.22 (4) \$3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an
165.23 episode of service which is required because of a recipient's symptoms, diagnosis, or
165.24 established illness, and which is delivered in an ambulatory setting by a physician or
165.25 physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse,
165.26 audiologist, optician, or optometrist; and

165.27 (5) \$6 for nonemergency visits to a hospital-based emergency room.

165.28 (b) Paragraph (a), clause (1), does not apply to parents and relative caretakers of
165.29 children under the age of 21 in households with family income equal to or less than 175
165.30 percent of the federal poverty guidelines. Paragraph (a), clause (1), does not apply to
165.31 parents and relative caretakers of children under the age of 21 in households with family
165.32 income greater than 175 percent of the federal poverty guidelines for inpatient hospital
165.33 admissions occurring on or after January 1, 2001.

165.34 (c) Paragraph (a), ~~clauses (1) to (4), do~~ does not apply to pregnant women and
165.35 children under the age of 21.

(d) Adult enrollees with family gross income that exceeds 175 percent of the federal poverty guidelines and who are not pregnant shall be financially responsible for the coinsurance amount, if applicable, and amounts which exceed the \$10,000 inpatient hospital benefit limit.

(e) When a MinnesotaCare enrollee becomes a member of a prepaid health plan, or changes from one prepaid health plan to another during a calendar year, any charges submitted towards the \$10,000 annual inpatient benefit limit, and any out-of-pocket expenses incurred by the enrollee for inpatient services, that were submitted or incurred prior to enrollment, or prior to the change in health plans, shall be disregarded.

Sec. 25. Minnesota Statutes 2006, section 256L.04, subdivision 1, is amended to read:

Subdivision 1. **Families with children.** (a) Families with children with family income equal to or less than 275 percent of the federal poverty guidelines for the applicable family size shall be eligible for MinnesotaCare according to this section. All other provisions of sections 256L.01 to 256L.18, including the insurance-related barriers to enrollment under section 256L.07, shall apply unless otherwise specified.

(b) Parents who enroll in the MinnesotaCare program must also enroll their children, if the children are eligible. Children may be enrolled separately without enrollment by parents. However, if one parent in the household enrolls, both parents must enroll, unless other insurance is available. If one child from a family is enrolled, all children must be enrolled, unless other insurance is available. If one spouse in a household enrolls, the other spouse in the household must also enroll, unless other insurance is available. Families cannot choose to enroll only certain uninsured members.

(c) Beginning October 1, 2003, the dependent sibling definition no longer applies to the MinnesotaCare program. These persons are no longer counted in the parental household and may apply as a separate household.

(d) Beginning July 1, 2003, or upon federal approval, whichever is later, parents are not eligible for MinnesotaCare if their gross income exceeds ~~\$50,000~~ \$25,000 for the six-month period of eligibility.

Sec. 26. Minnesota Statutes 2006, section 256L.04, subdivision 12, is amended to read:

Subd. 12. **Persons in detention.** Beginning January 1, 1999, an applicant residing in a correctional or detention facility is not eligible for MinnesotaCare. An enrollee residing in a correctional or detention facility is not eligible at renewal of eligibility under section 256L.05, subdivision ~~3b~~ 3a.

Sec. 27. Minnesota Statutes 2006, section 256L.11, subdivision 7, is amended to read:

Subd. 7. **Critical access dental providers.** Effective for dental services provided to MinnesotaCare enrollees ~~on or after~~ between January 1, 2007, and June 30, 2007, the commissioner shall increase payment rates to dentists and dental clinics deemed by the commissioner to be critical access providers under section 256B.76, paragraph (c), by 50 percent above the payment rate that would otherwise be paid to the provider. Effective for dental services provided to MinnesotaCare enrollees on or after July 1, 2007, the commissioner shall increase payment rates to dentists and dental clinics deemed by the commissioner to be critical access providers under section 256B.76, paragraph (c), by 33 percent above the payment rate that would otherwise be paid to the provider. The commissioner shall ~~adjust the rates paid on or after January 1, 2007, to pay the prepaid~~ health plans under contract with the commissioner amounts sufficient to reflect this rate increase. The prepaid health plan must pass this rate increase to providers who have been identified by the commissioner as critical access dental providers under section 256B.76, paragraph (c).

Sec. 28. **HENNEPIN COUNTY PILOT PROJECT.**

The commissioner of human services shall support a pilot project in Hennepin County to demonstrate the effectiveness of alternative strategies to redetermine eligibility for certain recipient populations in the medical assistance program. The target populations for the demonstration are persons who are eligible based upon disability or age, who have chronic medical conditions, and who are expected to experience minimal change in income or assets from month to month. The commissioner and the county shall analyze the issues and strategies employed and the outcomes to determine reasonable efforts to streamline eligibility statewide. The duration of the pilot project shall be no more than two years. The commissioner shall apply for any federal waivers needed to implement this section.

Sec. 29. **COUNTY-BASED PURCHASING STUDY.**

The commissioner of health shall study county-based purchasing initiatives established under Minnesota Statutes, section 256B.692, and compare these initiatives to managed care plans serving medical assistance, general assistance medical care, and MinnesotaCare enrollees. The study must:

(1) provide a history and description of county-based purchasing initiatives, including state and federal requirements and any federal waivers Minnesota counties have applied for or received;

168.1 (2) provide a history and description of managed care plan participation in the
168.2 prepaid medical assistance, prepaid general assistance medical care, and prepaid
168.3 Minnesota programs, and the provision by managed care plans of third-party administrator
168.4 services for county-based purchasing initiatives;
168.5 (3) provide relevant data, including limitations on data, data that was requested but
168.6 not received, and explanations for why requested data was not received;
168.7 (4) provide recommendations for further data collection and research;
168.8 (5) summarize successes and challenges of the two service delivery methods;
168.9 (6) provide recommendations for possible expansion of county-based purchasing
168.10 in rural and urban settings; and
168.11 (7) identify and describe features of county-based purchasing and managed care
168.12 plans serving medical assistance, general assistance medical care, and MinnesotaCare
168.13 enrollees, to provide a comparison of cost, quality, access, and community health
168.14 improvement that includes, but is not limited to:
168.15 (i) descriptions of how health care and social services are integrated and coordinated
168.16 for persons with complex care needs, including persons with high-risk pregnancies,
168.17 adolescents, persons who are disabled, persons who are elderly, and persons with chronic
168.18 health care and social needs;
168.19 (ii) use of monetary grants and surpluses to:
168.20 (A) increase provider reimbursement, including dental care reimbursement, in order
168.21 to improve health care access; and
168.22 (B) improve community health beyond the requirements of the public health care
168.23 programs, such as the funding of public education, research, and community initiatives to
168.24 enhance utilization of preventive services, social services, or mental health care;
168.25 (iii) administrative costs, including billing and collection of unpaid fees, co-pays or
168.26 other charges, and top five management salaries;
168.27 (iv) reporting requirements of contracts with the Department of Human Services;
168.28 (v) public access to all information about management and administration, including
168.29 but not limited to provider contracts and reimbursement, models of care management and
168.30 coordination, utilization review, contracts with consultants and other vendors, handling of
168.31 monetary grants and surpluses, and health outcomes data;
168.32 (vi) provider reimbursement by clinical practice area;
168.33 (vii) populations served, described by age, disability, income, race, language,
168.34 occupation, and other demographic characteristics;
168.35 (viii) utilization of community-based prevention interventions, including but not
168.36 limited to public health nursing visits to new parents, use of nurse-managed interventions

169.1 to reduce cardiac hospitalizations, and the use of medical homes for chronic disease
169.2 management;
169.3 (ix) utilization of cancer screening;
169.4 (x) utilization of interpreter services;
169.5 (xi) immunization rates for children age five and under;
169.6 (xii) hospitalization rates for conditions related to diabetes, asthma, or cardiac
169.7 illnesses;
169.8 (xiii) rates of rehospitalization within a month of hospital discharge;
169.9 (xiv) coordination with county agencies to increase enrollment;
169.10 (xv) number of new program enrollees and the rate of enrollment, including the
169.11 percentage of eligible persons who become enrollees;
169.12 (xvi) enrollee satisfaction with their care; and
169.13 (xvii) number of enrollees who do not receive care.
169.14 Managed care plans, county-based purchasing initiatives, health care providers,
169.15 counties, and the commissioner of human services shall, upon request, provide data to
169.16 the commissioner of health that is necessary to complete the study. The commissioner of
169.17 health shall submit the study to the legislature by December 31, 2007.

169.18 Sec. 30. **GRANT FOR TOLL-FREE HEALTH CARE ACCESS NUMBER.**

169.19 The commissioner of human services shall award a grant to the Neighborhood
169.20 Health Care Network to pay the costs of maintaining and staffing a toll-free telephone
169.21 number to provide callers with information on health coverage options, eligibility for
169.22 MinnesotaCare and other health care programs, and health care providers that offer free or
169.23 reduced-cost health care services.

169.24 Sec. 31. **IMPLEMENTATION OF PHARMACY DISPENSING FEE INCREASE.**

169.25 The commissioner, after consulting with the Pharmacy Payment Reform Advisory
169.26 Committee established under Laws 2006, chapter 282, article 16, section 15, may
169.27 proportionally increase or decrease the dispensing fee for multiple-source generic drugs
169.28 under Minnesota Statutes, section 256B.0625, subdivision 13e, paragraph (a), to reflect
169.29 the actual amount of reductions in program cost for ingredient reimbursement savings
169.30 obtained.

169.31 **EFFECTIVE DATE.** This section is effective upon implementation of changes to
169.32 the federal upper reimbursement limit under title VI, chapter IV of the federal Deficit
169.33 Reduction Act of 2005, United States Code, title 42, section 1396r-8(e)(5).

Sec. 32. **REPEALER.**

Minnesota Statutes 2006, section 256.969, subdivision 27, is repealed effective July 1, 2007.

ARTICLE 4
CONTINUING CARE

Section 1. Minnesota Statutes 2006, section 144A.071, subdivision 4c, is amended to read:

Subd. 4c. **Exceptions for replacement beds after June 30, 2003.** (a) The commissioner of health, in coordination with the commissioner of human services, may approve the renovation, replacement, upgrading, or relocation of a nursing home or boarding care home, under the following conditions:

(1) to license and certify an 80-bed city-owned facility in Nicollet County to be constructed on the site of a new city-owned hospital to replace an existing 85-bed facility attached to a hospital that is also being replaced. The threshold allowed for this project under section 144A.073 shall be the maximum amount available to pay the additional medical assistance costs of the new facility;

(2) to license and certify 29 beds to be added to an existing 69-bed facility in St. Louis County, provided that the 29 beds must be transferred from active or layaway status at an existing facility in St. Louis County that had 235 beds on April 1, 2003.

The licensed capacity at the 235-bed facility must be reduced to 206 beds, but the payment rate at that facility shall not be adjusted as a result of this transfer. The operating payment rate of the facility adding beds after completion of this project shall be the same as it was on the day prior to the day the beds are licensed and certified. This project shall not proceed unless it is approved and financed under the provisions of section 144A.073;

(3) to license and certify a new 60-bed facility in Austin, provided that: (i) 45 of the new beds are transferred from a 45-bed facility in Austin under common ownership that is closed and 15 of the new beds are transferred from a 182-bed facility in Albert Lea under common ownership; (ii) the commissioner of human services is authorized by the 2004 legislature to negotiate budget-neutral planned nursing facility closures; and (iii) money is available from planned closures of facilities under common ownership to make implementation of this clause budget-neutral to the state. The bed capacity of the Albert Lea facility shall be reduced to 167 beds following the transfer. Of the 60 beds at the new facility, 20 beds shall be used for a special care unit for persons with Alzheimer's disease or related dementias; ~~and~~

171.1 (4) to license and certify up to 80 beds transferred from an existing state-owned
171.2 nursing facility in Cass County to a new facility located on the grounds of the
171.3 Ah-Gwah-Ching campus. The operating cost payment rates for the new facility shall be
171.4 determined based on the interim and settle-up payment provisions of Minnesota Rules,
171.5 part 9549.0057, and the reimbursement provisions of section 256B.431. The property
171.6 payment rate for the first three years of operation shall be \$35 per day. For subsequent
171.7 years, the property payment rate of \$35 per day shall be adjusted for inflation as provided
171.8 in section 256B.434, subdivision 4, paragraph (c), as long as the facility has a contract
171.9 under section 256B.434; and

171.10 (5) to license and certify 180 beds transferred from an existing facility in
171.11 Minneapolis to a new facility in Robbinsdale; provided that the beds are transferred from a
171.12 219-bed facility under common ownership that shall be closed following the transfer. The
171.13 operating payment rate of the new facility after completion of this project shall be adjusted
171.14 upward by \$35 per day and the property payment rate shall be \$34.049 per day.

171.15 (b) Projects approved under this subdivision shall be treated in a manner equivalent
171.16 to projects approved under subdivision 4a.

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

171.18 Sec. 2. Minnesota Statutes 2006, section 252.27, subdivision 2a, is amended to read:

171.19 Subd. 2a. **Contribution amount.** (a) The natural or adoptive parents of a minor
171.20 child, including a child determined eligible for medical assistance without consideration of
171.21 parental income, must contribute to the cost of services used by making monthly payments
171.22 on a sliding scale based on income, unless the child is married or has been married,
171.23 parental rights have been terminated, or the child's adoption is subsidized according to
171.24 section 259.67 or through title IV-E of the Social Security Act. The parental contribution
171.25 is a partial or full payment for medical services provided for diagnostic, therapeutic,
171.26 curing, treating, mitigating, rehabilitation, and maintenance and personal care services as
171.27 defined in United States Code, title 26, section 213, needed by the child with a chronic
171.28 illness or disability.

171.29 (b) For households with adjusted gross income equal to or greater than 100 percent
171.30 of federal poverty guidelines, the parental contribution shall be computed by applying the
171.31 following schedule of rates to the adjusted gross income of the natural or adoptive parents:

171.32 (1) if the adjusted gross income is equal to or greater than 100 percent of federal
171.33 poverty guidelines and less than 175 percent of federal poverty guidelines, the parental
171.34 contribution is \$4 per month;

(2) if the adjusted gross income is equal to or greater than 175 percent of federal poverty guidelines and less than or equal to 545 percent of federal poverty guidelines, the parental contribution shall be determined using a sliding fee scale established by the commissioner of human services which begins at one percent of adjusted gross income at 175 percent of federal poverty guidelines and increases to 7.5 percent of adjusted gross income for those with adjusted gross income up to 545 percent of federal poverty guidelines;

(3) if the adjusted gross income is greater than 545 percent of federal poverty guidelines and less than 675 percent of federal poverty guidelines, the parental contribution shall be 7.5 percent of adjusted gross income;

(4) if the adjusted gross income is equal to or greater than 675 percent of federal poverty guidelines and less than 975 percent of federal poverty guidelines, the parental contribution shall be determined using a sliding fee scale established by the commissioner of human services which begins at 7.5 percent of adjusted gross income at 675 percent of federal poverty guidelines and increases to ten percent of adjusted gross income for those with adjusted gross income up to 975 percent of federal poverty guidelines; and

(5) if the adjusted gross income is equal to or greater than 975 percent of federal poverty guidelines, the parental contribution shall be 12.5 percent of adjusted gross income.

If the child lives with the parent, the annual ~~adjusted gross income~~ parental contribution is reduced by ~~\$2,400 prior to calculating the parental contribution~~ \$100 per month. If the child resides in an institution specified in section 256B.35, the parent is responsible for the personal needs allowance specified under that section in addition to the parental contribution determined under this section. The parental contribution is reduced by any amount required to be paid directly to the child pursuant to a court order, but only if actually paid.

(c) The household size to be used in determining the amount of contribution under paragraph (b) includes natural and adoptive parents and their dependents, including the child receiving services. Adjustments in the contribution amount due to annual changes in the federal poverty guidelines shall be implemented on the first day of July following publication of the changes.

(d) For purposes of paragraph (b), "income" means the adjusted gross income of the natural or adoptive parents determined according to the previous year's federal tax form, except, effective retroactive to July 1, 2003, taxable capital gains to the extent the funds have been used to purchase a home shall not be counted as income.

173.1 (e) The contribution shall be explained in writing to the parents at the time eligibility
173.2 for services is being determined. The contribution shall be made on a monthly basis
173.3 effective with the first month in which the child receives services. Annually upon
173.4 redetermination or at termination of eligibility, if the contribution exceeded the cost of
173.5 services provided, the local agency or the state shall reimburse that excess amount to
173.6 the parents, either by direct reimbursement if the parent is no longer required to pay
173.7 a contribution, or by a reduction in or waiver of parental fees until the excess amount
173.8 is exhausted.

173.9 (f) The monthly contribution amount must be reviewed at least every 12 months;
173.10 when there is a change in household size; and when there is a loss of or gain in income
173.11 from one month to another in excess of ten percent. The local agency shall mail a written
173.12 notice 30 days in advance of the effective date of a change in the contribution amount.
173.13 A decrease in the contribution amount is effective in the month that the parent verifies a
173.14 reduction in income or change in household size.

173.15 (g) Parents of a minor child who do not live with each other shall each pay the
173.16 contribution required under paragraph (a). An amount equal to the annual court-ordered
173.17 child support payment actually paid on behalf of the child receiving services shall be
173.18 deducted from the adjusted gross income of the parent making the payment prior to
173.19 calculating the parental contribution under paragraph (b).

173.20 (h) The contribution under paragraph (b) shall be increased by an additional five
173.21 percent if the local agency determines that insurance coverage is available but not
173.22 obtained for the child. For purposes of this section, "available" means the insurance is a
173.23 benefit of employment for a family member at an annual cost of no more than five percent
173.24 of the family's annual income. For purposes of this section, "insurance" means health
173.25 and accident insurance coverage, enrollment in a nonprofit health service plan, health
173.26 maintenance organization, self-insured plan, or preferred provider organization.

173.27 Parents who have more than one child receiving services shall not be required
173.28 to pay more than the amount for the child with the highest expenditures. There shall
173.29 be no resource contribution from the parents. The parent shall not be required to pay
173.30 a contribution in excess of the cost of the services provided to the child, not counting
173.31 payments made to school districts for education-related services. Notice of an increase in
173.32 fee payment must be given at least 30 days before the increased fee is due.

173.33 (i) The contribution under paragraph (b) shall be reduced by \$300 per fiscal year if,
173.34 in the 12 months prior to July 1:

173.35 (1) the parent applied for insurance for the child;

173.36 (2) the insurer denied insurance;

(3) the parents submitted a complaint or appeal, in writing to the insurer, submitted a complaint or appeal, in writing, to the commissioner of health or the commissioner of commerce, or litigated the complaint or appeal; and

(4) as a result of the dispute, the insurer reversed its decision and granted insurance.

For purposes of this section, "insurance" has the meaning given in paragraph (h).

A parent who has requested a reduction in the contribution amount under this paragraph shall submit proof in the form and manner prescribed by the commissioner or county agency, including, but not limited to, the insurer's denial of insurance, the written letter or complaint of the parents, court documents, and the written response of the insurer approving insurance. The determinations of the commissioner or county agency under this paragraph are not rules subject to chapter 14.

Sec. 3. Minnesota Statutes 2006, section 252.32, subdivision 3, is amended to read:

Subd. 3. **Amount of support grant; use.** Support grant amounts shall be determined by the county social service agency. Services and items purchased with a support grant must:

(1) be over and above the normal costs of caring for the dependent if the dependent did not have a disability;

(2) be directly attributable to the dependent's disabling condition; and

(3) enable the family to delay or prevent the out-of-home placement of the dependent.

The design and delivery of services and items purchased under this section must ~~suit the dependent's chronological age and~~ be provided in the least restrictive environment possible, consistent with the needs identified in the individual service plan.

Items and services purchased with support grants must be those for which there are no other public or private funds available to the family. Fees assessed to parents for health or human services that are funded by federal, state, or county dollars are not reimbursable through this program.

In approving or denying applications, the county shall consider the following factors:

(1) the extent and areas of the functional limitations of the disabled child;

(2) the degree of need in the home environment for additional support; and

(3) the potential effectiveness of the grant to maintain and support the person in the family environment.

The maximum monthly grant amount shall be \$250 per eligible dependent, or \$3,000 per eligible dependent per state fiscal year, within the limits of available funds and as adjusted by any legislatively authorized cost of living adjustment. The county social

175.1 service agency may consider the dependent's supplemental security income in determining
175.2 the amount of the support grant.

175.3 Any adjustments to their monthly grant amount must be based on the needs of the
175.4 family and funding availability.

175.5 Sec. 4. Minnesota Statutes 2006, section 252.46, is amended by adding a subdivision
175.6 to read:

175.7 Subd. 22. **Provider rate increase; St. Louis County.** A day training and
175.8 habilitation provider in St. Louis County licensed to provide services to up to 80
175.9 individuals shall receive a per diem rate increase that does not exceed 95 percent of the
175.10 greater of 125 percent of the current statewide median or 125 percent of the regional
175.11 average per diem rate, whichever is higher.

175.12 Sec. 5. Minnesota Statutes 2006, section 256.01, is amended by adding a subdivision
175.13 to read:

175.14 Subd. 24. **Disability linkage line.** The commissioner shall establish the disability
175.15 linkage line, a statewide consumer information, referral, and assistance system for people
175.16 with disabilities and chronic illnesses that:

175.17 (1) provides information about state and federal eligibility requirements, benefits,
175.18 and service options;

175.19 (2) makes referrals to appropriate support entities;

175.20 (3) delivers information and assistance based on national and state standards;

175.21 (4) assists people to make well-informed decisions; and

175.22 (5) supports the timely resolution of service access and benefit issues.

175.23 Sec. 6. Minnesota Statutes 2006, section 256.476, subdivision 1, is amended to read:

175.24 Subdivision 1. **Purpose and goals.** The commissioner of human services shall
175.25 establish a consumer support grant program for individuals with functional limitations and
175.26 their families who wish to purchase and secure their own supports. ~~The commissioner and~~
175.27 ~~local agencies shall jointly develop an implementation plan which must include a way to~~
175.28 ~~resolve the issues related to county liability.~~ The program shall:

175.29 (1) make support grants available to individuals or families as an effective alternative
175.30 to the ~~developmental disability~~ family support program, personal care attendant services,
175.31 home health aide services, and private duty nursing services;

175.32 (2) provide consumers more control, flexibility, and responsibility over their services
175.33 and supports;

- 176.1 (3) promote local program management and decision making; and
176.2 (4) encourage the use of informal and typical community supports.

176.3 Sec. 7. Minnesota Statutes 2006, section 256.476, subdivision 2, is amended to read:

176.4 Subd. 2. **Definitions.** For purposes of this section, the following terms have the
176.5 meanings given them:

176.6 (a) "County board" means the county board of commissioners for the county of
176.7 financial responsibility as defined in section 256G.02, subdivision 4, or its designated
176.8 representative. When a human services board has been established under sections 402.01
176.9 to 402.10, it shall be considered the county board for the purposes of this section.

176.10 (b) "Family" means the person's birth parents, adoptive parents or stepparents,
176.11 siblings or stepsiblings, children or stepchildren, grandparents, grandchildren, niece,
176.12 nephew, aunt, uncle, or spouse. For the purposes of this section, a family member is
176.13 at least 18 years of age.

176.14 (c) "Functional limitations" means the long-term inability to perform an activity or
176.15 task in one or more areas of major life activity, including self-care, understanding and use
176.16 of language, learning, mobility, self-direction, and capacity for independent living. For the
176.17 purpose of this section, the inability to perform an activity or task results from a mental,
176.18 emotional, psychological, sensory, or physical disability, condition, or illness.

176.19 (d) "Informed choice" means a voluntary decision made by the person or
176.20 the person's legal representative, or other authorized representative after becoming
176.21 familiarized with the alternatives to:

- 176.22 (1) select a preferred alternative from a number of feasible alternatives;
176.23 (2) select an alternative which may be developed in the future; and
176.24 (3) refuse any or all alternatives.

176.25 (e) "Local agency" means the local agency authorized by the county board or,
176.26 for counties not participating in the consumer grant program by July 1, 2002, the
176.27 commissioner, to carry out the provisions of this section.

176.28 (f) "Person" or "persons" means a person or persons meeting the eligibility criteria in
176.29 subdivision 3.

176.30 (g) "Authorized representative" means an individual designated by the person or
176.31 their legal representative to act on their behalf. This individual may be a family member,
176.32 guardian, representative payee, or other individual designated by the person or their legal
176.33 representative, if any, to assist in purchasing and arranging for supports. For the purposes
176.34 of this section, an authorized representative is at least 18 years of age.

177.1 (h) "Screening" means the screening of a person's service needs under sections
177.2 256B.0911 and 256B.092.

177.3 (i) "Supports" means services, care, aids, environmental modifications, or assistance
177.4 purchased by the person ~~or the person's family~~, the person's legal representative, or other
177.5 authorized representative. Examples of supports include respite care, assistance with daily
177.6 living, and assistive technology. For the purpose of this section, notwithstanding the
177.7 provisions of section 144A.43, supports purchased under the consumer support program
177.8 are not considered home care services.

177.9 (j) "Program of origination" means the program the individual transferred from
177.10 when approved for the consumer support grant program.

177.11 Sec. 8. Minnesota Statutes 2006, section 256.476, subdivision 3, is amended to read:

177.12 Subd. 3. **Eligibility to apply for grants.** (a) A person is eligible to apply for a
177.13 consumer support grant if the person meets all of the following criteria:

177.14 (1) the person is eligible for and has been approved to receive services under
177.15 medical assistance as determined under sections 256B.055 and 256B.056 or the person
177.16 has been approved to receive a grant under the ~~developmental disability~~ family support
177.17 program under section 252.32;

177.18 (2) the person is able to direct and purchase the person's own care and supports, or
177.19 the person has a family member, legal representative, or other authorized representative
177.20 who can purchase and arrange supports on the person's behalf;

177.21 (3) the person has functional limitations, requires ongoing supports to live in the
177.22 community, and is at risk of or would continue institutionalization without such supports;
177.23 and

177.24 (4) the person will live in a home. For the purpose of this section, "home" means the
177.25 person's own home or home of a person's family member. These homes are natural home
177.26 settings and are not licensed by the Department of Health or Human Services.

177.27 (b) Persons may not concurrently receive a consumer support grant if they are:

177.28 (1) receiving personal care attendant and home health aide services, or private duty
177.29 nursing under section 256B.0625; a ~~developmental disability~~ family support grant; or
177.30 alternative care services under section 256B.0913; or

177.31 (2) residing in an institutional or congregate care setting.

177.32 (c) A person or person's family receiving a consumer support grant shall not be
177.33 charged a fee or premium by a local agency for participating in the program.

177.34 (d) Individuals receiving home and community-based waivers under United States
177.35 Code, title 42, section 1396h(c), are not eligible for the consumer support grant, except

178.1 for individuals receiving consumer support grants before July 1, 2003, as long as other
178.2 eligibility criteria are met.

178.3 (e) The commissioner shall establish a budgeted appropriation each fiscal year
178.4 for the consumer support grant program. The number of individuals participating in
178.5 the program will be adjusted so the total amount allocated to counties does not exceed
178.6 the amount of the budgeted appropriation. The budgeted appropriation will be adjusted
178.7 annually to accommodate changes in demand for the consumer support grants.

178.8 Sec. 9. Minnesota Statutes 2006, section 256.476, subdivision 4, is amended to read:

178.9 Subd. 4. **Support grants; criteria and limitations.** (a) A county board may
178.10 choose to participate in the consumer support grant program. If a county has not chosen
178.11 to participate by July 1, 2002, the commissioner shall contract with another county or
178.12 other entity to provide access to residents of the nonparticipating county who choose
178.13 the consumer support grant option. The commissioner shall notify the county board
178.14 in a county that has declined to participate of the commissioner's intent to enter into
178.15 a contract with another county or other entity at least 30 days in advance of entering
178.16 into the contract. The local agency shall establish written procedures and criteria to
178.17 determine the amount and use of support grants. These procedures must include, at least,
178.18 the availability of respite care, assistance with daily living, and adaptive aids. The local
178.19 agency may establish monthly or annual maximum amounts for grants and procedures
178.20 where exceptional resources may be required to meet the health and safety needs of the
178.21 person on a time-limited basis, however, the total amount awarded to each individual may
178.22 not exceed the limits established in subdivision 11.

178.23 (b) Support grants to a person ~~or a person's family~~, a person's legal representative,
178.24 or other authorized representative will be provided through a monthly subsidy payment
178.25 and be in the form of cash, voucher, or direct county payment to vendor. Support grant
178.26 amounts must be determined by the local agency. Each service and item purchased with a
178.27 support grant must meet all of the following criteria:

178.28 (1) it must be over and above the normal cost of caring for the person if the person
178.29 did not have functional limitations;

178.30 (2) it must be directly attributable to the person's functional limitations;

178.31 (3) it must enable the person ~~or the person's family~~, a person's legal representative,
178.32 or other authorized representative to delay or prevent out-of-home placement of the
178.33 person; and

178.34 (4) it must be consistent with the needs identified in the service agreement, when
178.35 applicable.

(c) Items and services purchased with support grants must be those for which there are no other public or private funds available to the person ~~or the person's family~~, a person's legal representative, or other authorized representative. Fees assessed to the person or the person's family for health and human services are not reimbursable through the grant.

(d) In approving or denying applications, the local agency shall consider the following factors:

(1) the extent and areas of the person's functional limitations;

(2) the degree of need in the home environment for additional support; and

(3) the potential effectiveness of the grant to maintain and support the person in the family environment or the person's own home.

(e) At the time of application to the program or screening for other services, the person ~~or the person's family~~, a person's legal representative, or other authorized representative shall be provided sufficient information to ensure an informed choice of alternatives by the person, the person's legal representative, or other authorized representative, if any, ~~or the person's family~~. The application shall be made to the local agency and shall specify the needs of the person and family, the form and amount of grant requested, the items and services to be reimbursed, and evidence of eligibility for medical assistance.

(f) Upon approval of an application by the local agency and agreement on a support plan for the person or person's family, the local agency shall make grants to the person or the person's family. The grant shall be in an amount for the direct costs of the services or supports outlined in the service agreement.

(g) Reimbursable costs shall not include costs for resources already available, such as special education classes, day training and habilitation, case management, other services to which the person is entitled, medical costs covered by insurance or other health programs, or other resources usually available at no cost to the person or the person's family.

(h) The state of Minnesota, the county boards participating in the consumer support grant program, or the agencies acting on behalf of the county boards in the implementation and administration of the consumer support grant program shall not be liable for damages, injuries, or liabilities sustained through the purchase of support by the individual, the individual's family, or the authorized representative under this section with funds received through the consumer support grant program. Liabilities include but are not limited to: workers' compensation liability, the Federal Insurance Contributions Act (FICA), or the Federal Unemployment Tax Act (FUTA). For purposes of this section, participating county boards and agencies acting on behalf of county boards are exempt from the provisions of section 268.04.

Sec. 10. Minnesota Statutes 2006, section 256.476, subdivision 5, is amended to read:

Subd. 5. **Reimbursement, allocations, and reporting.** (a) For the purpose of transferring persons to the consumer support grant program from the ~~developmental disability~~ family support program and personal care assistant services, home health aide services, or private duty nursing services, the amount of funds transferred by the commissioner between the ~~developmental disability~~ family support program account, the medical assistance account, or the consumer support grant account shall be based on each county's participation in transferring persons to the consumer support grant program from those programs and services.

(b) At the beginning of each fiscal year, county allocations for consumer support grants shall be based on:

(1) the number of persons to whom the county board expects to provide consumer supports grants;

(2) their eligibility for current program and services;

(3) the amount of nonfederal dollars allowed under subdivision 11; and

(4) projected dates when persons will start receiving grants. County allocations shall be adjusted periodically by the commissioner based on the actual transfer of persons or service openings, and the nonfederal dollars associated with those persons or service openings, to the consumer support grant program.

(c) The amount of funds transferred by the commissioner from the medical assistance account for an individual may be changed if it is determined by the county or its agent that the individual's need for support has changed.

(d) The authority to utilize funds transferred to the consumer support grant account for the purposes of implementing and administering the consumer support grant program will not be limited or constrained by the spending authority provided to the program of origination.

(e) The commissioner may use up to five percent of each county's allocation, as adjusted, for payments for administrative expenses, to be paid as a proportionate addition to reported direct service expenditures.

(f) The county allocation for each individual or individual's family cannot exceed the amount allowed under subdivision 11.

(g) The commissioner may recover, suspend, or withhold payments if the county board, local agency, or grantee does not comply with the requirements of this section.

(h) Grant funds unexpended by consumers shall return to the state once a year. The annual return of unexpended grant funds shall occur in the quarter following the end of the state fiscal year.

181.1 Sec. 11. Minnesota Statutes 2006, section 256.476, subdivision 10, is amended to read:

181.2 Subd. 10. **Consumer responsibilities.** Persons receiving grants under this section
181.3 shall:

181.4 (1) spend the grant money in a manner consistent with their agreement with the
181.5 local agency;

181.6 (2) notify the local agency of any necessary changes in the grant or the items on
181.7 which it is spent;

181.8 (3) notify the local agency of any decision made by the person, ~~the~~ a person's legal
181.9 representative, ~~or the person's family~~ or other authorized representative that would change
181.10 their eligibility for consumer support grants;

181.11 (4) arrange and pay for supports; and

181.12 (5) inform the local agency of areas where they have experienced difficulty securing
181.13 or maintaining supports.

181.14 Sec. 12. Minnesota Statutes 2006, section 256.974, is amended to read:

181.15 **256.974 OFFICE OF OMBUDSMAN FOR ~~OLDER MINNESOTANS~~**
181.16 **LONG-TERM CARE; LOCAL PROGRAMS.**

181.17 The ombudsman for ~~older Minnesotans~~ long-term care serves in the classified service
181.18 under section 256.01, subdivision 7, in an office within the Minnesota Board on Aging that
181.19 incorporates the long-term care ombudsman program required by the Older Americans
181.20 Act, ~~Public Law 100-75~~ as amended, United States Code, title 42, section 3027(a)(12)
181.21 (9) and 3058g (a), and established within the Minnesota Board on Aging. The Minnesota
181.22 Board on Aging may make grants to and designate local programs for the provision of
181.23 ombudsman services to clients in county or multicounty areas. The local program may not
181.24 be an agency engaged in the provision of nursing home care, hospital care, or home care
181.25 services either directly or by contract, or have the responsibility for planning, coordinating,
181.26 funding, or administering nursing home care, hospital care, or home care services.

181.27 Sec. 13. Minnesota Statutes 2006, section 256.9741, subdivision 1, is amended to read:

181.28 Subdivision 1. **Long-term care facility.** "Long-term care facility" means a nursing
181.29 home licensed under sections 144A.02 to 144A.10 ~~or~~ a boarding care home licensed
181.30 under sections 144.50 to 144.56; or a licensed or registered residential setting which
181.31 provides or arranges for the provision of home care services.

181.32 Sec. 14. Minnesota Statutes 2006, section 256.9741, subdivision 3, is amended to read:

182.1 Subd. 3. **Client.** "Client" means an individual who requests, or on whose behalf a
182.2 request is made for, ombudsman services and is (a) a resident of a long-term care facility
182.3 or (b) a Medicare beneficiary who requests assistance relating to access, discharge, or
182.4 denial of inpatient or outpatient services, or (c) an individual reserving, receiving, or
182.5 requesting a home care service.

182.6 Sec. 15. Minnesota Statutes 2006, section 256.9742, subdivision 3, is amended to read:

182.7 Subd. 3. **Posting.** Every long-term care facility and acute care facility shall post in a
182.8 conspicuous place the address and telephone number of the office. A home care service
182.9 provider shall provide all recipients, including those in ~~elderly~~ housing with services
182.10 under chapter 144D, with the address and telephone number of the office. Counties shall
182.11 provide clients receiving ~~a consumer support grant or a service allowance~~ long-term care
182.12 consultation services under section 256B.0911 or home and community-based services
182.13 through a state or federally funded program with the name, address, and telephone number
182.14 of the office. The posting or notice is subject to approval by the ombudsman.

182.15 Sec. 16. Minnesota Statutes 2006, section 256.9742, subdivision 4, is amended to read:

182.16 Subd. 4. **Access to long-term care and acute care facilities and clients.** The
182.17 ombudsman or designee may:

182.18 (1) enter any long-term care facility without notice at any time;

182.19 (2) enter any acute care facility without notice during normal business hours;

182.20 (3) enter any acute care facility without notice at any time to interview a patient or
182.21 observe services being provided to the patient as part of an investigation of a matter that is
182.22 within the scope of the ombudsman's authority, but only if the ombudsman's or designee's
182.23 presence does not intrude upon the privacy of another patient or interfere with routine
182.24 hospital services provided to any patient in the facility;

182.25 (4) communicate privately and without restriction with any client ~~in accordance~~
182.26 ~~with section 144.651~~, as long as the ombudsman has the client's consent for such
182.27 communication;

182.28 (5) inspect records of a long-term care facility, home care service provider, or acute
182.29 care facility that pertain to the care of the client according to ~~sections~~ section 144.335 ~~and~~
182.30 ~~144.651~~; and

182.31 (6) with the consent of a client or client's legal guardian, the ombudsman or
182.32 designated staff shall have access to review records pertaining to the care of the client
182.33 according to ~~sections~~ section 144.335 ~~and 144.651~~. If a client cannot consent and has no
182.34 legal guardian, access to the records is authorized by this section.

183.1 A person who denies access to the ombudsman or designee in violation of this
183.2 subdivision or aids, abets, invites, compels, or coerces another to do so is guilty of a
183.3 misdemeanor.

183.4 Sec. 17. Minnesota Statutes 2006, section 256.9742, subdivision 6, is amended to read:

183.5 Subd. 6. **Prohibition against discrimination or retaliation.** (a) No entity shall take
183.6 discriminatory, disciplinary, or retaliatory action against an employee or volunteer, or a
183.7 patient, resident, or guardian or family member of a patient, resident, or guardian for filing
183.8 in good faith a complaint with or providing information to the ombudsman or designee
183.9 including volunteers. A person who violates this subdivision or who aids, abets, invites,
183.10 compels, or coerces another to do so is guilty of a misdemeanor.

183.11 (b) There shall be a rebuttable presumption that any adverse action, as defined below,
183.12 within 90 days of report, is discriminatory, disciplinary, or retaliatory. For the purpose
183.13 of this clause, the term "adverse action" refers to action taken by the entity involved in a
183.14 report against the person making the report or the person with respect to whom the report
183.15 was made because of the report, and includes, but is not limited to:

- 183.16 (1) discharge or transfer from a facility;
183.17 (2) termination of service;
183.18 (3) restriction or prohibition of access to the facility or its residents;
183.19 (4) discharge from or termination of employment;
183.20 (5) demotion or reduction in remuneration for services; and
183.21 (6) any restriction of rights set forth in section 144.651 or 144A.44, or 144A.751.

183.22 Sec. 18. Minnesota Statutes 2006, section 256.9744, subdivision 1, is amended to read:

183.23 Subdivision 1. **Classification.** Except as provided in this section, data maintained
183.24 by the office under sections 256.974 to 256.9744 are private data on individuals or
183.25 nonpublic data as defined in section 13.02, subdivision 9 or 12, and must be maintained
183.26 in accordance with the requirements of ~~Public Law 100-75~~ the Older Americans Act, as
183.27 amended, United States Code, title 42, section ~~3027(a)(12)(D)~~ 3058g(d).

183.28 Sec. 19. Minnesota Statutes 2006, section 256.975, subdivision 7, is amended to read:

183.29 Subd. 7. **Consumer information and assistance; senior linkage.** (a) The
183.30 Minnesota Board on Aging shall operate a statewide information and assistance service
183.31 to aid older Minnesotans and their families in making informed choices about long-term
183.32 care options and health care benefits. Language services to persons with limited English
183.33 language skills may be made available. The service, known as Senior LinkAge Line, must

184.1 be available during business hours through a statewide toll-free number and must also
184.2 be available through the Internet.

184.3 (b) The service must assist older adults, caregivers, and providers in accessing
184.4 information about choices in long-term care services that are purchased through private
184.5 providers or available through public options. The service must:

184.6 (1) develop a comprehensive database that includes detailed listings in both
184.7 consumer- and provider-oriented formats;

184.8 (2) make the database accessible on the Internet and through other telecommunication
184.9 and media-related tools;

184.10 (3) link callers to interactive long-term care screening tools and make these tools
184.11 available through the Internet by integrating the tools with the database;

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

184.14 (5) conduct an outreach campaign to assist older adults and their caregivers in
184.15 finding information on the Internet and through other means of communication;

184.16 (6) implement a messaging system for overflow callers and respond to these callers
184.17 by the next business day;

184.18 (7) link callers with county human services and other providers to receive more
184.19 in-depth assistance and consultation related to long-term care options; ~~and~~

184.20 (8) link callers with quality profiles for nursing facilities and other providers
184.21 developed by the commissioner of health; and

184.22 (9) incorporate information about housing with services and consumer rights
184.23 within the MinnesotaHelp.info network long-term care database to facilitate consumer
184.24 comparison of services and costs among housing with services establishments and with
184.25 other in-home services and to support financial self-sufficiency as long as possible.
184.26 Housing with services establishments and their arranged home care providers shall provide
184.27 information to the commissioner of human services that is consistent with information
184.28 required by the commissioner of health under section 144G.06, the Uniform Consumer
184.29 Information Guide. The commissioner of human services shall provide the data to the
184.30 Minnesota Board on Aging for inclusion in the MinnesotaHelp.info network long-term
184.31 care database.

184.32 (c) The Minnesota Board on Aging shall conduct an evaluation of the effectiveness
184.33 of the statewide information and assistance, and submit this evaluation to the legislature
184.34 by December 1, 2002. The evaluation must include an analysis of funding adequacy, gaps
184.35 in service delivery, continuity in information between the service and identified linkages,
184.36 and potential use of private funding to enhance the service.

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

185.2 Sec. 20. Minnesota Statutes 2006, section 256B.056, subdivision 1a, is amended to
185.3 read:

185.4 Subd. 1a. **Income and assets generally.** Unless specifically required by state law or
185.5 rule or federal law or regulation, the methodologies used in counting income and assets
185.6 to determine eligibility for medical assistance for persons whose eligibility category is
185.7 based on blindness, disability, or age of 65 or more years, the methodologies for the
185.8 supplemental security income program shall be used, except as provided under subdivision
185.9 3, paragraph (f). Increases in benefits under title II of the Social Security Act shall not be
185.10 counted as income for purposes of this subdivision until July 1 of each year. Effective
185.11 upon federal approval, for children eligible under section 256B.055, subdivision 12, or
185.12 for home and community-based waiver services whose eligibility for medical assistance
185.13 is determined without regard to parental income, child support payments, including any
185.14 payments made by an obligor in satisfaction of or in addition to a temporary or permanent
185.15 order for child support, and Social Security payments are not counted as income. For
185.16 families and children, which includes all other eligibility categories, the methodologies
185.17 under the state's AFDC plan in effect as of July 16, 1996, as required by the Personal
185.18 Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public
185.19 Law 104-193, shall be used, except that effective October 1, 2003, the earned income
185.20 disregards and deductions are limited to those in subdivision 1c. For these purposes, a
185.21 "methodology" does not include an asset or income standard, or accounting method,
185.22 or method of determining effective dates.

185.23 Sec. 21. Minnesota Statutes 2006, section 256B.056, subdivision 3, is amended to read:

185.24 Subd. 3. **Asset limitations for aged, blind, or disabled individuals ~~and families~~.**
185.25 To be eligible for medical assistance, a person whose eligibility is based on blindness,
185.26 disability, or age of 65 or more years must not individually own more than ~~\$3,000~~ \$6,000
185.27 in assets, or if a member of a household with two family members, husband and wife, or
185.28 parent and child, the household must not own more than ~~\$6,000~~ \$12,000 in assets, plus
185.29 ~~\$200~~ \$400 for each additional legal dependent. In addition to these maximum amounts,
185.30 an eligible individual or family may accrue interest on these amounts, but they must be
185.31 reduced to the maximum at the time of an eligibility redetermination. The accumulation
185.32 of the clothing and personal needs allowance according to section 256B.35 must also be
185.33 reduced to the maximum at the time of the eligibility redetermination. The value of assets
185.34 that are not considered in determining eligibility for medical assistance is the value of

those assets excluded under the supplemental security income program for aged, blind, and disabled persons, with the following exceptions:

(a) Household goods and personal effects are not considered.

(b) Capital and operating assets of a trade or business that the local agency determines are necessary to the person's ability to earn an income are not considered.

(c) Motor vehicles are excluded to the same extent excluded by the supplemental security income program.

(d) Assets designated as burial expenses are excluded to the same extent excluded by the supplemental security income program. Burial expenses funded by annuity contracts or life insurance policies must irrevocably designate the individual's estate as contingent beneficiary to the extent proceeds are not used for payment of selected burial expenses.

(e) Effective upon federal approval, for a person who no longer qualifies as an employed person with a disability due to loss of earnings, assets allowed while eligible for medical assistance under section 256B.057, subdivision 9, are not considered for 12 months, beginning with the first month of ineligibility as an employed person with a disability, to the extent that the person's total assets remain within the allowed limits of section 256B.057, subdivision 9, paragraph (b).

(f) When a person enrolled in medical assistance under section 256B.057, subdivision 9, reaches age 65 and has been enrolled during each of the 24 consecutive months before the person's 65th birthday, the assets owned by the person and the person's spouse must be disregarded, up to the limits of section 256B.057, subdivision 9, paragraph (b), when determining eligibility for medical assistance under section 256B.055, subdivision 7. The income of a spouse of a person enrolled in medical assistance under section 256B.057, subdivision 9, during each of the 24 consecutive months before the person's 65th birthday must be disregarded when determining eligibility for medical assistance under section 256B.055, subdivision 7, when the person reaches age 65. This paragraph does not apply at the time the person or the person's spouse requests medical assistance payment for long-term care services.

EFFECTIVE DATE. This section is effective July 1, 2007, except that the increase in the asset standard for persons whose eligibility for medical assistance is based on blindness, disability, or age of 65 or more years is effective July 1, 2008.

Sec. 22. Minnesota Statutes 2006, section 256B.056, subdivision 5c, is amended to read:

Subd. 5c. **Excess income standard.** (a) The excess income standard for families with children is the standard specified in subdivision 4.

187.1 (b) The excess income standard for a person whose eligibility is based on blindness,
187.2 disability, or age of 65 or more years is 70 percent of the federal poverty guidelines for the
187.3 family size. Effective July 1, 2002, the excess income standard for this paragraph shall
187.4 equal 75 percent of the federal poverty guidelines. Effective July 1, 2007, the excess
187.5 income standard for this paragraph shall equal 85 percent of the federal poverty guidelines.
187.6 The excess income standard for this paragraph shall be increased by five percentage points
187.7 on July 1 of each of the next three years, so that the excess income standard shall equal
187.8 100 percent of the federal poverty guidelines effective July 1, 2010.

187.9 **EFFECTIVE DATE.** This section is effective July 1, 2007.

187.10 Sec. 23. Minnesota Statutes 2006, section 256B.0621, subdivision 11, is amended to
187.11 read:

187.12 Subd. 11. **Data use agreement; Notice of relocation assistance.** The commissioner
187.13 shall ~~execute a data use agreement with the Centers for Medicare and Medicaid Services~~
187.14 ~~to obtain the long-term care minimum data set data to assist residents of nursing facilities~~
187.15 ~~who have~~ establish a process with the Centers for Independent Living that allows a person
187.16 residing in a Minnesota nursing facility to receive needed information, consultation, and
187.17 assistance from one of the centers about the available community support options that may
187.18 enable the person to relocate to the community, if the person: (1) is under the age of 65,
187.19 (2) has indicated a desire to live in the community. ~~The commissioner shall in turn enter~~
187.20 ~~into agreements with the Centers for Independent Living to provide information about~~
187.21 ~~assistance for persons who want to move to the community. The commissioner shall work~~
187.22 ~~with the Centers for Independent Living on both the content of the information to be~~
187.23 ~~provided and privacy protections for the individual residents, and (3) has signed a release~~
187.24 of information authorized by the person or the person's appointed legal representative.
187.25 The process established under this subdivision shall be coordinated with the long-term
187.26 care consultation service activities established in section 256B.0911.

187.27 Sec. 24. Minnesota Statutes 2006, section 256B.0625, subdivision 18a, is amended to
187.28 read:

187.29 Subd. 18a. **Access to medical services.** (a) Medical assistance reimbursement for
187.30 meals for persons traveling to receive medical care may not exceed \$5.50 for breakfast,
187.31 \$6.50 for lunch, or \$8 for dinner.

187.32 (b) Medical assistance reimbursement for lodging for persons traveling to receive
187.33 medical care may not exceed \$50 per day unless prior authorized by the local agency.

188.1 (c) Medical assistance direct mileage reimbursement to the eligible person or the
188.2 eligible person's driver may not exceed 20 cents per mile.

188.3 (d) Regardless of the number of employees that an enrolled health care provider
188.4 may have, medical assistance covers sign and oral language interpreter services when
188.5 provided by an enrolled health care provider during the course of providing a direct,
188.6 person-to-person covered health care service to an enrolled recipient with limited English
188.7 proficiency or who has a hearing loss and uses interpreting services.

188.8 Sec. 25. Minnesota Statutes 2006, section 256B.0625, is amended by adding a
188.9 subdivision to read:

188.10 Subd. 49. **Self-directed supports option.** Upon federal approval, medical
188.11 assistance covers the self-directed supports option as defined under section 256B.0657 and
188.12 section 6087 of the Federal Deficit Reduction Act of 2005, Public Law 109-171.

188.13 **EFFECTIVE DATE.** This section is effective upon federal approval of the state
188.14 Medicaid plan amendment. The commissioner of human services shall inform the Office
188.15 of the Revisor of Statutes when approval is obtained.

188.16 Sec. 26. **[256B.0657] SELF-DIRECTED SUPPORTS OPTION.**

188.17 Subdivision 1. **Definition.** "Self-directed supports option" means personal
188.18 assistance, supports, items, and related services purchased under an approved budget
188.19 plan and budget by a recipient.

188.20 Subd. 2. **Eligibility.** (a) The self-directed supports option is available to a person
188.21 who:

188.22 (1) is a recipient of medical assistance as determined under sections 256B.055,
188.23 256B.056, and 256B.057, subdivision 9;

188.24 (2) is eligible for personal care assistant services under section 256B.0655;

188.25 (3) lives in the person's own apartment or home, which is not owned, operated, or
188.26 controlled by a provider of services not related by blood or marriage;

188.27 (4) has the ability to hire, fire, supervise, establish staff compensation for, and
188.28 manage the individuals providing services, and to choose and obtain items, related
188.29 services, and supports as described in the participant's plan. If the recipient is not able to
188.30 carry out these functions but has a legal guardian or parent to carry them out, the guardian
188.31 or parent may fulfill these functions on behalf of the recipient; and

188.32 (5) has not been excluded or disenrolled by the commissioner.

188.33 (b) The commissioner may disenroll or exclude recipients, including guardians and
188.34 parents, under the following circumstances:

189.1 (1) recipients who have been restricted by the Primary Care Utilization Review
189.2 Committee may be excluded for a specified time period; and

189.3 (2) recipients who exit the self-directed supports option during the recipient's
189.4 service plan year shall not access the self-directed supports option for the remainder
189.5 of that service plan year.

189.6 Subd. 3. **Eligibility for other services.** Selection of the self-directed supports
189.7 option by a recipient shall not restrict access to other medically necessary care and
189.8 services furnished under the state plan medical assistance benefit, including home care
189.9 targeted case management, except that a person receiving home and community-based
189.10 waiver services, a family support grant or a consumer support grant is not eligible for
189.11 funding under the self-directed supports option.

189.12 Subd. 4. **Assessment requirements.** (a) The self-directed supports option
189.13 assessment must meet the following requirements:

189.14 (1) it shall be conducted by the county public health nurse or a certified public
189.15 health nurse under contract with the county;

189.16 (2) it shall be conducted face-to-face in the recipient's home initially, and at least
189.17 annually thereafter; when there is a significant change in the recipient's condition; and
189.18 when there is a change in the need for personal care assistant services. A recipient who is
189.19 residing in a facility may be assessed for the self-directed support option for the purpose
189.20 of returning to the community using this option; and

189.21 (3) it shall be completed using the format established by the commissioner.

189.22 (b) The results of the assessment and recommendations shall be communicated to
189.23 the commissioner and the recipient by the county public health nurse or certified public
189.24 health nurse under contract with the county.

189.25 Subd. 5. **Self-directed supports option plan requirements.** (a) The plan for the
189.26 self-directed supports option must meet the following requirements:

189.27 (1) the plan must be completed using a person-centered process that:

189.28 (i) builds upon the recipient's capacity to engage in activities that promote
189.29 community life;

189.30 (ii) respects the recipient's preferences, choices, and abilities;

189.31 (iii) involves families, friends, and professionals in the planning or delivery of
189.32 services or supports as desired or required by the recipient; and

189.33 (iv) addresses the need for personal care assistant services identified in the recipient's
189.34 self-directed supports option assessment;

189.35 (2) the plan shall be developed by the recipient or by the guardian of an adult
189.36 recipient or by a parent or guardian of a minor child, with the assistance of an enrolled

190.1 medical assistance home care targeted case manager provider who meets the requirements
190.2 established for using a person-centered planning process and shall be reviewed at least
190.3 annually upon reassessment or when there is a significant change in the recipient's
190.4 condition; and

190.5 (3) the plan must include the total budget amount available divided into monthly
190.6 amounts that cover the number of months of personal care assistant services authorization
190.7 included in the budget. The amount used each month may vary, but additional funds shall
190.8 not be provided above the annual personal care assistant services authorized amount
190.9 unless a change in condition is documented.

190.10 (b) The commissioner shall:

190.11 (1) establish the format and criteria for the plan as well as the requirements for
190.12 providers who assist with plan development;

190.13 (2) review the assessment and plan and, within 30 days after receiving the
190.14 assessment and plan, make a decision on approval of the plan;

190.15 (3) notify the recipient, parent, or guardian of approval or denial of the plan and
190.16 provide notice of the right to appeal under section 256.045; and

190.17 (4) provide a copy of the plan to the fiscal support entity selected by the recipient.

190.18 Subd. 6. **Services covered.** (a) Services covered under the self-directed supports
190.19 option include:

190.20 (1) personal care assistant services under section 256B.0655; and

190.21 (2) items, related services, and supports, including assistive technology, that increase
190.22 independence or substitute for human assistance to the extent expenditures would
190.23 otherwise be used for human assistance.

190.24 (b) Items, supports, and related services purchased under this option shall not be
190.25 considered home care services for the purposes of section 144A.43.

190.26 Subd. 7. **Noncovered services.** Services or supports that are not eligible for
190.27 payment under the self-directed supports option include:

190.28 (1) services, goods, or supports that do not benefit the recipient;

190.29 (2) any fees incurred by the recipient, such as Minnesota health care program fees
190.30 and co-pays, legal fees, or costs related to advocate agencies;

190.31 (3) insurance, except for insurance costs related to employee coverage or fiscal
190.32 support entity payments;

190.33 (4) room and board and personal items that are not related to the disability, except
190.34 that medically prescribed specialized diet items may be covered if they reduce the need for
190.35 human assistance;

190.36 (5) home modifications that add square footage;

191.1 (6) home modifications for a residence other than the primary residence of the
191.2 recipient, or in the event of a minor with parents not living together, the primary residences
191.3 of the parents;

191.4 (7) expenses for travel, lodging, or meals related to training the recipient, the parent
191.5 or guardian of an adult recipient, or the parent or guardian of a minor child, or paid or
191.6 unpaid caregivers that exceed \$500 in a 12-month period;

191.7 (8) experimental treatment;

191.8 (9) any service or item covered by other medical assistance state plan services,
191.9 including prescription and over-the-counter medications, compounds, and solutions and
191.10 related fees, including premiums and co-payments;

191.11 (10) membership dues or costs, except when the service is necessary and appropriate
191.12 to treat a physical condition or to improve or maintain the recipient's physical condition.

191.13 The condition must be identified in the recipient's plan of care and monitored by a
191.14 Minnesota health care program enrolled physician;

191.15 (11) vacation expenses other than the cost of direct services;

191.16 (12) vehicle maintenance or modifications not related to the disability;

191.17 (13) tickets and related costs to attend sporting or other recreational events; and

191.18 (14) costs related to Internet access, except when necessary for operation of assistive
191.19 technology, to increase independence, or to substitute for human assistance.

191.20 Subd. 8. **Self-directed budget requirements.** The budget for the provision of the
191.21 self-directed service option shall be equal to the greater of either:

191.22 (1) the annual amount of personal care assistant services under section 256B.0655
191.23 that the recipient has used in the most recent 12-month period; or

191.24 (2) the amount determined using the consumer support grant methodology under
191.25 section 256.476, subdivision 11, except that the budget amount shall include the federal
191.26 and nonfederal share of the average service costs.

191.27 Subd. 9. **Quality assurance and risk management.** (a) The commissioner
191.28 shall establish quality assurance and risk management measures for use in developing
191.29 and implementing self-directed plans and budgets that (1) recognize the roles and
191.30 responsibilities involved in obtaining services in a self-directed manner, and (2) assure
191.31 the appropriateness of such plans and budgets based upon a recipient's resources and
191.32 capabilities. These measures must include (i) background studies, and (ii) backup and
191.33 emergency plans, including disaster planning.

191.34 (b) The commissioner shall provide ongoing technical assistance and resource and
191.35 educational materials for families and recipients selecting the self-directed option.

192.1 (c) Performance assessments measures, such as of a recipient's satisfaction with the
192.2 services and supports, and ongoing monitoring of health and well-being shall be identified
192.3 in consultation with the stakeholder group.

192.4 Subd. 10. **Fiscal support entity.** (a) Each recipient shall choose a fiscal support
192.5 entity provider certified by the commissioner to make payments for services, items,
192.6 supports, and administrative costs related to managing a self-directed service plan
192.7 authorized for payment in the approved plan and budget. Recipients shall also choose
192.8 the payroll, agency with choice, or the fiscal conduit model of financial and service
192.9 management.

192.10 (b) The fiscal support entity:

192.11 (1) may not limit or restrict the recipient's choice of service or support providers,
192.12 including use of the payroll, agency with choice, or fiscal conduit model of financial
192.13 and service management;

192.14 (2) must have a written agreement with the recipient or the recipient's representative
192.15 that identifies the duties and responsibilities to be performed and the specific related
192.16 charges;

192.17 (3) must provide the recipient and the home care targeted case manager with a
192.18 monthly written summary of the self-directed supports option services that were billed,
192.19 including charges from the fiscal support entity;

192.20 (4) must be knowledgeable of and comply with Internal Revenue Service
192.21 requirements necessary to process employer and employee deductions, provide appropriate
192.22 and timely submission of employer tax liabilities, and maintain documentation to support
192.23 medical assistance claims;

192.24 (5) must have current and adequate liability insurance and bonding and sufficient
192.25 cash flow and have on staff or under contract a certified public accountant or an individual
192.26 with a baccalaureate degree in accounting; and

192.27 (6) must maintain records to track all self-directed supports option services
192.28 expenditures, including time records of persons paid to provide supports and receipts for
192.29 any goods purchased. The records must be maintained for a minimum of five years from
192.30 the claim date and be available for audit or review upon request. Claims submitted by
192.31 the fiscal support entity must correspond with services, amounts, and time periods as
192.32 authorized in the recipient's self-directed supports option plan.

192.33 (c) The commissioner shall have authority to:

192.34 (1) set or negotiate rates with fiscal support entities;

192.35 (2) limit the number of fiscal support entities;

193.1 (3) identify a process to certify and recertify fiscal support entities and assure fiscal
193.2 support entities are available to recipients throughout the state; and

193.3 (4) establish a uniform format and protocol to be used by eligible fiscal support
193.4 entities.

193.5 Subd. 11. **Stakeholder consultation.** The commissioner shall consult with a
193.6 statewide consumer-directed services stakeholder group, including representatives of
193.7 all types of consumer-directed service users, advocacy organizations, counties, and
193.8 consumer-directed service providers. The commissioner shall seek recommendations
193.9 from this stakeholder group in developing:

193.10 (1) the self-directed plan format;

193.11 (2) requirements and guidelines for the person-centered plan assessment and
193.12 planning process;

193.13 (3) implementation of the option and the quality assurance and risk management
193.14 techniques; and

193.15 (4) standards and requirements, including rates for the personal support plan
193.16 development provider and the fiscal support entity; policies; training; and implementation.

193.17 The stakeholder group shall provide recommendations on the repeal of the personal care
193.18 assistant choice option, transition issues, and whether the consumer support grant program
193.19 under section 256.476 should be modified. The stakeholder group shall meet at least
193.20 three times each year to provide advice on policy, implementation, and other aspects of
193.21 consumer and self-directed services.

193.22 **EFFECTIVE DATE.** Subdivisions 1 to 10 are effective upon federal approval of
193.23 the state Medicaid plan amendment. The commissioner of human services shall inform
193.24 the Office of the Revisor of Statutes when federal approval is obtained. Subdivision 11
193.25 is effective July 1, 2007.

193.26 Sec. 27. Minnesota Statutes 2006, section 256B.0911, subdivision 3a, is amended to
193.27 read:

193.28 Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment,
193.29 services planning, or other assistance intended to support community-based living,
193.30 including persons who need assessment in order to determine waiver or alternative care
193.31 program eligibility, must be visited by a long-term care consultation team within ten
193.32 working days after the date on which an assessment was requested or recommended.
193.33 Assessments must be conducted according to paragraphs (b) to ~~(g)~~ (i).

193.34 (b) The county may utilize a team of either the social worker or public health nurse,
193.35 or both, to conduct the assessment in a face-to-face interview. The consultation team

194.1 members must confer regarding the most appropriate care for each individual screened or
194.2 assessed.

194.3 (c) The long-term care consultation team must assess the health and social needs of
194.4 the person, using an assessment form provided by the commissioner.

194.5 (d) The team must conduct the assessment in a face-to-face interview with the
194.6 person being assessed and the person's legal representative, if applicable.

194.7 (e) The team must provide the person, or the person's legal representative, with
194.8 written recommendations for facility- or community-based services. The team must
194.9 document that the most cost-effective alternatives available were offered to the individual.
194.10 For purposes of this requirement, "cost-effective alternatives" means community services
194.11 and living arrangements that cost the same as or less than nursing facility care.

194.12 (f) If the person chooses to use community-based services, the team must provide
194.13 the person or the person's legal representative with a written community support plan,
194.14 regardless of whether the individual is eligible for Minnesota health care programs.
194.15 The person may request assistance in developing a community support plan without
194.16 participating in a complete assessment.

194.17 (g) The person has the right to make the final decision between nursing facility
194.18 placement and community placement after the screening team's recommendation, except
194.19 as provided in subdivision 4a, paragraph (c).

194.20 (h) The team must give the person receiving assessment or support planning, or
194.21 the person's legal representative, materials, and forms supplied by the commissioner
194.22 containing the following information:

194.23 (1) the need for and purpose of preadmission screening and assessment if the person
194.24 selects nursing facility placement;

194.25 (2) the role of the long-term care consultation assessment and support planning in
194.26 waiver and alternative care program eligibility determination;

194.27 ~~(2)~~ (3) information about Minnesota health care programs;

194.28 ~~(3)~~ (4) the person's freedom to accept or reject the recommendations of the team;

194.29 ~~(4)~~ (5) the person's right to confidentiality under the Minnesota Government Data
194.30 Practices Act, chapter 13; and

194.31 (6) the long-term care consultant's decision regarding the person's need for nursing
194.32 facility level of care;

194.33 ~~(5)~~ (7) the person's right to appeal the decision regarding the need for nursing facility
194.34 level of care or the county's final decisions regarding public programs eligibility according
194.35 to section 256.045, subdivision 3.

195.1 (i) Face-to-face assessment completed as part of eligibility determination for
195.2 the alternative care, elderly waiver, community alternatives for disabled individuals,
195.3 community alternative care, and traumatic brain injury waiver programs under sections
195.4 256B.0915, 256B.0917, and 256B.49 is valid to establish service eligibility for no more
195.5 than 60 calendar days after the date of assessment. The effective eligibility start date
195.6 for these programs can never be prior to the date of assessment. If an assessment was
195.7 completed more than 60 days before the effective waiver or alternative care program
195.8 eligibility start date, assessment and support plan information must be updated in a
195.9 face-to-face visit and documented in the department's Medicaid Management Information
195.10 System (MMIS). The effective date of program eligibility in this case cannot be prior to
195.11 the date the updated assessment is completed.

195.12 Sec. 28. Minnesota Statutes 2006, section 256B.0911, subdivision 3b, is amended to
195.13 read:

195.14 Subd. 3b. **Transition assistance.** (a) A long-term care consultation team shall
195.15 provide assistance to persons residing in a nursing facility, hospital, regional treatment
195.16 center, or intermediate care facility for persons with developmental disabilities who
195.17 request or are referred for assistance. Transition assistance must include assessment,
195.18 community support plan development, referrals to Minnesota health care programs,
195.19 and referrals to programs that provide assistance with housing. Transition assistance
195.20 must also include information about the Centers for Independent Living and about other
195.21 organizations that can provide assistance with relocation efforts, and information about
195.22 contacting these organizations to obtain their assistance and support.

195.23 (b) The county shall develop transition processes with institutional social workers
195.24 and discharge planners to ensure that:

195.25 (1) persons admitted to facilities receive information about transition assistance
195.26 that is available;

195.27 (2) the assessment is completed for persons within ten working days of the date of
195.28 request or recommendation for assessment; and

195.29 (3) there is a plan for transition and follow-up for the individual's return to the
195.30 community. The plan must require notification of other local agencies when a person
195.31 who may require assistance is screened by one county for admission to a facility located
195.32 in another county.

195.33 (c) If a person who is eligible for a Minnesota health care program is admitted to a
195.34 nursing facility, the nursing facility must include a consultation team member or the case
195.35 manager in the discharge planning process.

Sec. 29. Minnesota Statutes 2006, section 256B.0911, is amended by adding a subdivision to read:

Subd. 3c. **Transition to housing with services.** (a) Transitional consultation shall be offered to all prospective residents 65 years of age or older regardless of income, assets, or funding sources before housing with services establishments offering or providing assisted living execute a lease or contract with the prospective resident. The purpose of transitional long-term care consultation is to support persons with current or anticipated long-term care needs in making informed choices among options that include the most cost-effective and least restrictive settings, and to delay spenddown to eligibility for publicly funded programs by connecting people to alternative services in their homes before transition to housing with services.

(b) Transitional consultation services are provided as determined by the commissioner of human services in partnership with county long-term care consultation units, and the Area Agencies on Aging, and are a combination of telephone-based and in-person assistance provided under models developed by the commissioner. The consultation is to be performed in a manner which provides objective and complete information. Transitional consultation must be provided within five working days of the request of the prospective resident as follows:

(1) the consultation must be provided by a qualified professional as determined by the commissioner;

(2) the consultation must include a review of the prospective resident's reasons for considering assisted living, the prospective resident's personal goals, a discussion of the prospective resident's immediate and projected long-term care needs, and alternative community services or assisted living settings that may meet the prospective resident's needs; and

(3) the prospective resident will be informed of the availability of long-term care consultation services described in subdivision 3a that are available at no charge to the prospective resident to assist the prospective resident in assessment and planning to meet the prospective resident's long-term care needs. Regardless of the consultation, prospective residents maintain the right to choose housing with services or assisted living, if that is their choice.

EFFECTIVE DATE. This section is effective October 1, 2008.

Sec. 30. Minnesota Statutes 2006, section 256B.0911, subdivision 4b, is amended to read:

197.1 Subd. 4b. **Exemptions and emergency admissions.** (a) Exemptions from the
197.2 federal screening requirements outlined in subdivision 4a, paragraphs (b) and (c), are
197.3 limited to:

197.4 (1) a person who, having entered an acute care facility from a certified nursing
197.5 facility, is returning to a certified nursing facility;

197.6 (2) a person transferring from one certified nursing facility in Minnesota to another
197.7 certified nursing facility in Minnesota; and

197.8 (3) a person, 21 years of age or older, who satisfies the following criteria, as specified
197.9 in Code of Federal Regulations, title 42, section 483.106(b)(2):

197.10 (i) the person is admitted to a nursing facility directly from a hospital after receiving
197.11 acute inpatient care at the hospital;

197.12 (ii) the person requires nursing facility services for the same condition for which
197.13 care was provided in the hospital; and

197.14 (iii) the attending physician has certified before the nursing facility admission that
197.15 the person is likely to receive less than 30 days of nursing facility services.

197.16 (b) Persons who are exempt from preadmission screening for purposes of level of
197.17 care determination include:

197.18 (1) persons described in paragraph (a);

197.19 (2) an individual who has a contractual right to have nursing facility care paid for
197.20 indefinitely by the veterans' administration;

197.21 (3) an individual enrolled in a demonstration project under section 256B.69,
197.22 subdivision 8, at the time of application to a nursing facility; and

197.23 (4) an individual currently being served under the alternative care program or under
197.24 a home and community-based services waiver authorized under section 1915(c) of the
197.25 federal Social Security Act; ~~and,~~

197.26 ~~(5) individuals admitted to a certified nursing facility for a short-term stay, which~~
197.27 ~~is expected to be 14 days or less in duration based upon a physician's certification, and~~
197.28 ~~who have been assessed and approved for nursing facility admission within the previous~~
197.29 ~~six months. This exemption applies only if the consultation team member determines at~~
197.30 ~~the time of the initial assessment of the six-month period that it is appropriate to use the~~
197.31 ~~nursing facility for short-term stays and that there is an adequate plan of care for return to~~
197.32 ~~the home or community-based setting. If a stay exceeds 14 days, the individual must be~~
197.33 ~~referred no later than the first county working day following the 14th resident day for a~~
197.34 ~~screening, which must be completed within five working days of the referral. The payment~~
197.35 ~~limitations in subdivision 7 apply to an individual found at screening to not meet the level~~
197.36 ~~of care criteria for admission to a certified nursing facility.~~

(c) Persons admitted to a Medicaid-certified nursing facility from the community on an emergency basis as described in paragraph (d) or from an acute care facility on a nonworking day must be screened the first working day after admission.

(d) Emergency admission to a nursing facility prior to screening is permitted when all of the following conditions are met:

(1) a person is admitted from the community to a certified nursing or certified boarding care facility during county nonworking hours;

(2) a physician has determined that delaying admission until preadmission screening is completed would adversely affect the person's health and safety;

(3) there is a recent precipitating event that precludes the client from living safely in the community, such as sustaining an injury, sudden onset of acute illness, or a caregiver's inability to continue to provide care;

(4) the attending physician has authorized the emergency placement and has documented the reason that the emergency placement is recommended; and

(5) the county is contacted on the first working day following the emergency admission.

Transfer of a patient from an acute care hospital to a nursing facility is not considered an emergency except for a person who has received hospital services in the following situations: hospital admission for observation, care in an emergency room without hospital admission, or following hospital 24-hour bed care.

(e) A nursing facility must provide a written ~~notice to persons who satisfy the criteria in paragraph (a), clause (3),~~ information to all persons admitted regarding the person's right to request and receive long-term care consultation services as defined in subdivision 1a. The ~~notice~~ information must be provided prior to the person's discharge from the facility and in a format specified by the commissioner.

Sec. 31. Minnesota Statutes 2006, section 256B.0911, subdivision 4c, is amended to read:

Subd. 4c. **Screening requirements.** (a) A person may be screened for nursing facility admission by telephone or in a face-to-face screening interview. Consultation team members shall identify each individual's needs using the following categories:

(1) the person needs no face-to-face screening interview to determine the need for nursing facility level of care based on information obtained from other health care professionals;

199.1 (2) the person needs an immediate face-to-face screening interview to determine the
199.2 need for nursing facility level of care and complete activities required under subdivision
199.3 4a; or

199.4 (3) the person may be exempt from screening requirements as outlined in subdivision
199.5 4b, but will need transitional assistance after admission or in-person follow-along after
199.6 a return home.

199.7 (b) Persons admitted on a nonemergency basis to a Medicaid-certified nursing
199.8 facility must be screened prior to admission.

199.9 ~~(c) The long-term care consultation team shall recommend a case mix classification~~
199.10 ~~for persons admitted to a certified nursing facility when sufficient information is received~~
199.11 ~~to make that classification. The nursing facility is authorized to conduct all case mix~~
199.12 ~~assessments for persons who have been screened prior to admission for whom the county~~
199.13 ~~did not recommend a case mix classification. The nursing facility is authorized to conduct~~
199.14 ~~all case mix assessments for persons admitted to the facility prior to a preadmission~~
199.15 ~~screening. The county retains the responsibility of distributing appropriate case mix~~
199.16 ~~forms to the nursing facility.~~

199.17 ~~(d)~~ (c) The county screening or intake activity must include processes to identify
199.18 persons who may require transition assistance as described in subdivision 3b.

199.19 Sec. 32. Minnesota Statutes 2006, section 256B.0911, subdivision 6, is amended to
199.20 read:

199.21 Subd. 6. **Payment for long-term care consultation services.** (a) The total payment
199.22 for each county must be paid monthly by certified nursing facilities in the county. The
199.23 monthly amount to be paid by each nursing facility for each fiscal year must be determined
199.24 by dividing the county's annual allocation for long-term care consultation services by 12
199.25 to determine the monthly payment and allocating the monthly payment to each nursing
199.26 facility based on the number of licensed beds in the nursing facility. Payments to counties
199.27 in which there is no certified nursing facility must be made by increasing the payment
199.28 rate of the two facilities located nearest to the county seat.

199.29 (b) The commissioner shall include the total annual payment determined under
199.30 paragraph (a) for each nursing facility reimbursed under section 256B.431 or 256B.434
199.31 according to section 256B.431, subdivision 2b, paragraph (g), ~~or 256B.435.~~

199.32 (c) In the event of the layaway, delicensure and decertification, or removal from
199.33 layaway of 25 percent or more of the beds in a facility, the commissioner may adjust
199.34 the per diem payment amount in paragraph (b) and may adjust the monthly payment
199.35 amount in paragraph (a). The effective date of an adjustment made under this paragraph

shall be on or after the first day of the month following the effective date of the layaway, delicensure and decertification, or removal from layaway.

(d) Payments for long-term care consultation services are available to the county or counties to cover staff salaries and expenses to provide the services described in subdivision 1a. The county shall employ, or contract with other agencies to employ, within the limits of available funding, sufficient personnel to provide long-term care consultation services while meeting the state's long-term care outcomes and objectives as defined in section 256B.0917, subdivision 1. The county shall be accountable for meeting local objectives as approved by the commissioner in the biennial home and community-based services quality assurance plan on a form provided by the commissioner.

(e) Notwithstanding section 256B.0641, overpayments attributable to payment of the screening costs under the medical assistance program may not be recovered from a facility.

(f) The commissioner of human services shall amend the Minnesota medical assistance plan to include reimbursement for the local consultation teams.

(g) The county may bill, as case management services, assessments, support planning, and follow-along provided to persons determined to be eligible for case management under Minnesota health care programs. No individual or family member shall be charged for an initial assessment or initial support plan development provided under subdivision 3a or 3b.

Sec. 33. Minnesota Statutes 2006, section 256B.0911, is amended by adding a subdivision to read:

Subd. 6a. **Withholding.** If any provider obligated to pay the long-term care consultation amount as described in subdivision 6 is more than two months delinquent in the timely payment of the monthly installment, the commissioner may withhold payments, penalties, and interest in accordance with the methods outlined in section 256.9657, subdivision 7a. Any amount withheld under this provision must be returned to the county to whom the delinquent payments were due.

Sec. 34. Minnesota Statutes 2006, section 256B.0911, subdivision 7, is amended to read:

Subd. 7. Reimbursement for certified nursing facilities. (a) Medical assistance reimbursement for nursing facilities shall be authorized for a medical assistance recipient only if a preadmission screening has been conducted prior to admission or the county has authorized an exemption. Medical assistance reimbursement for nursing facilities shall not be provided for any recipient who the local screener has determined does not meet the

201.1 level of care criteria for nursing facility placement or, if indicated, has not had a level II
201.2 OBRA evaluation as required under the federal Omnibus Budget Reconciliation Act of
201.3 1987 completed unless an admission for a recipient with mental illness is approved by the
201.4 local mental health authority or an admission for a recipient with developmental disability
201.5 is approved by the state developmental disability authority.

201.6 (b) The nursing facility must not bill a person who is not a medical assistance
201.7 recipient for resident days that preceded the date of completion of screening activities as
201.8 required under subdivisions 4a, 4b, and 4c. The nursing facility must include unreimbursed
201.9 resident days in the nursing facility resident day totals reported to the commissioner.

201.10 ~~(c) The commissioner shall make a request to the Centers for Medicare and Medicaid~~
201.11 ~~Services for a waiver allowing team approval of Medicaid payments for certified nursing~~
201.12 ~~facility care. An individual has a choice and makes the final decision between nursing~~
201.13 ~~facility placement and community placement after the screening team's recommendation,~~
201.14 ~~except as provided in subdivision 4a, paragraph (c).~~

201.15 Sec. 35. Minnesota Statutes 2006, section 256B.0913, subdivision 4, is amended to
201.16 read:

201.17 Subd. 4. **Eligibility for funding for services for nonmedical assistance recipients.**

201.18 (a) Funding for services under the alternative care program is available to persons who
201.19 meet the following criteria:

201.20 (1) the person has been determined by a community assessment under section
201.21 256B.0911 to be a person who would require the level of care provided in a nursing
201.22 facility, but for the provision of services under the alternative care program;

201.23 (2) the person is age 65 or older;

201.24 (3) the person would be eligible for medical assistance within 135 days of admission
201.25 to a nursing facility;

201.26 (4) the person is not ineligible for the payment of long-term care services by the
201.27 medical assistance program due to an asset transfer penalty under section 256B.0595 or
201.28 equity interest in the home exceeding \$500,000 as stated in section 256B.056;

201.29 (5) the person needs long-term care services that are not funded through other state
201.30 or federal funding;

201.31 (6) the monthly cost of the alternative care services funded by the program for
201.32 this person does not exceed 75 percent of the monthly limit described under section
201.33 256B.0915, subdivision 3a. This monthly limit does not prohibit the alternative care client
201.34 from payment for additional services, but in no case may the cost of additional services
201.35 purchased under this section exceed the difference between the client's monthly service

202.1 limit defined under section 256B.0915, subdivision 3, and the alternative care program
202.2 monthly service limit defined in this paragraph. If ~~medical~~ care-related supplies and
202.3 equipment or environmental modifications and adaptations are or will be purchased for
202.4 an alternative care services recipient, the costs may be prorated on a monthly basis for
202.5 up to 12 consecutive months beginning with the month of purchase. If the monthly cost
202.6 of a recipient's other alternative care services exceeds the monthly limit established in
202.7 this paragraph, the annual cost of the alternative care services shall be determined. In this
202.8 event, the annual cost of alternative care services shall not exceed 12 times the monthly
202.9 limit described in this paragraph; and

202.10 (7) the person is making timely payments of the assessed monthly fee.

202.11 A person is ineligible if payment of the fee is over 60 days past due, unless the person
202.12 agrees to:

202.13 (i) the appointment of a representative payee;

202.14 (ii) automatic payment from a financial account;

202.15 (iii) the establishment of greater family involvement in the financial management of
202.16 payments; or

202.17 (iv) another method acceptable to the ~~county~~ lead agency to ensure prompt fee
202.18 payments.

202.19 The ~~county shall~~ lead agency may extend the client's eligibility as necessary while
202.20 making arrangements to facilitate payment of past-due amounts and future premium
202.21 payments. Following disenrollment due to nonpayment of a monthly fee, eligibility shall
202.22 not be reinstated for a period of 30 days.

202.23 (b) Alternative care funding under this subdivision is not available for a person
202.24 who is a medical assistance recipient or who would be eligible for medical assistance
202.25 without a spenddown or waiver obligation. A person whose initial application for medical
202.26 assistance and the elderly waiver program is being processed may be served under the
202.27 alternative care program for a period up to 60 days. If the individual is found to be eligible
202.28 for medical assistance, medical assistance must be billed for services payable under the
202.29 federally approved elderly waiver plan and delivered from the date the individual was
202.30 found eligible for the federally approved elderly waiver plan. Notwithstanding this
202.31 provision, alternative care funds may not be used to pay for any service the cost of which:
202.32 (i) is payable by medical assistance; (ii) is used by a recipient to meet a waiver obligation;
202.33 or (iii) is used to pay a medical assistance income spenddown for a person who is eligible
202.34 to participate in the federally approved elderly waiver program under the special income
202.35 standard provision.

203.1 (c) Alternative care funding is not available for a person who resides in a licensed
203.2 nursing home, certified boarding care home, hospital, or intermediate care facility, except
203.3 for case management services which are provided in support of the discharge planning
203.4 process for a nursing home resident or certified boarding care home resident to assist with
203.5 a relocation process to a community-based setting.

203.6 (d) Alternative care funding is not available for a person whose income is greater
203.7 than the maintenance needs allowance under section 256B.0915, subdivision 1d, but equal
203.8 to or less than 120 percent of the federal poverty guideline effective July 1 in the fiscal
203.9 year for which alternative care eligibility is determined, who would be eligible for the
203.10 elderly waiver with a waiver obligation.

203.11 Sec. 36. Minnesota Statutes 2006, section 256B.0913, subdivision 5, is amended to
203.12 read:

203.13 Subd. 5. **Services covered under alternative care.** Alternative care funding may
203.14 be used for payment of costs of:

- 203.15 (1) adult day care;
- 203.16 (2) home health aide;
- 203.17 (3) homemaker services;
- 203.18 (4) personal care;
- 203.19 (5) case management;
- 203.20 (6) respite care;
- 203.21 (7) care-related supplies and equipment;
- 203.22 (8) meals delivered to the home;
- 203.23 (9) nonmedical transportation;
- 203.24 (10) nursing services;
- 203.25 (11) chore services;
- 203.26 (12) companion services;
- 203.27 (13) nutrition services;
- 203.28 (14) training for direct informal caregivers;
- 203.29 (15) telehome care to provide services in their own homes in conjunction with
203.30 in-home visits;
- 203.31 (16) ~~discretionary services, for which counties may make payment from their~~
203.32 ~~alternative care program allocation or services not otherwise defined in this section~~
203.33 ~~or section 256B.0625, following approval by the commissioner~~ consumer-directed
203.34 community services under the alternative care programs which are available statewide and
203.35 limited to the average monthly expenditures representative of all alternative care program

participants for the same case mix resident class assigned in the most recent fiscal year for which complete expenditure data is available;

(17) environmental modifications and adaptations; and

(18) ~~direct cash payments for which counties may make payment from their alternative care program allocation to clients for the purpose of purchasing services, following approval by the commissioner, and subject to the provisions of subdivision 5h, until approval and implementation of consumer-directed services through the federally approved elderly waiver plan. Upon implementation, consumer-directed services under the alternative care program are available statewide and limited to the average monthly expenditures representative of all alternative care program participants for the same case mix resident class assigned in the most recent fiscal year for which complete expenditure data is available~~ discretionary services, for which lead agencies may make payment from their alternative care program allocation for services not otherwise defined in this section or section 256B.0625, following approval by the commissioner.

Total annual payments for discretionary services ~~and direct cash payments, until the federally approved consumer-directed service option is implemented statewide, for all clients within a county may~~ served by a lead agency must not exceed 25 percent of that county's lead agency's annual alternative care program base allocation. ~~Thereafter, discretionary services are limited to 25 percent of the county's annual alternative care program base allocation.~~

Sec. 37. Minnesota Statutes 2006, section 256B.0913, subdivision 5a, is amended to read:

Subd. 5a. **Services; service definitions; service standards.** (a) Unless specified in statute, the services, service definitions, and standards for alternative care services shall be the same as the services, service definitions, and standards specified in the federally approved elderly waiver plan, except ~~for~~ alternative care does not cover transitional support services, assisted living services, adult foster care services, and residential care ~~services~~ and benefits defined under section 256B.0625 that meet primary and acute health care needs.

(b) The ~~county~~ lead agency must ensure that the funds are not used to supplant or supplement services available through other public assistance or services programs, including supplementation of client co-pays, deductibles, premiums, or other cost-sharing arrangements for health-related benefits and services or entitlement programs and services that are available to the person, but in which they have elected not to enroll. For a provider of supplies and equipment when the monthly cost of the supplies and equipment is less

than \$250, persons or agencies must be employed by or under a contract with the ~~county~~ lead agency or the public health nursing agency of the local board of health in order to receive funding under the alternative care program. Supplies and equipment may be purchased from a vendor not certified to participate in the Medicaid program if the cost for the item is less than that of a Medicaid vendor.

(c) Personal care services must meet the service standards defined in the federally approved elderly waiver plan, except that a ~~county~~ lead agency may contract with a client's relative who meets the relative hardship waiver requirements or a relative who meets the criteria and is also the responsible party under an individual service plan that ensures the client's health and safety and supervision of the personal care services by a qualified professional as defined in section 256B.0625, subdivision 19c. Relative hardship is established by the ~~county~~ lead agency when the client's care causes a relative caregiver to do any of the following: resign from a paying job, reduce work hours resulting in lost wages, obtain a leave of absence resulting in lost wages, incur substantial client-related expenses, provide services to address authorized, unstaffed direct care time, or meet special needs of the client unmet in the formal service plan.

Sec. 38. Minnesota Statutes 2006, section 256B.0913, subdivision 8, is amended to read:

Subd. 8. Requirements for individual care plan. (a) The case manager shall implement the plan of care for each alternative care client and ensure that a client's service needs and eligibility are reassessed at least every 12 months. The plan shall include any services prescribed by the individual's attending physician as necessary to allow the individual to remain in a community setting. In developing the individual's care plan, the case manager should include the use of volunteers from families and neighbors, religious organizations, social clubs, and civic and service organizations to support the formal home care services. The ~~county~~ lead agency shall be held harmless for damages or injuries sustained through the use of volunteers under this subdivision including workers' compensation liability. The ~~county of service~~ case manager shall provide documentation in each individual's plan of care and, if requested, to the commissioner that the most cost-effective alternatives available have been offered to the individual and that the individual was free to choose among available qualified providers, both public and private, including qualified case management or service coordination providers other than those employed by any county; however, the county or tribe maintains responsibility for prior authorizing services in accordance with statutory and administrative requirements. The

case manager must give the individual a ten-day written notice of any denial, termination, or reduction of alternative care services.

(b) The county of service or tribe must provide access to and arrange for case management services, including assuring implementation of the plan. "County of service" has the meaning given it in Minnesota Rules, part 9505.0015, subpart 11. The county of service must notify the county of financial responsibility of the approved care plan and the amount of encumbered funds.

Sec. 39. Minnesota Statutes 2006, section 256B.0913, subdivision 9, is amended to read:

Subd. 9. **Contracting provisions for providers.** Alternative care funds paid to service providers are subject to audit by the commissioner for fiscal and utilization control.

The lead agency must select providers for contracts or agreements using the following criteria and other criteria established by the ~~county~~ lead agency:

(1) the need for the particular services offered by the provider;

(2) the population to be served, including the number of clients, the length of time services will be provided, and the medical condition of clients;

(3) the geographic area to be served;

(4) quality assurance methods, including appropriate licensure, certification, or standards, and supervision of employees when needed;

(5) rates for each service and unit of service exclusive of ~~county~~ lead agency administrative costs;

(6) evaluation of services previously delivered by the provider; and

(7) contract or agreement conditions, including billing requirements, cancellation, and indemnification.

The ~~county~~ lead agency must evaluate its own agency services under the criteria established for other providers.

Sec. 40. Minnesota Statutes 2006, section 256B.0913, subdivision 10, is amended to read:

Subd. 10. **Allocation formula.** (a) ~~The alternative care appropriation for fiscal years 1992 and beyond shall cover only alternative care eligible clients. By July 1 of~~ each year, the commissioner shall allocate to county agencies the state funds available for alternative care for persons eligible under subdivision 2.

(b) The adjusted base for each ~~county~~ lead agency is the ~~county's~~ lead agency's current fiscal year base allocation plus any targeted funds approved during the current

207.1 fiscal year. Calculations for paragraphs (c) and (d) are to be made as follows: for each
207.2 ~~county~~ lead agency, the determination of alternative care program expenditures shall be
207.3 based on payments for services rendered from April 1 through March 31 in the base year,
207.4 to the extent that claims have been submitted and paid by June 1 of that year.

207.5 (c) If the alternative care program expenditures as defined in paragraph (b) are 95
207.6 percent or more of the ~~county's~~ lead agency's adjusted base allocation, the allocation for
207.7 the next fiscal year is 100 percent of the adjusted base, plus inflation to the extent that
207.8 inflation is included in the state budget.

207.9 (d) If the alternative care program expenditures as defined in paragraph (b) are less
207.10 than 95 percent of the ~~county's~~ lead agency's adjusted base allocation, the allocation
207.11 for the next fiscal year is the adjusted base allocation less the amount of unspent funds
207.12 below the 95 percent level.

207.13 (e) If the annual legislative appropriation for the alternative care program is
207.14 inadequate to fund the combined ~~county~~ lead agency allocations for a biennium, the
207.15 commissioner shall distribute to each ~~county~~ lead agency the entire annual appropriation
207.16 as that ~~county's~~ lead agency's percentage of the computed base as calculated in paragraphs
207.17 (c) and (d).

207.18 (f) On agreement between the commissioner and the lead agency, the commissioner
207.19 may have discretion to reallocate alternative care base allocations distributed to lead
207.20 agencies in which the base amount exceeds program expenditures.

207.21 Sec. 41. Minnesota Statutes 2006, section 256B.0913, subdivision 11, is amended to
207.22 read:

207.23 Subd. 11. **Targeted funding.** (a) The purpose of targeted funding is to make
207.24 additional money available to ~~counties~~ lead agencies with the greatest need. Targeted
207.25 funds are not intended to be distributed equitably among all ~~counties~~ lead agencies, but
207.26 rather, allocated to those with long-term care strategies that meet state goals.

207.27 (b) The funds available for targeted funding shall be the total appropriation for each
207.28 fiscal year minus ~~county~~ lead agency allocations determined under subdivision 10 as
207.29 adjusted for any inflation increases provided in appropriations for the biennium.

207.30 (c) The commissioner shall allocate targeted funds to ~~counties~~ lead agencies that
207.31 demonstrate to the satisfaction of the commissioner that they have developed feasible
207.32 plans to increase alternative care spending. In making targeted funding allocations, the
207.33 commissioner shall use the following priorities:

(1) ~~counties~~ lead agencies that received a lower allocation in fiscal year 1991 than in fiscal year 1990. Counties remain in this priority until they have been restored to their fiscal year 1990 level plus inflation;

(2) ~~counties~~ lead agencies that sustain a base allocation reduction for failure to spend 95 percent of the allocation if they demonstrate that the base reduction should be restored;

(3) ~~counties~~ lead agencies that propose projects to divert community residents from nursing home placement or convert nursing home residents to community living; and

(4) ~~counties~~ lead agencies that can otherwise justify program growth by demonstrating the existence of waiting lists, demographically justified needs, or other unmet needs.

(d) ~~Counties~~ Lead agencies that would receive targeted funds according to paragraph (c) must demonstrate to the commissioner's satisfaction that the funds would be appropriately spent by showing how the funds would be used to further the state's alternative care goals as described in subdivision 1, and that the county has the administrative and service delivery capability to use them.

(e) The commissioner shall ~~request applications~~ make applications available for targeted funds by November 1 of each year. The ~~counties~~ lead agencies selected for targeted funds shall be notified of the amount of their additional funding. Targeted funds allocated to a ~~county~~ lead agency in one year shall be treated as part of the ~~county's~~ lead agency's base allocation for that year in determining allocations for subsequent years. No reallocations between ~~counties~~ lead agencies shall be made.

Sec. 42. Minnesota Statutes 2006, section 256B.0913, subdivision 12, is amended to read:

Subd. 12. **Client fees.** (a) A fee is required for all alternative care eligible clients to help pay for the cost of participating in the program. The amount of the fee for the alternative care client shall be determined as follows:

(1) when the alternative care client's income less recurring and predictable medical expenses is less than 100 percent of the federal poverty guideline effective on July 1 of the state fiscal year in which the fee is being computed, and total assets are less than \$10,000, the fee is zero;

(2) when the alternative care client's income less recurring and predictable medical expenses is equal to or greater than 100 percent but less than 150 percent of the federal poverty guideline effective on July 1 of the state fiscal year in which the fee is being computed, and total assets are less than \$10,000, the fee is five percent of the cost of alternative care services;

(3) when the alternative care client's income less recurring and predictable medical expenses is equal to or greater than 150 percent but less than 200 percent of the federal poverty guidelines effective on July 1 of the state fiscal year in which the fee is being computed and assets are less than \$10,000, the fee is 15 percent of the cost of alternative care services;

(4) when the alternative care client's income less recurring and predictable medical expenses is equal to or greater than 200 percent of the federal poverty guidelines effective on July 1 of the state fiscal year in which the fee is being computed and assets are less than \$10,000, the fee is 30 percent of the cost of alternative care services; and

(5) when the alternative care client's assets are equal to or greater than \$10,000, the fee is 30 percent of the cost of alternative care services.

For married persons, total assets are defined as the total marital assets less the estimated community spouse asset allowance, under section 256B.059, if applicable. For married persons, total income is defined as the client's income less the monthly spousal allotment, under section 256B.058.

All alternative care services shall be included in the estimated costs for the purpose of determining the fee.

Fees are due and payable each month alternative care services are received unless the actual cost of the services is less than the fee, in which case the fee is the lesser amount.

(b) The fee shall be waived by the commissioner when:

(1) a person ~~who is residing in a nursing facility is receiving case management only;~~

(2) a married couple is requesting an asset assessment under the spousal impoverishment provisions;

(3) a person is found eligible for alternative care, but is not yet receiving alternative care services including case management services; or

(4) a person has chosen to participate in a consumer-directed service plan for which the cost is no greater than the total cost of the person's alternative care service plan less the monthly fee amount that would otherwise be assessed.

~~(c) The county agency must record in the state's receivable system the client's assessed fee amount or the reason the fee has been waived. The commissioner will bill and collect the fee from the client. Money collected must be deposited in the general fund and is appropriated to the commissioner for the alternative care program. The client must supply the county lead agency with the client's Social Security number at the time of application. The county lead agency shall supply the commissioner with the client's Social Security number and other information the commissioner requires to collect the fee from the client. The commissioner shall collect unpaid fees using the Revenue Recapture Act in~~

chapter 270A and other methods available to the commissioner. The commissioner may require ~~counties~~ county lead agencies to inform clients of the collection procedures that may be used by the state if a fee is not paid. This paragraph does not apply to alternative care pilot projects authorized in Laws 1993, First Special Session chapter 1, article 5, section 133, if a county operating under the pilot project reports the following dollar amounts to the commissioner quarterly:

- (1) total fees billed to clients;
- (2) total collections of fees billed; and
- (3) balance of fees owed by clients.

If a ~~county~~ county lead agency does not adhere to these reporting requirements, the commissioner may terminate the billing, collecting, and remitting portions of the pilot project and require the ~~county~~ county lead agency involved to operate under the procedures set forth in this paragraph.

Sec. 43. Minnesota Statutes 2006, section 256B.0913, subdivision 13, is amended to read:

Subd. 13. **~~County~~ County Lead agency biennial plan.** The ~~county~~ county lead agency biennial plan for long-term care consultation services under section 256B.0911, the alternative care program under this section, and waivers for the elderly under section 256B.0915, shall be submitted by the lead agency as the home and community-based services quality assurance plan on a form provided by the commissioner.

Sec. 44. Minnesota Statutes 2006, section 256B.0913, subdivision 14, is amended to read:

Subd. 14. **Provider requirements, payment, and rate adjustments.** (a) Unless otherwise specified in statute, providers must be enrolled as Minnesota health care program providers and abide by the requirements for provider participation according to Minnesota Rules, part 9505.0195.

(b) Payment for provided alternative care services as approved by the client's case manager shall occur through the invoice processing procedures of the department's Medicaid Management Information System (MMIS). To receive payment, the ~~county~~ county lead agency or vendor must submit invoices within 12 months following the date of service. The ~~county~~ county lead agency and its vendors under contract shall not be reimbursed for services which exceed the county allocation.

(c) The ~~county~~ county lead agency shall negotiate individual rates with vendors and may authorize service payment for actual costs up to the county's current approved rate. Notwithstanding any other rule or statutory provision to the contrary, the commissioner

211.1 shall not be authorized to increase rates by an annual inflation factor, unless so authorized
211.2 by the legislature. To improve access to community services and eliminate payment
211.3 disparities between the alternative care program and the elderly waiver program, the
211.4 commissioner shall establish statewide maximum service rate limits and eliminate
211.5 county-specific service rate limits.

211.6 (1) Effective July 1, 2001, for service rate limits, except those in subdivision 5,
211.7 paragraphs (d) and (i), the rate limit for each service shall be the greater of the alternative
211.8 care statewide maximum rate or the elderly waiver statewide maximum rate.

211.9 (2) ~~Counties~~ Lead agencies may negotiate individual service rates with vendors for
211.10 actual costs up to the statewide maximum service rate limit.

211.11 Sec. 45. Minnesota Statutes 2006, section 256B.0915, is amended to read:

211.12 **256B.0915 MEDICAID WAIVER FOR ELDERLY SERVICES.**

211.13 Subdivision 1. **Authority.** The commissioner is authorized to apply for a home
211.14 and community-based services waiver for the elderly, authorized under section 1915(c)
211.15 of the Social Security Act, in order to obtain federal financial participation to expand
211.16 the availability of services for persons who are eligible for medical assistance. The
211.17 commissioner may apply for additional waivers or pursue other federal financial
211.18 participation which is advantageous to the state for funding home care services for the
211.19 frail elderly who are eligible for medical assistance. The provision of waived services
211.20 to elderly and disabled medical assistance recipients must comply with the criteria for
211.21 service definitions and provider standards approved in the waiver.

211.22 Subd. 1a. **Elderly waiver case management services.** (a) Elderly case management
211.23 services under the home and community-based services waiver for elderly individuals are
211.24 available from providers meeting qualification requirements and the standards specified
211.25 in subdivision 1b. Eligible recipients may choose any qualified provider of elderly case
211.26 management services.

211.27 Case management services assist individuals who receive waiver services in gaining
211.28 access to needed waiver and other state plan services, as well as needed medical, social,
211.29 educational, and other services regardless of the funding source for the services to which
211.30 access is gained.

211.31 A case aide shall provide assistance to the case manager in carrying out
211.32 administrative activities of the case management function. The case aide may not assume
211.33 responsibilities that require professional judgment including assessments, reassessments,
211.34 and care plan development. The case manager is responsible for providing oversight of
211.35 the case aide.

212.1 Case managers shall be responsible for ongoing monitoring of the provision of
212.2 services included in the individual's plan of care. Case managers shall initiate and oversee
212.3 the process of assessment and reassessment of the individual's care and review plan of
212.4 care at intervals specified in the federally approved waiver plan.

212.5 (b) The county of service or tribe must provide access to and arrange for case
212.6 management services. County of service has the meaning given it in Minnesota Rules,
212.7 part 9505.0015, subpart 11.

212.8 Subd. 1b. **Provider qualifications and standards.** The commissioner must
212.9 enroll qualified providers of elderly case management services under the home
212.10 and community-based waiver for the elderly under section 1915(c) of the Social
212.11 Security Act. The enrollment process shall ensure the provider's ability to meet the
212.12 qualification requirements and standards in this subdivision and other federal and state
212.13 requirements of this service. An elderly case management provider is an enrolled medical
212.14 assistance provider who is determined by the commissioner to have all of the following
212.15 characteristics:

212.16 (1) the demonstrated capacity and experience to provide the components of
212.17 case management to coordinate and link community resources needed by the eligible
212.18 population;

212.19 (2) administrative capacity and experience in serving the target population for
212.20 whom it will provide services and in ensuring quality of services under state and federal
212.21 requirements;

212.22 (3) a financial management system that provides accurate documentation of services
212.23 and costs under state and federal requirements;

212.24 (4) the capacity to document and maintain individual case records under state and
212.25 federal requirements; and

212.26 (5) the ~~county~~ lead agency may allow a case manager employed by the ~~county~~ lead
212.27 agency to delegate certain aspects of the case management activity to another individual
212.28 employed by the ~~county~~ lead agency provided there is oversight of the individual by
212.29 the case manager. The case manager may not delegate those aspects which require
212.30 professional judgment including assessments, reassessments, and care plan development.
212.31 Lead agencies include counties, health plans, and federally recognized tribes who
212.32 authorize services under this section.

212.33 ~~Subd. 1c. Case management activities under the state plan. The commissioner~~
212.34 ~~shall seek an amendment to the home and community-based services waiver for the~~
212.35 ~~elderly to implement the provisions of subdivisions 1a and 1b. If the commissioner~~
212.36 ~~is unable to secure the approval of the secretary of health and human services for the~~

~~requested waiver amendment by December 31, 1993, the commissioner shall amend the medical assistance state plan to provide that case management provided under the home and community-based services waiver for the elderly is performed by counties as an administrative function for the proper and effective administration of the state medical assistance plan. The state shall reimburse counties for the nonfederal share of costs for case management performed as an administrative function under the home and community-based services waiver for the elderly.~~

Subd. 1d. **Posteligibility treatment of income and resources for elderly waiver.**

Notwithstanding the provisions of section 256B.056, the commissioner shall make the following amendment to the medical assistance elderly waiver program effective July 1, 1999, or upon federal approval, whichever is later.

A recipient's maintenance needs will be an amount equal to the Minnesota supplemental aid equivalent rate as defined in section 256I.03, subdivision 5, plus the medical assistance personal needs allowance as defined in section 256B.35, subdivision 1, paragraph (a), when applying posteligibility treatment of income rules to the gross income of elderly waiver recipients, except for individuals whose income is in excess of the special income standard according to Code of Federal Regulations, title 42, section 435.236. Recipient maintenance needs shall be adjusted under this provision each July 1.

Subd. 2. **Spousal impoverishment policies.** The commissioner shall ~~seek to amend the federal waiver and the medical assistance state plan to allow~~ apply:

(1) the spousal impoverishment criteria as authorized under United States Code, title 42, section 1396r-5, and as implemented in sections 256B.0575, 256B.058, and 256B.059;
~~except that the amendment shall seek to add to;~~

(2) the personal needs allowance permitted in section 256B.0575; and

(3) an amount equivalent to the group residential housing rate as set by section 256I.03, subdivision 5, and according to the approved federal waiver and medical assistance state plan.

Subd. 3. **Limits of cases.** The number of medical assistance waiver recipients that a ~~county~~ lead agency may serve must be allocated according to the number of medical assistance waiver cases open on July 1 of each fiscal year. Additional recipients may be served with the approval of the commissioner.

Subd. 3a. **Elderly waiver cost limits.** (a) The monthly limit for the cost of waived services to an individual elderly waiver client shall be the weighted average monthly nursing facility rate of the case mix resident class to which the elderly waiver client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, less the recipient's maintenance needs allowance as described in subdivision 1d, paragraph (a), until the first

214.1 day of the state fiscal year in which the resident assessment system as described in section
214.2 256B.437 for nursing home rate determination is implemented. Effective on the first day
214.3 of the state fiscal year in which the resident assessment system as described in section
214.4 256B.437 for nursing home rate determination is implemented and the first day of each
214.5 subsequent state fiscal year, the monthly limit for the cost of waived services to an
214.6 individual elderly waiver client shall be the rate of the case mix resident class to which the
214.7 waiver client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059,
214.8 in effect on the last day of the previous state fiscal year, adjusted by the greater of any
214.9 legislatively adopted home and community-based services percentage rate increase or the
214.10 average statewide percentage increase in nursing facility payment rates.

214.11 (b) If extended medical supplies and equipment or environmental modifications are
214.12 or will be purchased for an elderly waiver client, the costs may be prorated for up to
214.13 12 consecutive months beginning with the month of purchase. If the monthly cost of a
214.14 recipient's waived services exceeds the monthly limit established in paragraph (a), the
214.15 annual cost of all waived services shall be determined. In this event, the annual cost of
214.16 all waived services shall not exceed 12 times the monthly limit of waived services as
214.17 described in paragraph (a).

214.18 Subd. 3b. **Cost limits for elderly waiver applicants who reside in a nursing**
214.19 **facility.** (a) For a person who is a nursing facility resident at the time of requesting a
214.20 determination of eligibility for elderly waived services, a monthly conversion limit for
214.21 the cost of elderly waived services may be requested. The monthly conversion limit for
214.22 the cost of elderly waiver services shall be the resident class assigned under Minnesota
214.23 Rules, parts 9549.0050 to 9549.0059, for that resident in the nursing facility where
214.24 the resident currently resides until July 1 of the state fiscal year in which the resident
214.25 assessment system as described in section 256B.437 for nursing home rate determination
214.26 is implemented. Effective on July 1 of the state fiscal year in which the resident
214.27 assessment system as described in section 256B.437 for nursing home rate determination
214.28 is implemented, the monthly conversion limit for the cost of elderly waiver services
214.29 shall be the per diem nursing facility rate as determined by the resident assessment
214.30 system as described in section 256B.437 for that resident in the nursing facility where
214.31 the resident currently resides multiplied by 365 and divided by 12, less the recipient's
214.32 maintenance needs allowance as described in subdivision 1d. The initially approved
214.33 conversion rate may be adjusted by the greater of any subsequent legislatively adopted
214.34 home and community-based services percentage rate increase or the average statewide
214.35 percentage increase in nursing facility payment rates. The limit under this subdivision
214.36 only applies to persons discharged from a nursing facility after a minimum 30-day stay

215.1 and found eligible for waived services on or after July 1, 1997. For conversions from the
215.2 nursing home to the elderly waiver with consumer directed community support services,
215.3 the conversion rate limit is equal to the nursing facility rate reduced by a percentage equal
215.4 to the percentage difference between the consumer directed services budget limit that
215.5 would be assigned according to the federally approved waiver plan and the corresponding
215.6 community case mix cap, but not to exceed 50 percent.

215.7 (b) The following costs must be included in determining the total monthly costs
215.8 for the waiver client:

215.9 (1) cost of all waived services, including extended medical supplies and equipment
215.10 and environmental modifications and adaptations; and

215.11 (2) cost of skilled nursing, home health aide, and personal care services reimbursable
215.12 by medical assistance.

215.13 Subd. 3c. **Service approval and contracting provisions.** (a) Medical assistance
215.14 funding for skilled nursing services, private duty nursing, home health aide, and personal
215.15 care services for waiver recipients must be approved by the case manager and included in
215.16 the individual care plan.

215.17 (b) A ~~county~~ lead agency is not required to contract with a provider of supplies and
215.18 equipment if the monthly cost of the supplies and equipment is less than \$250.

215.19 Subd. 3d. **Adult foster care rate.** The adult foster care rate shall be considered
215.20 a difficulty of care payment and shall not include room and board. The adult foster
215.21 care service rate shall be negotiated between the ~~county~~ lead agency and the foster care
215.22 provider. The elderly waiver payment for the foster care service in combination with
215.23 the payment for all other elderly waiver services, including case management, must not
215.24 exceed the limit specified in subdivision 3a, paragraph (a).

215.25 Subd. 3e. ~~Assisted living~~ **Customized living service rate.** (a) Payment for ~~assisted~~
215.26 ~~living service~~ customize living services shall be a monthly rate negotiated and authorized
215.27 by the ~~county agency based on an individualized service plan for each resident and may~~
215.28 ~~not cover direct rent or food costs.~~ lead agency within the parameters established by
215.29 the commissioner. The payment agreement must delineate the services that have been
215.30 customized for each recipient and specify the amount of each service to be provided. The
215.31 lead agency shall ensure that there is a documented need for all services authorized.
215.32 Customized living services must not include rent or raw food costs. The negotiated
215.33 payment rate must be based on services to be provided. Negotiated rates must not exceed
215.34 payment rates for comparable elderly waiver or medical assistance services and must
215.35 reflect economies of scale.

(b) The individualized monthly negotiated payment for ~~assisted living~~ customized living services ~~as described in section 256B.0913, subdivisions 5d to 5f, and residential care services as described in section 256B.0913, subdivision 5e,~~ shall not exceed the nonfederal share, in effect on July 1 of the state fiscal year for which the rate limit is being calculated, of the greater of either the statewide or any of the geographic groups' weighted average monthly nursing facility rate of the case mix resident class to which the elderly waiver eligible client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, less the maintenance needs allowance as described in subdivision 1d, paragraph (a), until the July 1 of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented. Effective on July 1 of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented and July 1 of each subsequent state fiscal year, the individualized monthly negotiated payment for the services described in this clause shall not exceed the limit described in this clause which was in effect on June 30 of the previous state fiscal year and which has been adjusted by the greater of any legislatively adopted home and community-based services cost-of-living percentage increase or any legislatively adopted statewide percent rate increase for nursing facilities.

(c) ~~The individualized monthly negotiated payment for assisted~~ Customized living services ~~described in section 144A.4605 and are~~ delivered by a provider licensed by the Department of Health as a class A or class F home care provider ~~or an assisted living home care provider~~ and provided in a building that is registered as a housing with services establishment under chapter 144D ~~and that provides 24-hour supervision in combination with the payment for other elderly waiver services, including case management, must not exceed the limit specified in subdivision 3a.~~

Subd. 3f. **Individual service rates; expenditure forecasts.** (a) The ~~county~~ lead agency shall negotiate individual service rates with vendors and may authorize payment for actual costs up to the ~~county's~~ lead agency's current approved rate. Persons or agencies must be employed by or under a contract with the ~~county~~ lead agency or the public health nursing agency of the local board of health in order to receive funding under the elderly waiver program, except as a provider of supplies and equipment when the monthly cost of the supplies and equipment is less than \$250.

(b) Reimbursement for the medical assistance recipients under the approved waiver shall be made from the medical assistance account through the invoice processing procedures of the department's Medicaid Management Information System (MMIS), only with the approval of the client's case manager. The budget for the state share of the

217.1 Medicaid expenditures shall be forecasted with the medical assistance budget, and shall
217.2 be consistent with the approved waiver.

217.3 Subd. 3g. **Service rate limits; state assumption of costs.** (a) To improve access
217.4 to community services and eliminate payment disparities between the alternative care
217.5 program and the elderly waiver, the commissioner shall establish statewide maximum
217.6 service rate limits and eliminate ~~county-specific~~ lead agency-specific service rate limits.

217.7 (b) Effective July 1, 2001, for service rate limits, except those described or defined in
217.8 subdivisions 3d and 3e, the rate limit for each service shall be the greater of the alternative
217.9 care statewide maximum rate or the elderly waiver statewide maximum rate.

217.10 (c) ~~Counties~~ Lead agencies may negotiate individual service rates with vendors for
217.11 actual costs up to the statewide maximum service rate limit.

217.12 Subd. 3h. **Service rate limits; 24-hour customized living services.** The payment
217.13 rates for 24-hour customized living services is a monthly rate negotiated and authorized by
217.14 the lead agency within the parameters established by the commissioner of human services.
217.15 The payment agreement must delineate the services that have been customized for each
217.16 recipient and specify the amount of each service to be provided. The lead agency shall
217.17 ensure that there is a documented need for all services authorized. The lead agency shall
217.18 not authorize 24-hour customized living services unless there is a documented need for
217.19 24-hour supervision. For purposes of this section, "24-hour supervision" means that the
217.20 recipient requires assistance due to needs related to one or more of the following:

217.21 (1) intermittent assistance with toileting or transferring;

217.22 (2) cognitive or behavioral issues;

217.23 (3) a medical condition that requires clinical monitoring; or

217.24 (4) other conditions or needs as defined by the commissioner of human services.

217.25 The lead agency shall ensure that the frequency and mode of supervision of the recipient
217.26 and the qualifications of staff providing supervision are described and meet the needs
217.27 of the recipient. Customized living services must not include rent or raw food costs.

217.28 The negotiated payment rate for 24-hour customized living services must be based on
217.29 services to be provided. Negotiated rates must not exceed payment rates for comparable
217.30 elderly waiver or medical assistance services and must reflect economies of scale. The
217.31 individually negotiated 24-hour customized living payments, in combination with the
217.32 payment for other elderly waiver services, including case management, must not exceed
217.33 the recipient's community budget cap specified in subdivision 3a.

217.34 Subd. 4. **Termination notice.** The case manager must give the individual a ten-day
217.35 written notice of any denial, reduction, or termination of waived services.

218.1 Subd. 5. **Assessments and reassessments for waiver clients.** Each client shall
218.2 receive an initial assessment of strengths, informal supports, and need for services in
218.3 accordance with section 256B.0911, subdivisions 3, 3a, and 3b. A reassessment of a
218.4 client served under the elderly waiver must be conducted at least every 12 months and
218.5 at other times when the case manager determines that there has been significant change
218.6 in the client's functioning. This may include instances where the client is discharged
218.7 from the hospital.

218.8 Subd. 6. **Implementation of care plan.** Each elderly waiver client shall be provided
218.9 a copy of a written care plan that meets the requirements outlined in section 256B.0913,
218.10 subdivision 8. The care plan must be implemented by the county ~~administering waived~~
218.11 ~~services~~ of service when it is different than the county of financial responsibility. The
218.12 county of service administering waived services must notify the county of financial
218.13 responsibility of the approved care plan.

218.14 Subd. 7. **Prepaid elderly waiver services.** An individual for whom a prepaid health
218.15 plan is liable for nursing home services or elderly waiver services according to section
218.16 256B.69, subdivision 6a, is not eligible to also receive county-administered elderly waiver
218.17 services ~~under this section~~.

218.18 Subd. 8. **Services and supports.** (a) Services and supports shall meet the
218.19 requirements set out in United States Code, title 42, section 1396n.

218.20 (b) Services and supports shall promote consumer choice and be arranged and
218.21 provided consistent with individualized, written care plans.

218.22 (c) The state of Minnesota, county, managed care organization, or tribal government
218.23 under contract to administer the elderly waiver shall not be liable for damages, injuries,
218.24 or liabilities sustained through the purchase of direct supports or goods by the person,
218.25 the person's family, or the authorized representatives with funds received through
218.26 consumer-directed community support services under the federally approved waiver plan.
218.27 Liabilities include, but are not limited to, workers' compensation liability, the Federal
218.28 Insurance Contributions Act (FICA), or the Federal Unemployment Tax Act (FUTA).

218.29 Subd. 9. **Tribal management of elderly waiver.** Notwithstanding contrary
218.30 provisions of this section, or those in other state laws or rules, the commissioner may
218.31 develop a model for tribal management of the elderly waiver program and implement this
218.32 model through a contract between the state and any of the state's federally recognized tribal
218.33 governments. The model shall include the provision of tribal waiver case management,
218.34 assessment for personal care assistance, and administrative requirements otherwise carried
218.35 out by ~~counties~~ lead agencies but shall not include tribal financial eligibility determination
218.36 for medical assistance.

219.1 **EFFECTIVE DATE.** Subdivision 3h is effective the day following final enactment.

219.2 Sec. 46. Minnesota Statutes 2006, section 256B.0917, subdivision 8, is amended to
219.3 read:

219.4 Subd. 8. **Living-at-home/block nurse program grant.** (a) The organization
219.5 awarded the contract under subdivision 7, shall develop and administer a grant program
219.6 to establish or expand up to ~~33~~ 51 community-based organizations that will implement
219.7 living-at-home/block nurse programs that are designed to enable senior citizens to live as
219.8 independently as possible in their homes and in their communities. At least one-half of
219.9 the programs must be in counties outside the seven-county metropolitan area. Nonprofit
219.10 organizations and units of local government are eligible to apply for grants to establish
219.11 the community organizations that will implement living-at-home/block nurse programs.
219.12 In awarding grants, the organization awarded the contract under subdivision 7 shall give
219.13 preference to nonprofit organizations and units of local government from communities
219.14 that:

219.15 (1) have high nursing home occupancy rates;

219.16 (2) have a shortage of health care professionals;

219.17 (3) are located in counties adjacent to, or are located in, counties with existing
219.18 living-at-home/block nurse programs; and

219.19 (4) meet other criteria established by LAH/BN, Inc., in consultation with the
219.20 commissioner.

219.21 (b) Grant applicants must also meet the following criteria:

219.22 (1) the local community demonstrates a readiness to establish a community model
219.23 of care, including the formation of a board of directors, advisory committee, or similar
219.24 group, of which at least two-thirds is comprised of community citizens interested in
219.25 community-based care for older persons;

219.26 (2) the program has sponsorship by a credible, representative organization within
219.27 the community;

219.28 (3) the program has defined specific geographic boundaries and defined its
219.29 organization, staffing and coordination/delivery of services;

219.30 (4) the program demonstrates a team approach to coordination and care, ensuring
219.31 that the older adult participants, their families, the formal and informal providers are all
219.32 part of the effort to plan and provide services; and

219.33 (5) the program provides assurances that all community resources and funding will
219.34 be coordinated and that other funding sources will be maximized, including a person's
219.35 own resources.

(c) Grant applicants must provide a minimum of five percent of total estimated development costs from local community funding. Grants shall be awarded for four-year periods, and the base amount shall not exceed ~~\$80,000~~ \$100,000 per applicant for the grant period. The organization under contract may increase the grant amount for applicants from communities that have socioeconomic characteristics that indicate a higher level of need for assistance. Subject to the availability of funding, grants and grant renewals awarded or entered into on or after July 1, 1997, shall be renewed by LAH/BN, Inc. every four years, unless LAH/BN, Inc. determines that the grant recipient has not satisfactorily operated the living-at-home/block nurse program in compliance with the requirements of paragraphs (b) and (d). Grants provided to living-at-home/block nurse programs under this paragraph may be used for both program development and the delivery of services.

(d) Each living-at-home/block nurse program shall be designed by representatives of the communities being served to ensure that the program addresses the specific needs of the community residents. The programs must be designed to:

(1) incorporate the basic community, organizational, and service delivery principles of the living-at-home/block nurse program model;

(2) provide senior citizens with registered nurse directed assessment, provision and coordination of health and personal care services on a sliding fee basis as an alternative to expensive nursing home care;

(3) provide information, support services, homemaking services, counseling, and training for the client and family caregivers;

(4) encourage the development and use of respite care, caregiver support, and in-home support programs, such as adult foster care and in-home adult day care;

(5) encourage neighborhood residents and local organizations to collaborate in meeting the needs of senior citizens in their communities;

(6) recruit, train, and direct the use of volunteers to provide informal services and other appropriate support to senior citizens and their caregivers; and

(7) provide coordination and management of formal and informal services to senior citizens and their families using less expensive alternatives.

Sec. 47. Minnesota Statutes 2006, section 256B.0919, subdivision 3, is amended to read:

Subd. 3. **County certification of persons providing adult foster care to related persons.** A person exempt from licensure under section 245A.03, subdivision 2, who provides adult foster care to a related individual age 65 and older, and who meets the requirements in Minnesota Rules, parts 9555.5105 to 9555.6265, may be certified by the

221.1 county to provide adult foster care. A person certified by the county to provide adult foster
221.2 care may be reimbursed for services provided and eligible for funding under ~~sections~~
221.3 ~~256B.0913 and~~ section 256B.0915, if the relative would suffer a financial hardship as
221.4 a result of providing care. For purposes of this subdivision, financial hardship refers
221.5 to a situation in which a relative incurs a substantial reduction in income as a result of
221.6 resigning from a full-time job or taking a leave of absence without pay from a full-time
221.7 job to care for the client.

221.8 Sec. 48. Minnesota Statutes 2006, section 256B.095, is amended to read:

221.9 **256B.095 QUALITY ASSURANCE SYSTEM ESTABLISHED.**

221.10 (a) Effective July 1, 1998, a quality assurance system for persons with developmental
221.11 disabilities, which includes an alternative quality assurance licensing system for programs,
221.12 is established in Dodge, Fillmore, Freeborn, Goodhue, Houston, Mower, Olmsted, Rice,
221.13 Steele, Wabasha, and Winona Counties for the purpose of improving the quality of
221.14 services provided to persons with developmental disabilities. A county, at its option, may
221.15 choose to have all programs for persons with developmental disabilities located within
221.16 the county licensed under chapter 245A using standards determined under the alternative
221.17 quality assurance licensing system or may continue regulation of these programs under
221.18 the licensing system operated by the commissioner. The project expires on June 30,
221.19 ~~2009~~ 2014.

221.20 (b) Effective July 1, 2003, a county not listed in paragraph (a) may apply to
221.21 participate in the quality assurance system established under paragraph (a). The
221.22 commission established under section 256B.0951 may, at its option, allow additional
221.23 counties to participate in the system.

221.24 (c) Effective July 1, 2003, any county or group of counties not listed in paragraph (a)
221.25 may establish a quality assurance system under this section. A new system established
221.26 under this section shall have the same rights and duties as the system established
221.27 under paragraph (a). A new system shall be governed by a commission under section
221.28 256B.0951. The commissioner shall appoint the initial commission members based
221.29 on recommendations from advocates, families, service providers, and counties in the
221.30 geographic area included in the new system. Counties that choose to participate in a
221.31 new system shall have the duties assigned under section 256B.0952. The new system
221.32 shall establish a quality assurance process under section 256B.0953. The provisions of
221.33 section 256B.0954 shall apply to a new system established under this paragraph. The
221.34 commissioner shall delegate authority to a new system established under this paragraph
221.35 according to section 256B.0955.

222.1 (d) Effective July 1, 2007, the quality assurance system may be expanded to include
222.2 programs for persons with disabilities and older adults.

222.3 Sec. 49. Minnesota Statutes 2006, section 256B.0951, subdivision 1, is amended to
222.4 read:

222.5 Subdivision 1. **Membership.** The Quality Assurance Commission is established.
222.6 The commission consists of at least 14 but not more than 21 members as follows: at
222.7 least three but not more than five members representing advocacy organizations; at
222.8 least three but not more than five members representing consumers, families, and their
222.9 legal representatives; at least three but not more than five members representing service
222.10 providers; at least three but not more than five members representing counties; and the
222.11 commissioner of human services or the commissioner's designee. The first commission
222.12 shall establish membership guidelines for the transition and recruitment of membership for
222.13 the commission's ongoing existence. Members of the commission who do not receive a
222.14 salary or wages from an employer for time spent on commission duties may receive a per
222.15 diem payment when performing commission duties and functions. All members may be
222.16 reimbursed for expenses related to commission activities. Notwithstanding the provisions
222.17 of section 15.059, subdivision 5, the commission expires on June 30, ~~2009~~ 2014.

222.18 Sec. 50. **[256B.096] QUALITY MANAGEMENT; ASSURANCE; AND**
222.19 **IMPROVEMENT SYSTEM FOR MINNESOTANS RECEIVING DISABILITY**
222.20 **SERVICES.**

222.21 Subdivision 1. **Scope.** In order to improve the quality of services provided to
222.22 Minnesotans with disabilities and to meet the requirements of the federally approved home
222.23 and community-based waivers under section 1915c of the Social Security Act, a statewide
222.24 quality assurance and improvement system for Minnesotans receiving disability services
222.25 shall be developed. The disability services included are the home and community-based
222.26 services waiver programs for persons with developmental disabilities under section
222.27 256B.092, subdivision 4, and persons with disabilities under section 256B.49.

222.28 Subd. 2. **Stakeholder advisory group.** The commissioner shall consult with a
222.29 stakeholder advisory group on the development and implementation of the state quality
222.30 management, assurance, and improvement system, including representatives from:
222.31 disability service recipients, disability service providers, disability advocacy groups,
222.32 county human service agencies, and state agency staff from the Departments of Human
222.33 Services and Health and ombudsman for mental health and developmental disabilities on
222.34 the development of a statewide quality assurance and improvement system.

223.1 Subd. 3. **Annual survey of service recipients.** The commissioner, in consultation
223.2 with the stakeholder advisory group, shall develop and conduct an annual independent
223.3 random statewide survey of between five and ten percent of service recipients to determine
223.4 the effectiveness and quality of disability services. The survey shall be consistent with
223.5 the system performance expectations of the Centers for Medicare and Medicaid Services
223.6 quality management requirements and framework. The survey shall analyze whether
223.7 desired outcomes have been achieved for persons with different demographic, diagnostic,
223.8 health, and functional needs and receiving different types of services, in different settings,
223.9 with different costs. The survey shall be field tested during 2008 and implemented by
223.10 February 1, 2009. Annual statewide and regional reports of the results shall be published
223.11 for use by regions, counties, and providers to plan and measure the impact of quality
223.12 improvement activities.

223.13 Subd. 4. **Improvements for incident reporting, investigation, analysis, and**
223.14 **follow-up.** In consultation with the stakeholder advisory group, the commissioner shall
223.15 identify the information, data sources, and technology needed to improve the system
223.16 of incident reporting, including:

- 223.17 (1) reports made under the Maltreatment of Minors and Vulnerable Adults Acts; and
223.18 (2) investigation, analysis, and follow-up for disability services.

223.19 The commissioner must ensure that the federal home and community-based waiver
223.20 requirements are met and that incidents that may have jeopardized safety; health; or
223.21 violated service-related assurances, civil and human rights, and other protections designed
223.22 to prevent abuse, neglect, and exploitation are reviewed, investigated, and acted upon
223.23 in a timely manner.

223.24 Subd. 5. **Biennial report.** The commissioner shall provide a biennial report to the
223.25 chairs of the legislative committees with jurisdiction over health and human services
223.26 policy and funding beginning January 15, 2009, on the development and activities of the
223.27 quality management, assurance, and improvement system designed to meet the federal
223.28 requirements under the home and community-based services waiver programs for persons
223.29 with disabilities. By January 15, 2008, the commissioner shall provide a preliminary
223.30 report on the priorities for meeting the federal requirements, progress on the annual
223.31 survey, recommendations for improvements in the incident reporting system, and a plan
223.32 for incorporating the quality assurance efforts under section 256B.095 and other regional
223.33 efforts into the statewide system.

223.34 Sec. 51. Minnesota Statutes 2006, section 256B.431, subdivision 1, is amended to read:

Subdivision 1. **In general.** The commissioner shall determine prospective payment rates for resident care costs. For rates established on or after July 1, 1985, the commissioner shall develop procedures for determining operating cost payment rates that take into account the mix of resident needs, geographic location, and other factors as determined by the commissioner. The commissioner shall consider whether the fact that a facility is attached to a hospital or has an average length of stay of 180 days or less should be taken into account in determining rates. The commissioner shall consider the use of the standard metropolitan statistical areas when developing groups by geographic location. The commissioner shall provide notice to each nursing facility on or before ~~May 1~~ August 15 of the rates effective for the following rate year except that if legislation is pending on ~~May 1~~ August 15 that may affect rates for nursing facilities, the commissioner shall set the rates after the legislation is enacted and provide notice to each facility as soon as possible.

Compensation for top management personnel shall continue to be categorized as a general and administrative cost and is subject to any limits imposed on that cost category.

Sec. 52. Minnesota Statutes 2006, section 256B.431, subdivision 2e, is amended to read:

Subd. 2e. **Contracts for services for ventilator-dependent persons.** (a) The commissioner may negotiate with a nursing facility eligible to receive medical assistance payments to provide services to a ventilator-dependent person identified by the commissioner according to criteria developed by the commissioner, including:

(1) nursing facility care has been recommended for the person by a preadmission screening team;

(2) the person has been hospitalized and no longer requires inpatient acute care hospital services; and

(3) the commissioner has determined that necessary services for the person cannot be provided under existing nursing facility rates.

The commissioner may negotiate an adjustment to the operating cost payment rate for a nursing facility with a resident who is ventilator-dependent, for that resident. The negotiated adjustment must reflect only the actual additional cost of meeting the specialized care needs of a ventilator-dependent person identified by the commissioner for whom necessary services cannot be provided under existing nursing facility rates and which are not otherwise covered under Minnesota Rules, parts 9549.0010 to 9549.0080 or 9505.0170 to 9505.0475. For persons who are initially admitted to a nursing facility before July 1, 2001, and have their payment rate under this subdivision negotiated after July 1, 2001, the negotiated payment rate must not exceed 200 percent of the highest multiple

bedroom payment rate for the facility, as initially established by the commissioner for the rate year for case mix classification K; or, upon implementation of the RUG's-based case mix system, 200 percent of the highest RUG's rate. For persons initially admitted to a nursing facility on or after July 1, 2001, the negotiated payment rate must not exceed 300 percent of the facility's multiple bedroom payment rate for case mix classification K; or, upon implementation of the RUG's-based case mix system, 300 percent of the highest RUG's rate. The negotiated adjustment shall not affect the payment rate charged to private paying residents under the provisions of section 256B.48, subdivision 1.

(b) Effective July 1, 2007, or upon opening a unit of at least ten beds dedicated to care of ventilator-dependent persons in partnership with Mayo Health Systems, whichever is later, the operating payment rates for residents determined eligible under paragraph (a) of a nursing facility in Waseca County that on February 1, 2007, was licensed for 70 beds and reimbursed under this section, section 256B.434, or section 256B.441, shall be 300 percent of the facility's highest RUG rate.

Sec. 53. Minnesota Statutes 2006, section 256B.431, subdivision 3f, is amended to read:

Subd. 3f. **Property costs after July 1, 1988.** (a) **Investment per bed limit.** For the rate year beginning July 1, 1988, the replacement-cost-new per bed limit must be \$32,571 per licensed bed in multiple bedrooms and \$48,857 per licensed bed in a single bedroom. For the rate year beginning July 1, 1989, the replacement-cost-new per bed limit for a single bedroom must be \$49,907 adjusted according to Minnesota Rules, part 9549.0060, subpart 4, item A, subitem (1). Beginning January 1, 1990, the replacement-cost-new per bed limits must be adjusted annually as specified in Minnesota Rules, part 9549.0060, subpart 4, item A, subitem (1). Beginning January 1, 1991, the replacement-cost-new per bed limits will be adjusted annually as specified in Minnesota Rules, part 9549.0060, subpart 4, item A, subitem (1), except that the index utilized will be the Bureau of ~~the Census: Composite fixed-weighted price index as published in the C30 Report, Value of New Construction Put in Place~~ Economic Analysis: Price Indexes for Private Fixed Investments in Structures; Special Care.

(b) **Rental factor.** For the rate year beginning July 1, 1988, the commissioner shall increase the rental factor as established in Minnesota Rules, part 9549.0060, subpart 8, item A, by 6.2 percent rounded to the nearest 100th percent for the purpose of reimbursing nursing facilities for soft costs and entrepreneurial profits not included in the cost valuation services used by the state's contracted appraisers. For rate years beginning on or after July

1, 1989, the rental factor is the amount determined under this paragraph for the rate year beginning July 1, 1988.

(c) **Occupancy factor.** For rate years beginning on or after July 1, 1988, in order to determine property-related payment rates under Minnesota Rules, part 9549.0060, for all nursing facilities except those whose average length of stay in a skilled level of care within a nursing facility is 180 days or less, the commissioner shall use 95 percent of capacity days. For a nursing facility whose average length of stay in a skilled level of care within a nursing facility is 180 days or less, the commissioner shall use the greater of resident days or 80 percent of capacity days but in no event shall the divisor exceed 95 percent of capacity days.

(d) **Equipment allowance.** For rate years beginning on July 1, 1988, and July 1, 1989, the commissioner shall add ten cents per resident per day to each nursing facility's property-related payment rate. The ten-cent property-related payment rate increase is not cumulative from rate year to rate year. For the rate year beginning July 1, 1990, the commissioner shall increase each nursing facility's equipment allowance as established in Minnesota Rules, part 9549.0060, subpart 10, by ten cents per resident per day. For rate years beginning on or after July 1, 1991, the adjusted equipment allowance must be adjusted annually for inflation as in Minnesota Rules, part 9549.0060, subpart 10, item E. For the rate period beginning October 1, 1992, the equipment allowance for each nursing facility shall be increased by 28 percent. For rate years beginning after June 30, 1993, the allowance must be adjusted annually for inflation.

(e) **Post chapter 199 related-organization debts and interest expense.** For rate years beginning on or after July 1, 1990, Minnesota Rules, part 9549.0060, subpart 5, item E, shall not apply to outstanding related organization debt incurred prior to May 23, 1983, provided that the debt was an allowable debt under Minnesota Rules, parts 9510.0010 to 9510.0480, the debt is subject to repayment through annual principal payments, and the nursing facility demonstrates to the commissioner's satisfaction that the interest rate on the debt was less than market interest rates for similar arm's-length transactions at the time the debt was incurred. If the debt was incurred due to a sale between family members, the nursing facility must also demonstrate that the seller no longer participates in the management or operation of the nursing facility. Debts meeting the conditions of this paragraph are subject to all other provisions of Minnesota Rules, parts 9549.0010 to 9549.0080.

(f) **Building capital allowance for nursing facilities with operating leases.** For rate years beginning on or after July 1, 1990, a nursing facility with operating lease costs incurred for the nursing facility's buildings shall receive its building capital allowance

227.1 computed in accordance with Minnesota Rules, part 9549.0060, subpart 8. If an operating
227.2 lease provides that the lessee's rent is adjusted to recognize improvements made by the
227.3 lessor and related debt, the costs for capital improvements and related debt shall be allowed
227.4 in the computation of the lessee's building capital allowance, provided that reimbursement
227.5 for these costs under an operating lease shall not exceed the rate otherwise paid.

227.6 Sec. 54. Minnesota Statutes 2006, section 256B.431, subdivision 17e, is amended to
227.7 read:

227.8 Subd. 17e. **Replacement-costs-new per bed limit effective July 1, 2001.**

227.9 Notwithstanding Minnesota Rules, part 9549.0060, subpart 11, item C, subitem (2),
227.10 for a total replacement, as defined in ~~paragraph (f)~~ subdivision 17d, authorized under
227.11 section 144A.071 or 144A.073 after July 1, 1999, or any building project that is a
227.12 relocation, renovation, upgrading, or conversion completed on or after July 1, 2001, the
227.13 replacement-costs-new per bed limit shall be \$74,280 per licensed bed in multiple-bed
227.14 rooms, \$92,850 per licensed bed in semiprivate rooms with a fixed partition separating
227.15 the resident beds, and \$111,420 per licensed bed in single rooms. Minnesota Rules, part
227.16 9549.0060, subpart 11, item C, subitem (2), does not apply. These amounts must be
227.17 adjusted annually as specified in subdivision 3f, paragraph (a), beginning January 1, 2000.

227.18 Sec. 55. Minnesota Statutes 2006, section 256B.434, subdivision 4, is amended to read:

227.19 Subd. 4. **Alternate rates for nursing facilities.** (a) For nursing facilities which
227.20 have their payment rates determined under this section rather than section 256B.431, the
227.21 commissioner shall establish a rate under this subdivision. The nursing facility must enter
227.22 into a written contract with the commissioner.

227.23 (b) A nursing facility's case mix payment rate for the first rate year of a facility's
227.24 contract under this section is the payment rate the facility would have received under
227.25 section 256B.431.

227.26 (c) A nursing facility's case mix payment rates for the second and subsequent years
227.27 of a facility's contract under this section are the previous rate year's contract payment
227.28 rates plus an inflation adjustment and, for facilities reimbursed under this section or
227.29 section 256B.431, an adjustment to include the cost of any increase in Health Department
227.30 licensing fees for the facility taking effect on or after July 1, 2001. The index for the
227.31 inflation adjustment must be based on the change in the Consumer Price Index-all items
227.32 (United States City average) (CPI-U) forecasted by the commissioner of finance's national
227.33 economic consultant, as forecasted in the fourth quarter of the calendar year preceding
227.34 the rate year. The inflation adjustment must be based on the 12-month period from the

228.1 midpoint of the previous rate year to the midpoint of the rate year for which the rate
228.2 is being determined. For the rate years beginning on July 1, 1999, July 1, 2000, July
228.3 1, 2001, July 1, 2002, July 1, 2003, July 1, 2004, July 1, 2005, July 1, 2006, July 1,
228.4 2007, ~~and~~ July 1, 2008, July 1, 2009, and July 1, 2010, this paragraph shall apply only
228.5 to the property-related payment rate, except that adjustments to include the cost of any
228.6 increase in Health Department licensing fees taking effect on or after July 1, 2001, shall
228.7 be provided. Beginning in 2005, adjustment to the property payment rate under this
228.8 section and section 256B.431 shall be effective on October 1. In determining the amount
228.9 of the property-related payment rate adjustment under this paragraph, the commissioner
228.10 shall determine the proportion of the facility's rates that are property-related based on the
228.11 facility's most recent cost report.

228.12 (d) The commissioner shall develop additional incentive-based payments of up to
228.13 five percent above a facility's operating payment rate for achieving outcomes specified
228.14 in a contract. The commissioner may solicit contract amendments and implement those
228.15 which, on a competitive basis, best meet the state's policy objectives. The commissioner
228.16 shall limit the amount of any incentive payment and the number of contract amendments
228.17 under this paragraph to operate the incentive payments within funds appropriated for this
228.18 purpose. The contract amendments may specify various levels of payment for various
228.19 levels of performance. Incentive payments to facilities under this paragraph may be in the
228.20 form of time-limited rate adjustments or onetime supplemental payments. In establishing
228.21 the specified outcomes and related criteria, the commissioner shall consider the following
228.22 state policy objectives:

228.23 (1) successful diversion or discharge of residents to the residents' prior home or other
228.24 community-based alternatives;

228.25 (2) adoption of new technology to improve quality or efficiency;

228.26 (3) improved quality as measured in the Nursing Home Report Card;

228.27 (4) reduced acute care costs; and

228.28 (5) any additional outcomes proposed by a nursing facility that the commissioner
228.29 finds desirable.

228.30 (e) Notwithstanding the threshold in section 256B.431, subdivision 16, facilities that
228.31 take action to come into compliance with existing or pending requirements of the life
228.32 safety code provisions or other federal regulations governing sprinkler systems shall
228.33 receive reimbursement for the costs associated with compliance if all of the following
228.34 conditions are met:

228.35 (1) the expenses associated with compliance occurred on or after January 1, 2005,
228.36 and before December 31, 2008;

(2) the costs were not otherwise reimbursed under section 144A.071, 144A.073, or 256B.434, subdivision 4f; and

(3) the total allowable costs reported under this paragraph are less than the minimum threshold established under section 256B.431, subdivisions 15, paragraph (e), and 16.

The commissioner shall use funds appropriated for this purpose to provide to qualifying nursing facilities a rate adjustment beginning October 1, 2007, and ending September 30, 2008. Nursing facilities that have expended funds or anticipate the need to expend funds to satisfy the most recent life safety code requirements by (1) installing a sprinkler system or (2) replacing all or portions of an existing sprinkler system may submit to the commissioner by June 30, 2007, on a form provided by the commissioner the actual costs of a completed project or the estimated costs, based on a project bid, of a planned project. The commissioner shall calculate a rate adjustment equal to the allowable costs of the project divided by the resident days reported for the report year ending September 30, 2006. If the costs from all projects exceed the appropriation for this purpose, the commissioner shall allocate the funds appropriated on a pro rata basis to the qualifying facilities by reducing the rate adjustment determined for each facility by an equal percentage. If the rate adjustments under this subdivision are reduced to fit the appropriation, facilities may include the portion of the costs that are not reimbursed by the rate adjustment as part of a project that meets the requirements of subdivision 4f. If the commissioner determines that there are any unexpended funds for the purposes of this paragraph, the commissioner may allocate the remainder of the funds to the qualifying facilities on a pro rata basis for other physical plant changes required by the nursing facility in order to meet the most recent life safety code compliance standards. Facilities that used estimated costs when requesting the rate adjustment shall report to the commissioner by January 31, 2009, on the use of these funds on a form provided by the commissioner. If the nursing facility fails to provide the report, the commissioner shall recoup the funds appropriated to the facility for this purpose. If the facility reports expenditures allowable under this subdivision that are less than the amount received in the facility's annualized rate adjustment, the commissioner shall recoup the difference.

Sec. 56. Minnesota Statutes 2006, section 256B.434, is amended by adding a subdivision to read:

Subd. 4i. Nursing facility rate increase effective October 1, 2007; Hennepin County. For the rate year beginning October 1, 2007, the commissioner shall provide to a nursing facility in Hennepin County licensed for 268 beds as of February 1, 2007, an increase in the property payment rate of \$6.52 per resident per day. The increase under

230.1 this subdivision must be added following the determination under this chapter of the
230.2 payment rate for the rate year beginning October 1, 2007, and must be included in the
230.3 facility's total payment rate for purposes of determining future rates under this section or
230.4 any other section.

230.5 Sec. 57. Minnesota Statutes 2006, section 256B.434, is amended by adding a
230.6 subdivision to read:

230.7 Subd. 4j. **Rate increase for facilities in Chisago County.** Effective October
230.8 1, 2007, operating payment rates of all nursing facilities in Chisago County that are
230.9 reimbursed under this section or section 256B.441 shall be increased to be equal, for
230.10 a RUG's rate with a weight of 1.00, to the geographic group III median rate for the
230.11 same RUG's weight. The percentage of the operating payment rate for each facility to
230.12 be case-mix adjusted shall be equal to the percentage that is case-mix adjusted in that
230.13 facility's September 30, 2007, operating payment rate. This subdivision applies only if it
230.14 results in a rate increase. Increases provided by this subdivision shall be added to the rate
230.15 determined under any new reimbursement system established under section 256B.441.

230.16 Sec. 58. Minnesota Statutes 2006, section 256B.434, is amended by adding a
230.17 subdivision to read:

230.18 Subd. 4k. **Nursing facility rate increase effective January 1, 2008; Hennepin**
230.19 **County.** Effective January 1, 2008, a nursing facility in Hennepin County licensed for
230.20 137 beds as of February 1, 2007, shall receive an increase of \$2.81 in each case mix
230.21 payment rate to offset property tax payments due as a result of the facility's conversion
230.22 from nonprofit to for-profit status. The increase under this subdivision must be added
230.23 following the determination under this chapter of the payment rate for the rate year
230.24 beginning October 1, 2007, and must be included in the facility's total payment rate for the
230.25 purposes of determining future rates under this section or any other section.

230.26 Sec. 59. Minnesota Statutes 2006, section 256B.434, is amended by adding a
230.27 subdivision to read:

230.28 Subd. 4l. **Property rate adjustment; Kanabec County.** The commissioner
230.29 shall allow a property rate adjustment for a facility located in Kanabec County that
230.30 was approved for a moratorium exception project in 2001, but experienced a delay and
230.31 additional costs associated with the project, and completed the project in 2005. The
230.32 property payment rate for the rate years beginning October 1, 2007, and ending September
230.33 30, 2009, must be \$22.73 per resident day. For subsequent years, the property rate of

231.1 \$22.73 per resident day shall be adjusted as provided in subdivision 4, paragraph (c), as
231.2 long as the facility has a contract under this section.

231.3 Sec. 60. Minnesota Statutes 2006, section 256B.434, is amended by adding a
231.4 subdivision to read:

231.5 Subd. 4m. **Rate increase for facilities in Rice County.** Effective July 1, 2007,
231.6 operating payment rates of nursing facilities in Rice County located within two miles
231.7 of Scott County or Dakota County that are reimbursed under this section or section
231.8 256B.441 must be increased to be equal, for a RUG's rate with a weight of 1.00, to the
231.9 geographic group III median rate for the same RUG's weight. The percentage of the
231.10 operating payment rate for each facility to be case-mix adjusted must be equal to the
231.11 percentage that is case-mix adjusted in that facility's June 30, 2006, operating payment
231.12 rate. This subdivision applies only if it results in a rate increase.

231.13 Sec. 61. Minnesota Statutes 2006, section 256B.434, is amended by adding a
231.14 subdivision to read:

231.15 Subd. 4n. **Facility rate increase.** For the rate year beginning October 1, 2007, a
231.16 nursing facility in Faribault County licensed for 50 beds as of April 19, 2006, shall receive
231.17 a rate increase of \$2.64 in each case mix payment rate to offset property tax payments
231.18 due as a result of the facility's conversion from nonprofit to for-profit status. The increase
231.19 under this subdivision shall be added to the payment rates in effect for the facility on
231.20 September 30, 2007, and shall be included in the facility's total payment rates for the
231.21 purposes of determining future rates under this section or any other section.

231.22 Sec. 62. Minnesota Statutes 2006, section 256B.434, is amended by adding a
231.23 subdivision to read:

231.24 Subd. 19. **Nursing facility rate increases beginning October 1, 2007, and**
231.25 **October 1, 2008.** (a) For the rate year beginning October 1, 2007, the commissioner
231.26 shall make available to each nursing facility reimbursed under this section operating
231.27 payment rate adjustments equal to three percent of the operating payment rates in effect
231.28 on September 30, 2007. For the rate year beginning October 1, 2008, the commissioner
231.29 shall make available to each nursing facility reimbursed under this section operating
231.30 payment rate adjustments equal to three percent of the operating payment rates in effect
231.31 on September 30, 2008.

232.1 (b) Seventy-five percent of the money resulting from the rate adjustments under
232.2 paragraph (a) must be used for increases in compensation-related costs of eligible
232.3 employees.

232.4 (c) For purposes of this subdivision, eligible employees includes all persons directly
232.5 employed by the nursing facility on or after the effective date of the rate adjustments,
232.6 except:

232.7 (1) persons employed in the central office of a corporation that has an ownership
232.8 interest in the nursing facility or exercises control over the nursing facility; and

232.9 (2) persons paid by the nursing facility under a management contract.

232.10 (d) The commissioner shall allow as compensation-related costs all costs for:

232.11 (1) wages and salaries;

232.12 (2) FICA taxes, Medicare taxes, state and federal unemployment taxes, and workers'
232.13 compensation;

232.14 (3) the employer's share of health and dental insurance, life insurance, disability
232.15 insurance, long-term care insurance, uniform allowance, and pensions; and

232.16 (4) other benefits provided, subject to the approval of the commissioner.

232.17 (e) The portion of the rate adjustments under paragraph (a) that is not subject to the
232.18 requirements in paragraph (b) shall be provided to nursing facilities effective October
232.19 1 of each year.

232.20 (f) Nursing facilities may apply for the portion of the rate adjustments under
232.21 paragraph (a) that is subject to the requirements in paragraph (b). The application
232.22 must be submitted to the commissioner within six months of the effective date of the
232.23 rate adjustments, and the nursing facility must provide additional information required
232.24 by the commissioner within nine months of the effective date of the rate adjustments.
232.25 The commissioner must respond to all applications within three weeks of receipt.
232.26 The commissioner may waive the deadlines in this paragraph under extraordinary
232.27 circumstances, to be determined at the sole discretion of the commissioner. The
232.28 application must contain:

232.29 (1) an estimate of the amounts of money that must be used as specified in paragraph
232.30 (b);

232.31 (2) a detailed distribution plan specifying the allowable compensation-related
232.32 increases the nursing facility will implement to use the funds available in clause (1);

232.33 (3) a description of how the nursing facility will notify eligible employees of
232.34 the contents of the approved application, which must provide for giving each eligible
232.35 employee a copy of the approved application, excluding the information required in clause
232.36 (1), or posting a copy of the approved application, excluding the information required in

233.1 clause (1), for a period of at least six weeks in an area of the nursing facility to which all
233.2 eligible employees have access; and

233.3 (4) instructions for employees who believe they have not received the
233.4 compensation-related increases specified in clause (2), as approved by the commissioner,
233.5 and which must include a mailing address, e-mail address, and the telephone number
233.6 that may be used by the employee to contact the commissioner or the commissioner's
233.7 representative.

233.8 (g) The commissioner shall ensure that cost increases in distribution plans under
233.9 paragraph (f), clause (2), that may be included in approved applications, comply with
233.10 requirements in clauses (1) to (4):

233.11 (1) costs to be incurred during the applicable rate year resulting from wage and
233.12 salary increases implemented prior to the first day of the nursing facility's payroll period
233.13 that includes October 1 of each year shall be allowed if they were not used in a prior
233.14 year's application;

233.15 (2) a portion of the costs resulting from tenure-related wage or salary increases may
233.16 be considered to be allowable compensation-related increases, in accordance with existing
233.17 formulas that the commissioner shall provide;

233.18 (3) the annualized amount of increases in costs for the employer's share of health
233.19 and dental insurance, life insurance, disability insurance, and workers' compensation shall
233.20 be allowable compensation-related increases if they are effective on or after April 1 of
233.21 the year in which the rate adjustments are effective and prior to April 1 of the following
233.22 year; and

233.23 (4) for nursing facilities in which employees are represented by an exclusive
233.24 bargaining representative, an agreement negotiated and agreed to by the employer and
233.25 the exclusive bargaining representative constitutes the plan. The commissioner shall not
233.26 review and shall not require changes to the portions of the plan covered by collective
233.27 bargaining agreements. A negotiated agreement may constitute the plan only if the
233.28 agreement is finalized after the date of enactment of all increases for the rate year and
233.29 signed by both parties prior to submission to the commissioner.

233.30 (h) The commissioner shall review applications received under paragraph (f) and
233.31 shall provide the portion of the rate adjustments under paragraph (b) if the requirements of
233.32 this subdivision have been met. The rate adjustments shall be effective October 1 of each
233.33 year. Notwithstanding paragraph (a), if the approved application distributes less money
233.34 than is available, the amount of the rate adjustment shall be reduced so that the amount of
233.35 money made available is equal to the amount to be distributed.

Sec. 63. Minnesota Statutes 2006, section 256B.434, is amended by adding a subdivision to read:

Subd. 20. **Payment of Public Employees Retirement Association costs.** Nursing facilities that participate in the Public Employees Retirement Association (PERA) shall have the component of their payment rate associated with the costs of PERA determined for each rate year. Effective for rate years beginning on and after October 1, 2007, the commissioner shall determine the portion of the payment rate in effect on September 30 each year and shall subtract that amount from the payment rate to be effective on the following October 1. The portion that shall be deemed to be included in the September 30, 2007, rate that is associated with PERA costs shall be the allowed costs in the facility's base for determining rates under this section, divided by the resident days reported for that year. The commissioner shall add to the payment rate to be effective on October 1 each year an amount equal to the reported costs associated with PERA, for the year ended on the most recent September 30 for which data is available, divided by total resident days for that year, as reported by the facility and audited under section 256B.441.

Sec. 64. Minnesota Statutes 2006, section 256B.437, is amended by adding a subdivision to read:

Subd. 11. **Big Stone County rate adjustment.** Notwithstanding the time period specified in subdivision 3, the commissioner shall approve a planned closure rate adjustment in Big Stone County for an eight-bed facility in Clinton for reassignment to a 50-bed facility in Graceville. The adjustment shall be calculated according to subdivisions 3 and 6.

Sec. 65. Minnesota Statutes 2006, section 256B.438, subdivision 3, is amended to read:

Subd. 3. **Case mix indices.** (a) The commissioner of human services shall assign a case mix index to each resident class based on the Centers for Medicare and Medicaid Services staff time measurement study and adjusted for Minnesota-specific wage indices. The case mix indices assigned to each resident class shall be published in the Minnesota State Register at least 120 days prior to the implementation of the 34 group, RUG-III resident classification system.

(b) An index maximization approach shall be used to classify residents.

~~(c) After implementation of the revised case mix system, the commissioner of human services may annually rebase case mix indices and base rates using more current data on average wage rates and staff time measurement studies. This rebasing shall be calculated under subdivision 7, paragraph (b). The commissioner shall publish in the~~

235.1 ~~Minnesota State Register adjusted case mix indices at least 45 days prior to the effective~~
235.2 ~~date of the adjusted case mix indices.~~

235.3 Sec. 66. Minnesota Statutes 2006, section 256B.439, subdivision 1, is amended to read:

235.4 Subdivision 1. **Development and implementation of quality profiles.** (a) The
235.5 commissioner of human services, in cooperation with the commissioner of health, shall
235.6 develop and implement a quality profile system for nursing facilities and, beginning not
235.7 later than July 1, 2004, other providers of long-term care services, except when the quality
235.8 profile system would duplicate requirements under section 256B.5011, 256B.5012, or
235.9 256B.5013. Beginning July 1, 2008, the commissioners shall include quality profiles of
235.10 nursing homes that are not medical assistance certified in the Minnesota Nursing Home
235.11 Report Card. The nonmedical assistance certified nursing homes may provide to the
235.12 commissioners information necessary to conduct consumer satisfaction surveys and to
235.13 determine other quality measures. The system must be developed and implemented to the
235.14 extent possible without the collection of significant amounts of new data. To the extent
235.15 possible, the system must incorporate or be coordinated with information on quality
235.16 maintained by area agencies on aging, long-term care trade associations, and other entities.
235.17 The system must be designed to provide information on quality to:

235.18 (1) consumers and their families to facilitate informed choices of service providers;

235.19 (2) providers to enable them to measure the results of their quality improvement
235.20 efforts and compare quality achievements with other service providers; and

235.21 (3) public and private purchasers of long-term care services to enable them to
235.22 purchase high-quality care.

235.23 (b) The system must be developed in consultation with the long-term care task force,
235.24 area agencies on aging, and representatives of consumers, providers, and labor unions.

235.25 Within the limits of available appropriations, the commissioners may employ consultants
235.26 to assist with this project.

235.27 Sec. 67. Minnesota Statutes 2006, section 256B.441, subdivision 1, is amended to read:

235.28 Subdivision 1. ~~Rate determination~~ **Rebasing of nursing facility operating cost**
235.29 **payment rates.** (a) ~~The commissioner shall establish a value-based nursing facility~~
235.30 ~~reimbursement system which will provide facility-specific, prospective rates for nursing~~
235.31 ~~facilities participating in the medical assistance program. The rates shall be determined~~
235.32 ~~using an annual statistical and cost report filed by each nursing facility. The total payment~~
235.33 ~~rate shall be composed of four rate components: direct care services, support services,~~
235.34 ~~external fixed, and property-related rate components. The payment rate shall be derived~~

236.1 ~~from statistical measures of actual costs incurred in facility operation of nursing facilities.~~
236.2 ~~From this cost basis, the components of the total payment rate shall be adjusted for quality~~
236.3 ~~of services provided, recognition of staffing levels, geographic variation in labor costs, and~~
236.4 ~~resident acuity.~~ The commissioner shall rebase nursing facility operating cost payment
236.5 rates to align payments to facilities with the cost of providing care. The rebased operating
236.6 cost payment rates shall be calculated using the statistical and cost report filed by each
236.7 nursing facility for the report period ending one year prior to the rate year.

236.8 (b) ~~Rates shall be rebased annually.~~ The new operating cost payment rates based on
236.9 this section shall take effect beginning with the rate year beginning October 1, 2009, and
236.10 shall be phased in over three rate years through October 1, 2011.

236.11 (c) Operating cost payment rates shall be rebased on October 1, 2012, and every
236.12 two years after that date.

236.13 (d) Operating cost payment rates for rate years in which rebasing does not occur
236.14 shall be increased by the Global Insight SNF Market Basket inflation factor from the
236.15 midpoint of the previous rate year to the midpoint of the next rate year.

236.16 (e) Each cost reporting year shall begin on October 1 and end on the following
236.17 September 30. Beginning in 2006, a statistical and cost report shall be filed by each
236.18 nursing facility by January 15. Notice of rates shall be distributed by August 15 and the
236.19 rates shall go into effect on October 1 for one year.

236.20 (e) ~~The commissioner shall begin to phase in the new reimbursement system~~
236.21 ~~beginning October 1, 2007. Full phase-in shall be completed by October 1, 2011.~~

236.22 Sec. 68. Minnesota Statutes 2006, section 256B.441, subdivision 2, is amended to read:

236.23 Subd. 2. **Definitions.** For purposes of this section, the terms in subdivisions 3 to
236.24 ~~42~~ 42a have the meanings given unless otherwise provided for in this section.

236.25 Sec. 69. Minnesota Statutes 2006, section 256B.441, subdivision 5, is amended to read:

236.26 Subd. 5. **Administrative costs.** "Administrative costs" means the direct costs for
236.27 administering the overall activities of the nursing home. These costs include salaries and
236.28 wages of the administrator, assistant administrator, business office employees, security
236.29 guards, and associated fringe benefits and payroll taxes, fees, contracts, or purchases
236.30 related to business office functions, licenses, and permits except as provided in the
236.31 external fixed costs category, employee recognition, travel including meals and lodging,
236.32 training, voice and data communication or transmission, office supplies, liability insurance
236.33 and other forms of insurance not designated to other areas, personnel recruitment, legal
236.34 services, accounting services, management or business consultants, data processing,

237.1 information technology, Web site, central or home office costs, business meetings and
237.2 seminars, postage, fees for professional organizations, subscriptions, security services,
237.3 advertising, board of director's fees, working capital interest expense, and bad debts and
237.4 bad debt collection fees.

237.5 Sec. 70. Minnesota Statutes 2006, section 256B.441, subdivision 6, is amended to read:

237.6 Subd. 6. **Allowed costs.** "Allowed costs" means the amounts reported by the facility
237.7 which are necessary for the operation of the facility and the care of residents and which
237.8 are reviewed by the department for accuracy, ~~reasonableness~~, and compliance with this
237.9 section and generally accepted accounting principles. All references to costs in this section
237.10 shall be assumed to refer to allowed costs.

237.11 Sec. 71. Minnesota Statutes 2006, section 256B.441, subdivision 10, is amended to
237.12 read:

237.13 Subd. 10. **Dietary costs.** "Dietary costs" means the costs for the salaries and wages
237.14 of the dietary supervisor, dietitians, chefs, cooks, dishwashers, and other employees
237.15 assigned to the kitchen and dining room, and associated fringe benefits and payroll
237.16 taxes. Dietary costs also includes the salaries or fees of dietary consultants, ~~direct costs~~
237.17 ~~of raw food (both normal and special diet food), dietary supplies, and food preparation~~
237.18 ~~and serving. Also included are special dietary supplements used for tube feeding or oral~~
237.19 ~~feeding, such as elemental high nitrogen diet, even if written as a prescription item by a~~
237.20 ~~physician.~~

237.21 Sec. 72. Minnesota Statutes 2006, section 256B.441, subdivision 11, is amended to
237.22 read:

237.23 Subd. 11. **Direct care costs category.** ~~"Direct care costs category"~~ "Direct care
237.24 costs" means costs for ~~nursing services, activities, and social services~~ the wages of nursing
237.25 administration, staff education, direct care registered nurses, licensed practical nurses,
237.26 certified nursing assistants, trained medication aides, and associated fringe benefits and
237.27 payroll taxes; services from a supplemental nursing services agency; supplies that are
237.28 stocked at nursing stations or on the floor and distributed or used individually, including,
237.29 but not limited to: alcohol, applicators, cotton balls, incontinence pads, disposable ice
237.30 bags, dressings, bandages, water pitchers, tongue depressors, disposable gloves, enemas,
237.31 enema equipment, soap, medication cups, diapers, plastic waste bags, sanitary products,
237.32 thermometers, hypodermic needles and syringes, clinical reagents or similar diagnostic
237.33 agents, drugs that are not paid for on a separate fee schedule by the medical assistance

238.1 program or any other payer, and technology related to the provision of nursing care to
238.2 residents, such as electronic charting systems.

238.3 Sec. 73. Minnesota Statutes 2006, section 256B.441, subdivision 13, is amended to
238.4 read:

238.5 Subd. 13. **External fixed costs category.** ~~"External fixed costs category"~~ "External
238.6 fixed costs" means costs related to the nursing home surcharge under section 256.9657,
238.7 subdivision 1; licensure fees under section 144.122; long-term care consultation fees
238.8 under section 256B.0911, subdivision 6; family advisory council fee under section
238.9 144A.33; scholarships under section 256B.431, subdivision 36; planned closure rate
238.10 adjustments under section 256B.436 or 256B.437; or single bed room incentives under
238.11 section 256B.431, subdivision 42; property taxes and property insurance; and PERA.

238.12 Sec. 74. Minnesota Statutes 2006, section 256B.441, subdivision 14, is amended to
238.13 read:

238.14 Subd. 14. **Facility average case mix index.** "Facility average case mix index" or
238.15 "CMI" means a numerical value score that describes the relative resource use for all
238.16 residents within the groups under the resource utilization group (RUG-III) classification
238.17 system prescribed by the commissioner based on an assessment of each resident. The
238.18 facility average CMI shall be computed as the standardized days divided by total days for
238.19 all residents in the facility. The RUG's weights used in this section shall be as follows
238.20 for each RUG's class: SE3 1.605; SE2 1.247; SE1 1.081; RAD 1.509; RAC 1.259; RAB
238.21 1.109; RAA 0.957; SSC 1.453; SSB 1.254; SSA 1.047; CC2 1.292; CC1 1.200; CB2
238.22 1.086; CB1 1.017; CA2 0.908; CA1 0.834; IB2 0.877; IB1 0.817; IA2 0.720; IA1 0.676;
238.23 BB2 0.956; BB1 0.885; BA2 0.716; BA1 0.673; PE2 1.199; PE1 1.104; PD2 1.023;
238.24 PD1 0.948; PC2 0.926; PC1 0.860; PB2 0.786; PB1 0.734; PA2 0.691; PA1 0.651; BC1
238.25 0.651; and DDF 1.000

238.26 Sec. 75. Minnesota Statutes 2006, section 256B.441, is amended by adding a
238.27 subdivision to read:

238.28 Subd. 14a. **Facility type groups.** Facilities shall be classified into two groups,
238.29 called "facility type groups," which shall consist of:

238.30 (1) C&NC/R80: facilities that are hospital-attached, or are licensed under Minnesota
238.31 Rules, parts 9570.2000 to 9570.3400; and

238.32 (2) freestanding: all other facilities.

239.1 Sec. 76. Minnesota Statutes 2006, section 256B.441, subdivision 17, is amended to
239.2 read:

239.3 Subd. 17. **Fringe benefit costs.** "Fringe benefit costs" means the costs for group
239.4 life, health, dental, workers' compensation, and other employee insurances and pension,
239.5 profit-sharing, and retirement plans for which the employer pays all or a portion of the
239.6 costs ~~and that are available to at least all employees who work at least 20 hours per week.~~

239.7 Sec. 77. Minnesota Statutes 2006, section 256B.441, subdivision 20, is amended to
239.8 read:

239.9 Subd. 20. **Housekeeping costs.** "Housekeeping costs" means the costs for the
239.10 salaries and wages of the housekeeping supervisor, housekeepers, and other cleaning
239.11 employees and associated fringe benefits and payroll taxes. It also includes the cost of
239.12 housekeeping supplies, including, but not limited to, cleaning and lavatory supplies and
239.13 contract services.

239.14 Sec. 78. Minnesota Statutes 2006, section 256B.441, subdivision 24, is amended to
239.15 read:

239.16 Subd. 24. **Maintenance and plant operations costs.** "Maintenance and plant
239.17 operations costs" means the costs for the salaries and wages of the maintenance supervisor,
239.18 engineers, heating-plant employees, and other maintenance employees and associated
239.19 fringe benefits and payroll taxes. It also includes direct costs for maintenance and
239.20 operation of the building and grounds, including, but not limited to, fuel, electricity,
239.21 medical waste and garbage removal, water, sewer, supplies, tools, and repairs.

239.22 Sec. 79. Minnesota Statutes 2006, section 256B.441, is amended by adding a
239.23 subdivision to read:

239.24 Subd. 28a. **Other direct care costs.** "Other direct care costs" means the costs
239.25 for the salaries and wages and associated fringe benefits and payroll taxes of mental
239.26 health workers, religious personnel, and other direct care employees not specified in
239.27 the definition of direct care costs.

239.28 Sec. 80. Minnesota Statutes 2006, section 256B.441, subdivision 30, is amended to
239.29 read:

239.30 Subd. 30. **Peer groups.** Facilities shall be classified into three groups, ~~called "peer~~
239.31 ~~groups," which~~ by county. The groups shall consist of:

(1) ~~C&NC/Short Stay/R80 - facilities that have three or more admissions per bed per year, are hospital-attached, or are licensed under Minnesota Rules, parts 9570.2000 to 9570.3600~~ group one: facilities in Anoka, Benton, Carlton, Carver, Chisago, Dakota, Dodge, Goodhue, Hennepin, Isanti, Mille Lacs, Morrison, Olmsted, Ramsey, Rice, Scott, Sherburne, St. Louis, Stearns, Steele, Wabasha, Washington, Winona, or Wright County;

(2) ~~boarding care homes - facilities that have more than 50 percent of their beds licensed as boarding care homes~~ group two: facilities in Aitkin, Beltrami, Blue Earth, Brown, Cass, Clay, Cook, Crow Wing, Faribault, Fillmore, Freeborn, Houston, Hubbard, Itasca, Kanabec, Koochiching, Lake, Lake of the Woods, Le Sueur, Martin, McLeod, Meeker, Mower, Nicollet, Norman, Pine, Roseau, Sibley, Todd, Wadena, Waseca, Watonwan, or Wilkin County; and

(3) ~~standard - all other facilities~~ group three: facilities in all other counties.

Sec. 81. Minnesota Statutes 2006, section 256B.441, subdivision 31, is amended to read:

Subd. 31. **Prior rate-setting method system operating cost payment rate.** ~~"Prior rate-setting method"~~ "Prior system operating cost payment rate" means the operating cost payment rate ~~determination process~~ in effect prior to October 1, 2006 on September 30, 2009, under Minnesota Rules and Minnesota Statutes, not including planned closure rate adjustments under section 256B.436 or 256B.437, or single bed room incentives under section 256B.431, subdivision 42.

Sec. 82. Minnesota Statutes 2006, section 256B.441, is amended by adding a subdivision to read:

Subd. 33a. **Raw food costs.** "Raw food costs" means the cost of food provided to nursing facility residents. Also included are special dietary supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet.

Sec. 83. Minnesota Statutes 2006, section 256B.441, subdivision 34, is amended to read:

Subd. 34. **Related organization.** "Related organization" means a person that furnishes goods or services to a nursing facility and that is a close relative of a nursing facility, an affiliate of a nursing facility, a close relative of an affiliate of a nursing facility, or an affiliate of a close relative of an affiliate of a nursing facility. As used in this subdivision, paragraphs (a) to (d) apply:

241.1 (a) "Affiliate" means a person that directly, or indirectly through one or more
241.2 intermediaries, controls or is controlled by, or is under common control with another
241.3 person.

241.4 (b) "Person" means an individual, a corporation, a partnership, an association, a
241.5 trust, an unincorporated organization, or a government or political subdivision.

241.6 (c) "Close relative of an affiliate of a nursing facility" means an individual whose
241.7 relationship by blood, marriage, or adoption to an individual who is an affiliate of a
241.8 nursing facility is no more remote than first cousin.

241.9 (d) "Control" including the terms "controlling," "controlled by," and "under common
241.10 control with" means the possession, direct or indirect, of the power to direct or cause the
241.11 direction of the management, operations, or policies of a person, whether through the
241.12 ownership of voting securities, by contract, or otherwise, ~~or to influence in any manner~~
241.13 ~~other than through an arms-length, legal transaction.~~

241.14 Sec. 84. Minnesota Statutes 2006, section 256B.441, subdivision 38, is amended to
241.15 read:

241.16 Subd. 38. **Social services costs.** "Social services costs" means the costs for the
241.17 salaries and wages of the supervisor and other social work employees, associated fringe
241.18 benefits and payroll taxes, supplies, services, and consultants. This category includes the
241.19 cost of those employees who manage and process admission to the nursing facility.

241.20 Sec. 85. Minnesota Statutes 2006, section 256B.441, is amended by adding a
241.21 subdivision to read:

241.22 Subd. 42a. **Therapy costs.** "Therapy costs" means any costs related to medical
241.23 assistance therapy services provided to residents that are not billed separately from the
241.24 daily operating rate.

241.25 Sec. 86. Minnesota Statutes 2006, section 256B.441, is amended by adding a
241.26 subdivision to read:

241.27 Subd. 48. **Calculation of operating per diems.** The direct care per diem for
241.28 each facility shall be the facility's direct care costs divided by its standardized days.
241.29 The other care-related per diem shall be the sum of the facility's activities costs, other
241.30 direct care costs, raw food costs, therapy costs, and social services costs, divided by the
241.31 facility's resident days. The other operating per diem shall be the sum of the facility's
241.32 administrative costs, dietary costs, housekeeping costs, laundry costs, and maintenance
241.33 and plant operations costs divided by the facility's resident days.

242.1 Sec. 87. Minnesota Statutes 2006, section 256B.441, is amended by adding a
242.2 subdivision to read:

242.3 Subd. 49. **Determination of total care-related per diem.** The total care-related
242.4 per diem for each facility shall be the sum of the direct care per diem and the other
242.5 care-related per diem.

242.6 Sec. 88. Minnesota Statutes 2006, section 256B.441, is amended by adding a
242.7 subdivision to read:

242.8 Subd. 50. **Determination of total care-related limit.** The limit on the total
242.9 care-related per diem shall be determined for each peer group and facility type group
242.10 combination. A facility's total care-related per diems shall be limited to 120 percent of the
242.11 median for the facility's peer and facility type group. The facility-specific direct care costs
242.12 used in making this comparison and in the calculation of the median shall be based on a
242.13 RUG's weight of 1.00. A facility that is above that limit shall have its total care-related per
242.14 diem reduced to the limit. If a reduction of the total care-related per diem is necessary
242.15 because of this limit, the reduction shall be made proportionally to both the direct care per
242.16 diem and the other care-related per diem.

242.17 Sec. 89. Minnesota Statutes 2006, section 256B.441, is amended by adding a
242.18 subdivision to read:

242.19 Subd. 51. **Determination of other operating limit.** The limit on the other operating
242.20 per diem shall be determined for each peer group. A facility's other operating per diem
242.21 shall be limited to 105 percent of the median for its peer group. A facility that is above
242.22 that limit shall have its other operating per diem reduced to the limit.

242.23 Sec. 90. Minnesota Statutes 2006, section 256B.441, is amended by adding a
242.24 subdivision to read:

242.25 Subd. 52. **Determination of efficiency incentive.** Each facility shall be eligible
242.26 for an efficiency incentive based on its other operating per diem. A facility with an other
242.27 operating per diem that exceeds the limit in subdivision 51 shall receive no efficiency
242.28 incentive. All other facilities shall receive an incentive calculated as 50 percent times the
242.29 difference between the facility's other operating per diem and its other operating per diem
242.30 limit, up to a maximum incentive of \$3.

242.31 Sec. 91. Minnesota Statutes 2006, section 256B.441, is amended by adding a
242.32 subdivision to read:

243.1 Subd. 53. Calculation of payment rate for external fixed costs. The commissioner
243.2 shall calculate a payment rate for external fixed costs.

243.3 (a) For a facility licensed as a nursing home, the portion related to section 256.9657
243.4 shall be equal to \$8.86. For a facility licensed as both a nursing home and a boarding care
243.5 home, the portion related to section 256.9657 shall be equal to \$8.86 multiplied by the
243.6 result of its number of nursing home beds divided by its total number of licensed beds.

243.7 (b) The portion related to the licensure fee under section 144.122, paragraph (d),
243.8 shall be the amount of the fee divided by actual resident days.

243.9 (c) The portion related to scholarships shall be determined under section 256B.431,
243.10 subdivision 36.

243.11 (d) The portion related to long-term care consultation shall be determined according
243.12 to section 256B.0911, subdivision 6.

243.13 (e) The portion related to development and education of resident and family advisory
243.14 councils under section 144A.33 shall be \$5 divided by 365.

243.15 (f) The portion related to planned closure rate adjustments shall be as determined
243.16 under sections 256B.436 and 256B.437, subdivision 6.

243.17 (g) The portions related to property insurance, real estate taxes, special assessments,
243.18 and payments made in lieu of real estate taxes directly identified or allocated to the nursing
243.19 facility shall be the actual amounts divided by actual resident days.

243.20 (h) The portion related to the Public Employees Retirement Association shall be
243.21 actual costs divided by resident days.

243.22 (i) The single bed room incentives shall be as determined under section 256B.431,
243.23 subdivision 42.

243.24 (j) The payment rate for external fixed costs shall be the sum of the amounts in
243.25 paragraphs (a) to (i).

243.26 Sec. 92. Minnesota Statutes 2006, section 256B.441, is amended by adding a
243.27 subdivision to read:

243.28 Subd. 54. Adjustment of per diem for inflation. The total care-related per diem
243.29 and other operating per diem calculated under this section shall be adjusted for inflation to
243.30 adjust for the delay between the reporting year and the rate year. The total care-related
243.31 payment rate and other operating payment rate shall be calculated as the per diem
243.32 increased by the Global Insight Consumer Price Index urban inflation factor for the period
243.33 from the midpoint of the reporting year to the midpoint of the rate year.

244.1 Sec. 93. Minnesota Statutes 2006, section 256B.441, is amended by adding a
244.2 subdivision to read:

244.3 Subd. 55. **Determination of total payment rates.** In rate years when rates are
244.4 rebased, the total payment rate for a RUG's weight of 1.00 shall be the sum of the total
244.5 care-related payment rate, other operating payment rate, efficiency incentive, external
244.6 fixed cost rate, and the property rate determined under section 256B.434. To determine
244.7 a total payment rate for each RUG's level, the total care-related payment rate shall be
244.8 divided into the direct care payment rate and the other care-related payment rate, and the
244.9 direct care payment rate multiplied by the RUG's weight for each RUG's level using the
244.10 weights in subdivision 14.

244.11 Sec. 94. Minnesota Statutes 2006, section 256B.441, is amended by adding a
244.12 subdivision to read:

244.13 Subd. 56. **Phase-in of rebased operating cost payment rates.** For the rate years
244.14 beginning October 1, 2009, October 1, 2010, and October 1, 2011, the operating cost
244.15 payment rate calculated under this section shall be phased in by blending it with the
244.16 operating cost payment rate determined under section 256B.434. For the rate year
244.17 beginning October 1, 2009, the operating cost payment rate for each facility shall be
244.18 25 percent of the operating cost payment rate from this section, and 75 percent of the
244.19 operating cost payment rate from section 256B.434. For the rate year beginning October 1,
244.20 2010, the operating cost payment rate for each facility shall be 35 percent of the operating
244.21 cost payment rate from this section, and 65 percent of the operating cost payment rate
244.22 from section 256B.434. For the rate year beginning October 1, 2011, the operating cost
244.23 payment rate for each facility shall be the operating cost payment rate determined under
244.24 this section. The blending of operating cost payment rates under this section shall be
244.25 performed separately for each RUG's class.

244.26 Sec. 95. Minnesota Statutes 2006, section 256B.441, is amended by adding a
244.27 subdivision to read:

244.28 Subd. 57. **Adjustment for inflation during phase-in of rebased operating cost**
244.29 **payment rates.** During the phase-in of operating cost payment rates under subdivision
244.30 56, both the operating costs per diem under this section and the operating cost payment
244.31 rate under section 256B.434 shall be adjusted for inflation. The adjustment for each year
244.32 for the operating cost per diems shall be the Global Insight Consumer Price Index urban
244.33 inflation factor from the midpoint of the reporting year to the midpoint of the current rate
244.34 year. The adjustment for each year for the operating cost payment rate under section

245.1 256B.434 shall be the Global Insight Consumer Price Index urban inflation factor from the
245.2 midpoint of the October 1, 2007, rate year to the midpoint of the current rate year.

245.3 Sec. 96. Minnesota Statutes 2006, section 256B.441, is amended by adding a
245.4 subdivision to read:

245.5 Subd. 58. **Hold harmless.** For the rate years beginning October 1, 2009, October 1,
245.6 2010, and October 1, 2011, no nursing facility shall receive an operating cost payment
245.7 rate less than its operating cost payment rate under section 256B.434. The comparison
245.8 of operating cost payment rates under this section shall be made for each of the RUG's
245.9 classes separately, and the operating cost payment rates under section 256B.434 used
245.10 under this section shall not include the inflation increases described in subdivision 57.

245.11 Sec. 97. Minnesota Statutes 2006, section 256B.441, is amended by adding a
245.12 subdivision to read:

245.13 Subd. 59. **Appeals.** Nursing facilities may appeal, as defined under section 256B.50,
245.14 the determination of a payment rate established under this chapter.

245.15 Sec. 98. Minnesota Statutes 2006, section 256B.49, subdivision 11, is amended to read:

245.16 Subd. 11. **Authority.** (a) The commissioner is authorized to apply for home and
245.17 community-based service waivers, as authorized under section 1915(c) of the Social
245.18 Security Act to serve persons under the age of 65 who are determined to require the level
245.19 of care provided in a nursing home and persons who require the level of care provided in a
245.20 hospital. The commissioner shall apply for the home and community-based waivers in
245.21 order to:

245.22 (i) promote the support of persons with disabilities in the most integrated settings;

245.23 (ii) expand the availability of services for persons who are eligible for medical
245.24 assistance;

245.25 (iii) promote cost-effective options to institutional care; and

245.26 (iv) obtain federal financial participation.

245.27 (b) The provision of waived services to medical assistance recipients with
245.28 disabilities shall comply with the requirements outlined in the federally approved
245.29 applications for home and community-based services and subsequent amendments,
245.30 including provision of services according to a service plan designed to meet the needs of
245.31 the individual. For purposes of this section, the approved home and community-based
245.32 application is considered the necessary federal requirement.

246.1 (c) The commissioner shall provide interested persons serving on agency advisory
246.2 committees ~~and~~, task forces, the Centers for Independent Living, and others upon who
246.3 request, with to be on a list to receive, notice of, and an opportunity to comment on,
246.4 at least 30 days before any effective dates, (1) any substantive changes to the state's
246.5 disability services program manual, or (2) changes or amendments to the federally
246.6 approved applications for home and community-based waivers, prior to their submission
246.7 to the federal Centers for Medicare and Medicaid Services.

246.8 (d) The commissioner shall seek approval, as authorized under section 1915(c) of
246.9 the Social Security Act, to allow medical assistance eligibility under this section for
246.10 children under age 21 without deeming of parental income or assets.

246.11 (e) The commissioner shall seek approval, as authorized under section 1915(c) of
246.12 the Social Act, to allow medical assistance eligibility under this section for individuals
246.13 under age 65 without deeming the spouse's income or assets.

246.14 Sec. 99. Minnesota Statutes 2006, section 256B.49, is amended by adding a
246.15 subdivision to read:

246.16 Subd. 16a. **Medical assistance reimbursement.** (a) The commissioner shall
246.17 seek federal approval for medical assistance reimbursement of independent living skills
246.18 services, foster care waiver service, supported employment, prevocational service,
246.19 structured day service, and adult day care under the home and community-based waiver
246.20 for persons with a traumatic brain injury, the community alternatives for disabled
246.21 individuals waivers, and the community alternative care waivers.

246.22 (b) Medical reimbursement shall be made only when the provider demonstrates
246.23 evidence of its capacity to meet basic health, safety, and protection standards through
246.24 one of the methods in paragraphs (c) to (e).

246.25 (c) The provider is licensed to provide services under chapter 245B and agrees to
246.26 apply these standards to services funded through the traumatic brain injury, community
246.27 alternatives for disabled, or community alternative care home and community-based
246.28 waivers.

246.29 (d) The local agency contracting for the services certifies on a form provided by the
246.30 commissioner that the provider has the capacity to meet the individual needs as identified
246.31 in each person's individual service plan. When certifying that the service provider meets
246.32 the necessary provider qualifications, the local agency shall verify that the provider has
246.33 policies and procedures governing the following:

246.34 (1) protection of the consumer's rights and privacy;

246.35 (2) risk assessment and planning;

247.1 (3) record keeping and reporting of incidents and emergencies with documentation
247.2 of corrective action if needed;

247.3 (4) service outcomes, regular reviews of progress, and periodic reports;
247.4 (5) complaint and grievance procedures;
247.5 (6) service termination or suspension;
247.6 (7) necessary training and supervision of direct care staff that includes:
247.7 (i) documentation in personnel files of 20 hours of orientation training in providing
247.8 training related to service provision;
247.9 (ii) training in recognizing the symptoms and effects of certain disabilities, health
247.10 conditions, and positive behavioral supports and interventions; and
247.11 (iii) a minimum of five hours of related training annually; and
247.12 (8) when applicable, the local agency shall verify that the provider has policies and
247.13 procedures in place governing the following:

247.14 (i) safe medication administration;
247.15 (ii) proper handling of consumer funds; and
247.16 (iii) behavioral interventions that are in compliance with prohibitions and standards
247.17 developed by the commissioner to meet federal requirements regarding the use of
247.18 restraints and restrictive interventions.

247.19 (e) For foster care waiver services or independent living skills services, the local
247.20 agency contracting for the services certifies on a form provided by the commissioner that
247.21 the provider meets the following:

247.22 (1) the provider of foster care waiver services is licensed to provide adult foster
247.23 care under Minnesota Rules, parts 9555.5105 to 9555.6265, or child foster care under
247.24 Minnesota Rules, parts 2960.3000 to 2960.3230;

247.25 (2) the provider of independent living skills services also provides licensed foster
247.26 care services and agrees to apply the foster care standards under Minnesota Rules, parts
247.27 9555.5105; 9555.5705, subpart 2; 9555.6167; 9555.6185; 9555.6195; 9555.6225, subpart
247.28 8; 9555.6245; 9555.6255; and 9555.6265, or parts 2960.3010; 2960.3080, subparts 10
247.29 and 11; 2960.3210; 2960.3220, subparts 5 to 7; and 2960.3230, for the provision of those
247.30 services; and

247.31 (3) the provider has policies and procedures applying to the provision of foster
247.32 care waiver services or independent living skills services that govern (i) behavioral
247.33 interventions that are in compliance with prohibitions and standards developed by the
247.34 commissioner to meet federal requirements regarding the use of restraints and restrictive
247.35 interventions and (ii) documentation of service needs and outcomes, regular reviews
247.36 of progress, and periodic reports.

248.1 (f) The local agency shall review each provider's continued compliance with
248.2 the basic health, safety, and protection standards on a regular basis. For the review
248.3 of paragraph (e), the local agency shall coordinate the review with the county review
248.4 of foster care licensure.

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

248.6 Sec. 100. Minnesota Statutes 2006, section 256B.5012, is amended by adding a
248.7 subdivision to read:

248.8 **Subd. 7. ICF/MR rate increases October 1, 2007, and October 1, 2008.** (a) For
248.9 the rate periods beginning October 1, 2007, and October 1, 2008, the commissioner shall
248.10 make available to each facility reimbursed under this section an adjustment to the total
248.11 operating payment rate of three percent.

248.12 (b) Seventy-five percent of the money resulting from the rate adjustment under
248.13 paragraph (a) must be used to increase wages and benefits and pay associated costs for
248.14 employees, except for administrative and central office employees. Seventy-five percent
248.15 of the money received by a facility as a result of the rate adjustment provided in paragraph
248.16 (a) must be used only for wage, benefit, and staff increases implemented on or after
248.17 the effective date of the rate increase each year, and must not be used for increases
248.18 implemented prior to that date. The wage adjustment eligible employees may receive may
248.19 vary based on merit, seniority, or other factors determined by the provider.

248.20 (c) For each facility, the commissioner shall make available an adjustment, based
248.21 on occupied beds, using the percentage specified in paragraph (a) multiplied by the total
248.22 payment rate, including variable rate but excluding the property-related payment rate, in
248.23 effect on the preceding day. The total payment rate must include the adjustment provided
248.24 in section 256B.501, subdivision 12.

248.25 (d) A facility whose payment rates are governed by closure agreements, receivership
248.26 agreements, or Minnesota Rules, part 9553.0075, is not eligible for an adjustment
248.27 otherwise granted under this subdivision.

248.28 (e) A facility may apply for the portion of the payment rate adjustment provided
248.29 under paragraph (a) for employee wages and benefits and associated costs. The application
248.30 must be made to the commissioner and contain a plan by which the facility will distribute
248.31 the funds according to paragraph (b). For facilities in which the employees are represented
248.32 by an exclusive bargaining representative, an agreement negotiated and agreed to by
248.33 the employer and the exclusive bargaining representative constitutes the plan. The
248.34 commissioner shall not review, and shall not require changes, to the portion or portions
248.35 of the plan covered by collective bargaining agreements. A negotiated agreement may

249.1 constitute the plan only if the agreement is finalized after the date of enactment of all rate
249.2 increases for the rate year. The commissioner shall review the plan to ensure that the
249.3 payment rate adjustment per diem is used as provided in this subdivision. To be eligible, a
249.4 facility must submit its plan by March 31, 2008, and December 31, 2008, respectively.
249.5 If a facility's plan is effective for its employees after the first day of the applicable rate
249.6 period that the funds are available, the payment rate adjustment per diem is effective
249.7 the same date as its plan.

249.8 (f) A copy of the approved distribution plan must be made available to all employees
249.9 by giving each employee a copy or by posting it in an area of the facility to which all
249.10 employees have access. If an employee does not receive the wage and benefit adjustment
249.11 described in the facility's approved plan and is unable to resolve the problem with the
249.12 facility's management or through the employee's union representative, the employee
249.13 may contact the commissioner at an address or telephone number provided by the
249.14 commissioner and included in the approved plan.

249.15 Sec. 101. Minnesota Statutes 2006, section 256B.69, subdivision 23, is amended to
249.16 read:

249.17 Subd. 23. **Alternative services; elderly and disabled persons.** (a) The
249.18 commissioner may implement demonstration projects to create alternative integrated
249.19 delivery systems for acute and long-term care services to elderly persons and persons
249.20 with disabilities as defined in section 256B.77, subdivision 7a, that provide increased
249.21 coordination, improve access to quality services, and mitigate future cost increases.
249.22 The commissioner may seek federal authority to combine Medicare and Medicaid
249.23 capitation payments for the purpose of such demonstrations and may contract with
249.24 Medicare-approved special needs plans to provide Medicaid services. Medicare funds and
249.25 services shall be administered according to the terms and conditions of the federal contract
249.26 and demonstration provisions. For the purpose of administering medical assistance funds,
249.27 demonstrations under this subdivision are subject to subdivisions 1 to 22. The provisions
249.28 of Minnesota Rules, parts 9500.1450 to 9500.1464, apply to these demonstrations,
249.29 with the exceptions of parts 9500.1452, subpart 2, item B; and 9500.1457, subpart 1,
249.30 items B and C, which do not apply to persons enrolling in demonstrations under this
249.31 section. An initial open enrollment period may be provided. Persons who disenroll from
249.32 demonstrations under this subdivision remain subject to Minnesota Rules, parts 9500.1450
249.33 to 9500.1464. When a person is enrolled in a health plan under these demonstrations and
249.34 the health plan's participation is subsequently terminated for any reason, the person shall
249.35 be provided an opportunity to select a new health plan and shall have the right to change

health plans within the first 60 days of enrollment in the second health plan. Persons required to participate in health plans under this section who fail to make a choice of health plan shall not be randomly assigned to health plans under these demonstrations. Notwithstanding section 256L.12, subdivision 5, and Minnesota Rules, part 9505.5220, subpart 1, item A, if adopted, for the purpose of demonstrations under this subdivision, the commissioner may contract with managed care organizations, including counties, to serve only elderly persons eligible for medical assistance, elderly and disabled persons, or disabled persons only. For persons with a primary diagnosis of developmental disability, serious and persistent mental illness, or serious emotional disturbance, the commissioner must ensure that the county authority has approved the demonstration and contracting design. Enrollment in these projects for persons with disabilities shall be voluntary. The commissioner shall not implement any demonstration project under this subdivision for persons with a primary diagnosis of developmental disabilities, serious and persistent mental illness, or serious emotional disturbance, without approval of the county board of the county in which the demonstration is being implemented.

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

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

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

251.5 (e) The commissioner, in consultation with the commissioners of commerce and
251.6 health, may approve and implement programs for all-inclusive care for the elderly (PACE)
251.7 according to federal laws and regulations governing that program and state laws or rules
251.8 applicable to participating providers. The process for approval of these programs shall
251.9 begin only after the commissioner receives grant money in an amount sufficient to cover
251.10 the state share of the administrative and actuarial costs to implement the programs during
251.11 state fiscal years 2006 and 2007. Grant amounts for this purpose shall be deposited in an
251.12 account in the special revenue fund and are appropriated to the commissioner to be used
251.13 solely for the purpose of PACE administrative and actuarial costs. A PACE provider is
251.14 not required to be licensed or certified as a health plan company as defined in section
251.15 62Q.01, subdivision 4. Persons age 55 and older who have been screened by the county
251.16 and found to be eligible for services under the elderly waiver or community alternatives
251.17 for disabled individuals or who are already eligible for Medicaid but meet level of
251.18 care criteria for receipt of waiver services may choose to enroll in the PACE program.
251.19 Medicare and Medicaid services will be provided according to this subdivision and
251.20 federal Medicare and Medicaid requirements governing PACE providers and programs.
251.21 PACE enrollees will receive Medicaid home and community-based services through the
251.22 PACE provider as an alternative to services for which they would otherwise be eligible
251.23 through home and community-based waiver programs and Medicaid State Plan Services.
251.24 The commissioner shall establish Medicaid rates for PACE providers that do not exceed
251.25 costs that would have been incurred under fee-for-service or other relevant managed care
251.26 programs operated by the state.

251.27 (f) The commissioner shall seek federal approval to expand the Minnesota disability
251.28 health options (MnDHO) program established under this subdivision in stages, first to
251.29 regional population centers outside the seven-county metro area and then to all areas
251.30 of the state. Until ~~January 1, 2008~~ July 1, 2009, expansion for MnDHO projects that
251.31 include home and community-based services is limited to the two projects and service
251.32 areas in effect on March 1, 2006. Enrollment in integrated MnDHO programs that
251.33 include home and community-based services shall remain voluntary. Costs for home
251.34 and community-based services included under MnDHO must not exceed costs that
251.35 would have been incurred under the fee-for-service program. In developing program
251.36 specifications for expansion of integrated programs, the commissioner shall involve and

252.1 consult the state-level stakeholder group established in subdivision 28, paragraph (d),
252.2 including consultation on whether and how to include home and community-based waiver
252.3 programs. Plans for further expansion of MnDHO projects shall be presented to the chairs
252.4 of the house and senate committees with jurisdiction over health and human services
252.5 policy and finance by February 1, 2007.

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

252.10 Sec. 102. Minnesota Statutes 2006, section 256B.69, subdivision 28, is amended to
252.11 read:

252.12 Subd. 28. **Medicare special needs plans; medical assistance basic health care.**

252.13 (a) The commissioner may contract with qualified Medicare-approved special needs
252.14 plans to provide medical assistance basic health care services to persons with disabilities,
252.15 including those with developmental disabilities. Basic health care services include:

252.16 (1) those services covered by the medical assistance state plan except for ICF/MR
252.17 services, home and community-based waiver services, case management for persons with
252.18 developmental disabilities under section 256B.0625, subdivision 20a, and personal care
252.19 and certain home care services defined by the commissioner in consultation with the
252.20 stakeholder group established under paragraph (d); and

252.21 (2) basic health care services may also include risk for up to 100 days of nursing
252.22 facility services for persons who reside in a noninstitutional setting and home health
252.23 services related to rehabilitation as defined by the commissioner after consultation with
252.24 the stakeholder group.

252.25 The commissioner may exclude other medical assistance services from the basic
252.26 health care benefit set. Enrollees in these plans can access any excluded services on the
252.27 same basis as other medical assistance recipients who have not enrolled.

252.28 Unless a person is otherwise required to enroll in managed care, enrollment in these
252.29 plans for Medicaid services must be voluntary. For purposes of this subdivision, automatic
252.30 enrollment with an option to opt out is not voluntary enrollment.

252.31 (b) Beginning January 1, 2007, the commissioner may contract with qualified
252.32 Medicare special needs plans to provide basic health care services under medical
252.33 assistance to persons who are dually eligible for both Medicare and Medicaid and those
252.34 Social Security beneficiaries eligible for Medicaid but in the waiting period for Medicare.
252.35 The commissioner shall consult with the stakeholder group under paragraph ~~(d)~~ (e) in

253.1 developing program specifications for these services. The commissioner shall report to
253.2 the chairs of the house and senate committees with jurisdiction over health and human
253.3 services policy and finance by February 1, 2007, on implementation of these programs and
253.4 the need for increased funding for the ombudsman for managed care and other consumer
253.5 assistance and protections needed due to enrollment in managed care of persons with
253.6 disabilities. Payment for Medicaid services provided under this subdivision for the months
253.7 of May and June will be made no earlier than July 1 of the same calendar year.

253.8 (c) Beginning January 1, 2008, the commissioner may expand contracting under this
253.9 subdivision to all persons with disabilities not otherwise required to enroll in managed
253.10 care.

253.11 (d) By February 1, 2009, the commissioner shall report to the chairs of the house and
253.12 senate committees with jurisdiction over health and human services policy and finance on
253.13 the initial results of implementation of contracts with qualified Medicare special needs
253.14 plans to provide basic health care services under medical assistance to persons who are
253.15 dually eligible for both Medicare and Medicaid. This report shall include an overall
253.16 assessment of the impact on quality of care including actual costs and benefits.

253.17 (e) The commissioner shall establish a state-level stakeholder group to provide
253.18 advice on managed care programs for persons with disabilities, including both MnDHO
253.19 and contracts with special needs plans that provide basic health care services as described
253.20 in paragraphs (a) and (b). The stakeholder group shall include representatives of the
253.21 counties and labor organizations representing county social service workers, members,
253.22 consumer advocates, and providers, and provide advice on program expansions under this
253.23 subdivision and subdivision 23, including:

253.24 (1) implementation efforts;

253.25 (2) consumer protections; ~~and~~

253.26 (3) program specifications such as quality assurance measures, data collection and
253.27 reporting, and evaluation of costs, quality, and results; and

253.28 (4) county safety net protections for persons with disabilities.

253.29 ~~(e)~~ (f) Each plan under contract to provide medical assistance basic health care
253.30 services shall establish a local or regional stakeholder group, including representatives
253.31 of the counties covered by the plan and labor organizations representing county social
253.32 service workers, members, consumer advocates, and current providers, for advice on
253.33 issues that arise in the local or regional area.

253.34 Sec. 103. **[256C.261] SERVICES FOR DEAF-BLIND PERSONS.**

254.1 (a) The commissioner of human services shall combine the existing biennial base
254.2 level funding for deaf-blind services into a single grant program. At least 35 percent
254.3 of the total funding is awarded for services and other supports to deaf-blind children
254.4 and their families and at least 25 percent is awarded for services and other supports to
254.5 deaf-blind adults.

254.6 The commissioner shall award grants for the purposes of:

254.7 (1) providing services and supports to individuals who are deaf-blind; and

254.8 (2) developing and providing training to counties and the network of senior citizen
254.9 service providers. The purpose of the training grants is to teach counties how to use
254.10 existing programs that capture federal financial participation to meet the needs of eligible
254.11 deaf-blind persons and to build capacity of senior service programs to meet the needs of
254.12 seniors with a dual sensory hearing and vision loss.

254.13 (b) The commissioner may make grants:

254.14 (1) for services and training provided by organizations; and

254.15 (2) to develop and administer consumer-directed services.

254.16 (c) Any entity that is able to satisfy the grant criteria is eligible to receive a grant
254.17 under paragraph (a).

254.18 (d) Deaf-blind service providers are not required to, but may, provide intervenor
254.19 services as part of the service package provided with grant funds under this section.

254.20 Sec. 104. Minnesota Statutes 2006, section 256D.44, subdivision 2, is amended to read:

254.21 Subd. 2. **Standard of assistance for persons eligible for medical assistance**
254.22 **waivers or at risk of placement in a group residential housing facility.** The state
254.23 standard of assistance for a person (1) who is eligible for a medical assistance home
254.24 and community-based services waiver ~~or a person,~~ (2) who has been determined by the
254.25 local agency to meet the plan requirements for placement in a group residential housing
254.26 facility under section 256I.04, subdivision 1a, or (3) who is eligible for a shelter needy
254.27 payment under subdivision 5, paragraph (f), is the standard established in subdivision 3,
254.28 paragraph (a) or (b).

254.29 Sec. 105. Minnesota Statutes 2006, section 256D.44, subdivision 5, is amended to read:

254.30 Subd. 5. **Special needs.** In addition to the state standards of assistance established in
254.31 subdivisions 1 to 4, payments are allowed for the following special needs of recipients of
254.32 Minnesota supplemental aid who are not residents of a nursing home, a regional treatment
254.33 center, or a group residential housing facility.

255.1 (a) The county agency shall pay a monthly allowance for medically prescribed
255.2 diets if the cost of those additional dietary needs cannot be met through some other
255.3 maintenance benefit. The need for special diets or dietary items must be prescribed by
255.4 a licensed physician. Costs for special diets shall be determined as percentages of the
255.5 allotment for a one-person household under the thrifty food plan as defined by the United
255.6 States Department of Agriculture. The types of diets and the percentages of the thrifty
255.7 food plan that are covered are as follows:

- 255.8 (1) high protein diet, at least 80 grams daily, 25 percent of thrifty food plan;
255.9 (2) controlled protein diet, 40 to 60 grams and requires special products, 100 percent
255.10 of thrifty food plan;
255.11 (3) controlled protein diet, less than 40 grams and requires special products, 125
255.12 percent of thrifty food plan;
255.13 (4) low cholesterol diet, 25 percent of thrifty food plan;
255.14 (5) high residue diet, 20 percent of thrifty food plan;
255.15 (6) pregnancy and lactation diet, 35 percent of thrifty food plan;
255.16 (7) gluten-free diet, 25 percent of thrifty food plan;
255.17 (8) lactose-free diet, 25 percent of thrifty food plan;
255.18 (9) antidumping diet, 15 percent of thrifty food plan;
255.19 (10) hypoglycemic diet, 15 percent of thrifty food plan; or
255.20 (11) ketogenic diet, 25 percent of thrifty food plan.

255.21 (b) Payment for nonrecurring special needs must be allowed for necessary home
255.22 repairs or necessary repairs or replacement of household furniture and appliances using
255.23 the payment standard of the AFDC program in effect on July 16, 1996, for these expenses,
255.24 as long as other funding sources are not available.

255.25 (c) A fee for guardian or conservator service is allowed at a reasonable rate
255.26 negotiated by the county or approved by the court. This rate shall not exceed five percent
255.27 of the assistance unit's gross monthly income up to a maximum of \$100 per month. If the
255.28 guardian or conservator is a member of the county agency staff, no fee is allowed.

255.29 (d) The county agency shall continue to pay a monthly allowance of \$68 for
255.30 restaurant meals for a person who was receiving a restaurant meal allowance on June 1,
255.31 1990, and who eats two or more meals in a restaurant daily. The allowance must continue
255.32 until the person has not received Minnesota supplemental aid for one full calendar month
255.33 or until the person's living arrangement changes and the person no longer meets the criteria
255.34 for the restaurant meal allowance, whichever occurs first.

255.35 (e) A fee of ten percent of the recipient's gross income or \$25, whichever is less,
255.36 is allowed for representative payee services provided by an agency that meets the

requirements under SSI regulations to charge a fee for representative payee services. This special need is available to all recipients of Minnesota supplemental aid regardless of their living arrangement.

(f) Notwithstanding the language in this subdivision, an amount equal to the maximum allotment authorized by the federal Food Stamp Program for a single individual which is in effect on the first day of ~~January~~ July of the previous each year will be added to the standards of assistance established in subdivisions 1 to 4 for ~~individuals~~ adults under the age of 65 who qualify as shelter needy and are: (1) relocating from an institution, or an adult mental health residential treatment program under section 256B.0622, and who are shelter needy; (2) self-directed supports option participants defined under section 256B.0657 if enacted in the 2007 legislative session; or (3) home and community-based waiver recipients living in their own rented, leased, or owned apartment or home not owned, operated, or controlled by a provider of service not related by blood or marriage. Notwithstanding subdivision 3, paragraph (c), an individual eligible for the shelter needy benefit under subdivision 5, paragraph (f), is considered a household of one. An eligible individual who receives this benefit prior to age 65 may continue to receive the benefit after the age of 65.

(g)(1) Persons eligible for shelter needy funding under paragraph (f), who are not receiving medial assistance home and community-based waiver services, are eligible for a state-funded transitional supports allowance under section 256B.49, subdivision 16, paragraph (e), to establish their own residence not owned, operated, or controlled by a provider of service not related by blood or marriage.

(2) "Shelter needy" means that the assistance unit incurs monthly shelter costs that exceed 40 percent of the assistance unit's gross income before the application of this special needs standard. "Gross income" for the purposes of this section is the applicant's or recipient's income as defined in section 256D.35, subdivision 10, or the standard specified in subdivision 3, paragraph (a) or (b), whichever is greater. A recipient of a federal or state housing subsidy, that limits shelter costs to a percentage of gross income, shall not be considered shelter needy for purposes of this paragraph.

Sec. 106. Minnesota Statutes 2006, section 256I.04, subdivision 3, is amended to read:

Subd. 3. **Moratorium on the development of group residential housing beds.** (a) County agencies shall not enter into agreements for new group residential housing beds with total rates in excess of the MSA equivalent rate except: (1) for group residential housing establishments licensed under Minnesota Rules, parts 9525.0215 to 9525.0355, provided the facility is needed to meet the census reduction targets for persons with

257.1 developmental disabilities at regional treatment centers; (2) to ensure compliance with
257.2 the federal Omnibus Budget Reconciliation Act alternative disposition plan requirements
257.3 for inappropriately placed persons with developmental disabilities or mental illness;
257.4 (3) up to 80 beds in a single, specialized facility located in Hennepin County that will
257.5 provide housing for chronic inebriates who are repetitive users of detoxification centers
257.6 and are refused placement in emergency shelters because of their state of intoxication,
257.7 and planning for the specialized facility must have been initiated before July 1, 1991, in
257.8 anticipation of receiving a grant from the Housing Finance Agency under section 462A.05,
257.9 subdivision 20a, paragraph (b); (4) notwithstanding the provisions of subdivision 2a, for
257.10 up to 190 supportive housing units in Anoka, Dakota, Hennepin, or Ramsey County
257.11 for homeless adults with a mental illness, a history of substance abuse, or human
257.12 immunodeficiency virus or acquired immunodeficiency syndrome. For purposes of this
257.13 section, "homeless adult" means a person who is living on the street or in a shelter or
257.14 discharged from a regional treatment center, community hospital, or residential treatment
257.15 program and has no appropriate housing available and lacks the resources and support
257.16 necessary to access appropriate housing. At least 70 percent of the supportive housing
257.17 units must serve homeless adults with mental illness, substance abuse problems, or human
257.18 immunodeficiency virus or acquired immunodeficiency syndrome who are about to be
257.19 or, within the previous six months, has been discharged from a regional treatment center,
257.20 or a state-contracted psychiatric bed in a community hospital, or a residential mental
257.21 health or chemical dependency treatment program. If a person meets the requirements of
257.22 subdivision 1, paragraph (a), and receives a federal or state housing subsidy, the group
257.23 residential housing rate for that person is limited to the supplementary rate under section
257.24 256I.05, subdivision 1a, and is determined by subtracting the amount of the person's
257.25 countable income that exceeds the MSA equivalent rate from the group residential housing
257.26 supplementary rate. A resident in a demonstration project site who no longer participates
257.27 in the demonstration program shall retain eligibility for a group residential housing
257.28 payment in an amount determined under section 256I.06, subdivision 8, using the MSA
257.29 equivalent rate. Service funding under section 256I.05, subdivision 1a, will end June 30,
257.30 1997, if federal matching funds are available and the services can be provided through a
257.31 managed care entity. If federal matching funds are not available, then service funding will
257.32 continue under section 256I.05, subdivision 1a; ~~or (6) (5)~~ for group residential housing
257.33 beds in settings meeting the requirements of subdivision 2a, clauses (1) and (3), which
257.34 are used exclusively for recipients receiving home and community-based waiver services
257.35 under sections 256B.0915, 256B.092, subdivision 5, 256B.093, and 256B.49, and who
257.36 resided in a nursing facility for the six months immediately prior to the month of entry

into the group residential housing setting. The group residential housing rate for these beds must be set so that the monthly group residential housing payment for an individual occupying the bed when combined with the nonfederal share of services delivered under the waiver for that person does not exceed the nonfederal share of the monthly medical assistance payment made for the person to the nursing facility in which the person resided prior to entry into the group residential housing establishment. The rate may not exceed the MSA equivalent rate plus \$426.37 for any case; or (6) for an additional two beds, resulting in a total of 32 beds, for a facility located in Hennepin County providing services for recovering and chemically dependent men that has had a group residential housing contract with the county and has been licensed as a board and lodge facility with special services since 1980; (7) for a group residential housing provider located in Stearns County that operates a 40-bed facility, that received financing through the Minnesota Housing Finance Agency Ending Long-Term Homelessness Initiative and serves chemically dependent clientele, providing 24-hour-a-day supervision; (8) for a group residential housing provider located in Crow Wing County that serves a chemically dependent clientele, providing 24-hour-a-day supervision and limiting a resident's maximum length of stay to 13 months out of a consecutive 24-month period; (9) for a 60-bed facility in St. Louis County which opened in January 2006 that will serve chemically dependent persons operated by a group residential housing provider that currently operates a 304-bed facility in Minneapolis; and (10) for a group residential housing provider that operates two ten-bed facilities, one located in Hennepin County and one located in Ramsey County, which provide community support and serve the mental health needs of individuals who have chronically lived unsheltered, providing 24-hour-a-day supervision.

(b) A county agency may enter into a group residential housing agreement for beds with rates in excess of the MSA equivalent rate in addition to those currently covered under a group residential housing agreement if the additional beds are only a replacement of beds with rates in excess of the MSA equivalent rate which have been made available due to closure of a setting, a change of licensure or certification which removes the beds from group residential housing payment, or as a result of the downsizing of a group residential housing setting. The transfer of available beds from one county to another can only occur by the agreement of both counties.

Sec. 107. Minnesota Statutes 2006, section 256I.05, is amended by adding a subdivision to read:

Subd. 1h. Supplementary rate for certain facilities serving chemically dependent males. Notwithstanding subdivisions 1a and 1c, beginning July 1, 2007, a

259.1 county agency shall negotiate a supplementary rate in addition to the rate specified in
259.2 subdivision 1, not to exceed \$737.87 per month, including any legislatively authorized
259.3 inflationary adjustments, for a group residential housing provider that:

259.4 (1) is located in Ramsey County and has had a group residential housing contract
259.5 with the county since 1982 and has been licensed as a board and lodge facility with special
259.6 services since 1979; and

259.7 (2) serves recovering and chemically dependent males, providing 24-hour-a-day
259.8 supervision.

259.9 Sec. 108. Minnesota Statutes 2006, section 256I.05, is amended by adding a
259.10 subdivision to read:

259.11 Subd. 1i. **Supplementary rate for certain facilities; Hennepin County.**

259.12 Notwithstanding the provisions of subdivisions 1a and 1c, a county agency shall negotiate
259.13 a supplementary rate in addition to the rate specified in subdivision 1, not to exceed \$700
259.14 per month, including any legislatively authorized inflationary adjustments, for a facility
259.15 located in Hennepin County with a capacity of up to 48 beds that has been licensed since
259.16 1978 as a board and lodging facility and that until August 1, 2007, operated as a licensed
259.17 chemical dependency treatment program.

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

259.19 Sec. 109. Minnesota Statutes 2006, section 256I.05, is amended by adding a
259.20 subdivision to read:

259.21 Subd. 1j. **Supplementary rate for certain facilities; St. Louis County.** (a)

259.22 Notwithstanding the provisions of subdivisions 1a and 1c, beginning July 1, 2007, a
259.23 county agency shall negotiate a supplementary rate in addition to the rate specified in
259.24 subdivision 1, not to exceed \$700 per month, including any legislatively authorized
259.25 inflationary adjustments, for a 60-bed facility in St. Louis County which opened in
259.26 January 2006 that will serve chemically dependent persons operated by a group residential
259.27 housing provider that currently operates a 304-bed facility in Minneapolis.

259.28 (b) The supplementary rate in paragraph (a) applies to the 48 beds which do not
259.29 already receive a supplementary rate.

259.30 Sec. 110. Minnesota Statutes 2006, section 256I.05, is amended by adding a
259.31 subdivision to read:

259.32 Subd. 1k. **Supplementary rate for certain facilities; Crow Wing County.**

259.33 Notwithstanding the provisions of subdivisions 1a and 1c, beginning July 1, 2007, a

260.1 county agency shall negotiate a supplementary rate in addition to the rate specified in
260.2 subdivision 1, not to exceed \$700 per month, including any legislatively authorized
260.3 inflationary adjustments, for a new 65-bed facility in Crow Wing County that will serve
260.4 chemically dependent persons operated by a group residential housing provider that
260.5 currently operates a 304-bed facility in Minneapolis and a 44-bed facility in Duluth which
260.6 opened in January of 2006.

260.7 Sec. 111. Minnesota Statutes 2006, section 256I.05, is amended by adding a
260.8 subdivision to read:

260.9 Subd. 11. **Supplementary rate for certain facilities; Stearns County.**
260.10 Notwithstanding the provisions of this section, beginning July 1, 2007, a county agency
260.11 shall negotiate a supplementary service rate in addition to the rate specified in subdivision
260.12 1, not to exceed \$700 per month, including any legislatively authorized inflationary
260.13 adjustments, for a group residential housing provider located in Stearns County that
260.14 operates a 40-bed facility, that received financing through the Minnesota Housing Finance
260.15 Agency Ending Long-Term Homelessness Initiative and serves chemically dependent
260.16 clientele, providing 24-hour-a-day supervision.

260.17 Sec. 112. Minnesota Statutes 2006, section 256I.05, is amended by adding a
260.18 subdivision to read:

260.19 Subd. 1m. **Supplementary rate for certain facilities; St. Louis County.**
260.20 Notwithstanding the provisions of this section, beginning July 1, 2007, a county agency
260.21 shall negotiate a supplementary service rate in addition to the rate specified in subdivision
260.22 1, not to exceed \$700 per month, including any legislatively authorized inflationary
260.23 adjustments, for a group residential housing provider located in St. Louis County that
260.24 operates a 30-bed facility, that received financing through the Minnesota Housing Finance
260.25 Agency Ending Long-Term Homelessness Initiative and serves chemically dependent
260.26 clientele, providing 24-hour-a-day supervision.

260.27 Sec. 113. Minnesota Statutes 2006, section 256I.05, is amended by adding a
260.28 subdivision to read:

260.29 Subd. 1n. **Supplemental rate for certain facilities; Hennepin and Ramsey**
260.30 **Counties.** Notwithstanding the provisions of this section, beginning July 1, 2007, a county
260.31 agency shall negotiate a supplemental service rate in addition to the rate specified in
260.32 subdivision 1, not to exceed \$715.78 per month, including any legislatively authorized
260.33 inflationary adjustments, for a group residential housing provider that operates two

261.1 ten-bed facilities, one located in Hennepin County and one located in Ramsey County,
261.2 which provide community support and serve the mental health needs of individuals who
261.3 have chronically lived unsheltered, providing 24-hour-a-day supervision.

261.4 Sec. 114. Laws 2000, chapter 340, section 19, is amended to read:

261.5 Sec. 19. **ALTERNATIVE CARE PILOT PROJECTS.**

261.6 (a) Expenditures for housing with services and adult foster care shall be excluded
261.7 when determining average monthly expenditures per client for alternative care pilot
261.8 projects authorized in Laws 1993, First Special Session chapter 1, article 5, section 133.

261.9 (b) Alternative care pilot projects shall not expire on June 30, 2001, but shall
261.10 continue until June 30, ~~2005~~ 2007.

261.11 **EFFECTIVE DATE.** This section is effective retroactively from June 29, 2005, for
261.12 activities related to discontinuing pilot projects under this section.

261.13 Sec. 115. Laws 2006, chapter 282, article 20, section 37, is amended to read:

261.14 Sec. 37. **REPAYMENT DELAY.**

261.15 A county that overspent its allowed amounts in calendar year 2004 or 2005 under
261.16 the waived services program for persons with developmental disabilities shall not be
261.17 required to pay back the amount of overspending ~~until May 31, 2007~~.

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

261.19 Sec. 116. **LICENSURE; SERVICES FOR YOUTH WITH DISABILITIES.**

261.20 (a) Notwithstanding the requirements of Minnesota Statutes, chapter 245A, upon the
261.21 recommendation of a county agency, the commissioner of human services shall grant a
261.22 license with any necessary variances to a nonresidential program for youth which provides
261.23 services to youth with disabilities under age 21 during nonschool hours established
261.24 to ensure health and safety, prevent out-of-home placement, and increase community
261.25 inclusion of youth with disabilities. The nonresidential youth program is subject to the
261.26 conditions of any variances granted and with consumer rights under Minnesota Statutes,
261.27 section 245B.04, consumer protection standards under Minnesota Statutes, section
261.28 245B.05, service standards under Minnesota Statutes, section 245B.06, management
261.29 standards under Minnesota Statutes, section 245B.07, and fire marshal inspections under
261.30 Minnesota Statutes, section 245A.151, until the commissioner develops other licensure
261.31 requirements for this type of program.

262.1 (b) By February 1, 2008, the commissioner shall recommend amendments to
262.2 licensure requirements in Minnesota Statutes, chapter 245A, to allow licensure of
262.3 appropriate services for school-age youth with disabilities under age 21 who need
262.4 supervision and services to develop skills necessary to maintain personal safety and
262.5 increase their independence, productivity, and participation in their communities during
262.6 nonschool hours. As part of developing the recommendations, the commissioner shall
262.7 survey county agencies to determine how the needs of youth with disabilities under age 21
262.8 who require supervision and support services are being met and the funding sources used.
262.9 The recommendations must be provided to the house and senate chairs of the committees
262.10 with jurisdiction over licensing of programs for youth with disabilities.

262.11 Sec. 117. **INDEPENDENT LIVING.**

262.12 An individual who has lived in one of the facilities under Minnesota Statutes,
262.13 section 256I.05, subdivision 1n, who is being transitioned to independent living as
262.14 part of the program plan continues to be eligible for group residential housing and the
262.15 supplemental service rate negotiated with the county under Minnesota Statutes, section
262.16 256I.05, subdivision 1n.

262.17 Sec. 118. **ASSISTIVE TECHNOLOGY RECOMMENDATIONS.**

262.18 Subdivision 1. **Review.** (a) During the biennium ending June 30, 2009, the Council
262.19 on Disability shall facilitate a statewide review of the assistive technology needs of people
262.20 with disabling conditions, and seniors. The council shall identify community-based
262.21 service providers, state agencies, and other entities involved in providing assistive
262.22 technology supports.

262.23 (b) The council shall provide oversight and direction to the Minnesota Regions
262.24 Assistive Technology Collaborative during the biennium ending June 30, 2009.

262.25 Subd. 2. **Recommendations.** The council shall present to the chairs of the house
262.26 and senate committees having jurisdiction over human services, by January 1, 2009,
262.27 recommendations, including proposed legislation creating a statewide comprehensive plan
262.28 to meet the assistive technology needs of people with disabling conditions and seniors.
262.29 The statewide plan must include steps to coordinate and streamline assistive technology
262.30 services.

262.31 Sec. 119. **COMMUNITY SERVICES PROVIDER RATE INCREASES.**

262.32 (a) The commissioner of human services shall increase allocations, reimbursement
262.33 rates, or rate limits, as applicable, by three percent for the rate period beginning October 1,

263.1 2007, and the rate period beginning October 1, 2008, effective for services rendered on
263.2 or after those dates.

263.3 (b) The three percent annual rate increase described in this section must be provided
263.4 to:

263.5 (1) home and community-based waived services for persons with developmental
263.6 disabilities or related conditions under Minnesota Statutes, section 256B.501;

263.7 (2) home and community-based waived services for the elderly under Minnesota
263.8 Statutes, section 256B.0915;

263.9 (3) waived services under community alternatives for disabled individuals under
263.10 Minnesota Statutes, section 256B.49;

263.11 (4) community alternative care waived services under Minnesota Statutes, section
263.12 256B.49;

263.13 (5) traumatic brain injury waived services under Minnesota Statutes, section
263.14 256B.49;

263.15 (6) nursing services and home health services under Minnesota Statutes, section
263.16 256B.0625, subdivision 6a;

263.17 (7) personal care services and nursing supervision of personal care services under
263.18 Minnesota Statutes, section 256B.0625, subdivision 19a;

263.19 (8) private duty nursing services under Minnesota Statutes, section 256B.0625,
263.20 subdivision 7;

263.21 (9) day training and habilitation services for adults with developmental disabilities
263.22 or related conditions under Minnesota Statutes, sections 252.40 to 252.46, including the
263.23 additional cost of rate adjustments on day training and habilitation service, provided as a
263.24 social service under Minnesota Statutes, section 256M.60;

263.25 (10) alternative care services under Minnesota Statutes, section 256B.0913;

263.26 (11) adult residential program grants under Minnesota Statutes, section 245.73;

263.27 (12) adult and children's mental health grants under Minnesota Rules, parts
263.28 9535.1700 to 9535.1760;

263.29 (13) the group residential housing supplementary service rate under Minnesota
263.30 Statutes, section 256I.05, subdivision 1a;

263.31 (14) adult mental health integrated fund grants under Minnesota Statutes, section
263.32 245.4661;

263.33 (15) semi-independent living services (SILS) under Minnesota Statutes, section
263.34 252.275, including SILS funding under county social services grants formerly funded
263.35 under Minnesota Statutes, chapter 256I;

- 264.1 (16) community support services for deaf and hard-of-hearing adults with mental
264.2 illness who use or wish to use sign language as their primary means of communication
264.3 under Minnesota Statutes, section 256.01, subdivision 2;
- 264.4 (17) living skills training programs for persons with intractable epilepsy who need
264.5 assistance in the transition to independent living under Laws 1988, chapter 689;
- 264.6 (18) physical therapy services under Minnesota Statutes, sections 256B.0625,
264.7 subdivision 8, and 256D.03, subdivision 4;
- 264.8 (19) occupational therapy services under Minnesota Statutes, sections 256B.0625,
264.9 subdivision 8a, and 256D.03, subdivision 4;
- 264.10 (20) speech-language therapy services under Minnesota Statutes, section 256D.03,
264.11 subdivision 4, and Minnesota Rules, part 9505.0390;
- 264.12 (21) respiratory therapy services under Minnesota Statutes, section 256D.03,
264.13 subdivision 4, and Minnesota Rules, part 9505.0295;
- 264.14 (22) aging grants under Minnesota Statutes, sections 256.975 to 256.977, 256B.0917,
264.15 and 256B.0928;
- 264.16 (23) deaf and hard-of-hearing grants under Minnesota Statutes, sections 256C.233;
264.17 256C.25; Laws 1985, chapter 9, article 1; and Laws 1997, First Special Session chapter
264.18 5, section 20;
- 264.19 (24) children's therapeutic services and supports under Minnesota Statutes, section
264.20 256B.0943;
- 264.21 (25) tier I chemical health services under Minnesota Statutes, chapter 254B;
- 264.22 (26) consumer support grants under Minnesota Statutes, section 256.476;
- 264.23 (27) family support grants under Minnesota Statutes, section 252.32;
- 264.24 (28) case management services to persons with HIV or AIDS under Minnesota
264.25 Statutes, section 256.01, subdivision 19; and
- 264.26 (29) adult rehabilitative mental health services under Minnesota Statutes, section
264.27 256B.0623.
- 264.28 (c) Providers that receive a rate increase under this section shall use 75 percent of
264.29 the additional revenue to increase wages and benefits and pay associated costs for all
264.30 employees, except for management fees, the administrator, and central office staff.
- 264.31 (d) For public employees, the increase for wages and benefits for certain staff is
264.32 available and pay rates must be increased only to the extent that they comply with laws
264.33 governing public employees' collective bargaining. Money received by a provider for pay
264.34 increases under this section may be used only for increases implemented on or after the
264.35 first day of the rate period in which the increase is available and must not be used for
264.36 increases implemented prior to that date.

265.1 (e) A copy of the provider's plan for complying with paragraph (c) must be made
265.2 available to all employees by giving each employee a copy or by posting a copy in an area
265.3 of the provider's operation to which all employees have access. If an employee does not
265.4 receive the adjustment, if any, described in the plan and is unable to resolve the problem
265.5 with the provider, the employee may contact the employee's union representative. If the
265.6 employee is not covered by a collective bargaining agreement, the employee may contact
265.7 the commissioner at a telephone number provided by the commissioner and included in
265.8 the provider's plan.

265.9 (f) The commissioner and each county agency shall take steps necessary to
265.10 implement the increases required by this section on the dates specified, and the increases
265.11 must be effective on the dates specified, regardless of the client's service authorization date
265.12 and notwithstanding the terms of any provider contract, service agreement, or schedule
265.13 that limits when a county may increase payment rates.

265.14 Sec. 120. **DENTAL ACCESS FOR PERSONS WITH DISABILITIES.**

265.15 The commissioner of human services shall study access to dental services for
265.16 persons with disabilities, and shall present recommendations for improving access to
265.17 dental services to the legislature by January 15, 2008. The study must examine physical
265.18 and geographic access, the willingness of dentists to serve persons with disabilities
265.19 enrolled in state health care programs, reimbursement rates for dental service providers,
265.20 and other factors identified by the commissioner.

265.21 Sec. 121. **COMMISSIONER REQUIRED TO SEEK FEDERAL APPROVAL.**

265.22 By October 1, 2007, the commissioner shall seek federal approval to allow persons
265.23 who have been eligible for medical assistance for employed persons with disabilities
265.24 (MA-EPD) under Minnesota Statutes, section 256B.057, subdivision 9, for each of the 24
265.25 consecutive months prior to becoming age 65 to continue using the MA-EPD eligibility
265.26 rules as long as they qualify.

265.27 Sec. 122. **MINNESOTA RULES.**

265.28 The Department of Administration shall publish adopted rules in the State Register
265.29 making the terminology changes specified in section 92 in Minnesota Rules. Upon
265.30 publication in the State Register, the terminology changes for Minnesota Rules are
265.31 adopted without further administrative action.

265.32 Sec. 123. **REVISOR'S INSTRUCTION.**

266.1 The revisor of statutes shall change the terms in column A to the terms in column B

266.2 wherever they appear in Minnesota Statutes:

	<u>Column A</u>	<u>Column B</u>
266.3		
266.4	<u>"Office of Ombudsman</u>	<u>"Office of Ombudsman</u>
266.5	<u>for Older Minnesotans"</u>	<u>for Long-Term Care"</u>
266.6	<u>and "Office of the</u>	
266.7	<u>Ombudsman for Older</u>	
266.8	<u>Minnesotans"</u>	
266.9	<u>"ombudsman for older</u>	<u>"ombudsman for</u>
266.10	<u>Minnesotans"</u>	<u>long-term care"</u>

266.11 Sec. 124. **REPEALER.**
266.12 Minnesota Statutes 2006, sections 252.21; 252.22; 252.23; 252.24; 252.25; 252.261;
266.13 252.275, subdivision 5; 256.9743; 256B.0913, subdivisions 5b, 5c, 5d, 5e, 5f, 5g, and 5h;
266.14 and 256B.441, subdivisions 12, 16, 21, 26, 28, 42, and 45, are repealed.

266.15 **ARTICLE 5**
266.16 **MENTAL HEALTH**

266.17 Section 1. Minnesota Statutes 2006, section 245.462, subdivision 20, is amended to
266.18 read:

Subd. 20. **Mental illness.** (a) "Mental illness" means an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that is listed in the clinical manual of the International Classification of Diseases (ICD-9-CM), current edition, code range 290.0 to 302.99 or 306.0 to 316.0 or the corresponding code in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-MD), current edition, Axes I, II, or III, and that seriously limits a person's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, and recreation.

266.27 (b) An "adult with acute mental illness" means an adult who has a mental illness that
266.28 is serious enough to require prompt intervention.

266.29 (c) For purposes of case management and community support services, a "person
266.30 with serious and persistent mental illness" means an adult who has a mental illness and
266.31 meets at least one of the following criteria:

266.32 (1) the adult has undergone two or more episodes of inpatient care for a mental
266.33 illness within the preceding 24 months;

266.34 (2) the adult has experienced a continuous psychiatric hospitalization or residential
266.35 treatment exceeding six months' duration within the preceding 12 months;

267.1 (3) the adult has been treated by a crisis team two or more times within the preceding
267.2 24 months;

267.3 (4) the adult:

267.4 (i) has a diagnosis of schizophrenia, bipolar disorder, major depression, or borderline
267.5 personality disorder;

267.6 (ii) indicates a significant impairment in functioning; and

267.7 (iii) has a written opinion from a mental health professional, in the last three years,
267.8 stating that the adult is reasonably likely to have future episodes requiring inpatient or
267.9 residential treatment, of a frequency described in clause (1) or (2), unless ongoing case
267.10 management or community support services are provided;

267.11 ~~(4)~~ (5) the adult has, in the last three years, been committed by a court as a person
267.12 who is mentally ill under chapter 253B, or the adult's commitment has been stayed or
267.13 continued; or

267.14 ~~(5)~~ (6) the adult (i) was eligible under clauses (1) to ~~(4)~~ (5), but the specified time
267.15 period has expired or the adult was eligible as a child under section 245.4871, subdivision
267.16 6; and (ii) has a written opinion from a mental health professional, in the last three years,
267.17 stating that the adult is reasonably likely to have future episodes requiring inpatient or
267.18 residential treatment, of a frequency described in clause (1) or (2), unless ongoing case
267.19 management or community support services are provided.

267.20 Sec. 2. Minnesota Statutes 2006, section 245.465, is amended by adding a subdivision
267.21 to read:

267.22 Subd. 3. **Responsibility not duplicated.** For individuals who have health care
267.23 coverage, the county board is not responsible for providing mental health services which
267.24 are within the limits of the individual's health care coverage.

267.25 Sec. 3. Minnesota Statutes 2006, section 245.4874, is amended to read:

267.26 **245.4874 DUTIES OF COUNTY BOARD.**

267.27 Subdivision 1. **Duties of the county board.** (a) The county board must:

267.28 (1) develop a system of affordable and locally available children's mental health
267.29 services according to sections 245.487 to 245.4887;

267.30 (2) establish a mechanism providing for interagency coordination as specified in
267.31 section 245.4875, subdivision 6;

267.32 (3) consider the assessment of unmet needs in the county as reported by the local
267.33 children's mental health advisory council under section 245.4875, subdivision 5, paragraph

268.1 (b), clause (3). The county shall provide, upon request of the local children's mental health
268.2 advisory council, readily available data to assist in the determination of unmet needs;
268.3 (4) assure that parents and providers in the county receive information about how to
268.4 gain access to services provided according to sections 245.487 to 245.4887;
268.5 (5) coordinate the delivery of children's mental health services with services
268.6 provided by social services, education, corrections, health, and vocational agencies to
268.7 improve the availability of mental health services to children and the cost-effectiveness of
268.8 their delivery;
268.9 (6) assure that mental health services delivered according to sections 245.487
268.10 to 245.4887 are delivered expeditiously and are appropriate to the child's diagnostic
268.11 assessment and individual treatment plan;
268.12 (7) provide the community with information about predictors and symptoms of
268.13 emotional disturbances and how to access children's mental health services according to
268.14 sections 245.4877 and 245.4878;
268.15 (8) provide for case management services to each child with severe emotional
268.16 disturbance according to sections 245.486; 245.4871, subdivisions 3 and 4; and 245.4881,
268.17 subdivisions 1, 3, and 5;
268.18 (9) provide for screening of each child under section 245.4885 upon admission
268.19 to a residential treatment facility, acute care hospital inpatient treatment, or informal
268.20 admission to a regional treatment center;
268.21 (10) prudently administer grants and purchase-of-service contracts that the county
268.22 board determines are necessary to fulfill its responsibilities under sections 245.487 to
268.23 245.4887;
268.24 (11) assure that mental health professionals, mental health practitioners, and case
268.25 managers employed by or under contract to the county to provide mental health services
268.26 are qualified under section 245.4871;
268.27 (12) assure that children's mental health services are coordinated with adult mental
268.28 health services specified in sections 245.461 to 245.486 so that a continuum of mental
268.29 health services is available to serve persons with mental illness, regardless of the person's
268.30 age;
268.31 (13) assure that culturally informed mental health consultants are used as necessary
268.32 to assist the county board in assessing and providing appropriate treatment for children of
268.33 cultural or racial minority heritage; and
268.34 (14) consistent with section 245.486, arrange for or provide a children's mental
268.35 health screening to a child receiving child protective services or a child in out-of-home
268.36 placement, a child for whom parental rights have been terminated, a child found to be

delinquent, and a child found to have committed a juvenile petty offense for the third or subsequent time, unless a screening has been performed within the previous 180 days, or the child is currently under the care of a mental health professional. The court or county agency must notify a parent or guardian whose parental rights have not been terminated of the potential mental health screening and the option to prevent the screening by notifying the court or county agency in writing. The screening shall be conducted with a screening instrument approved by the commissioner of human services according to criteria that are updated and issued annually to ensure that approved screening instruments are valid and useful for child welfare and juvenile justice populations, and shall be conducted by a mental health practitioner as defined in section 245.4871, subdivision 26, or a probation officer or local social services agency staff person who is trained in the use of the screening instrument. Training in the use of the instrument shall include training in the administration of the instrument, the interpretation of its validity given the child's current circumstances, the state and federal data practices laws and confidentiality standards, the parental consent requirement, and providing respect for families and cultural values. If the screen indicates a need for assessment, the child's family, or if the family lacks mental health insurance, the local social services agency, in consultation with the child's family, shall have conducted a diagnostic assessment, including a functional assessment, as defined in section 245.4871. The administration of the screening shall safeguard the privacy of children receiving the screening and their families and shall comply with the Minnesota Government Data Practices Act, chapter 13, and the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191. Screening results shall be considered private data and the commissioner shall not collect individual screening results.

(b) When the county board refers clients to providers of children's therapeutic services and supports under section 256B.0943, the county board must clearly identify the desired services components not covered under section 256B.0943 and identify the reimbursement source for those requested services, the method of payment, and the payment rate to the provider.

Subd. 2. **Responsibility not duplicated.** For individuals who have health care coverage, the county board is not responsible for providing mental health services which are within the limits of the individual's health care coverage.

Sec. 4. Minnesota Statutes 2006, section 245.50, subdivision 5, is amended to read:

Subd. 5. Special contracts; bordering states. (a) An individual who is detained, committed, or placed on an involuntary basis under chapter 253B may be confined or treated in a bordering state pursuant to a contract under this section. An individual who is

270.1 detained, committed, or placed on an involuntary basis under the civil law of a bordering
270.2 state may be confined or treated in Minnesota pursuant to a contract under this section. A
270.3 peace or health officer who is acting under the authority of the sending state may transport
270.4 an individual to a receiving agency that provides services pursuant to a contract under
270.5 this section and may transport the individual back to the sending state under the laws
270.6 of the sending state. Court orders valid under the law of the sending state are granted
270.7 recognition and reciprocity in the receiving state for individuals covered by a contract
270.8 under this section to the extent that the court orders relate to confinement for treatment
270.9 or care of mental illness or chemical dependency. Such treatment or care may address
270.10 other conditions that may be co-occurring with the mental illness or chemical dependency.
270.11 These court orders are not subject to legal challenge in the courts of the receiving state.
270.12 Individuals who are detained, committed, or placed under the law of a sending state and
270.13 who are transferred to a receiving state under this section continue to be in the legal
270.14 custody of the authority responsible for them under the law of the sending state. Except
270.15 in emergencies, those individuals may not be transferred, removed, or furloughed from
270.16 a receiving agency without the specific approval of the authority responsible for them
270.17 under the law of the sending state.

270.18 (b) While in the receiving state pursuant to a contract under this section, an
270.19 individual shall be subject to the sending state's laws and rules relating to length of
270.20 confinement, reexaminations, and extensions of confinement. No individual may be sent
270.21 to another state pursuant to a contract under this section until the receiving state has
270.22 enacted a law recognizing the validity and applicability of this section.

270.23 (c) If an individual receiving services pursuant to a contract under this section leaves
270.24 the receiving agency without permission and the individual is subject to involuntary
270.25 confinement under the law of the sending state, the receiving agency shall use all
270.26 reasonable means to return the individual to the receiving agency. The receiving agency
270.27 shall immediately report the absence to the sending agency. The receiving state has the
270.28 primary responsibility for, and the authority to direct, the return of these individuals
270.29 within its borders and is liable for the cost of the action to the extent that it would be
270.30 liable for costs of its own resident.

270.31 (d) Responsibility for payment for the cost of care remains with the sending agency.

270.32 (e) This subdivision also applies to county contracts under subdivision 2 which
270.33 include emergency care and treatment provided to a county resident in a bordering state.

270.34 (f) If a Minnesota resident is admitted to a facility in a bordering state under this
270.35 chapter, a physician, licensed psychologist who has a doctoral degree in psychology, or
270.36 an advance practice registered nurse certified in mental health, who is licensed in the

271.1 bordering state, may act as an examiner under sections 253B.07, 253B.08, 253B.092,
271.2 253B.12, and 253B.17 subject to the same requirements and limitations in section
271.3 253B.02, subdivision 7.

271.4 Sec. 5. Minnesota Statutes 2006, section 245.98, subdivision 2, is amended to read:

271.5 Subd. 2. **Program.** The commissioner of human services shall establish a program
271.6 for the treatment of compulsive gamblers. The commissioner may contract with an
271.7 entity with expertise regarding the treatment of compulsive gambling to operate the
271.8 program. The program may include the establishment of a statewide toll-free number,
271.9 resource library, public education programs; regional in-service training programs and
271.10 conferences for health care professionals, educators, treatment providers, employee
271.11 assistance programs, and criminal justice representatives; and the establishment of
271.12 certification standards for programs and service providers. The commissioner may enter
271.13 into agreements with other entities and may employ or contract with consultants to
271.14 facilitate the provision of these services or the training of individuals to qualify them to
271.15 provide these services. The program may also include inpatient and outpatient treatment
271.16 and rehabilitation services ~~and~~ for residents in a temporary or permanent residential
271.17 setting for mental health or chemical dependency, and individuals in jails or correctional
271.18 facilities. The program may also include research studies. The research studies must
271.19 include baseline and prevalence studies for adolescents and adults to identify those at the
271.20 highest risk. The program must be approved by the commissioner before it is established.

271.21 Sec. 6. Minnesota Statutes 2006, section 245.98, subdivision 5, is amended to read:

271.22 Subd. 5. **Standards.** The commissioner shall create standards for treatment and
271.23 provider qualifications for the treatment component of the compulsive gambling program.
271.24 The commissioner, in coordination with the commissioner of corrections, shall create
271.25 standards for the assessment and treatment of compulsive gamblers in programs operated
271.26 by the commissioner of corrections.

271.27 Sec. 7. **[245A.175] MENTAL HEALTH TRAINING REQUIREMENT.**

271.28 Prior to placement of a child in a foster care home, the child foster care provider, if
271.29 required to be licensed, must complete two hours of training that addresses the causes,
271.30 symptoms, and key warning signs of mental health disorders; cultural considerations; and
271.31 effective approaches for dealing with a child's behaviors. At least one hour of the annual
271.32 12-hour training requirement for foster parents must be on children's mental health issues

272.1 and treatment. Training curriculum shall be approved by the commissioner of human
272.2 services.

272.3 Sec. 8. Minnesota Statutes 2006, section 246.54, subdivision 1, is amended to read:

272.4 Subdivision 1. **County portion for cost of care.** Except for chemical dependency
272.5 services provided under sections 254B.01 to 254B.09, the client's county shall pay to the
272.6 state of Minnesota a portion of the cost of care provided in a regional treatment center
272.7 or a state nursing facility to a client legally settled in that county. A county's payment
272.8 shall be made from the county's own sources of revenue and payments shall be ~~paid as~~
272.9 ~~follows: payments to the state from the county shall equal 20 percent~~ a percentage of the
272.10 cost of care, as determined by the commissioner, for each day, or the portion thereof, that
272.11 the client spends at a regional treatment center or a state nursing facility- according to
272.12 the following schedule for each admission:

272.13 (1) for the first 30 days: 20 percent until January 1, 2008, ten percent from January
272.14 1, 2008, to June 30, 2009, and zero percent thereafter;

272.15 (2) 20 percent for days 31 to 60; and

272.16 (3) for any days over 60: 20 percent until January 1, 2008, 30 percent from January
272.17 1, 2008, to June 30, 2009, 40 percent from July 1, 2009, to June 30, 2010, and 50 percent
272.18 thereafter.

272.19 If payments received by the state under sections 246.50 to 246.53 exceed ~~80 percent~~ the
272.20 noncounty portion of the cost of care, the county shall be responsible for paying the state
272.21 only the remaining amount. The county shall not be entitled to reimbursement from
272.22 the client, the client's estate, or from the client's relatives, except as provided in section
272.23 246.53. ~~No such payments shall be made for any client who was last committed prior to~~
272.24 ~~July 1, 1947.~~

272.25 Sec. 9. Minnesota Statutes 2006, section 256B.0625, subdivision 20, is amended to
272.26 read:

272.27 Subd. 20. **Mental health case management.** (a) To the extent authorized by rule
272.28 of the state agency, medical assistance covers case management services to persons with
272.29 serious and persistent mental illness and children with severe emotional disturbance.
272.30 Services provided under this section must meet the relevant standards in sections 245.461
272.31 to 245.4887, the Comprehensive Adult and Children's Mental Health Acts, Minnesota
272.32 Rules, parts 9520.0900 to 9520.0926, and 9505.0322, excluding subpart 10.

272.33 (b) Entities meeting program standards set out in rules governing family community
272.34 support services as defined in section 245.4871, subdivision 17, are eligible for medical

273.1 assistance reimbursement for case management services for children with severe
273.2 emotional disturbance when these services meet the program standards in Minnesota
273.3 Rules, parts 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

273.4 (c) Medical assistance and MinnesotaCare payment for mental health case
273.5 management shall be made on a monthly basis. In order to receive payment for an eligible
273.6 child, the provider must document at least a face-to-face contact with the child, the child's
273.7 parents, or the child's legal representative. To receive payment for an eligible adult, the
273.8 provider must document:

273.9 (1) at least a face-to-face contact with the adult or the adult's legal representative; or

273.10 (2) at least a telephone contact with the adult or the adult's legal representative and
273.11 document a face-to-face contact with the adult or the adult's legal representative within
273.12 the preceding two months.

273.13 (d) Payment for mental health case management provided by county or state staff
273.14 shall be based on the monthly rate methodology under section 256B.094, subdivision 6,
273.15 paragraph (b), with separate rates calculated for child welfare and mental health, and
273.16 within mental health, separate rates for children and adults.

273.17 (e) Payment for mental health case management provided by Indian health services
273.18 or by agencies operated by Indian tribes may be made according to this section or other
273.19 relevant federally approved rate setting methodology.

273.20 (f) Payment for mental health case management provided by vendors who contract
273.21 with a county or Indian tribe shall be based on a monthly rate negotiated by the host county
273.22 or tribe. The negotiated rate must not exceed the rate charged by the vendor for the same
273.23 service to other payers. If the service is provided by a team of contracted vendors, the
273.24 county or tribe may negotiate a team rate with a vendor who is a member of the team. The
273.25 team shall determine how to distribute the rate among its members. No reimbursement
273.26 received by contracted vendors shall be returned to the county or tribe, except to reimburse
273.27 the county or tribe for advance funding provided by the county or tribe to the vendor.

273.28 (g) If the service is provided by a team which includes contracted vendors, tribal
273.29 staff, and county or state staff, the costs for county or state staff participation in the team
273.30 shall be included in the rate for county-provided services. In this case, the contracted
273.31 vendor, the tribal agency, and the county may each receive separate payment for services
273.32 provided by each entity in the same month. In order to prevent duplication of services,
273.33 each entity must document, in the recipient's file, the need for team case management and
273.34 a description of the roles of the team members.

273.35 (h) The commissioner shall calculate the nonfederal share of actual medical
273.36 assistance and general assistance medical care payments for each county, based on the

higher of calendar year 1995 or 1996, by service date, project that amount forward to 1999, and transfer one-half of the result from medical assistance and general assistance medical care to each county's mental health grants under section 256E.12 for calendar year 1999.

The annualized minimum amount added to each county's mental health grant shall be \$3,000 per year for children and \$5,000 per year for adults. The commissioner may reduce the statewide growth factor in order to fund these minimums. The annualized total amount transferred shall become part of the base for future mental health grants for each county.

(i) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for mental health case management shall be provided by the recipient's county of responsibility, as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds used to match other federal funds. If the service is provided by a tribal agency, the nonfederal share, if any, shall be provided by the recipient's tribe. When this service is paid by the state without a federal share through fee-for-service, 50 percent of the cost shall be provided by the recipient's county of responsibility.

(j) Notwithstanding any administrative rule to the contrary, prepaid medical assistance, general assistance medical care, and MinnesotaCare include mental health case management. When the service is provided through prepaid capitation, the nonfederal share is paid by the state and the county pays no share.

~~(k)~~ (k) The commissioner may suspend, reduce, or terminate the reimbursement to a provider that does not meet the reporting or other requirements of this section. The county of responsibility, as defined in sections 256G.01 to 256G.12, or, if applicable, the tribal agency, is responsible for any federal disallowances. The county or tribe may share this responsibility with its contracted vendors.

~~(l)~~ (l) The commissioner shall set aside a portion of the federal funds earned for county expenditures under this section to repay the special revenue maximization account under section 256.01, subdivision 2, clause (15). The repayment is limited to:

(1) the costs of developing and implementing this section; and

(2) programming the information systems.

~~(m)~~ (m) Payments to counties and tribal agencies for case management expenditures under this section shall only be made from federal earnings from services provided under this section. When this service is paid by the state without a federal share through fee-for-service, 50 percent of the cost shall be provided by the state. Payments to county-contracted vendors shall include ~~both~~ the federal earnings, the state share, and the county share.

~~(n)~~ (n) Notwithstanding section 256B.041, county payments for the cost of mental health case management services provided by county or state staff shall not be made

275.1 to the commissioner of finance. For the purposes of mental health case management
275.2 services provided by county or state staff under this section, the centralized disbursement
275.3 of payments to counties under section 256B.041 consists only of federal earnings from
275.4 services provided under this section.

275.5 ~~(n)~~ (o) Case management services under this subdivision do not include therapy,
275.6 treatment, legal, or outreach services.

275.7 ~~(o)~~ (p) If the recipient is a resident of a nursing facility, intermediate care facility,
275.8 or hospital, and the recipient's institutional care is paid by medical assistance, payment
275.9 for case management services under this subdivision is limited to the last 180 days of
275.10 the recipient's residency in that facility and may not exceed more than six months in a
275.11 calendar year.

275.12 ~~(p)~~ (q) Payment for case management services under this subdivision shall not
275.13 duplicate payments made under other program authorities for the same purpose.

275.14 ~~(q)~~ (r) By July 1, 2000, the commissioner shall evaluate the effectiveness of the
275.15 changes required by this section, including changes in number of persons receiving
275.16 mental health case management, changes in hours of service per person, and changes in
275.17 caseload size.

275.18 ~~(r)~~ (s) For each calendar year beginning with the calendar year 2001, the annualized
275.19 amount of state funds for each county determined under paragraph (h) shall be adjusted by
275.20 the county's percentage change in the average number of clients per month who received
275.21 case management under this section during the fiscal year that ended six months prior to
275.22 the calendar year in question, in comparison to the prior fiscal year.

275.23 ~~(s)~~ (t) For counties receiving the minimum allocation of \$3,000 or \$5,000 described
275.24 in paragraph (h), the adjustment in paragraph (s) shall be determined so that the county
275.25 receives the higher of the following amounts:

275.26 (1) a continuation of the minimum allocation in paragraph (h); or

275.27 (2) an amount based on that county's average number of clients per month who
275.28 received case management under this section during the fiscal year that ended six months
275.29 prior to the calendar year in question, times the average statewide grant per person per
275.30 month for counties not receiving the minimum allocation.

275.31 ~~(t)~~ (u) The adjustments in paragraphs (s) and (t) shall be calculated separately for
275.32 children and adults.

275.33 **EFFECTIVE DATE.** This section is effective January 1, 2009, except the
275.34 amendment to paragraph (i) is effective January 1, 2008.

276.1 Sec. 10. Minnesota Statutes 2006, section 256B.0625, subdivision 47, is amended to
276.2 read:

276.3 Subd. 47. **Treatment foster care services.** Effective July 1, ~~2006~~ 2009, and subject
276.4 to federal approval, medical assistance covers treatment foster care services according to
276.5 section 256B.0946.

276.6 Sec. 11. Minnesota Statutes 2006, section 256B.0945, subdivision 4, is amended to
276.7 read:

276.8 Subd. 4. **Payment rates.** (a) Notwithstanding sections 256B.19 and 256B.041,
276.9 payments to counties for residential services provided by a residential facility shall only
276.10 be made of federal earnings for services provided under this section, and the nonfederal
276.11 share of costs for services provided under this section shall be paid by the county from
276.12 sources other than federal funds or funds used to match other federal funds. Payment to
276.13 counties for services provided according to this section shall be a proportion of the per
276.14 day contract rate that relates to rehabilitative mental health services and shall not include
276.15 payment for costs or services that are billed to the IV-E program as room and board.

276.16 (b) Per diem rates paid to providers under this section by prepaid plans shall be the
276.17 proportion of the per-day contract rate that relates to rehabilitative mental health services
276.18 and shall not include payment for group foster care costs or services that are billed to the
276.19 county of financial responsibility.

276.20 (c) The commissioner shall set aside a portion not to exceed five percent of the
276.21 federal funds earned for county expenditures under this section to cover the state costs of
276.22 administering this section. Any unexpended funds from the set-aside shall be distributed
276.23 to the counties in proportion to their earnings under this section.

276.24 **EFFECTIVE DATE.** This section is effective January 1, 2009.

276.25 Sec. 12. Minnesota Statutes 2006, section 256B.69, subdivision 5g, is amended to read:

276.26 Subd. 5g. **Payment for covered services.** For services rendered on or after January
276.27 1, 2003, the total payment made to managed care plans for providing covered services
276.28 under the medical assistance and general assistance medical care programs is reduced by
276.29 .5 percent from their current statutory rates. This provision excludes payments for nursing
276.30 home services, home and community-based waivers, ~~and~~ payments to demonstration
276.31 projects for persons with disabilities, and mental health services added as covered benefits
276.32 after December 31, 2007.

276.33 Sec. 13. Minnesota Statutes 2006, section 256B.69, subdivision 5h, is amended to read:

277.1 Subd. 5h. **Payment reduction.** In addition to the reduction in subdivision 5g,
277.2 the total payment made to managed care plans under the medical assistance program is
277.3 reduced 1.0 percent for services provided on or after October 1, 2003, and an additional
277.4 1.0 percent for services provided on or after January 1, 2004. This provision excludes
277.5 payments for nursing home services, home and community-based waivers, ~~and~~ payments
277.6 to demonstration projects for persons with disabilities, and mental health services added as
277.7 covered benefits after December 1, 2007.

277.8 Sec. 14. Minnesota Statutes 2006, section 256B.763, is amended to read:

277.9 **256B.763 CRITICAL ACCESS MENTAL HEALTH RATE INCREASE.**

277.10 (a) For services defined in paragraph (b) and rendered on or after July 1, 2007,
277.11 payment rates shall be increased by 23.7 percent over the rates in effect on January 1,
277.12 2006, for:

- 277.13 (1) psychiatrists and advanced practice registered nurses with a psychiatric specialty;
277.14 (2) community mental health centers under section 256B.0625, subdivision 5; and
277.15 (3) mental health clinics and centers certified under Minnesota Rules, parts
277.16 9520.0750 to 9520.0870, or hospital outpatient psychiatric departments that are designated
277.17 as essential community providers under section 62Q.19.

277.18 (b) This increase applies to group skills training when provided as a component of
277.19 children's therapeutic services and support, psychotherapy, medication management,
277.20 evaluation and management, diagnostic assessment, explanation of findings, psychological
277.21 testing, neuropsychological services, direction of behavioral aides, and inpatient
277.22 consultation.

277.23 (c) This increase does not apply to rates that are governed by section 256B.0625,
277.24 subdivision 30, or 256B.761, paragraph (b), other cost-based rates, rates that are
277.25 negotiated with the county, rates that are established by the federal government, or rates
277.26 that increased between January 1, 2004, and January 1, 2005.

277.27 (d) The commissioner shall adjust rates paid to prepaid health plans under contract
277.28 with the commissioner to reflect the rate increases provided in paragraph (a). The prepaid
277.29 health plan must pass this rate increase to the providers identified in ~~paragraph (a)~~
277.30 paragraphs (a), (e), and (f). The prepaid plan must pass this rate increase to the providers
277.31 identified in paragraphs (a), (e), and (f).

277.32 (e) For MinnesotaCare only, payment rates shall be increased by 23.7 percent over
277.33 the rates in effect on December 31, 2007, for:

- 277.34 (1) medication education services provided on or after January 1, 2008, by adult
277.35 rehabilitative mental health services providers certified under section 256B.0623; and

(2) mental health behavioral aide services provided on or after January 1, 2008, by children's therapeutic services and support providers certified under section 256B.0943.

(f) For services defined in paragraph (b) and rendered on or after January 1, 2008, by children's therapeutic services and support providers certified under section 256B.0943 and not already included in paragraph (a), payment rates for MinnesotaCare shall be increased by 23.7 percent over the rates in effect on December 31, 2007.

Sec. 15. Minnesota Statutes 2006, section 256L.03, subdivision 1, is amended to read:

Subdivision 1. **Covered health services.** For individuals under section 256L.04, subdivision 7, with income no greater than 75 percent of the federal poverty guidelines or for families with children under section 256L.04, subdivision 1, all subdivisions of this section apply. "Covered health services" means the health services reimbursed under chapter 256B, with the exception of inpatient hospital services, special education services, private duty nursing services, adult dental care services other than services covered under section 256B.0625, subdivision 9, orthodontic services, nonemergency medical transportation services, personal care assistant and case management services, nursing home or intermediate care facilities services, inpatient mental health services, and chemical dependency services. ~~Outpatient mental health services covered under the MinnesotaCare program are limited to diagnostic assessments, psychological testing, explanation of findings, mental health telemedicine, psychiatric consultation, medication management by a physician, day treatment, partial hospitalization, and individual, family, and group psychotherapy.~~

"Covered health services" also includes intensive mental health outpatient treatment for dialectical behavioral therapy for adults.

No public funds shall be used for coverage of abortion under MinnesotaCare except where the life of the female would be endangered or substantial and irreversible impairment of a major bodily function would result if the fetus were carried to term; or where the pregnancy is the result of rape or incest.

Covered health services shall be expanded as provided in this section.

EFFECTIVE DATE. This section is effective January 1, 2008, except coverage for mental health case management is effective January 1, 2009.

Sec. 16. Minnesota Statutes 2006, section 256L.03, subdivision 5, is amended to read:

Subd. 5. **Co-payments and coinsurance.** (a) Except as provided in paragraphs (b) and (c), the MinnesotaCare benefit plan shall include the following co-payments and coinsurance requirements for all enrollees:

(1) ten percent of the paid charges for inpatient hospital services for adult enrollees, subject to an annual inpatient out-of-pocket maximum of \$1,000 per individual and \$3,000 per family;

(2) \$3 per prescription for adult enrollees;

(3) \$25 for eyeglasses for adult enrollees;

(4) \$3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist; and

(5) \$6 for nonemergency visits to a hospital-based emergency room.

(b) Paragraph (a), clause (1), does not apply to parents and relative caretakers of children under the age of 21 in households with family income equal to or less than 175 percent of the federal poverty guidelines. Paragraph (a), clause (1), does not apply to parents and relative caretakers of children under the age of 21 in households with family income greater than 175 percent of the federal poverty guidelines for inpatient hospital admissions occurring on or after January 1, 2001.

(c) Paragraph (a), clauses (1) to (4), do not apply to pregnant women and children under the age of 21.

(d) Paragraph (a), clause (4), does not apply to mental health services.

(e) Adult enrollees with family gross income that exceeds 175 percent of the federal poverty guidelines and who are not pregnant shall be financially responsible for the coinsurance amount, if applicable, and amounts which exceed the \$10,000 inpatient hospital benefit limit.

~~(f)~~ (f) When a MinnesotaCare enrollee becomes a member of a prepaid health plan, or changes from one prepaid health plan to another during a calendar year, any charges submitted towards the \$10,000 annual inpatient benefit limit, and any out-of-pocket expenses incurred by the enrollee for inpatient services, that were submitted or incurred prior to enrollment, or prior to the change in health plans, shall be disregarded.

Sec. 17. Minnesota Statutes 2006, section 256L.035, is amended to read:

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

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

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

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

(3) physician services not provided during an inpatient stay; outpatient hospital services; freestanding ambulatory surgical center services; chiropractic services; lab and diagnostic services; diabetic supplies and equipment; mental health services as covered under chapter 256B; and prescription drugs; subject to the following co-payments:

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

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

(iii) \$5 co-pay per nonpreventive visit; except this co-pay does not apply to mental health services or community mental health services.

The services covered under this section may be provided by a physician, physician ancillary, chiropractor, psychologist, ~~or~~ licensed independent clinical social worker, or other mental health providers covered under chapter 256B if the services are within the scope of practice of that health care professional.

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

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

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

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

EFFECTIVE DATE. This section is effective January 1, 2008, except coverage for mental health case management under paragraph (a), clause (3), is effective January 1, 2009.

Sec. 18. Minnesota Statutes 2006, section 256L.12, subdivision 9a, is amended to read:

Subd. 9a. **Rate setting; ratable reduction.** For services rendered on or after October 1, 2003, the total payment made to managed care plans under the MinnesotaCare

281.1 program is reduced 1.0 percent. This provision excludes payments for mental health
281.2 services added as covered benefits after December 31, 2007.

281.3 Sec. 19. Minnesota Statutes 2006, section 609.115, subdivision 9, is amended to read:

281.4 Subd. 9. **Compulsive gambling assessment required.** (a) If a person is convicted
281.5 of theft under section 609.52, embezzlement of public funds under section 609.54, or
281.6 forgery under section 609.625, 609.63, or 609.631, the probation officer shall determine in
281.7 the report prepared under subdivision 1 whether or not compulsive gambling contributed
281.8 to the commission of the offense. If so, the report shall contain the results of a compulsive
281.9 gambling assessment conducted in accordance with this subdivision. The probation officer
281.10 shall make an appointment for the offender to undergo the assessment if so indicated.

281.11 (b) The compulsive gambling assessment report must include a recommended level
281.12 of treatment for the offender if the assessor concludes that the offender is in need of
281.13 compulsive gambling treatment. The assessment must be conducted by an assessor
281.14 qualified under section 245.98, subdivision 2a, to perform these assessments or to
281.15 provide compulsive gambling treatment. An assessor providing a compulsive gambling
281.16 assessment may not have any direct or shared financial interest or referral relationship
281.17 resulting in shared financial gain with a treatment provider. If an independent assessor is
281.18 not available, the probation officer may use the services of an assessor with a financial
281.19 interest or referral relationship as authorized under rules adopted by the commissioner
281.20 of human services under section 245.98, subdivision 2a.

281.21 (c) The commissioner of human services shall reimburse the assessor for the
281.22 costs associated with a compulsive gambling assessment at a rate established by the
281.23 commissioner up to a maximum of \$100 for each assessment. To the extent practicable, the
281.24 commissioner shall standardize reimbursement rates for assessments. The commissioner
281.25 shall reimburse these costs after receiving written verification from the probation officer
281.26 that the assessment was performed and found acceptable.

281.27 Sec. 20. **REPORT.**

281.28 The commissioner shall make a report to the legislature by January 15, 2008,
281.29 regarding the transfer of funds to counties for state registered nurses employed in
281.30 community mental health pilot projects as part of the assertive community treatment
281.31 teams under Minnesota Statutes, section 245.4661. The report shall address the impact
281.32 of the nursing shortage on replacing these positions, continuity of patient care if these
281.33 positions cannot be filled, and ways to maintain state registered nurses in these positions

282.1 until the nurse retires or leaves employment. No funds for state registered nurse positions
282.2 may be transferred before the report date.

282.3 Sec. 21. **CASE MANAGEMENT; BEST PRACTICES.**

282.4 The commissioner of human services, in consultation with consumers, families,
282.5 counties, and other interested stakeholders, will develop recommendations for changes in
282.6 the adult mental health act related to case management, consistent with evidence-based
282.7 and best practices.

282.8 Sec. 22. **REGIONAL CHILDREN'S MENTAL HEALTH INITIATIVE.**

282.9 Subdivision 1. **Pilot project authorized; purpose.** A two-year Regional Children's
282.10 Mental Health Initiative pilot project is established to improve children's mental health
282.11 service coordination, communication, and processes in Blue Earth, Brown, Faribault,
282.12 Freeborn, Le Sueur, Martin, Nicollet, Rice, Sibley, Waseca, and Watonwan Counties. The
282.13 purpose of the Regional Children's Mental Health Initiative will be to plan and develop
282.14 new programs and services related to children's mental health in south central Minnesota.

282.15 Subd. 2. **Goals.** To accomplish its purpose, the Regional Children's Mental Health
282.16 Initiative shall have the following goals:

282.17 (1) work to streamline delivery and regional access to services;

282.18 (2) share strategies and resources for the management of out-of-home placements;

282.19 (3) establish standard protocols and operating procedures for functions that are
282.20 performed across all counties;

282.21 (4) share information to improve resource allocation and service delivery across
282.22 counties;

282.23 (5) evaluate outcomes of various treatment alternatives;

282.24 (6) create a network for and provide support to service delivery groups;

282.25 (7) establish a regional process to match children in need of out-of-home placement
282.26 with foster homes that can meet their needs; and

282.27 (8) recruit and retain foster homes.

282.28 Subd. 3. **Director's Council.** The Director's Council shall govern the operations of
282.29 the Regional Children's Mental Health Initiative. Members of the Director's Council shall
282.30 represent each of the 11 counties participating in the pilot project.

282.31 Subd. 4. **Regional Children's Mental Health Initiative Team.** The members
282.32 of the Regional Children's Mental Health Initiative Team shall conduct planning and
282.33 development of new and modified children's mental health programs and services in the
282.34 region. Members of the team shall reflect the cultural, demographic, and geographic

283.1 diversity of the region and shall be composed of representatives from each of the
283.2 following:

- 283.3 (1) the medical community;
- 283.4 (2) human services;
- 283.5 (3) corrections;
- 283.6 (4) education;
- 283.7 (5) mental health providers and vendors;
- 283.8 (6) advocacy organizations;
- 283.9 (7) parents; and
- 283.10 (8) children and youth.

283.11 Subd. 5. **Authority.** The regional children's mental health initiative shall have the
283.12 authority to develop and implement the following programs:

283.13 (1) Flexible funding payments. This program will make funds available to respond to
283.14 the unique and unpredictable needs of children with mental health issues such as the need
283.15 for prescription drugs, transportation, clothing, and assessments not otherwise available.

283.16 (2) Transition to self-sufficiency. This program will help youths between the ages of
283.17 14 and 21 establish professional relationships, find jobs, build financial foundations, and
283.18 learn to fulfill their roles as productive citizens.

283.19 (3) Crisis response. This program will establish public and private partnerships
283.20 to offer a range of options to meet the needs of children in crisis. Methods to meet
283.21 these needs may include accessible local services, holistic assessments, urgent care and
283.22 stabilization services, and telehealth for specialized diagnosis and therapeutic sessions.

283.23 (4) Integrated services for complex conditions. This program will design, develop,
283.24 and implement packages of integrated services to meet the needs of children with specific,
283.25 complex conditions.

283.26 Subd. 6. **Evaluation and report.** The regional children's mental health initiative
283.27 shall develop a method for evaluating the effectiveness of this pilot project focusing on
283.28 identifiable goals and outcomes. An interim report on the pilot project's effectiveness
283.29 shall be submitted to the house and senate finance committees having jurisdiction over
283.30 mental health, the commissioner of human services, and the Minnesota Association of
283.31 County Social Service Administrators no later than December 31, 2008. A final report
283.32 is due no later than December 31, 2009.

283.33 Sec. 23. **TRAUMA-FOCUSED EVIDENCE-BASED PRACTICES TO**
283.34 **CHILDREN.**

284.1 Organizations that are certified to provide children's therapeutic services and
284.2 supports under Minnesota Statutes, section 256B.0943, are eligible to apply for a grant.
284.3 Grants are to be used to provide trauma-focused evidence-based practices to children
284.4 who are living in a battered women's shelter, homeless shelter, transitional housing, or
284.5 supported housing. Children served must have been exposed to or witnessed domestic
284.6 violence, have been exposed to or witnessed community violence, or be a refugee. Priority
284.7 shall be given to organizations that demonstrate collaboration with battered women's
284.8 shelters, homeless shelters, or providers of transitional housing or supported housing. The
284.9 commissioner shall specify which constitutes evidence-based practice. Organizations shall
284.10 use all available funding streams.

284.11 Sec. 24. **DUAL DIAGNOSIS; DEMONSTRATION PROJECT.**

284.12 (a) The commissioner of human services shall fund demonstration projects for high
284.13 risk adults with serious mental illness and co-occurring substance abuse problems. The
284.14 projects must include, but not be limited to, the following:

284.15 (1) housing services, including rent or housing subsidies, housing with clinical
284.16 staff, or housing support;

284.17 (2) assertive outreach services; and

284.18 (3) intensive direct therapeutic, rehabilitative, and care management services
284.19 oriented to harm reduction.

284.20 (b) The commissioner shall work with providers to ensure proper licensure or
284.21 certification to meet medical assistance or third-party payor reimbursement requirements.

284.22 Sec. 25. **MINNESOTA FAMILY INVESTMENT PROGRAM AND CHILDREN'S**
284.23 **MENTAL HEALTH PILOT PROJECT.**

284.24 Subdivision 1. **Pilot project authorized.** The commissioner of human services
284.25 shall fund a three-year pilot project to measure the effect of children's identified mental
284.26 health needs, including social and emotional needs, on Minnesota family investment
284.27 program (MFIP) participants' ability to obtain and retain employment. The project shall
284.28 also measure the effect on work activity of MFIP participants' needs to address their
284.29 children's identified mental health needs.

284.30 Subd. 2. **Provider and agency proposals.** (a) Interested MFIP providers and
284.31 agencies shall:

284.32 (1) submit proposals defining how they will identify participants whose children
284.33 have mental health needs that hinder the employment process;

285.1 (2) connect families with appropriate developmental, social, and emotional
285.2 screenings and services; and

285.3 (3) incorporate those services into the participant's employment plan.

285.4 Each proposal under this paragraph must include an evaluation component.

285.5 (b) Interested MFIP providers and agencies shall develop a protocol to inform MFIP
285.6 participants of the following:

285.7 (1) the availability of developmental, social, and emotional screening tools for
285.8 children and youth;

285.9 (2) the purpose of the screenings;

285.10 (3) how the information will be used to assist the participants in identifying and
285.11 addressing potential barriers to employment; and

285.12 (4) that their employment plan may be modified based on the screening results.

285.13 Subd. 3. **Program components.** (a) MFIP providers shall obtain the participant's
285.14 written consent for participation in the pilot project, including consent for developmental,
285.15 social, and emotional screening.

285.16 (b) MFIP providers shall coordinate with county social service agencies and health
285.17 plans to assist recipients in arranging referrals indicated by the screening results.

285.18 (c) Tools used for developmental, social, and emotional screenings shall be approved
285.19 by the commissioner of human services.

285.20 Subd. 4. **Program evaluation.** The commissioner of human services shall conduct
285.21 an evaluation of the pilot project to determine:

285.22 (1) the number of participants who took part in the screening;

285.23 (2) the number of children who were screened and what screening tools were used;

285.24 (3) the number of children who were identified in the screening who needed referral
285.25 or follow-up services;

285.26 (4) the number of children who received services, what agency provided the services,
285.27 and what type of services were provided;

285.28 (5) the number of employment plans that were adjusted to include the activities
285.29 recommended in the screenings;

285.30 (6) the changes in work participation rates;

285.31 (7) the changes in earned income;

285.32 (8) the changes in sanction rates; and

285.33 (9) the participants' report of program effectiveness.

285.34 Subd. 5. **Work activity.** Participant involvement in screenings and subsequent
285.35 referral and follow-up services shall count as work activity under Minnesota Statutes,
285.36 section 256J.49, subdivision 13.

Sec. 26. **SOCIAL AND ECONOMIC COSTS OF GAMBLING.**

Subdivision 1. **Report.** The commissioner of human services, in consultation with the state affiliate of the National Council on Problem Gambling, stakeholders, and licensed vendors, shall prepare a report that provides a process and funding mechanism to study the issues in subdivisions 2 and 3. The commissioner, in consultation with the state affiliate of the National Council on Problem Gambling, stakeholders, and licensed vendors, shall include in the report potential financial commitments made by stakeholders and others in order to fund the study. The report is due to the legislative committees having jurisdiction over compulsive gambling issues by December 1, 2007.

Subd. 2. **Issues to be addressed.** The study must address:

(1) state, local, and tribal government policies and practices in Minnesota to legalize or prohibit gambling;

(2) the relationship between gambling and crime in Minnesota, including: (i) the relationship between gambling and overall crime rates; (ii) the relationship between gambling and crimes rates for specific crimes, such as forgery, domestic abuse, child neglect and abuse, alcohol and drug offenses, and youth crime; and (iii) enforcement and regulation practices that are intended to address the relationship between gambling and levels of crime;

(3) the relationship between expanded gambling and increased rates of problem gambling in Minnesota, including the impact of pathological or problem gambling on individuals, families, businesses, social institutions, and the economy;

(4) the social impact of gambling on individuals, families, businesses, and social institutions in Minnesota, including an analysis of the relationship between gambling and depression, abuse, divorce, homelessness, suicide, and bankruptcy;

(5) the economic impact of gambling on state, local, and tribal economies in Minnesota; and

(6) any other issues deemed necessary in assessing the social and economic impact of gambling in Minnesota.

Subd. 3. **Quantification of social and economic impact.** The study shall quantify the social and economic impact on both (1) state, local, and tribal governments in Minnesota, and (2) Minnesota's communities and social institutions, including individuals, families, and businesses within those communities and institutions.

Sec. 27. **REPEALER.**

Minnesota Rules, part 9585.0030, is repealed.

ARTICLE 6

DEPARTMENT OF HEALTH

Section 1. Minnesota Statutes 2006, section 62J.17, subdivision 2, is amended to read:

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

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

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

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

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

~~(e)~~ (b) "Health care service" means:

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

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

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

~~(f)~~ (c) "Major spending commitment" means an expenditure in excess of \$1,000,000 for:

(1) acquisition of a unit of medical equipment;

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

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

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

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

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

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

- 288.9 (1) an extracorporeal shock wave lithotripter;
288.10 (2) a computerized axial tomography (CAT) scanner;
288.11 (3) a magnetic resonance imaging (MRI) unit;
288.12 (4) a positron emission tomography (PET) scanner; and
288.13 (5) emergency and nonemergency medical transportation equipment and vehicles.

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

- 288.17 (1) cardiac catheterization services involving high-risk patients as defined in the
288.18 Guidelines for Coronary Angiography established by the American Heart Association
288.19 and the American College of Cardiology;
288.20 (2) heart, heart-lung, liver, kidney, bowel, or pancreas transplantation service, or
288.21 any other service for transplantation of any other organ;
288.22 (3) megavoltage radiation therapy;
288.23 (4) open heart surgery;
288.24 (5) neonatal intensive care services; and
288.25 (6) any new medical technology for which premarket approval has been granted by
288.26 the United States Food and Drug Administration, excluding implantable and wearable
288.27 devices.

288.28 (f) "Specialty care" includes but is not limited to cardiac, neurology, orthopedic,
288.29 obstetrics, mental health, chemical dependency, and emergency services.

288.30 Sec. 2. Minnesota Statutes 2006, section 62J.17, subdivision 4a, is amended to read:

288.31 Subd. 4a. **Expenditure reporting.** ~~(a) A provider making a major spending~~
288.32 ~~commitment after April 1, 1992, shall submit notification of the expenditure to the~~
288.33 ~~commissioner and provide the commissioner with any relevant background information.~~

~~(b) Notification must include a report, submitted within 60 days after the date of the major spending commitment, using terms conforming to the definitions in section 62J.03 and this section. Each report is subject to retrospective review and must contain:~~

~~(1) a detailed description of the major spending commitment, including the specific dollar amount of each expenditure, and its purpose;~~

~~(2) the date of the major spending commitment;~~

~~(3) a statement of the expected impact that the major spending commitment will have on charges by the provider to patients and third party payers;~~

~~(4) a statement of the expected impact on the clinical effectiveness or quality of care received by the patients that the provider expects to serve;~~

~~(5) a statement of the extent to which equivalent services or technology are already available to the provider's actual and potential patient population;~~

~~(6) a statement of the distance from which the nearest equivalent services or technology are already available to the provider's actual and potential population;~~

~~(7) a statement describing the pursuit of any lawful collaborative arrangements; and~~

~~(8) a statement of assurance that the provider will not use, purchase, or perform health care technologies and procedures that are not clinically effective and cost-effective, unless the technology is used for experimental or research purposes to determine whether a technology or procedure is clinically effective and cost-effective.~~

~~The provider may submit any additional information that it deems relevant.~~

~~(c) The commissioner may request additional information from a provider for the purpose of review of a report submitted by that provider, and may consider relevant information from other sources. A provider shall provide any information requested by the commissioner within the time period stated in the request, or within 30 days after the date of the request if the request does not state a time.~~

~~(d) If the provider fails to submit a complete and timely expenditure report, including any additional information requested by the commissioner, the commissioner may make the provider's subsequent major spending commitments subject to the procedures of prospective review and approval under subdivision 6a.~~

Each hospital, outpatient surgical center, diagnostic imaging center, and physician clinic shall report annually to the commissioner on all major spending commitments, in the form and manner specified by the commissioner. The report shall include the following information:

(a) a description of major spending commitments made during the previous year, including the total dollar amount of major spending commitments and purpose of the expenditures;

290.1 (b) the cost of land acquisition, construction of new facilities, and renovation of
290.2 existing facilities;

290.3 (c) the cost of purchased or leased medical equipment, by type of equipment;

290.4 (d) expenditures by type for specialty care and new specialized services;

290.5 (e) information on the amount and types of added capacity for diagnostic imaging
290.6 services, outpatient surgical services, and new specialized services; and

290.7 (f) information on investments in electronic medical records systems.

290.8 For hospitals and outpatient surgical centers, this information shall be included in reports
290.9 to the commissioner that are required under section 144.698. For diagnostic imaging
290.10 centers, this information shall be included in reports to the commissioner that are required
290.11 under section 144.565. For physician clinics, this information shall be included in reports
290.12 to the commissioner that are required under section 62J.41. For all other health care
290.13 providers that are subject to this reporting requirement, reports must be submitted to the
290.14 commissioner by March 1 each year for the preceding calendar year.

290.15 Sec. 3. Minnesota Statutes 2006, section 62J.17, subdivision 7, is amended to read:

290.16 Subd. 7. **Exceptions.** (a) ~~The retrospective review process as described in~~
290.17 ~~subdivision 5a and the prospective review and approval process as described in subdivision~~
290.18 ~~6a reporting requirement in subdivision 4a do~~ does not apply to:

290.19 ~~(1) a major spending commitment to replace existing equipment with comparable~~
290.20 ~~equipment used for direct patient care, upgrades of equipment beyond the current model,~~
290.21 ~~or comparable model must be reported;~~

290.22 ~~(2)~~ (1) a major spending commitment made by a research and teaching institution
290.23 for purposes of conducting medical education, medical research supported or sponsored
290.24 by a medical school, or by a federal or foundation grant or clinical trials;

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

290.29 ~~(4)~~ (2) a major spending commitment for building maintenance including heating,
290.30 water, electricity, and other maintenance-related expenditures; and

290.31 ~~(5)~~ (3) a major spending commitment for activities, not directly related to the
290.32 delivery of patient care services, including food service, laundry, housekeeping, and
290.33 other service-related activities; ~~and.~~

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

(b) In addition to the exceptions listed in paragraph (a), the ~~prospective review and approval process described in subdivision 6a~~ reporting requirement in subdivision 4a does not apply to mergers, acquisitions, and other changes in ownership or control that, in the judgment of the commissioner, do not involve a substantial expansion of service capacity or a substantial change in the nature of health care services provided.

Sec. 4. Minnesota Statutes 2006, section 62J.41, subdivision 1, is amended to read:

Subdivision 1. **Cost containment data to be collected from providers.** The commissioner shall require health care providers to collect and provide both patient specific information and descriptive and financial aggregate data on:

- (1) the total number of patients served;
- (2) the total number of patients served by state of residence and Minnesota county;
- (3) the site or sites where the health care provider provides services;
- (4) the number of individuals employed, by type of employee, by the health care provider;
- (5) the services and their costs for which no payment was received;
- (6) total revenue by type of payer or by groups of payers, including but not limited to, revenue from Medicare, medical assistance, MinnesotaCare, nonprofit health service plan corporations, commercial insurers, health maintenance organizations, and individual patients;
- (7) revenue from research activities;
- (8) revenue from educational activities;
- (9) revenue from out-of-pocket payments by patients;
- (10) revenue from donations; ~~and~~
- (11) a report on health care capital expenditures during the previous year, as required by section 62J.17; and

~~(11)~~ (12) any other data required by the commissioner, including data in unaggregated form, for the purposes of developing spending estimates, setting spending limits, monitoring actual spending, and monitoring costs.

The commissioner may, by rule, modify the data submission categories listed above if the commissioner determines that this will reduce the reporting burden on providers without having a significant negative effect on necessary data collection efforts.

292.1 Sec. 5. Minnesota Statutes 2006, section 62J.52, subdivision 1, is amended to read:

292.2 Subdivision 1. **Uniform billing form CMS 1450.** (a) On and after January 1,
292.3 1996, all institutional inpatient hospital services, ancillary services, institutionally owned
292.4 or operated outpatient services rendered by providers in Minnesota, and institutional
292.5 or noninstitutional home health services that are not being billed using an equivalent
292.6 electronic billing format, must be billed using the uniform billing form CMS 1450, except
292.7 as provided in subdivision 5.

292.8 (b) The instructions and definitions for the use of the uniform billing form CMS
292.9 1450 shall be in accordance with the uniform billing form manual specified by the
292.10 commissioner. In promulgating these instructions, the commissioner may utilize the
292.11 manual developed by the National Uniform Billing Committee, as adopted and finalized
292.12 by the Minnesota Uniform Billing Committee.

292.13 (c) Services to be billed using the uniform billing form CMS 1450 include:
292.14 institutional inpatient hospital services and distinct units in the hospital such as psychiatric
292.15 unit services, physical therapy unit services, swing bed (SNF) services, inpatient state
292.16 psychiatric hospital services, inpatient skilled nursing facility services, home health
292.17 services (Medicare part A), and hospice services; ancillary services, where benefits are
292.18 exhausted or patient has no Medicare part A, from hospitals, state psychiatric hospitals,
292.19 skilled nursing facilities, and home health (Medicare part B); institutional owned or
292.20 operated outpatient services such as waived services, hospital outpatient services,
292.21 including ambulatory surgical center services, hospital referred laboratory services,
292.22 hospital-based ambulance services, and other hospital outpatient services, skilled nursing
292.23 facilities, home health, freestanding renal dialysis centers, comprehensive outpatient
292.24 rehabilitation facilities (CORF), outpatient rehabilitation facilities (ORF), rural health
292.25 clinics, and community mental health centers; home health services such as home health
292.26 intravenous therapy providers, waived services, personal care attendants, and hospice;
292.27 and any other health care provider certified by the Medicare program to use this form.

292.28 (d) On and after January 1, 1996, a mother and newborn child must be billed
292.29 separately, and must not be combined on one claim form.

292.30 (e) Services provided by Medicare Critical Access Hospitals electing Method
292.31 II billing will be allowed an exception to this provision to allow the inclusion of the
292.32 professional fees on the CMS 1450.

292.33 Sec. 6. Minnesota Statutes 2006, section 62J.52, subdivision 2, is amended to read:

292.34 Subd. 2. **Uniform billing form CMS 1500.** (a) On and after January 1, 1996, all
292.35 noninstitutional health care services rendered by providers in Minnesota except dental

293.1 or pharmacy providers, that are not currently being billed using an equivalent electronic
293.2 billing format, must be billed using the health insurance claim form CMS 1500, except as
293.3 provided in subdivision 5.

293.4 (b) The instructions and definitions for the use of the uniform billing form CMS
293.5 1500 shall be in accordance with the manual developed by the Administrative Uniformity
293.6 Committee entitled standards for the use of the CMS 1500 form, dated February 1994,
293.7 as further defined by the commissioner.

293.8 (c) Services to be billed using the uniform billing form CMS 1500 include physician
293.9 services and supplies, durable medical equipment, noninstitutional ambulance services,
293.10 independent ancillary services including occupational therapy, physical therapy, speech
293.11 therapy and audiology, home infusion therapy, podiatry services, optometry services,
293.12 mental health licensed professional services, substance abuse licensed professional
293.13 services, nursing practitioner professional services, certified registered nurse anesthetists,
293.14 chiropractors, physician assistants, laboratories, medical suppliers, and other health care
293.15 providers such as day activity centers and freestanding ambulatory surgical centers.

293.16 (d) Services provided by Medicare Critical Access Hospitals electing Method
293.17 II billing will be allowed an exception to this provision to allow the inclusion of the
293.18 professional fees on the CMS 1450.

293.19 Sec. 7. Minnesota Statutes 2006, section 62J.60, subdivision 2, is amended to read:

293.20 Subd. 2. **General characteristics.** (a) The Minnesota uniform health care
293.21 identification card must be a preprinted card constructed of plastic, paper, or any other
293.22 medium that conforms with ANSI and ISO 7810 physical characteristics standards. The
293.23 card dimensions must also conform to ANSI and ISO 7810 physical characteristics
293.24 standard. The use of a signature panel is optional. The uniform prescription drug
293.25 information contained on the card must conform with the format adopted by the NCPDP
293.26 and, except as provided in subdivision 3, paragraph (a), clause (2), must include all of
293.27 the fields required to submit a claim in conformance with the most recent pharmacy
293.28 identification card implementation guide produced by the NCPDP. All information
293.29 required to submit a prescription drug claim, exclusive of information provided on a
293.30 prescription that is required by law, must be included on the card in a clear, readable, and
293.31 understandable manner. If a health benefit plan requires a conditional or situational field,
293.32 as defined by the NCPDP, the conditional or situational field must conform to the most
293.33 recent pharmacy information card implementation guide produced by the NCPDP.

293.34 (b) The Minnesota uniform health care identification card must have an essential
293.35 information window on the front side with the following data elements: card issuer name,

294.1 electronic transaction routing information, card issuer identification number, cardholder
294.2 (insured) identification number, and cardholder (insured) identification name. No optional
294.3 data may be interspersed between these data elements.

294.4 (c) Standardized labels are required next to human readable data elements and
294.5 must come before the human data elements.

294.6 Sec. 8. Minnesota Statutes 2006, section 62J.60, subdivision 3, is amended to read:

294.7 Subd. 3. **Human readable data elements.** (a) The following are the minimum
294.8 human readable data elements that must be present on the front side of the Minnesota
294.9 uniform health care identification card:

294.10 (1) card issuer name or logo, which is the name or logo that identifies the card issuer.
294.11 The card issuer name or logo may be located at the top of the card. No standard label
294.12 is required for this data element;

294.13 (2) complete electronic transaction routing information including, at a minimum,
294.14 the international identification number. The standardized label of this data element
294.15 is "RxBIN." Processor control numbers and group numbers are required if needed to
294.16 electronically process a prescription drug claim. The standardized label for the process
294.17 control numbers data element is "RxPCN" and the standardized label for the group
294.18 numbers data element is "RxGrp," except that if the group number data element is a
294.19 universal element to be used by all health care providers, the standardized label may be
294.20 "Grp." To conserve vertical space on the card, the international identification number and
294.21 the processor control number may be printed on the same line;

294.22 (3) cardholder (insured) identification number, which is the unique identification
294.23 number of the individual card holder established and defined under this section. The
294.24 standardized label for the data element is "ID";

294.25 (4) cardholder (insured) identification name, which is the name of the individual
294.26 card holder. The identification name must be formatted as follows: first name, space,
294.27 optional middle initial, space, last name, optional space and name suffix. The standardized
294.28 label for this data element is "Name";

294.29 (5) care type, which is the description of the group purchaser's plan product under
294.30 which the beneficiary is covered. The description shall include the health plan company
294.31 name and the plan or product name. The standardized label for this data element is
294.32 "Care Type";

294.33 (6) service type, which is the description of coverage provided such as hospital,
294.34 dental, vision, prescription, or mental health. The standard label for this data element
294.35 is "Svc Type"; and

(7) provider/clinic name, which is the name of the primary care clinic the card holder is assigned to by the health plan company. The standard label for this field is "PCP." This information is mandatory only if the health plan company assigns a specific primary care provider to the card holder.

(b) The following human readable data elements shall be present on the back side of the Minnesota uniform health care identification card. These elements must be left justified, and no optional data elements may be interspersed between them:

(1) claims submission names and addresses, which are the names and addresses of the entity or entities to which claims should be submitted. If different destinations are required for different types of claims, this must be labeled;

(2) telephone numbers and names that pharmacies and other health care providers may call for assistance. These telephone numbers and names are required on the back side of the card only if one of the contacts listed in clause (3) cannot provide pharmacies or other providers with assistance or with the telephone numbers and names of contacts for assistance; and

(3) telephone numbers and names; which are the telephone numbers and names of the following contacts with a standardized label describing the service function as applicable:

(i) eligibility and benefit information;

(ii) utilization review;

(iii) precertification; or

(iv) customer services.

(c) The following human readable data elements are mandatory on the back side of the Minnesota uniform health care identification card for health maintenance organizations:

(1) emergency care authorization telephone number or instruction on how to receive authorization for emergency care. There is no standard label required for this information; and

(2) one of the following:

(i) telephone number to call to appeal to or file a complaint with the commissioner of health; or

(ii) for persons enrolled under section 256B.69, 256D.03, or 256L.12, the telephone number to call to file a complaint with the ombudsperson designated by the commissioner of human services under section 256B.69 and the address to appeal to the commissioner of human services. There is no standard label required for this information.

(d) All human readable data elements not required under paragraphs (a) to (c) are optional and may be used at the issuer's discretion.

296.1 Sec. 9. Minnesota Statutes 2006, section 62Q.80, is amended by adding a subdivision
296.2 to read:

296.3 Subd. 1a. **Demonstration project.** The commissioner of health shall award a
296.4 demonstration project grant to a community-based health care initiative to develop and
296.5 operate a community-based health care coverage program to operate within Carlton,
296.6 Cook, Lake, and St. Louis Counties. The demonstration project shall extend for five years
296.7 and must comply with all the requirements of this section.

296.8 Sec. 10. Minnesota Statutes 2006, section 62Q.80, subdivision 3, is amended to read:

296.9 Subd. 3. **Approval.** (a) Prior to the operation of a community-based health care
296.10 coverage program, a community-based health initiative shall submit to the commissioner
296.11 of health for approval the community-based health care coverage program developed by
296.12 the initiative. ~~The commissioner shall only approve a program that has been awarded~~
296.13 ~~a community access program grant from the United States Department of Health and~~
296.14 ~~Human Services.~~ The commissioner shall ensure that the program meets the federal grant
296.15 requirements and any requirements described in this section and is actuarially sound based
296.16 on a review of appropriate records and methods utilized by the community-based health
296.17 initiative in establishing premium rates for the community-based health care coverage
296.18 program.

296.19 (b) Prior to approval, the commissioner shall also ensure that:

296.20 (1) the benefits offered comply with subdivision 8 and that there are adequate
296.21 numbers of health care providers participating in the community-based health network to
296.22 deliver the benefits offered under the program;

296.23 (2) the activities of the program are limited to activities that are exempt under this
296.24 section or otherwise from regulation by the commissioner of commerce;

296.25 (3) the complaint resolution process meets the requirements of subdivision 10; and

296.26 (4) the data privacy policies and procedures comply with state and federal law.

296.27 Sec. 11. Minnesota Statutes 2006, section 62Q.80, subdivision 4, is amended to read:

296.28 Subd. 4. **Establishment.** ~~(a)~~ The initiative shall establish and operate upon approval
296.29 by the commissioner of health a community-based health care coverage program. The
296.30 operational structure established by the initiative shall include, but is not limited to:

296.31 (1) establishing a process for enrolling eligible individuals and their dependents;

296.32 (2) collecting and coordinating premiums from enrollees and employers of enrollees;

296.33 (3) providing payment to participating providers;

297.1 (4) establishing a benefit set according to subdivision 8 and establishing premium
297.2 rates and cost-sharing requirements;

297.3 (5) creating incentives to encourage primary care and wellness services; and

297.4 (6) initiating disease management services, as appropriate.

297.5 ~~(b) The payments collected under paragraph (a), clause (2), may be used to capture~~
297.6 ~~available federal funds.~~

297.7 Sec. 12. Minnesota Statutes 2006, section 62Q.80, subdivision 13, is amended to read:

297.8 Subd. 13. **Report.** (a) The initiative shall submit quarterly status reports to the
297.9 commissioner of health on January 15, April 15, July 15, and October 15 of each year,
297.10 with the first report due January 15, ~~2007~~ 2008. The status report shall include:

297.11 (1) the financial status of the program, including the premium rates, cost per member
297.12 per month, claims paid out, premiums received, and administrative expenses;

297.13 (2) a description of the health care benefits offered and the services utilized;

297.14 (3) the number of employers participating, the number of employees and dependents
297.15 covered under the program, and the number of health care providers participating;

297.16 (4) a description of the health outcomes to be achieved by the program and a status
297.17 report on the performance measurements to be used and collected; and

297.18 (5) any other information requested by the commissioner of health or commerce or
297.19 the legislature.

297.20 (b) The initiative shall contract with an independent entity to conduct an evaluation
297.21 of the program to be submitted to the commissioners of health and commerce and the
297.22 legislature by January 15, ~~2009~~ 2010. The evaluation shall include:

297.23 (1) an analysis of the health outcomes established by the initiative and the
297.24 performance measurements to determine whether the outcomes are being achieved;

297.25 (2) an analysis of the financial status of the program, including the claims to
297.26 premiums loss ratio and utilization and cost experience;

297.27 (3) the demographics of the enrollees, including their age, gender, family income,
297.28 and the number of dependents;

297.29 (4) the number of employers and employees who have been denied access to the
297.30 program and the basis for the denial;

297.31 (5) specific analysis on enrollees who have aggregate medical claims totaling over
297.32 \$5,000 per year, including data on the enrollee's main diagnosis and whether all the
297.33 medical claims were covered by the program;

297.34 (6) number of enrollees referred to state public assistance programs;

(7) a comparison of employer-subsidized health coverage provided in a comparable geographic area to the designated community-based geographic area served by the program, including, to the extent available:

(i) the difference in the number of employers with 50 or fewer employees offering employer-subsidized health coverage;

(ii) the difference in uncompensated care being provided in each area; and

(iii) a comparison of health care outcomes and measurements established by the initiative; and

(8) any other information requested by the commissioner of health or commerce.

Sec. 13. Minnesota Statutes 2006, section 62Q.80, subdivision 14, is amended to read:

Subd. 14. **Sunset.** This section expires December 31, ~~2011~~ 2012.

Sec. 14. **[144.291] MINNESOTA HEALTH RECORDS ACT.**

Subdivision 1. **Short title.** Sections 144.291 to 144.298 may be cited as the Minnesota Health Records Act.

Subd. 2. **Definitions.** For the purposes of sections 144.291 to 144.298, the following terms have the meanings given.

(a) **Affiliate.** "Affiliate" has the meaning given in section 144.6521, subdivision 3, paragraph (b).

(b) **Group purchaser.** "Group purchaser" has the meaning given in section 62J.03, subdivision 6.

(c) **Health record.** "Health record" means any information, whether oral or recorded in any form or medium, that relates to the past, present, or future physical or mental health or condition of a patient; the provision of health care to a patient; or the past, present, or future payment for the provision of health care to a patient.

(d) **Identifying information.** "Identifying information" means the patient's name, address, date of birth, gender, parent's or guardian's name regardless of the age of the patient, and other nonclinical data which can be used to uniquely identify a patient.

(e) **Individually identifiable form.** "Individually identifiable form" means a form in which the patient is or can be identified as the subject of the health records.

(f) **Medical emergency.** "Medical emergency" means medically necessary care which is immediately needed to preserve life, prevent serious impairment to bodily functions, organs, or parts, or prevent placing the physical or mental health of the patient in serious jeopardy.

299.1 (g) **Patient.** "Patient" means a natural person who has received health care services
299.2 from a provider for treatment or examination of a medical, psychiatric, or mental
299.3 condition, the surviving spouse and parents of a deceased patient, or a person the patient
299.4 appoints in writing as a representative, including a health care agent acting according to
299.5 chapter 145C, unless the authority of the agent has been limited by the principal in the
299.6 principal's health care directive. Except for minors who have received health care services
299.7 under sections 144.341 to 144.347, in the case of a minor, patient includes a parent or
299.8 guardian, or a person acting as a parent or guardian in the absence of a parent or guardian.

299.9 (h) **Provider.** "Provider" means:

299.10 (1) any person who furnishes health care services and is regulated to furnish the
299.11 services under chapter 147, 147A, 147B, 147C, 147D, 148, 148B, 148C, 148D, 150A,
299.12 151, 153, or 153A;

299.13 (2) a home care provider licensed under section 144A.46;

299.14 (3) a health care facility licensed under this chapter or chapter 144A;

299.15 (4) a physician assistant registered under chapter 147A; and

299.16 (5) an unlicensed mental health practitioner regulated under sections 148B.60 to
299.17 148B.71.

299.18 (i) **Record locator service.** "Record locator service" means an electronic index of
299.19 patient identifying information that directs providers in a health information exchange to
299.20 the location of patient health records held by providers and group purchasers.

299.21 (j) **Related health care entity.** "Related health care entity" means an affiliate of
299.22 the provider releasing the health records.

299.23 Sec. 15. [144.292] **PATIENT RIGHTS.**

299.24 Subdivision 1. **Scope.** Patients have the rights specified in this section regarding the
299.25 treatment the patient receives and the patient's health record.

299.26 Subd. 2. **Patient access.** Upon request, a provider shall supply to a patient complete
299.27 and current information possessed by that provider concerning any diagnosis, treatment,
299.28 and prognosis of the patient in terms and language the patient can reasonably be expected
299.29 to understand.

299.30 Subd. 3. **Additional patient rights.** A patient's right specified in this section and
299.31 sections 144.293 to 144.298 are in addition to the rights specified in sections 144.651 and
299.32 144.652 and any other provision of law relating to the access of a patient to the patient's
299.33 health records.

Subd. 4. **Notice of rights; information on release.** A provider shall provide to patients, in a clear and conspicuous manner, a written notice concerning practices and rights with respect to access to health records. The notice must include an explanation of:

(1) disclosures of health records that may be made without the written consent of the patient, including the type of records and to whom the records may be disclosed; and

(2) the right of the patient to have access to and obtain copies of the patient's health records and other information about the patient that is maintained by the provider.

The notice requirements of this subdivision are satisfied if the notice is included with the notice and copy of the patient and resident bill of rights under section 144.652 or if it is displayed prominently in the provider's place of business. The commissioner of health shall develop the notice required in this subdivision and publish it in the State Register.

Subd. 5. **Copies of health records to patients.** Except as provided in section 144.296, upon a patient's written request, a provider, at a reasonable cost to the patient, shall promptly furnish to the patient:

(1) copies of the patient's health record, including but not limited to laboratory reports, x-rays, prescriptions, and other technical information used in assessing the patient's health conditions; or

(2) the pertinent portion of the record relating to a condition specified by the patient.

With the consent of the patient, the provider may instead furnish only a summary of the record. The provider may exclude from the health record written speculations about the patient's health condition, except that all information necessary for the patient's informed consent must be provided.

Subd. 6. **Cost.** (a) When a patient requests a copy of the patient's record for purposes of reviewing current medical care, the provider must not charge a fee.

(b) When a provider or its representative makes copies of patient records upon a patient's request under this section, the provider or its representative may charge the patient or the patient's representative no more than 75 cents per page, plus \$10 for time spent retrieving and copying the records, unless other law or a rule or contract provide for a lower maximum charge. This limitation does not apply to x-rays. The provider may charge a patient no more than the actual cost of reproducing x-rays, plus no more than \$10 for the time spent retrieving and copying the x-rays.

(c) The respective maximum charges of 75 cents per page and \$10 for time provided in this subdivision are in effect for calendar year 1992 and may be adjusted annually each calendar year as provided in this subdivision. The permissible maximum charges shall change each year by an amount that reflects the change, as compared to the previous year.

in the Consumer Price Index for all Urban Consumers, Minneapolis-St. Paul (CPI-U), published by the Department of Labor.

(d) A provider or its representative must not charge a fee to provide copies of records requested by a patient or the patient's authorized representative if the request for copies of records is for purposes of appealing a denial of Social Security disability income or Social Security disability benefits under title II or title XVI of the Social Security Act. For the purpose of further appeals, a patient may receive no more than two medical record updates without charge, but only for medical record information previously not provided. For purposes of this paragraph, a patient's authorized representative does not include units of state government engaged in the adjudication of Social Security disability claims.

Subd. 7. **Withholding health records from patient.** (a) If a provider reasonably determines that the information is detrimental to the physical or mental health of the patient, or is likely to cause the patient to inflict self harm, or to harm another, the provider may withhold the information from the patient and may supply the information to an appropriate third party or to another provider. The other provider or third party may release the information to the patient.

(b) A provider shall release information upon written request unless, prior to the request, a provider has designated and described a specific basis for withholding the information as authorized by paragraph (a).

Sec. 16. **[144.293] RELEASE OR DISCLOSURE OF HEALTH RECORDS.**

Subdivision 1. **Release or disclosure of health records.** Health records can be released or disclosed as specified in subdivisions 2 to 9 and sections 144.294 and 144.295.

Subd. 2. **Patient consent to release of records.** A provider, or a person who receives health records from a provider, may not release a patient's health records to a person without:

(1) a signed and dated consent from the patient or the patient's legally authorized representative authorizing the release;

(2) specific authorization in law; or

(3) a representation from a provider that the provider holds a consent from the patient.

Subd. 3. **Release from one provider to another.** A patient's health record, including, but not limited to, laboratory reports, x-rays, prescriptions, and other technical information used in assessing the patient's condition, or the pertinent portion of the record relating to a specific condition, or a summary of the record, shall promptly be furnished to another provider upon the written request of the patient. The written request shall specify

the name of the provider to whom the health record is to be furnished. The provider who furnishes the health record or summary may retain a copy of the materials furnished. The patient shall be responsible for the reasonable costs of furnishing the information.

Subd. 4. **Duration of consent.** Except as provided in this section, a consent is valid for one year or for a lesser period specified in the consent or for a different period provided by law.

Subd. 5. **Exceptions to consent requirement.** This section does not prohibit the release of health records:

(1) for a medical emergency when the provider is unable to obtain the patient's consent due to the patient's condition or the nature of the medical emergency;

(2) to other providers within related health care entities when necessary for the current treatment of the patient; or

(3) to a health care facility licensed by this chapter, chapter 144A, or to the same types of health care facilities licensed by this chapter and chapter 144A that are licensed in another state when a patient:

(i) is returning to the health care facility and unable to provide consent; or

(ii) who resides in the health care facility, has services provided by an outside resource under Code of Federal Regulations, title 42, section 483.75(h), and is unable to provide consent.

Subd. 6. **Consent does not expire.** Notwithstanding subdivision 4, if a patient explicitly gives informed consent to the release of health records for the purposes and restrictions in clauses (1) and (2), the consent does not expire after one year for:

(1) the release of health records to a provider who is being advised or consulted with in connection with the releasing provider's current treatment of the patient;

(2) the release of health records to an accident and health insurer, health service plan corporation, health maintenance organization, or third-party administrator for purposes of payment of claims, fraud investigation, or quality of care review and studies, provided that:

(i) the use or release of the records complies with sections 72A.49 to 72A.505;

(ii) further use or release of the records in individually identifiable form to a person other than the patient without the patient's consent is prohibited; and

(iii) the recipient establishes adequate safeguards to protect the records from unauthorized disclosure, including a procedure for removal or destruction of information that identifies the patient.

Subd. 7. **Exception to consent.** Subdivision 2 does not apply to the release of health records to the commissioner of health or the Health Data Institute under chapter 62J, provided that the commissioner encrypts the patient identifier upon receipt of the data.

303.1 Subd. 8. Record locator service. (a) A provider or group purchaser may send
303.2 patient identifying information and information about the location of the patient's health
303.3 records to a record locator service without consent from the patient. Except in the case of
303.4 a medical emergency, a provider participating in a health information exchange using a
303.5 record locator service cannot access patient identifying information and information
303.6 about the location of the patient's health records until the patient has provided consent.
303.7 The Minnesota Department of Health may not access the record locator service or receive
303.8 data from the record locator service. Only a provider may access patient identifying
303.9 information in a record locator service. The consent does not expire and may be revoked
303.10 by the patient at any time by providing written notice of the revocation to the provider.

303.11 (b) A health information exchange maintaining a record locator service or an entity
303.12 maintaining a record locator service for a health information exchange must maintain an
303.13 audit log of providers accessing information in a record locator service that minimally
303.14 contains information on:

303.15 (1) the identity of the provider accessing the information;

303.16 (2) the identity of the patient whose information was accessed by the provider; and

303.17 (3) the date the information was accessed.

303.18 (c) No group purchaser may in any way require a provider to participate in any
303.19 record locator service as a condition of payment or participation.

303.20 (d) A record locator service must provide a mechanism for patients to opt out of
303.21 including their identifying information and information about the location of their health
303.22 records in a record locator service. At a minimum, any consent form that permits a
303.23 provider to access a record locator service must include a check-box option that allows a
303.24 patient to completely opt out of the record locator service which shall be clearly displayed
303.25 to the patient. A provider participating in a health information exchange with a record
303.26 locator service who receives a patient's request to completely opt out of the record locator
303.27 service or to not have a specific provider contact in the record locator service shall be
303.28 responsible for removing the patient's information from the record locator service.

303.29 Subd. 9. Documentation of release. (a) In cases where a provider releases health
303.30 records without patient consent as authorized by law, the release must be documented in
303.31 the patient's health record. In the case of a release under section 144.294, subdivision 2, the
303.32 documentation must include the date and circumstances under which the release was made,
303.33 the person or agency to whom the release was made, and the records that were released.

303.34 (b) When a health record is released using a representation from a provider that
303.35 holds a consent from the patient, the releasing provider shall document:

303.36 (1) the provider requesting the health records;

- 304.1 (2) the identity of the patient;
304.2 (3) the health records requested; and
304.3 (4) the date the health records were requested.

304.4 Sec. 17. **[144.294] RECORDS RELATING TO MENTAL HEALTH.**

304.5 Subdivision 1. **Provider inquiry.** Upon the written request of a spouse, parent,
304.6 child, or sibling of a patient being evaluated for or diagnosed with mental illness, a
304.7 provider shall inquire of a patient whether the patient wishes to authorize a specific
304.8 individual to receive information regarding the patient's current and proposed course of
304.9 treatment. If the patient so authorizes, the provider shall communicate to the designated
304.10 individual the patient's current and proposed course of treatment. Section 144.293,
304.11 subdivisions 2 and 4, apply to consents given under this subdivision.

304.12 Subd. 2. **Disclosure to law enforcement agency.** Notwithstanding section 144.293,
304.13 subdivisions 2 and 4, a provider must disclose health records relating to a patient's mental
304.14 health to a law enforcement agency if the law enforcement agency provides the name
304.15 of the patient and communicates that the:

304.16 (1) patient is currently involved in an emergency interaction with the law
304.17 enforcement agency; and

304.18 (2) disclosure of the records is necessary to protect the health or safety of the patient
304.19 or of another person.

304.20 The scope of disclosure under this subdivision is limited to the minimum necessary
304.21 for law enforcement to respond to the emergency. A law enforcement agency that obtains
304.22 health records under this subdivision shall maintain a record of the requestor, the provider
304.23 of the information, and the patient's name. Health records obtained by a law enforcement
304.24 agency under this subdivision are private data on individuals as defined in section 13.02,
304.25 subdivision 12, and must not be used by law enforcement for any other purpose.

304.26 Subd. 3. **Records release for family and caretaker; mental health care.** (a)
304.27 Notwithstanding section 144.293, a provider providing mental health care and treatment
304.28 may disclose health record information described in paragraph (b) about a patient to a
304.29 family member of the patient or other person who requests the information if:

304.30 (1) the request for information is in writing;

304.31 (2) the family member or other person lives with, provides care for, or is directly
304.32 involved in monitoring the treatment of the patient;

304.33 (3) the involvement under clause (2) is verified by the patient's mental health care
304.34 provider, the patient's attending physician, or a person other than the person requesting the
304.35 information, and is documented in the patient's medical record;

(4) before the disclosure, the patient is informed in writing of the request, the name of the person requesting the information, the reason for the request, and the specific information being requested;

(5) the patient agrees to the disclosure, does not object to the disclosure, or is unable to consent or object, and the patient's decision or inability to make a decision is documented in the patient's medical record; and

(6) the disclosure is necessary to assist in the provision of care or monitoring of the patient's treatment.

(b) The information disclosed under this paragraph is limited to diagnosis, admission to or discharge from treatment, the name and dosage of the medications prescribed, side effects of the medication, consequences of failure of the patient to take the prescribed medication, and a summary of the discharge plan.

(c) If a provider reasonably determines that providing information under this subdivision would be detrimental to the physical or mental health of the patient or is likely to cause the patient to inflict self harm or to harm another, the provider must not disclose the information.

(d) This subdivision does not apply to disclosures for a medical emergency or to family members as authorized or required under subdivision 1 or section 144.293, subdivision 5, clause (1).

Sec. 18. **[144.295] DISCLOSURE OF HEALTH RECORDS FOR EXTERNAL RESEARCH.**

Subdivision 1. **Methods of release.** (a) Notwithstanding section 144.293, subdivisions 2 and 4, health records may be released to an external researcher solely for purposes of medical or scientific research only as follows:

(1) health records generated before January 1, 1997, may be released if the patient has not objected or does not elect to object after that date;

(2) for health records generated on or after January 1, 1997, the provider must:

(i) disclose in writing to patients currently being treated by the provider that health records, regardless of when generated, may be released and that the patient may object, in which case the records will not be released; and

(ii) use reasonable efforts to obtain the patient's written general authorization that describes the release of records in item (i), which does not expire but may be revoked or limited in writing at any time by the patient or the patient's authorized representative;

(3) the provider must advise the patient of the rights specified in clause (4); and

(4) the provider must, at the request of the patient, provide information on how the patient may contact an external researcher to whom the health record was released and the date it was released.

(b) Authorization may be established if an authorization is mailed at least two times to the patient's last known address with a postage prepaid return envelope and a conspicuous notice that the patient's medical records may be released if the patient does not object, and at least 60 days have expired since the second notice was sent.

Subd. 2. **Duties of researcher.** In making a release for research purposes, the provider shall make a reasonable effort to determine that:

(1) the use or disclosure does not violate any limitations under which the record was collected;

(2) the use or disclosure in individually identifiable form is necessary to accomplish the research or statistical purpose for which the use or disclosure is to be made;

(3) the recipient has established and maintains adequate safeguards to protect the records from unauthorized disclosure, including a procedure for removal or destruction of information that identifies the patient; and

(4) further use or release of the records in individually identifiable form to a person other than the patient without the patient's consent is prohibited.

Sec. 19. **[144.296] COPIES OF VIDEOTAPES.**

A provider may not release a copy of a videotape of a child victim or alleged victim of physical or sexual abuse without a court order under section 13.03, subdivision 6, or as provided in section 611A.90. This section does not limit the right of a patient to view the videotape.

Sec. 20. **[144.297] INDEPENDENT MEDICAL EXAMINATION.**

This section applies to the subject and provider of an independent medical examination requested by or paid for by a third party. Notwithstanding section 144.293, a provider may release health records created as part of an independent medical examination to the third party who requested or paid for the examination.

Sec. 21. **[144.298] PENALTIES.**

Subdivision 1. **Licensing action.** A violation of sections 144.291 to 144.298 may be grounds for disciplinary action against a provider by the appropriate licensing board or agency.

307.1 Subd. 2. **Allocation of liability.** In adjudicating a dispute involving the disclosure
307.2 of patient health records, a court shall use the criteria in this subdivision in determining
307.3 how liability will be allocated.

307.4 (a) When requesting health records using consent, a person warrants that the consent:
307.5 (1) contains no information known to the person to be false; and
307.6 (2) accurately states the patient's desire to have health records disclosed or that there
307.7 is specific authorization in law.

307.8 (b) When requesting health records using consent or the representation authorized in
307.9 section 144.293, subdivision 2, a provider warrants that the request:

307.10 (1) contains no information known to the provider to be false;
307.11 (2) accurately states the patient's desire to have health records disclosed or that
307.12 there is specific authorization in law; and

307.13 (3) does not exceed any limits imposed by the patient in the consent.

307.14 (c) When disclosing health records, a person releasing health records warrants that
307.15 the person:

307.16 (1) has complied with the requirements of this section regarding disclosure of
307.17 health records;

307.18 (2) knows of no information related to the request that is false; and
307.19 (3) has complied with the limits set by the patient in the consent or as described
307.20 in the representation of consent.

307.21 (d) A court of this state presumes that:

307.22 (1) a request made by a person that complies with the provisions of this section is
307.23 valid and represents the wishes of the patient;

307.24 (2) the information listed in a consent or representation of consent is accurate;
307.25 (3) the recipient of a consent or representation of consent has no knowledge or
307.26 notice that the person making the request breached a duty to the patient or does not
307.27 rightfully have a consent;

307.28 (4) the signature on the consent or representation of consent is not forged;
307.29 (5) the consent or representation of consent was not obtained under false pretenses;
307.30 and

307.31 (6) the consent or representation of consent was not altered without the patient's
307.32 permission.

307.33 (e) No person or provider may disclaim or contractually limit the application of this
307.34 section, or obtain indemnity for its effects, if the disclaimer, limitation, or indemnity
307.35 restricts liability for misrepresentation against persons reasonably relying on the consent,
307.36 representation of consent, or disclosure.

(f) A court of this state shall give effect to liability allocations between the parties provided by contract that does not allocate liability to the detriment of the patient and the allocation is consistent with the requirements of sections 144.291 to 144.298.

(g) A patient is eligible to receive compensatory damages plus costs and reasonable attorney fees if there is a negligent or intentional violation of sections 144.293 to 144.295.

Subd. 3. **Liability for a record locator service.** A patient is eligible to receive compensatory damages plus costs and reasonable attorney fees if a health information exchange maintaining a record locator service, or an entity maintaining a record locator service for a health information exchange, negligently or intentionally violates the provisions of section 144.293, subdivision 8.

Sec. 22. Minnesota Statutes 2006, section 144.3345, is amended to read:

144.3345 INTERCONNECTED ELECTRONIC HEALTH RECORD GRANTS.

Subdivision 1. **Definitions.** The following definitions are used for the purposes of this section.

(a) "Eligible community e-health collaborative" means an existing or newly established collaborative to support the adoption and use of interoperable electronic health records. A collaborative must consist of at least ~~three~~ two or more eligible health care entities in at least two of the categories listed in paragraph (b) and have a focus on interconnecting the members of the collaborative for secure and interoperable exchange of health care information.

(b) "Eligible health care entity" means one of the following:

(1) community clinics, as defined under section 145.9268;

(2) hospitals eligible for rural hospital capital improvement grants, as defined in section 144.148;

(3) physician clinics located in a community with a population of less than 50,000 according to United States Census Bureau statistics and outside the seven-county metropolitan area;

(4) nursing facilities licensed under sections 144A.01 to 144A.27;

(5) community health boards or boards of health as established under chapter 145A;

(6) nonprofit entities with a purpose to provide health information exchange coordination governed by a representative, multi-stakeholder board of directors; and

(7) other providers of health or health care services approved by the commissioner for which interoperable electronic health record capability would improve quality of care, patient safety, or community health.

309.1 Subd. 2. **Grants authorized.** The commissioner of health shall award grants to:

309.2 (a) eligible community e-health collaborative projects to improve the implementation

309.3 and use of interoperable electronic health records including but not limited to the

309.4 following projects:

309.5 (1) collaborative efforts to host and support fully functional interoperable electronic

309.6 health records in multiple care settings;

309.7 (2) electronic medication history and electronic patient ~~registration~~ medical history

309.8 information;

309.9 (3) electronic personal health records for persons with chronic diseases and for

309.10 prevention services;

309.11 (4) rural and underserved community models for electronic prescribing; ~~and~~

309.12 (5) ~~enabling~~ modernize local public health information systems to rapidly and

309.13 electronically exchange information needed to participate in community e-health

309.14 collaboratives or for public health emergency preparedness and response; ~~and~~

309.15 (6) implement regional or community-based health information exchange

309.16 organizations;

309.17 (b) community clinics, as defined under section 145.9268, to implement and use

309.18 interoperable electronic health records, including but not limited to the following projects:

309.19 (1) efforts to plan for and implement fully functional, standards-based interoperable

309.20 electronic health records; and

309.21 (2) purchases and implementation of computer hardware, software, and technology

309.22 to fully implement interoperable electronic health records;

309.23 (c) regional or community-based health information exchange organizations to

309.24 connect and facilitate the exchange of health information between eligible health care

309.25 entities, including but not limited to the development, testing, and implementation of:

309.26 (1) data exchange standards, including data, vocabulary, and messaging standards,

309.27 for the exchange of health information, provided that such standards are consistent with

309.28 state and national standards;

309.29 (2) security standards necessary to ensure the confidentiality and integrity of health

309.30 records;

309.31 (3) computer interfaces and mechanisms for standardizing health information

309.32 exchanged between eligible health care entities;

309.33 (4) a record locator service for identifying the location of patient health records; or

309.34 (5) interfaces and mechanisms for implementing patient consent requirements; and

309.35 (d) community health boards and boards of health as established under chapter

309.36 145A to modernize local public health information systems to be standards-based and

interoperable with other electronic health records and information systems, or for enhanced public health emergency preparedness and response.

Grant funds may not be used for construction of health care or other buildings or facilities.

Subd. 3. **Allocation of grants.** (a) To receive a grant under this section, an eligible community e-health collaborative, community clinic, regional or community-based health information exchange, or community health boards and boards of health must submit an application to the commissioner of health by the deadline established by the commissioner.

A grant may be awarded upon the signing of a grant contract. In awarding grants, the commissioner shall give preference to projects benefiting providers located in rural and underserved areas of Minnesota which the commissioner has determined have an unmet need for the development and funding of electronic health records. Applicants may apply for and the commissioner may award grants for one-year, two-year, or three-year periods.

(b) An application must be on a form and contain information as specified by the commissioner but at a minimum must contain:

(1) a description of the purpose or project for which grant funds will be used;

(2) a description of the problem or problems the grant funds will be used to address, including an assessment of the likelihood of the project occurring absent grant funding;

(3) a description of achievable objectives, a workplan, budget, budget narrative, a project communications plan, a timeline for implementation and completion of processes or projects enabled by the grant, and an assessment of privacy and security issues and a proposed approach to address these issues;

(4) a description of the health care entities and other groups participating in the project, including identification of the lead entity responsible for applying for and receiving grant funds;

(5) a plan for how patients and consumers will be involved in development of policies and procedures related to the access to and interchange of information;

(6) evidence of consensus and commitment among the health care entities and others who developed the proposal and are responsible for its implementation; ~~and~~

(7) a plan for documenting and evaluating results of the grant: ; and

(8) a plan for use of data exchange standards, including data and vocabulary.

(c) The commissioner shall review each application to determine whether the application is complete and whether the applicant and the project are eligible for a grant. In evaluating applications, the commissioner shall take into consideration factors, including but not limited to, the following:

(1) the degree to which the proposal interconnects ~~the various providers of care with~~ other health care entities in the applicant's geographic community;

(2) the degree to which the project provides for the interoperability of electronic health records or related health information technology ~~between the members of the collaborative, and presence and scope of a description of how the project intends to interconnect with other providers not part of the project into the future;~~

(3) the degree to which the project addresses current unmet needs pertaining to interoperable electronic health records in a geographic area of Minnesota and the likelihood that the needs would not be met absent grant funds;

(4) the applicant's thoroughness and clarity in describing the project, how the project will improve patient safety, quality of care, and consumer empowerment, and the role of the various collaborative members;

(5) the recommendations of the Health Information and Technology Infrastructure Advisory Committee; and

(6) other factors that the commissioner deems relevant.

(d) Grant funds shall be awarded on a three-to-one match basis. Applicants shall be required to provide \$1 in the form of cash or in-kind staff or services for each \$3 provided under the grant program.

(e) Grants shall not exceed \$900,000 per grant. The commissioner has discretion over the size and number of grants awarded.

Subd. 4. **Evaluation and report.** The commissioner of health shall evaluate the overall effectiveness of the grant program. The commissioner shall collect progress and expenditure reports to evaluate the grant program from the eligible community collaboratives receiving grants.

Sec. 23. Minnesota Statutes 2006, section 144.565, is amended to read:

144.565 DIAGNOSTIC IMAGING FACILITIES.

Subdivision 1. **Utilization and services data; economic and financial interests.**

The commissioner shall require diagnostic imaging facilities and providers of diagnostic imaging services in Minnesota to annually report by March 1 each year for the preceding fiscal year to the commissioner, in the form and manner specified by the commissioner:

(1) utilization data for each health plan company and each public program, including workers' compensation, ~~as follows:~~ of diagnostic imaging services as defined in subdivision 4, paragraph (b);

~~(i) the number of computerized tomography (CT) procedures performed;~~

~~(ii) the number of magnetic resonance imaging (MRI) procedures performed; and~~

- 312.1 ~~(iii) the number of positron emission tomography (PET) procedures performed; and~~
312.2 (2) the names of all physicians with any financial or economic interest and all other
312.3 individuals with a ten percent or greater financial or economic interest in the facility;
312.4 (3) the location where procedures were performed;
312.5 (4) the number of units of each type of fixed, portable, and mobile scanner used at
312.6 each location;
312.7 (5) the average number of hours per month each mobile scanner was operated at
312.8 each location;
312.9 (6) the number of hours per month each scanner was leased, if applicable;
312.10 (7) the total number of diagnostic imaging procedures billed for by the provider at
312.11 each location, by type of diagnostic imaging service as defined in subdivision 4, paragraph
312.12 (b); and
312.13 (8) a report on major health care capital expenditures during the previous year, as
312.14 required by section 62J.17.

312.15 Subd. 2. **Commissioner's right to inspect records.** If the report is not filed or
312.16 the commissioner of health has reason to believe the report is incomplete or false, the
312.17 commissioner shall have the right to inspect diagnostic imaging facility books, audits,
312.18 and records.

312.19 Subd. 3. **Separate reports.** ~~For a diagnostic imaging facility that is not attached~~
312.20 ~~or not contiguous to a hospital or a hospital affiliate, the commissioner shall require~~
312.21 ~~the information in subdivision 1 be reported separately for each detached diagnostic~~
312.22 ~~imaging facility as part of the report required under section 144.702.~~ If any entity owns
312.23 more than one diagnostic imaging facility, that entity must report by individual facility.
312.24 Reports must include only services that were billed by the provider of diagnostic imaging
312.25 services submitting the report. If a diagnostic imaging facility leases capacity, technical
312.26 services, or professional services to one or more other providers of diagnostic imaging
312.27 services, each provider must submit a separate annual report to the commissioner for all
312.28 diagnostic imaging services that it provided and billed. The owner of the leased capacity
312.29 must provide a report listing the names and addresses of providers to whom the diagnostic
312.30 imaging services and equipment were leased.

312.31 Subd. 4. **Definitions.** For purposes of this section, the following terms have the
312.32 meanings given:

312.33 (a) "Diagnostic imaging facility" means a health care facility that ~~provides~~ is not
312.34 a hospital or location licensed as a hospital which offers diagnostic imaging services
312.35 ~~through the use of ionizing radiation or other imaging technique including, but not limited~~
312.36 ~~to magnetic resonance imaging (MRI) or computerized tomography (CT) scan on a~~

313.1 ~~freestanding or mobile basis~~ in Minnesota, regardless of whether the equipment used
313.2 to provide the service is owned or leased. For the purposes of this section, diagnostic
313.3 imaging facility includes, but is not limited to, facilities such as a physician's office, clinic,
313.4 mobile transport vehicle, outpatient imaging center, or surgical center.

313.5 (b) "Diagnostic imaging service" means the use of ionizing radiation or other
313.6 imaging technique on a human patient including, but not limited to, magnetic resonance
313.7 imaging (MRI) or computerized tomography (CT), positron emission tomography (PET),
313.8 or single photon emission computerized tomography (SPECT) scans using fixed, portable,
313.9 or mobile equipment.

313.10 ~~(b)~~ (c) "Financial or economic interest" means a direct or indirect:

313.11 (1) equity or debt security issued by an entity, including, but not limited to, shares of
313.12 stock in a corporation, membership in a limited liability company, beneficial interest in
313.13 a trust, units or other interests in a partnership, bonds, debentures, notes or other equity
313.14 interests or debt instruments, or any contractual arrangements;

313.15 (2) membership, proprietary interest, or co-ownership with an individual, group, or
313.16 organization to which patients, clients, or customers are referred to; or

313.17 (3) employer-employee or independent contractor relationship, including, but not
313.18 limited to, those that may occur in a limited partnership, profit-sharing arrangement, or
313.19 other similar arrangement with any facility to which patients are referred, including any
313.20 compensation between a facility and a health care provider, the group practice of which
313.21 the provider is a member or employee or a related party with respect to any of them.

313.22 ~~(c)~~ (d) "~~Freestanding~~ Fixed equipment" means a stationary diagnostic imaging
313.23 ~~facility that is not located within a~~ machine installed in a permanent location.

313.24 ~~(1) hospital;~~

313.25 ~~(2) location licensed as a hospital; or~~

313.26 ~~(3) physician's office or clinic where the professional practice of medicine by~~
313.27 ~~licensed physicians is the primary purpose and not the provision of ancillary services~~
313.28 ~~such as diagnostic imaging.~~

313.29 ~~(d)~~ (e) "Mobile equipment" means a diagnostic imaging ~~facility that is transported to~~
313.30 ~~various sites not including movement within a hospital or a physician's office or clinic~~
313.31 machine in a self-contained transport vehicle designed to be brought to a temporary offsite
313.32 location to perform diagnostic imaging services.

313.33 (f) "Portable equipment" means a diagnostic imaging machine designed to be
313.34 temporarily transported within a permanent location to perform diagnostic imaging
313.35 services.

314.1 (g) "Provider of diagnostic imaging services" means a diagnostic imaging facility
314.2 or an entity that offers and bills for diagnostic imaging services at a facility owned or
314.3 leased by the entity.

314.4 Subd. 5. **Reports open to public inspection.** All reports filed pursuant to this
314.5 section shall be open to public inspection.

314.6 Sec. 24. **[144.585] METHICILLIN-RESISTANT STAPHYLOCOCCUS AUREUS**
314.7 **CONTROL PROGRAMS.**

314.8 In order to improve the prevention of hospital-associated bloodstream infections due
314.9 to methicillin-resistant Staphylococcus aureus ("MRSA"), every hospital shall establish
314.10 an MRSA control program that meets Minnesota Department of Health best practices
314.11 standards as published January 15, 2008, including considerations of:

314.12 (1) identification of all MRSA-colonized patients in all intensive care units, and
314.13 other at-risk patients identified by the hospital, through active surveillance testing;

314.14 (2) isolation of identified MRSA-colonized or MRSA-infected patients in an
314.15 appropriate manner;

314.16 (3) monitoring and strict enforcement of hand hygiene requirements; and

314.17 (4) maintenance of records.

314.18 Sec. 25. Minnesota Statutes 2006, section 144.651, subdivision 26, is amended to read:

314.19 Subd. 26. **Right to associate.** (a) Residents may meet with and receive visitors
314.20 and participate in activities of commercial, religious, political, as defined in section
314.21 203B.11 and community groups without interference at their discretion if the activities
314.22 do not infringe on the right to privacy of other residents or are not programmatically
314.23 contraindicated. This includes:

314.24 (1) the right to join with other individuals within and outside the facility to work for
314.25 improvements in long-term care;

314.26 (2) the right to visitation by an individual the patient has appointed as the patient's
314.27 health care agent under chapter 145C;

314.28 (3) the right to visitation and health care decision making by an individual designated
314.29 by the patient under paragraph (c).

314.30 (b) Upon admission to a facility where federal law prohibits unauthorized disclosure
314.31 of patient or resident identifying information to callers and visitors, the patient or
314.32 resident, or the legal guardian or conservator of the patient or resident, shall be given the
314.33 opportunity to authorize disclosure of the patient's or resident's presence in the facility
314.34 to callers and visitors who may seek to communicate with the patient or resident. To the

extent possible, the legal guardian or conservator of a patient or resident shall consider the opinions of the patient or resident regarding the disclosure of the patient's or resident's presence in the facility.

(c) Upon admission to a facility, the patient or resident, or the legal guardian or conservator of the patient or resident, must be given the opportunity to designate a person who is not related who will have the status of the patient's next of kin with respect to visitation and making a health care decision. A designation must be included in the patient's health record. With respect to making a health care decision, a health care directive or appointment of a health care agent under chapter 145C prevails over a designation made under this paragraph. The unrelated person may also be identified as such by the patient or by the patient's family.

Sec. 26. Minnesota Statutes 2006, section 144D.03, subdivision 1, is amended to read:

Subdivision 1. **Registration procedures.** The commissioner shall establish forms and procedures for annual registration of housing with services establishments. The commissioner shall charge an annual registration fee of ~~\$35~~ \$155. No fee shall be refunded. A registered establishment shall notify the commissioner within 30 days of the date it is no longer required to be registered under this chapter or of any change in the business name or address of the establishment, the name or mailing address of the owner or owners, or the name or mailing address of the managing agent. There shall be no fee for submission of the notice.

Sec. 27. **[145.9269] FEDERALLY QUALIFIED HEALTH CENTERS.**

Subdivision 1. Definitions. For purposes of this section, "federally qualified health center" means an entity that is receiving a grant under United States Code, title 42, section 254b, or, based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the secretary to meet the requirements for receiving such a grant.

Subd. 2. Allocation of subsidies. The commissioner of health shall distribute subsidies to federally qualified health centers operating in Minnesota to continue, expand, and improve federally qualified health center services to low-income populations. The commissioner shall distribute the funds appropriated under this section to federally qualified health centers operating in Minnesota as of January 1, 2007. The amount of each subsidy shall be in proportion to each federally qualified health center's amount of discounts granted to patients during calendar year 2006 as reported on the federal Uniform Data System report in conformance with the Bureau of Primary Health Care Program

316.1 Expectations Policy Information Notice 98-23, except that each eligible federally qualified
316.2 health center shall receive at least two percent but no more than 30 percent of the total
316.3 amount of money available under this section.

316.4 Sec. 28. Minnesota Statutes 2006, section 145C.05, is amended to read:

316.5 **145C.05 SUGGESTED FORM; PROVISIONS THAT MAY BE INCLUDED.**

316.6 Subdivision 1. **Content.** A health care directive executed pursuant to this chapter
316.7 may, but need not, be in the form contained in section 145C.16.

316.8 Subd. 2. **Provisions that may be included.** (a) A health care directive may include
316.9 provisions consistent with this chapter, including, but not limited to:

316.10 (1) the designation of one or more alternate health care agents to act if the named
316.11 health care agent is not reasonably available to serve;

316.12 (2) directions to joint health care agents regarding the process or standards by which
316.13 the health care agents are to reach a health care decision for the principal, and a statement
316.14 whether joint health care agents may act independently of one another;

316.15 (3) limitations, if any, on the right of the health care agent or any alternate health
316.16 care agents to receive, review, obtain copies of, and consent to the disclosure of the
316.17 principal's medical records or to visit the principal when the principal is a patient in a
316.18 health care facility;

316.19 (4) limitations, if any, on the nomination of the health care agent as guardian for
316.20 purposes of sections 524.5-202, 524.5-211, 524.5-302, and 524.5-303;

316.21 (5) a document of gift for the purpose of making an anatomical gift, as set forth in
316.22 sections 525.921 to 525.9224, or an amendment to, revocation of, or refusal to make
316.23 an anatomical gift;

316.24 (6) a declaration regarding intrusive mental health treatment under section 253B.03,
316.25 subdivision 6d, or a statement that the health care agent is authorized to give consent for
316.26 the principal under section 253B.04, subdivision 1a;

316.27 (7) a funeral directive as provided in section 149A.80, subdivision 2;

316.28 (8) limitations, if any, to the effect of dissolution or annulment of marriage or
316.29 termination of domestic partnership on the appointment of a health care agent under
316.30 section 145C.09, subdivision 2;

316.31 (9) specific reasons why a principal wants a health care provider or an employee
316.32 of a health care provider attending the principal to be eligible to act as the principal's
316.33 health care agent;

316.34 (10) health care instructions by a woman of child bearing age regarding how she
316.35 would like her pregnancy, if any, to affect health care decisions made on her behalf; and

317.1 (11) health care instructions regarding artificially administered nutrition or hydration.

317.2 (b) A health care directive may include a statement of the circumstances under
317.3 which the directive becomes effective other than upon the judgment of the principal's
317.4 attending physician in the following situations:

317.5 (1) a principal who in good faith generally selects and depends upon spiritual means
317.6 or prayer for the treatment or care of disease or remedial care and does not have an
317.7 attending physician, may include a statement appointing an individual who may determine
317.8 the principal's decision-making capacity; and

317.9 (2) a principal who in good faith does not generally select a physician or a health
317.10 care facility for the principal's health care needs may include a statement appointing an
317.11 individual who may determine the principal's decision-making capacity, provided that if
317.12 the need to determine the principal's capacity arises when the principal is receiving care
317.13 under the direction of an attending physician in a health care facility, the determination
317.14 must be made by an attending physician after consultation with the appointed individual.

317.15 If a person appointed under clause (1) or (2) is not reasonably available and the
317.16 principal is receiving care under the direction of an attending physician in a health care
317.17 facility, an attending physician shall determine the principal's decision-making capacity.

317.18 (c) A health care directive may authorize a health care agent to make health care
317.19 decisions for a principal even though the principal retains decision-making capacity.

317.20 Sec. 29. Minnesota Statutes 2006, section 145C.07, is amended by adding a
317.21 subdivision to read:

317.22 Subd. 5. Visitation. A health care agent may visit the principal when the
317.23 principal is a patient in a health care facility regardless of whether the principal retains
317.24 decision-making capacity, unless:

317.25 (1) the principal has otherwise specified in the health care directive;

317.26 (2) a principal who retains decision-making capacity indicates otherwise; or

317.27 (3) a health care provider reasonably determines that the principal must be isolated
317.28 from all visitors or that the presence of the health care agent would endanger the health or
317.29 safety of the principal, other patients, or the facility in which the care is being provided.

317.30 Sec. 30. Minnesota Statutes 2006, section 148.6445, subdivision 1, is amended to read:

317.31 Subdivision 1. **Initial licensure fee.** The initial licensure fee for occupational
317.32 therapists is ~~\$180~~ \$145. The initial licensure fee for occupational therapy assistants is
317.33 ~~\$100~~ \$80. The commissioner shall prorate fees based on the number of quarters remaining
317.34 in the biennial licensure period.

318.1 Sec. 31. Minnesota Statutes 2006, section 148.6445, subdivision 2, is amended to read:

318.2 Subd. 2. **Licensure renewal fee.** The biennial licensure renewal fee for
318.3 occupational therapists is ~~\$180~~ \$145. The biennial licensure renewal fee for occupational
318.4 therapy assistants is ~~\$100~~ \$80.

318.5 Sec. 32. **[148.785] FEES.**

318.6 The fees charged by the board are fixed at the following rates:

318.7 (1) application fee for physical therapists and physical therapist assistants, \$100;

318.8 (2) annual licensure for physical therapists and physical therapist assistants, \$60;

318.9 (3) licensure renewal late fee, \$20;

318.10 (4) temporary permit, \$25;

318.11 (5) duplicate license or registration, \$20;

318.12 (6) certification letter, \$25;

318.13 (7) education or training program approval, \$100;

318.14 (8) report creation and generation, \$60 per hour billed in quarter-hour increments

318.15 with a quarter-hour minimum; and

318.16 (9) examination administration:

318.17 (i) half day, \$50; and

318.18 (ii) full day, \$80.

318.19 Sec. 33. Minnesota Statutes 2006, section 148B.53, subdivision 3, is amended to read:

318.20 Subd. 3. **Fee.** Nonrefundable fees are as follows:

318.21 (1) initial license application fee for licensed professional counseling (LPC) - ~~\$250~~
318.22 \$150;

318.23 (2) initial license fee for LPC - \$250;

318.24 (3) annual active license renewal fee for LPC - ~~\$200~~ \$250 or equivalent;

318.25 ~~(3)~~ (4) annual inactive license renewal fee for LPC - ~~\$100~~ \$125;

318.26 (5) initial license application fee for licensed professional clinical counseling
318.27 (LPCC) - \$150;

318.28 (6) initial license fee for LPCC - \$250;

318.29 (7) annual active license renewal fee for LPCC - \$250 or equivalent;

318.30 (8) annual inactive license renewal fee for LPCC - \$125;

318.31 ~~(4)~~ (9) license renewal late fee - \$100 per month or portion thereof;

318.32 ~~(5)~~ (10) copy of board order or stipulation - \$10;

318.33 ~~(6)~~ (11) certificate of good standing or license verification - ~~\$10~~ \$25;

318.34 ~~(7)~~ (12) duplicate certificate fee - ~~\$10~~ \$25;

- 319.1 ~~(8)~~ (13) professional firm renewal fee - \$25;
319.2 ~~(9)~~ (14) sponsor application for approval of a continuing education course - \$60;
319.3 (15) initial registration fee - \$50; ~~and~~
319.4 ~~(10)~~ (16) annual registration renewal fee - \$25; and
319.5 (17) approved supervisor application processing fee - \$30.

319.6 Sec. 34. Minnesota Statutes 2006, section 149A.52, subdivision 3, is amended to read:

319.7 Subd. 3. **Application procedure; documentation; initial inspection.** An applicant
319.8 for a license to operate a crematory shall submit to the commissioner a completed
319.9 application. A completed application includes:

- 319.10 (1) a completed application form, as provided by the commissioner;
319.11 (2) proof of business form and ownership; and
319.12 (3) proof of liability insurance coverage or other financial documentation, as
319.13 determined by the commissioner, that demonstrates the applicant's ability to respond in
319.14 damages for liability arising from the ownership, maintenance, management, or operation
319.15 of a crematory.

319.16 Upon receipt of the application and appropriate fee, the commissioner shall review
319.17 and verify all information. Upon completion of the verification process and resolution
319.18 of any deficiencies in the application information, the commissioner shall conduct an
319.19 initial inspection of the premises to be licensed. After the inspection and resolution of
319.20 any deficiencies found and any reinspections as may be necessary, the commissioner shall
319.21 make a determination, based on all the information available, to grant or deny licensure. If
319.22 the commissioner's determination is to grant the license, the applicant shall be notified and
319.23 the license shall issue and remain valid for a period prescribed on the license, but not to
319.24 exceed one calendar year from the date of issuance of the license. If the commissioner's
319.25 determination is to deny the license, the commissioner must notify the applicant, in
319.26 writing, of the denial and provide the specific reason for denial.

319.27 Sec. 35. **[149A.65] FEES.**

319.28 Subdivision 1. **Generally.** This section establishes the fees for registrations,
319.29 examinations, initial and renewal licenses, and late fees authorized under the provisions
319.30 of this chapter.

319.31 Subd. 2. **Mortuary science fees.** Fees for mortuary science are:

- 319.32 (1) \$50 for the initial and renewal registration of a mortuary science intern;
319.33 (2) \$100 for the mortuary science examination;
319.34 (3) \$125 for issuance of initial and renewal mortuary science licenses;

320.1 (4) \$25 late fee charge for a license renewal; and

320.2 (5) \$200 for issuing a mortuary science license by endorsement.

320.3 Subd. 3. **Funeral directors.** The license renewal fee for funeral directors is \$125.

320.4 The late fee charge for a license renewal is \$25.

320.5 Subd. 4. **Funeral establishments.** The initial and renewal fee for funeral

320.6 establishments is \$300. The late fee charge for a license renewal is \$25.

320.7 Subd. 5. **Crematories.** The initial and renewal fee for a crematory is \$300. The

320.8 late fee charge for a license renewal is \$25.

320.9 Sec. 36. Minnesota Statutes 2006, section 149A.97, subdivision 7, is amended to read:

320.10 Subd. 7. **Reports to commissioner.** Every funeral provider lawfully doing business
320.11 in Minnesota that accepts funds under subdivision 2 must make a complete annual report
320.12 to the commissioner. The reports may be on forms provided by the commissioner or
320.13 substantially similar forms containing, at least, identification and the state of each trust
320.14 account, including all transactions involving principal and accrued interest, and must be
320.15 filed by March 31 of the calendar year following the reporting year along with a filing
320.16 fee of ~~\$15~~ \$25 for each report. Fees shall be paid to the commissioner of finance, state of
320.17 Minnesota, for deposit in the state government special revenue fund in the state treasury.
320.18 Reports must be signed by an authorized representative of the funeral provider and
320.19 notarized under oath. All reports to the commissioner shall be reviewed for account
320.20 inaccuracies or possible violations of this section. If the commissioner has a reasonable
320.21 belief to suspect that there are account irregularities or possible violations of this section,
320.22 the commissioner shall report that belief, in a timely manner, to the state auditor. The
320.23 commissioner shall also file an annual letter with the state auditor disclosing whether or
320.24 not any irregularities or possible violations were detected in review of the annual trust
320.25 fund reports filed by the funeral providers. This letter shall be filed with the state auditor
320.26 by May 31 of the calendar year following the reporting year.

320.27 Sec. 37. Minnesota Statutes 2006, section 157.16, subdivision 1, is amended to read:

320.28 Subdivision 1. **License required annually.** A license is required annually for every
320.29 person, firm, or corporation engaged in the business of conducting a food and beverage
320.30 service establishment, hotel, motel, lodging establishment, or resort. Any person wishing
320.31 to operate a place of business licensed in this section shall first make application, pay the
320.32 required fee specified in this section, and receive approval for operation, including plan
320.33 review approval. Seasonal and temporary food stands and special event food stands are
320.34 not required to submit plans. Nonprofit organizations operating a special event food

321.1 stand with multiple locations at an annual one-day event shall be issued only one license.
321.2 Application shall be made on forms provided by the commissioner and shall require
321.3 the applicant to state the full name and address of the owner of the building, structure,
321.4 or enclosure, the lessee and manager of the food and beverage service establishment,
321.5 hotel, motel, lodging establishment, or resort; the name under which the business is to
321.6 be conducted; and any other information as may be required by the commissioner to
321.7 complete the application for license.

321.8 Sec. 38. **HEALTH PROMOTION PROGRAM.**

321.9 The State Community Health Services Advisory Committee established in
321.10 Minnesota Statutes, section 145A.10, subdivision 10, shall develop a plan to fund and
321.11 implement an ongoing comprehensive health promotion program that can effect change
321.12 more effectively and at lower cost at a community level rather than through individual
321.13 counseling and change promotion. The program shall use proven public health strategies
321.14 to promote healthy lifestyles and behaviors in order to establish a sustainable, long-term
321.15 approach to reducing preventable disability, chronic health conditions, and disease. The
321.16 focus shall be on community based initiatives that address childhood and adult obesity,
321.17 tobacco and substance abuse, improved activity levels among senior citizens, and other
321.18 lifestyle issues that impact health and healthcare costs. Because of its population health
321.19 focus, funding shall be related to the size of the population to be served. The plan shall be
321.20 completed by September 15, 2007, and shared with the Legislative Health Care Access
321.21 Commission.

321.22 Sec. 39. **INJUNCTIVE RELIEF REPORT.**

321.23 The commissioner of health shall present to the 2008 legislature, by December 15,
321.24 2007, recommendations to fund the cost of bringing actions for injunctive relief under
321.25 Minnesota Statutes, section 144G.02, subdivision 2, paragraph (b).

321.26 Sec. 40. **DIAGNOSTIC IMAGING SERVICES ADVISORY COMMITTEE;**
321.27 **ESTABLISHMENT.**

321.28 (a) The commissioner of health shall establish a Diagnostic Imaging Services
321.29 Advisory Committee to perform the following duties:

321.30 (1) gather and analyze data to understand the factors driving utilization of diagnostic
321.31 imaging services, including computed tomography (CT), magnetic resonance imaging
321.32 (MRI), positron emission tomography (PET), magnetic resonance angiography (MRA),
321.33 and nuclear cardiology, in the state relative to evidence-based guidelines; and

322.1 (2) develop recommendations, based on the data collected, on how to improve
322.2 the delivery of evidence-based diagnostic imaging services. In developing these
322.3 recommendations, the advisory committee shall consider the impacts on patient care,
322.4 premium costs, and administrative simplicity.

322.5 (b) The members of the Diagnostic Imaging Services Advisory Committee shall
322.6 include the commissioners of health and human services or the commissioners' designees
322.7 and the following:

322.8 (1) three physicians representing speciality and geographic diversity, appointed by
322.9 the Minnesota Medical Association;

322.10 (2) two hospital representatives, one from a metropolitan hospital and one from a
322.11 rural hospital, appointed by the Minnesota Hospital Association;

322.12 (3) three health plan company representatives appointed by the Minnesota Council
322.13 of Health Plans;

322.14 (4) two representatives appointed by the Institute for Clinical System Improvement;
322.15 and

322.16 (5) one clinic manager appointed by the Minnesota Medical Group Management
322.17 Association.

322.18 (c) The Diagnostic Imaging Services Advisory Committee shall convene no later
322.19 than September 1, 2007. The commissioner shall report back to the legislature no later
322.20 than January 15, 2008. The advisory committee is governed under Minnesota Statutes,
322.21 section 15.059, except that members shall not receive a per diem and may only be
322.22 reimbursed for expenses.

322.23 (d) A strategy to improve the delivery of evidence-based diagnostic imaging services
322.24 may be developed by health plans. The commissioner of health shall report the agreement
322.25 to the chairs of the senate and house health care committees immediately.

322.26 **EFFECTIVE DATE.** This section is effective July 1, 2007.

322.27 Sec. 41. **HEARING AID DISPENSER FEES.**

322.28 Fees relating to hearing aid dispensers, as provided in Minnesota Statutes, section
322.29 153A.17, may not be increased until after the Department of Health provides a report to
322.30 the legislature regarding the need and reasons for fee increases.

322.31 Sec. 42. **REVISOR'S INSTRUCTION.**

322.32 In Minnesota Statutes and Minnesota Rules, the revisor shall change the references
322.33 in column A with the references in column B.

	<u>Column A</u>	<u>Column B</u>
323.1		
323.2	<u>section 144.335</u>	<u>sections 144.291 to 144.298</u>
323.3	<u>section 144.335, subdivision 1</u>	<u>section 144.291, subdivision 2</u>
323.4	<u>section 144.335, subdivision 1, paragraph</u>	<u>section 144.291, subdivision 2, paragraph</u>
323.5	<u>(b)</u>	<u>(h)</u>
323.6	<u>section 144.335, subdivision 2, paragraphs</u>	
323.7	<u>(a) and (b)</u>	<u>section 144.292, subdivisions 2 and 5</u>
323.8	<u>section 144.335, subdivision 2</u>	<u>section 144.292</u>
323.9	<u>section 144.335, subdivision 3a</u>	<u>section 144.294, subdivision 2</u>
323.10	<u>section 144.335, subdivision 3a, paragraph</u>	
323.11	<u>(d)</u>	<u>section 144.295</u>
323.12	<u>section 144.335, subdivision 3a, paragraph</u>	
323.13	<u>(f)</u>	<u>section 144.294</u>
323.14	<u>section 144.335, subdivision 3b</u>	<u>section 144.293, subdivision 7</u>

323.15 **Sec. 43. REPEALER.**

323.16 (a) Minnesota Statutes 2006, section 144.335, is repealed.

323.17 (b) Minnesota Statutes 2006, section 62J.17, subdivisions 1, 5a, 6a, and 8, are
323.18 repealed.

323.19 (c) Minnesota Rules, part 4610.2800, is repealed.

323.20 ARTICLE 7

323.21 MISCELLANEOUS

323.22 Section 1. Minnesota Statutes 2006, section 16A.10, is amended by adding a
323.23 subdivision to read:

323.24 Subd. 2a. **Base budget detail.** Within one week of the release of the budget forecasts
323.25 required in section 16A.102 in November of an even-numbered year and February of an
323.26 odd-numbered year, the commissioner, after consulting with the commissioners of human
323.27 services and health, must provide to the legislature information at the program, budget
323.28 activity and management activity level for the base level budget of the Department of
323.29 Human Services and the Department of Health for the next biennium. The information
323.30 must be organized in a manner that explains how base level budget appropriations are
323.31 projected to be spent. Within one week of the release of the budget forecasts required in
323.32 section 16A.102 in November of an even-numbered year, the commissioner must also
323.33 provide the legislature with the information submitted by the commissioners of human
323.34 services and health under subdivision 2, clauses (3) and (4).

Sec. 2. Minnesota Statutes 2006, section 43A.316, is amended to read:

43A.316 PUBLIC EMPLOYEES INSURANCE PROGRAM.

Subdivision 1. **Intent.** The legislature finds that the creation of a statewide program to provide public employees and other eligible persons with life insurance and hospital, medical, and dental benefit coverage ~~through provider organizations~~ would result in a ~~greater utilization~~ more efficient use of government resources and would advance the health and welfare of the citizens of the state.

Subd. 2. **Definitions.** For the purpose of this section, the terms defined in this subdivision have the meaning given them.

(a) **Commissioner.** "Commissioner" means the commissioner of employee relations.

(b) **Employee.** "Employee" means:

(1) a person who is a public employee within the definition of section 179A.03, subdivision 14, who is insurance eligible and is employed by an eligible employer;

(2) an elected public official of an eligible employer who is insurance eligible;

(3) a person employed by a labor organization or employee association certified as an exclusive representative of employees of an eligible employer or by another public employer approved by the commissioner, so long as the plan meets the requirements of a governmental plan under United States Code, title 29, section 1002(32); or

(4) a person employed by a county or municipal hospital.

(c) **Eligible employer.** "Eligible employer" means:

(1) a public employer within the definition of section 179A.03, subdivision 15, that is a town, county, city, school district as defined in section 120A.05, service cooperative as defined in section 123A.21, intermediate district as defined in section 136D.01, Cooperative Center for Vocational Education as defined in section 123A.22, regional management information center as defined in section 123A.23, or an education unit organized under the joint powers action, section 471.59; or

(2) an exclusive representative of employees, as defined in paragraph (b);

(3) a county or municipal hospital; ~~or~~

(4) another public employer approved by the commissioner; or

(5) a nursing home as defined in section 144A.01, subdivision 5, located in this state.

(d) **Exclusive representative.** "Exclusive representative" means an exclusive representative as defined in section 179A.03, subdivision 8.

(e) **Labor-Management Committee.** "Labor-Management Committee" means the committee established by subdivision 4.

(f) **Program.** "Program" means the statewide public employees insurance program created by subdivision 3.

Subd. 3. **Public employee insurance program.** The commissioner shall be the administrator of the public employee insurance program and may determine its funding arrangements. The commissioner may contract with a qualified entity to perform the administrative functions. The commissioner shall model the program after the plan established in section 43A.18, subdivision 2, but may ~~modify~~ adopt variations from that plan, in consultation with the Labor-Management Committee. The variations may include different deductibles, coinsurance, co-pays, or other enrollee cost-sharing provisions.

Subd. 4. **Labor-Management Committee.** (a) The Labor-Management Committee consists of ten members appointed by the commissioner. The Labor-Management Committee must comprise five members who represent employees, including at least one retired employee, and five members who represent eligible employers. Committee members are eligible for expense reimbursement in the same manner and amount as authorized by the commissioner's plan adopted under section 43A.18, subdivision 2. The commissioner shall consult with the labor-management committee in major decisions that affect the program. The committee shall study issues and make recommendations relating to the insurance program including, but not limited to, flexible benefits, utilization review, quality assessment, and cost efficiency. The committee continues to exist while the program remains in operation.

(b) The five members of the Labor-Management Committee who represent employees must be chosen by the commissioner from among persons nominated as provided in this paragraph. Exclusive representatives of employees of counties, cities, school districts, and nursing homes are entitled to nominate two candidates for the Labor-Management Committee from each of those four categories, and the commissioner shall appoint one of those two nominees from each category. The commissioner shall choose the fifth employee to represent retired employees.

(c) The five members of the Labor-Management Committee who represent employers must be chosen by the commissioner from among persons nominated as provided in this paragraph. The Association of Minnesota Counties, Minnesota League of Cities, Minnesota School Boards Association, and the Minnesota Association of Nursing Homes are each entitled to nominate two candidates for the committee, and the commissioner shall appoint one of those from each group. The commissioner shall select the fifth employer member from an employer participating in the program and not represented by the other four employer members, if any, or if that is not reasonably possible, the commissioner may appoint any other person as the fifth employer representative.

Subd. 5. **Public employee participation.** (a) Participation in the program is subject to the conditions in this subdivision.

(b) Each exclusive representative for an eligible employer determines whether the employees it represents will participate in the program. The exclusive representative shall give the employer notice of intent to participate at least ~~30~~ 60 days before the expiration date of the collective bargaining agreement preceding the collective bargaining agreement that covers the date of entry into the program. Either all or none of the employees represented by an exclusive representative must participate. The exclusive representative and the eligible employer shall give notice to the commissioner of the determination to participate in the program at least ~~30~~ 60 days before entry into the program. Entry into the program is governed by a schedule established by the commissioner.

(c) Employees not represented by exclusive representatives may become members of the program upon a determination of an eligible employer to include these employees in the program. Either all or none of the employer's unrepresented employees must participate. The eligible employer shall give at least ~~30~~ 60 days' notice to the commissioner before entering the program. Entry into the program is governed by a schedule established by the commissioner.

(d) Participation in the program is for a ~~two-year~~ three-year term. Participation is automatically renewed for an additional ~~two-year~~ three-year term unless the exclusive representative, or the employer for unrepresented employees, gives the commissioner notice of withdrawal at least ~~30~~ 60 days before expiration of the participation period. A group that withdraws must wait two years before rejoining, except with the approval of the commissioner. An exclusive representative, or employer for unrepresented employees, may also withdraw if premiums increase ~~50 percent~~ by more than 20 percent in excess of the Consumer Price Index for all urban consumers or more from one insurance year to the next.

(e) The exclusive representative shall give the employer notice of intent to withdraw ~~to the commissioner~~ at least ~~30~~ 60 days before the expiration date of a collective bargaining agreement that includes the date on which the term of participation expires.

(f) Each participating eligible employer shall notify the commissioner of the names of individuals who will be participating within two weeks ~~of~~ after the commissioner ~~receiving~~ receives notice of the parties' intent to participate. The employer shall also submit other information as required by the commissioner for administration of the program.

(g) An employer that withdraws from the program under circumstances that do not permit withdrawal under this subdivision is liable to the board for premiums payable by the employer until the time that the employer is eligible to withdraw, and the employer shall pay those premiums voluntarily and no later than their due date. If the premiums are

not paid voluntarily, the board has authority to and shall collect these premiums under any method permitted by law for a governmental or nongovernmental creditor of the employer.

Subd. 6. **Coverage.** (a) ~~By January 1, 1989,~~ The commissioner shall announce the benefits of the program. The program shall include employee hospital, medical, dental, and life insurance for employees and hospital and medical benefits for dependents. Health maintenance organization options and other delivery system options may be provided if they are available, cost-effective, and capable of servicing the number of people covered in the program. Participation in optional coverages may be provided by collective bargaining agreements. For employees not represented by an exclusive representative, the employer may offer the optional coverages to eligible employees and their dependents provided in the program. Health coverage must include at least the benefits required of a health plan company regulated under chapter 62A, 62C, or 62D.

(b) The commissioner, with the assistance of the Labor-Management Committee, shall periodically assess whether it is financially feasible for the program to offer or to continue an individual retiree program that has competitive premium rates and benefits. If the commissioner determines it to be feasible to offer an individual retiree program, the commissioner shall announce the applicable benefits, premium rates, and terms of participation. Eligibility to participate in the individual retiree program is governed by subdivision 8, but applies to retirees of eligible employers that do not participate in the program and to those retirees' dependents and surviving spouses.

Subd. 6a. ~~Chiropractic services~~ Choice of type of provider. All benefits provided by the program ~~or a successor program~~ relating to expenses incurred for medical treatment or services of a ~~physician~~ health care provider must also include ~~chiropractic~~ treatment and services of a ~~chiropractor~~ any other type of licensed, certified, or registered health care provider to the extent that the ~~chiropractic~~ services and treatment are within the scope of ~~chiropractic licensure~~ the provider's licensure, certification, or registration.

~~This subdivision is intended to provide equal access to benefits for program members who choose to obtain treatment for illness or injury from a doctor of chiropractic, as long as the treatment falls within the chiropractor's scope of practice. This subdivision is not intended to change or add to the benefits provided for in the program.~~

Subd. 7. **Premiums.** (a) The proportion of premium paid by the employer and employee is subject to collective bargaining or personnel policies. If, at the beginning of the coverage period, no collective bargaining agreement has been finalized, the increased dollar costs, if any, from the previous year is the sole responsibility of the individual participant until a collective bargaining agreement states otherwise. Premiums, including an administration fee, shall be established by the commissioner. The commissioner may

328.1 decide to rate specific employers separately for premium purposes, if the commissioner
328.2 determines that doing so is in the best interests of the program. Each employer shall pay
328.3 monthly the amounts due for employee benefits including the amounts under subdivision
328.4 8 to the commissioner no later than the dates established by the commissioner. If an
328.5 employer fails to make the payments as required, the commissioner ~~may~~ shall cancel
328.6 program benefits and pursue other civil remedies, as provided in subdivision 5, paragraph
328.7 (d).

328.8 (b) The premium charged for an employer's first month in the program must be
328.9 three times the regular monthly premium charged to that employer, to help establish
328.10 and maintain the program's financial resources. The extra two months premium must
328.11 be refunded to the employer if the employer leaves the program, if the refund would
328.12 not reduce the program's reserves below the level determined to be appropriate by the
328.13 commissioner.

328.14 Subd. 8. **Continuation of coverage.** (a) A former employee of an employer
328.15 participating in the program who is receiving a public pension disability benefit or an
328.16 annuity or has met the age and service requirements necessary to receive an annuity under
328.17 chapter 353, 353C, 354, 354A, 356, 422A, 423, 423A, or 424, and the former employee's
328.18 dependents, are eligible to participate in the program. This participation is at the person's
328.19 expense unless a collective bargaining agreement or personnel policy provides otherwise.
328.20 Premiums for these participants must be established by the commissioner.

328.21 The commissioner may provide policy exclusions for preexisting conditions
328.22 only when there is a break in coverage between a participant's coverage under the
328.23 employment-based group insurance program and the participant's coverage under this
328.24 section. An employer shall notify an employee of the option to participate under this
328.25 paragraph no later than the effective date of retirement. The retired employee or the
328.26 employer of a participating group on behalf of a current or retired employee shall notify
328.27 the commissioner within 30 days of the effective date of retirement of intent to participate
328.28 in the program according to the rules established by the commissioner.

328.29 (b) The spouse of a deceased employee or former employee may purchase the
328.30 benefits provided at premiums established by the commissioner if the spouse was a
328.31 dependent under the employee's or former employee's coverage under this section at the
328.32 time of the death. The spouse remains eligible to participate in the program as long as
328.33 the group that included the deceased employee or former employee participates in the
328.34 program. Coverage under this clause must be coordinated with relevant insurance benefits
328.35 provided through the federally sponsored Medicare program.

(c) The program benefits must continue in the event of strike permitted by section 179A.18, if the exclusive representative chooses to have coverage continue and the employee pays the total monthly premiums when due.

~~(d) A participant who discontinues coverage may not reenroll.~~

(d) Persons participating under these paragraphs this subdivision shall make appropriate premium payments in the time and manner established by the commissioner. They are not subject to the payment of the extra payments required under subdivision 7, paragraph (b).

Subd. 9. **Insurance trust fund.** The insurance trust fund in the state treasury consists of deposits of the premiums received from employers participating in the program and transfers before July 1, 1994, from the excess contributions holding account established by section 353.65, subdivision 7. All money in the fund is appropriated to the commissioner to pay insurance premiums, approved claims, refunds, administrative costs, and other related service costs. Premiums paid by employers to the fund are exempt from the taxes imposed by chapter 297I. The commissioner shall reserve an amount of money to cover the estimated costs of claims incurred but unpaid. The State Board of Investment shall invest the money according to section 11A.24. Investment income and losses attributable to the fund must be credited to the fund.

Subd. 10. **Exemption.** The public employee insurance program and, where applicable, the employers participating in it are exempt from chapters 60A, 62A, 62C, 62D, 62E, and 62H, section 471.617, subdivisions 2 and 3, and the bidding requirements of section 471.6161, except as otherwise provided in subdivision 6, paragraph (a).

Subd. 11. **Reinsurance.** The commissioner may, on behalf of the program, participate in an insured or self-insured reinsurance pool.

Sec. 3. Minnesota Statutes 2006, section 62H.02, is amended to read:

62H.02 REQUIRED PROVISIONS.

(a) A joint self-insurance plan must include aggregate excess stop-loss coverage and individual excess stop-loss coverage provided by an insurance company licensed by the state of Minnesota.

(b) Aggregate excess stop-loss coverage must include provisions to cover incurred, unpaid claim liability in the event of plan termination. In addition,

(c) The plan of self-insurance must have participating employers fund an amount at least equal to the point at which the excess or stop-loss insurer has contracted to assume 100 percent of additional liability.

(d) A joint self-insurance plan must submit its proposed excess or stop-loss insurance contract to the commissioner of commerce at least 30 days prior to the proposed plan's effective date and at least 30 days subsequent to any renewal date. The commissioner shall review the contract to determine if they meet the standards established by sections 62H.01 to 62H.08 and respond within a 30-day period.

(e) Any excess or stop-loss insurance plan must contain a provision that the excess or stop-loss insurer will give the plan and the commissioner of commerce a minimum of 180 days' notice of termination or nonrenewal. If the plan fails to secure replacement coverage within 60 days after receipt of the notice of cancellation or nonrenewal, the commissioner shall issue an order providing for the orderly termination of the plan.

(f) The commissioner may waive the requirements of this section and of any rule relating to the requirements of this section, if the commissioner determines that a joint self-insurance plan has established alternative arrangements that fully fund the plan's liability or incurred but unpaid claims. The commissioner may not waive the requirement that a joint self-insurance plan have excess stop-loss coverage.

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

Sec. 4. [62Q.40] LANGUAGE INTERPRETER SERVICES.

(a) A health plan must cover sign language interpreter services provided to deaf and hard-of-hearing enrollees and language interpreter services provided to enrollees with limited English proficiency in order to facilitate the provision of health care services by a provider. For purposes of this section, "provider" has the meaning given in section 62J.03, subdivision 8, and includes a health care provider facility; and "health plan" includes coverage excluded under section 62A.011, subdivision 3, clauses (6), (7), (9), and (10). Interpreter services may be provided in person, by telephone, facsimile, video or audio streaming, or by video conference. In accordance with paragraphs (b) and (c), a health plan company shall reimburse either the party providing interpreter services directly for the costs of language interpreter services provided to the enrollee or the provider arranging for the provision of interpreter services. Providers that employ or contract with interpreters may bill and shall be reimbursed directly by health plan companies for such services in accordance with paragraph (b). A health plan company shall provide to enrollees, upon request, the policies and procedures for addressing the needs of deaf and hard-of-hearing enrollees and enrollees with limited English proficiency. All parties providing interpreter services must disclose their methods for ensuring competency upon request of any health plan company, provider, or consumer.

331.1 (b) A health plan company shall pay for interpreter services as required in paragraph
331.2 (a) by establishing a network of interpreter service providers and requiring use of its own
331.3 network of interpreter services providers. The health plan company shall consider, as part
331.4 of its interpreter service provider network, entering into an agreement with a provider for
331.5 use of an interpreter service provider employed by or under contract with the provider if:

331.6 (1) the provider accepts as reimbursement for services rendered by the provider's
331.7 employed or contracted interpreter service provider the lesser of either the health plan
331.8 company's reimbursement rate for its in-network interpreter service providers or the
331.9 provider's fee for services rendered by the provider's interpreter service provider; and

331.10 (2) the interpreter service provider meets the published quality standards of the
331.11 health plan company.

331.12 (c) If a health plan company's or a provider's employed or contracted interpreter
331.13 service provider is unavailable to provide interpreter services, the health plan company
331.14 shall reimburse the interpreter service provider at the lesser of the health plan company's
331.15 median reimbursement rate for its in-network interpreter service providers or the
331.16 interpreter service provider's fee. An interpreter service provider not employed or under
331.17 contract with a health plan company or provider who fails to meet the quality standards
331.18 of a health plan company or as required by law, shall be ineligible for reimbursement
331.19 under this section.

331.20 (d) If the health plan company pays the interpreter service provider directly, it has no
331.21 obligation to pay the provider under this section.

331.22 (e) Nothing in this section requires a health plan company to establish a network
331.23 of interpreter service providers.

331.24 **EFFECTIVE DATE.** This section is effective July 1, 2008, and applies to plans
331.25 issued or renewed to provide coverage to Minnesota residents on or after that date unless
331.26 the legislature enacts alternative funding sources based on the recommendations of the
331.27 commissioner.

331.28 Sec. 5. Minnesota Statutes 2006, section 144.05, is amended by adding a subdivision
331.29 to read:

331.30 Subd. 5. **Base budget detail.** The commissioner shall provide the commissioner
331.31 of finance with the information necessary to provide base budget detail to the legislature
331.32 under section 16A.10, subdivision 2a.

331.33 Sec. 6. Minnesota Statutes 2006, section 148.235, is amended by adding a subdivision
331.34 to read:

332.1 Subd. 11. **Dispensing by protocol.** A registered nurse in a family planning agency
332.2 as defined in Minnesota Rules, part 9505.0280, subpart 3, may dispense oral contraceptives
332.3 prescribed by a licensed practitioner as defined in section 151.01, subdivision 23, pursuant
332.4 to a dispensing protocol established by the agency's medical director or under the direction
332.5 of a physician. The dispensing protocol must address the requirements of sections 151.01,
332.6 subdivision 30, and 151.212, subdivision 1.

332.7 Sec. 7. Minnesota Statutes 2006, section 151.37, subdivision 2, is amended to read:

332.8 Subd. 2. **Prescribing and filing.** (a) A licensed practitioner in the course of
332.9 professional practice only, may prescribe, administer, and dispense a legend drug, and may
332.10 cause the same to be administered by a nurse, a physician assistant, or medical student or
332.11 resident under the practitioner's direction and supervision, and may cause a person who
332.12 is an appropriately certified, registered, or licensed health care professional to prescribe,
332.13 dispense, and administer the same within the expressed legal scope of the person's practice
332.14 as defined in Minnesota Statutes. A licensed practitioner may prescribe a legend drug,
332.15 without reference to a specific patient, by directing a nurse, pursuant to section 148.235,
332.16 subdivisions 8 and 9, physician assistant, or medical student or resident to adhere to
332.17 a particular practice guideline or protocol when treating patients whose condition falls
332.18 within such guideline or protocol, and when such guideline or protocol specifies the
332.19 circumstances under which the legend drug is to be prescribed and administered. An
332.20 individual who verbally, electronically, or otherwise transmits a written, oral, or electronic
332.21 order, as an agent of a prescriber, shall not be deemed to have prescribed the legend drug.
332.22 This paragraph applies to a physician assistant only if the physician assistant meets the
332.23 requirements of section 147A.18.

332.24 (b) A licensed practitioner that dispenses for profit a legend drug that is to be
332.25 administered orally, is ordinarily dispensed by a pharmacist, and is not a vaccine, must
332.26 file with the practitioner's licensing board a statement indicating that the practitioner
332.27 dispenses legend drugs for profit, the general circumstances under which the practitioner
332.28 dispenses for profit, and the types of legend drugs generally dispensed. It is unlawful to
332.29 dispense legend drugs for profit after July 31, 1990, unless the statement has been filed
332.30 with the appropriate licensing board. For purposes of this paragraph, "profit" means (1)
332.31 any amount received by the practitioner in excess of the acquisition cost of a legend drug
332.32 for legend drugs that are purchased in prepackaged form, or (2) any amount received
332.33 by the practitioner in excess of the acquisition cost of a legend drug plus the cost of
332.34 making the drug available if the legend drug requires compounding, packaging, or other
332.35 treatment. The statement filed under this paragraph is public data under section 13.03.

333.1 This paragraph does not apply to a licensed doctor of veterinary medicine or a registered
333.2 pharmacist. Any person other than a licensed practitioner with the authority to prescribe,
333.3 dispense, and administer a legend drug under paragraph (a) shall not dispense for profit.
333.4 To dispense for profit does not include dispensing by a community health clinic when the
333.5 profit from dispensing is used to meet operating expenses.

333.6 (c) A prescription or drug order for a legend drug is not valid unless it is issued
333.7 for a legitimate medical purpose arising from a prescriber-patient relationship that
333.8 includes a documented patient evaluation adequate to establish diagnoses and identify
333.9 underlying conditions and contraindications to the treatment. Treatment, including issuing
333.10 a prescription or drug order, based solely on an online questionnaire does not constitute a
333.11 legitimate medical purpose.

333.12 Sec. 8. Minnesota Statutes 2006, section 152.11, is amended by adding a subdivision to
333.13 read:

333.14 Subd. 2d. **Identification requirement for schedule II or III controlled substance.**
333.15 No person may dispense a controlled substance included in schedule II or III without
333.16 requiring the person purchasing the controlled substance, who need not be the person for
333.17 whom the controlled substance prescription is written, to present valid photographic
333.18 identification, unless the person purchasing the controlled substance, or if applicable the
333.19 person for whom the controlled substance prescription is written, is known to the dispenser.

333.20 Sec. 9. **[152.126] SCHEDULE II AND III CONTROLLED SUBSTANCES**
333.21 **PRESCRIPTION ELECTRONIC REPORTING SYSTEM.**

333.22 Subdivision 1. **Definitions.** For purposes of this section, the terms defined in this
333.23 subdivision have the meanings given.

333.24 (a) "Board" means the Minnesota State Board of Pharmacy established under
333.25 chapter 151.

333.26 (b) "Controlled substances" means those substances listed in section 152.02,
333.27 subdivisions 3 and 4, and those substances defined by the board pursuant to section
333.28 152.02, subdivisions 8 and 12.

333.29 (c) "Dispense" or "dispensing" has the meaning given in section 151.01, subdivision
333.30 30. Dispensing does not include the direct administering of a controlled substance to a
333.31 patient by a licensed health care professional.

333.32 (d) "Dispenser" means a person authorized by law to dispense a controlled substance,
333.33 pursuant to a valid prescription. A dispenser does not include a licensed hospital pharmacy
333.34 that distributes controlled substances for inpatient hospital care.

(e) "Prescriber" means a licensed health care professional who is authorized to prescribe a controlled substance under section 152.12, subdivision 1.

(f) "Prescription" has the meaning given in section 151.01, subdivision 16.

Subd. 2. Prescription electronic reporting system. (a) By January 1, 2009, or upon enactment of legislation that implements the recommendations of the Board of Pharmacy under subdivision 3, paragraph (c), whichever is later, the board shall establish an electronic system for reporting the information required under subdivision 4 for all controlled substances dispensed within the state. Data for controlled substance prescriptions that are dispensed in a quantity small enough to provide treatment to a patient for a period of 48 hours or less need not be reported.

(b) The board may contract with a vendor for the purpose of obtaining technical assistance in the design, implementation, and maintenance of the electronic reporting system. The vendor's role shall be limited to providing technical support to the board concerning the software, databases, and computer systems required to interface with the existing systems currently used by pharmacies to dispense prescriptions and transmit prescription data to other third parties.

(c) The board may issue a waiver to a dispenser that is unable to submit dispensing information by electronic means. The waiver may permit the dispenser to submit dispensing information by paper form or other means, provided all information required by subdivision 4 is submitted in this alternative format.

Subd. 3. Prescription Electronic Reporting Advisory Committee. (a) The board shall convene an advisory committee. The committee must include at least one representative of:

- (1) the Department of Health;
- (2) the Department of Human Services;
- (3) each health-related licensing board that licenses prescribers;
- (4) a professional medical association, which may include an association of pain management and chemical dependency specialists;
- (5) a professional pharmacy association;
- (6) a consumer privacy or security advocate; and
- (7) a consumer or patient rights organization.

(b) The advisory committee shall advise the board on the development and operation of the electronic reporting system, including, but not limited to:

- (1) technical standards for electronic prescription drug reporting;
- (2) proper analysis and interpretation of prescription monitoring data; and
- (3) an evaluation process for the program.

(c) The Board of Pharmacy, after consultation with the advisory committee, shall present recommendations and draft legislation on the issues addressed by the advisory committee under paragraph (b), to the legislature by December 15, 2007.

Subd. 4. Reporting requirements and notice. (a) Each dispenser must submit the following data to the board or its designated vendor, subject to the notice required under paragraph (d):

(1) prescriber DEA number;

(2) dispenser DEA number;

(3) name of the patient for whom the prescription was written;

(4) date of birth of the patient for whom the prescription was written;

(5) date the prescription was written;

(6) date the prescription was filled;

(7) NDC code for drug dispensed; and

(8) quantity of controlled substance dispensed.

(b) The dispenser must submit the required information according to the format and protocols specified in the "ASAP Telecommunications Format for Controlled Substances," May 1995 edition, published by the American Society for Automation in Pharmacy, which is hereby adopted by reference, by a procedure established by the board.

(c) A dispenser is not required to submit this data for those controlled substance prescriptions dispensed for:

(1) individuals residing in licensed skilled nursing or intermediate care facilities;

(2) individuals receiving assisted living services under chapter 144G or through a medical assistance home and community-based waiver;

(3) individuals receiving medication intravenously;

(4) individuals receiving hospice and other palliative or end-of-life care; and

(5) individuals receiving services from a home care provider regulated under chapter 144A.

(d) A dispenser must not submit data under this subdivision unless a conspicuous notice of the reporting requirements of this section is given to the patient for whom the prescription was written.

Subd. 5. Use of data by board. (a) The board shall develop and maintain a database of the data reported under subdivision 4. The board shall maintain data that could identify an individual prescriber or dispenser in encrypted form. The database may be used by permissible users identified under subdivision 6 for the identification of:

(1) individuals receiving prescriptions for controlled substances from prescribers who subsequently obtain controlled substances from dispensers in quantities or with a

336.1 frequency inconsistent with generally recognized standards of dosage for those controlled
336.2 substances; and

336.3 (2) individuals presenting forged or otherwise false or altered prescriptions for
336.4 controlled substances to dispensers.

336.5 (b) No permissible user identified under subdivision 6 may access the database
336.6 for the sole purpose of identifying prescribers of controlled substances for unusual or
336.7 excessive prescribing patterns without a valid search warrant or court order.

336.8 (c) No personnel of a state or federal occupational licensing board or agency may
336.9 access the database for the purpose of obtaining information to be used to initiate or
336.10 substantiate a disciplinary action against a prescriber.

336.11 (d) Data reported under subdivision 4 shall be retained by the board in the database
336.12 for a six-month period, and shall be removed from the database six months from the
336.13 date the data was received.

336.14 Subd. 6. **Access to reporting system data.** (a) Except as indicated in this
336.15 subdivision, the data submitted to the board under subdivision 4 is private data on
336.16 individuals as defined in section 13.02, subdivision 12, and not subject to public disclosure.

336.17 (b) Except as specified in subdivision 5, the following persons shall be considered
336.18 permissible users and may access the data submitted under subdivision 4 in the same or
336.19 similar manner, and for the same or similar purposes, as those persons who are authorized
336.20 to access similar private data on individuals under federal and state law:

336.21 (1) a prescriber, to the extent the information relates specifically to a current patient
336.22 of the prescriber, to whom the practitioner is prescribing or considering prescribing any
336.23 controlled substance;

336.24 (2) a dispenser to the extent the information relates specifically to a current patient to
336.25 whom that dispenser is dispensing or considering dispensing any controlled substance;

336.26 (3) an individual who is the recipient of a controlled substance prescription for
336.27 which data was submitted under subdivision 4;

336.28 (4) personnel of the board specifically assigned to conduct a bona fide investigation
336.29 of a specific board licensee;

336.30 (5) personnel of the board engaged in the collection of controlled substance
336.31 prescription information as part of the assigned duties and responsibilities under this
336.32 section;

336.33 (6) authorized personnel of a vendor under contract with the board who are engaged
336.34 in the design, implementation, and maintenance of the electronic reporting system as part
336.35 of the assigned duties and responsibilities of their employment, provided that access to data
336.36 is limited to the minimum amount necessary to test and maintain the system databases;

(7) federal, state, and local law enforcement authorities engaged in a bona fide investigation of a specific person; and

(8) personnel of the medical assistance program assigned to use the data collected under this section to identify recipients whose usage of controlled substances may warrant restriction to a single primary care physician, a single outpatient pharmacy, or a single hospital.

(c) Any permissible user identified in paragraph (b), who directly accesses the data electronically, shall implement and maintain a comprehensive information security program that contains administrative, technical, and physical safeguards that are appropriate to the user's size and complexity, and the sensitivity of the personal information obtained. The permissible user shall identify reasonably foreseeable internal and external risks to the security, confidentiality, and integrity of personal information that could result in the unauthorized disclosure, misuse, or other compromise of the information and assess the sufficiency of any safeguards in place to control the risks.

(d) The board shall not release data submitted under this section unless it is provided with evidence, satisfactory to the board, that the person requesting the information is entitled to receive the data. Access to the data by law enforcement authorities must be accompanied by a valid search warrant.

(e) The board shall not release the name of a prescriber without the written consent of the prescriber or a valid search warrant or court order. The board shall provide a mechanism for a prescriber to submit to the board a signed consent authorizing the release of the prescriber's name when data containing the prescriber's name is requested.

(f) The board shall maintain a log of all persons who access the data and shall ensure that any permissible user complies with paragraph (c) prior to attaining direct access to the data.

Subd. 7. Disciplinary action. (a) A dispenser who knowingly fails to submit data to the board as required under this section is subject to disciplinary action by the appropriate health-related licensing board.

(b) A prescriber or dispenser authorized to access the data who knowingly discloses the data in violation of state or federal laws relating to the privacy of health care data shall be subject to disciplinary action by the appropriate health-related licensing board, and appropriate civil penalties.

Subd. 8. Evaluation and reporting. (a) The board shall evaluate the prescription electronic reporting system to determine if the system is cost-effective and whether it is negatively impacting appropriate prescribing practices of controlled substances. The board may contract with a vendor to design and conduct the evaluation.

338.1 (b) The board shall submit the evaluation of the system to the legislature by January
338.2 15, 2010.

338.3 Subd. 9. Immunity from liability; no requirement to obtain information. (a) A
338.4 pharmacist, prescriber, or other dispenser making a report to the program in good faith
338.5 under this section is immune from any civil, criminal, or administrative liability, which
338.6 might otherwise be incurred or imposed as a result of the report, or on the basis that the
338.7 pharmacist or prescriber did or did not seek or obtain or use information from the program.

338.8 (b) Nothing in this section shall require a pharmacist, prescriber, or other dispenser
338.9 to obtain information about a patient from the program, and the pharmacist, prescriber,
338.10 or other dispenser, if acting in good faith, is immune from any civil, criminal, or
338.11 administrative liability that might otherwise be incurred or imposed for requesting,
338.12 receiving, or using information from the program.

338.13 EFFECTIVE DATE. This section is effective July 1, 2007, or upon receiving
338.14 sufficient nonstate funds to implement the prescription electronic reporting program,
338.15 whichever is later. In the event that nonstate funds are not secured by the Board of
338.16 Pharmacy to adequately fund the implementation of the prescription electronic reporting
338.17 program, the board is not required to implement this section without a subsequent
338.18 appropriation from the legislature.

338.19 Sec. 10. Minnesota Statutes 2006, section 179A.03, subdivision 7, is amended to read:

338.20 Subd. 7. **Essential employee.** "Essential employee" means firefighters, peace
338.21 officers subject to licensure under sections 626.84 to 626.863, 911 system and police and
338.22 fire department public safety dispatchers, guards at correctional facilities, confidential
338.23 employees, supervisory employees, assistant county attorneys, assistant city attorneys,
338.24 principals, and assistant principals. However, for state employees, "essential employee"
338.25 means all employees, except for nonprofessional employees employed by the Department
338.26 of Human Services in mental health facilities for the treatment of psychopathic
338.27 personalities, sexual predators, and the criminally insane, in law enforcement, public
338.28 safety radio communications operators, health care professionals, correctional guards,
338.29 professional engineering, and supervisory collective bargaining units, irrespective of
338.30 severance, and no other employees. For University of Minnesota employees, "essential
338.31 employee" means all employees in law enforcement, nursing professional and supervisory
338.32 units, irrespective of severance, and no other employees. "Firefighters" means salaried
338.33 employees of a fire department whose duties include, directly or indirectly, controlling,
338.34 extinguishing, preventing, detecting, or investigating fires. Employees for whom the state

339.1 court administrator is the negotiating employer are not essential employees. For Hennepin
339.2 Healthcare System, Inc. employees, "essential employees" means all employees.

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

339.4 Sec. 11. Minnesota Statutes 2006, section 245.4874, is amended to read:

339.5 **245.4874 DUTIES OF COUNTY BOARD.**

339.6 (a) The county board must:

339.7 (1) develop a system of affordable and locally available children's mental health
339.8 services according to sections 245.487 to 245.4887;

339.9 (2) establish a mechanism providing for interagency coordination as specified in
339.10 section 245.4875, subdivision 6;

339.11 (3) consider the assessment of unmet needs in the county as reported by the local
339.12 children's mental health advisory council under section 245.4875, subdivision 5, paragraph
339.13 (b), clause (3). The county shall provide, upon request of the local children's mental health
339.14 advisory council, readily available data to assist in the determination of unmet needs;

339.15 (4) assure that parents and providers in the county receive information about how to
339.16 gain access to services provided according to sections 245.487 to 245.4887;

339.17 (5) coordinate the delivery of children's mental health services with services
339.18 provided by social services, education, corrections, health, and vocational agencies to
339.19 improve the availability of mental health services to children and the cost-effectiveness of
339.20 their delivery;

339.21 (6) assure that mental health services delivered according to sections 245.487
339.22 to 245.4887 are delivered expeditiously and are appropriate to the child's diagnostic
339.23 assessment and individual treatment plan;

339.24 (7) provide the community with information about predictors and symptoms of
339.25 emotional disturbances and how to access children's mental health services according to
339.26 sections 245.4877 and 245.4878;

339.27 (8) provide for case management services to each child with severe emotional
339.28 disturbance according to sections 245.486; 245.4871, subdivisions 3 and 4; and 245.4881,
339.29 subdivisions 1, 3, and 5;

339.30 (9) provide for screening of each child under section 245.4885 upon admission
339.31 to a residential treatment facility, acute care hospital inpatient treatment, or informal
339.32 admission to a regional treatment center;

340.1 (10) prudently administer grants and purchase-of-service contracts that the county
340.2 board determines are necessary to fulfill its responsibilities under sections 245.487 to
340.3 245.4887;

340.4 (11) assure that mental health professionals, mental health practitioners, and case
340.5 managers employed by or under contract to the county to provide mental health services
340.6 are qualified under section 245.4871;

340.7 (12) assure that children's mental health services are coordinated with adult mental
340.8 health services specified in sections 245.461 to 245.486 so that a continuum of mental
340.9 health services is available to serve persons with mental illness, regardless of the person's
340.10 age;

340.11 (13) assure that culturally informed mental health consultants are used as necessary
340.12 to assist the county board in assessing and providing appropriate treatment for children of
340.13 cultural or racial minority heritage; and

340.14 (14) consistent with section 245.486, arrange for or provide a children's mental
340.15 health screening to a child receiving child protective services or a child in out-of-home
340.16 placement, a child for whom parental rights have been terminated, a child found to be
340.17 delinquent, and a child found to have committed a juvenile petty offense for the third
340.18 or subsequent time, unless a screening or diagnostic assessment has been performed
340.19 within the previous 180 days, or the child is currently under the care of a mental health
340.20 professional. The court or county agency must notify a parent or guardian whose
340.21 parental rights have not been terminated of the potential mental health screening and the
340.22 option to prevent the screening by notifying the court or county agency in writing. The
340.23 screening shall be conducted with a screening instrument approved by the commissioner
340.24 of human services according to criteria that are updated and issued annually to ensure
340.25 that approved screening instruments are valid and useful for child welfare and juvenile
340.26 justice populations, and shall be conducted by a mental health practitioner as defined in
340.27 section 245.4871, subdivision 26, or a probation officer or local social services agency
340.28 staff person who is trained in the use of the screening instrument. Training in the use of the
340.29 instrument shall include training in the administration of the instrument, the interpretation
340.30 of its validity given the child's current circumstances, the state and federal data practices
340.31 laws and confidentiality standards, the parental consent requirement, and providing respect
340.32 for families and cultural values. If the screen indicates a need for assessment, the child's
340.33 family, or if the family lacks mental health insurance, the local social services agency,
340.34 in consultation with the child's family, shall have conducted a diagnostic assessment,
340.35 including a functional assessment, as defined in section 245.4871. The administration of
340.36 the screening shall safeguard the privacy of children receiving the screening and their

341.1 families and shall comply with the Minnesota Government Data Practices Act, chapter
341.2 13, and the federal Health Insurance Portability and Accountability Act of 1996, Public
341.3 Law 104-191. Screening results shall be considered private data and the commissioner
341.4 shall not collect individual screening results.

341.5 (b) When the county board refers clients to providers of children's therapeutic
341.6 services and supports under section 256B.0943, the county board must clearly identify
341.7 the desired services components not covered under section 256B.0943 and identify the
341.8 reimbursement source for those requested services, the method of payment, and the
341.9 payment rate to the provider.

341.10 Sec. 12. Minnesota Statutes 2006, section 253B.185, subdivision 2, is amended to read:

341.11 Subd. 2. **Transfer to correctional facility.** (a) If a person has been committed
341.12 under this section and later is committed to the custody of the commissioner of corrections
341.13 for any reason, including but not limited to, being sentenced for a crime or revocation of
341.14 the person's supervised release or conditional release under section 244.05, ~~609.108,~~
341.15 ~~subdivision 6,~~ or 609.109, subdivision 7, the person shall be transferred to a facility
341.16 designated by the commissioner of corrections without regard to the procedures provided
341.17 in section 253B.18.

341.18 (b) If a person is committed under this section after a commitment to the
341.19 commissioner of corrections, the person shall first serve the sentence in a facility
341.20 designated by the commissioner of corrections. After the person has served the sentence,
341.21 the person shall be transferred to a treatment program designated by the commissioner
341.22 of human services.

341.23 Sec. 13. Minnesota Statutes 2006, section 254A.03, subdivision 3, is amended to read:

341.24 Subd. 3. **Rules for chemical dependency care.** The commissioner of human
341.25 services shall establish by rule criteria to be used in determining the appropriate level
341.26 of chemical dependency care, ~~whether outpatient, inpatient or short-term treatment~~
341.27 ~~programs,~~ for each recipient of public assistance seeking treatment for alcohol or other
341.28 drug dependency and abuse problems. ~~The criteria shall address, at least, the family~~
341.29 ~~relationship, past treatment history, medical or physical problems, arrest record, and~~
341.30 ~~employment situation.~~

341.31 Sec. 14. Minnesota Statutes 2006, section 254A.16, subdivision 2, is amended to read:

341.32 Subd. 2. **Program and service guidelines.** (a) The commissioner shall provide
341.33 program and service guidelines and technical assistance to the county boards in carrying

out services authorized under ~~sections~~ section 254A.08, 254A.12, 254A.14, and their
~~responsibilities under chapter 256E.~~

(b) The commissioner shall recommend to the governor means of improving
the efficiency and effectiveness of comprehensive program services in the state and
maximizing the use of nongovernmental funds for providing comprehensive programs.

Sec. 15. **[254A.20] CHEMICAL USE ASSESSMENTS; FINANCIAL CONFLICT**
OF INTEREST.

(a) Except as provided in paragraph (b), an assessor conducting a chemical use
assessment under Minnesota Rules, parts 9530.6600 to 9530.6655, may not have any
direct or shared financial interest or referral relationship resulting in shared financial
interest or referral relationship resulting in shared financial gain with a treatment provider.

(b) A county may contract with an assessor having a conflict described in paragraph
(a) if the county documents that:

(1) the assessor is employed by a culturally specific service provider or a service
provider with a program designed to treat individuals of a specific age, sex, or sexual
preference;

(2) the county does not employ a sufficient number of qualified assessors and the
only qualified assessors available in the county have a direct or shared financial interest or
a referral relationship resulting in shared financial gain with a treatment provider; or

(3) the county social service agency has an existing relationship with an assessor
or service provider and elects to enter into a contract with that assessor to provide both
assessment and treatment under circumstances specified in the county's contract, provided
the county retains responsibility for making placement decisions.

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

Sec. 16. Minnesota Statutes 2006, section 254B.02, subdivision 1, is amended to read:

Subdivision 1. **Chemical dependency treatment allocation.** The chemical
dependency funds appropriated for allocation shall be placed in a special revenue account.
The commissioner shall annually transfer funds from the chemical dependency fund to pay
for operation of the drug and alcohol abuse normative evaluation system and to pay for all
costs incurred by adding two positions for licensing of chemical dependency treatment
and rehabilitation programs located in hospitals for which funds are not otherwise
appropriated. ~~For each year of the biennium ending June 30, 1999, the commissioner shall~~
~~allocate funds to the American Indian chemical dependency tribal account for treatment~~
~~of American Indians by eligible vendors under section 254B.05, equal to the amount~~

343.1 ~~allocated in fiscal year 1997.~~ Six percent of the remaining money must be reserved for
343.2 tribal allocation under section 254B.09, subdivisions 4 and 5. The commissioner shall
343.3 annually divide the money available in the chemical dependency fund that is not held
343.4 in reserve by counties from a previous allocation, or allocated to the American Indian
343.5 chemical dependency tribal account. Six percent of the remaining money must be
343.6 reserved for the nonreservation American Indian chemical dependency allocation for
343.7 treatment of American Indians by eligible vendors under section 254B.05, subdivision
343.8 1. The remainder of the money must be allocated among the counties according to the
343.9 following formula, using state demographer data and other data sources determined by
343.10 the commissioner:

343.11 (a) For purposes of this formula, American Indians and children under age 14 are
343.12 subtracted from the population of each county to determine the restricted population.

343.13 (b) The amount of chemical dependency fund expenditures for entitled persons for
343.14 services not covered by prepaid plans governed by section 256B.69 in the previous year is
343.15 divided by the amount of chemical dependency fund expenditures for entitled persons for
343.16 all services to determine the proportion of exempt service expenditures for each county.

343.17 (c) The prepaid plan months of eligibility is multiplied by the proportion of exempt
343.18 service expenditures to determine the adjusted prepaid plan months of eligibility for
343.19 each county.

343.20 (d) The adjusted prepaid plan months of eligibility is added to the number of
343.21 restricted population fee for service months of eligibility for the Minnesota family
343.22 investment program, general assistance, and medical assistance and divided by the county
343.23 restricted population to determine county per capita months of covered service eligibility.

343.24 (e) The number of adjusted prepaid plan months of eligibility for the state is added
343.25 to the number of fee for service months of eligibility for the Minnesota family investment
343.26 program, general assistance, and medical assistance for the state restricted population and
343.27 divided by the state restricted population to determine state per capita months of covered
343.28 service eligibility.

343.29 (f) The county per capita months of covered service eligibility is divided by the
343.30 state per capita months of covered service eligibility to determine the county welfare
343.31 caseload factor.

343.32 (g) The median married couple income for the most recent three-year period
343.33 available for the state is divided by the median married couple income for the same period
343.34 for each county to determine the income factor for each county.

343.35 (h) The county restricted population is multiplied by the sum of the county welfare
343.36 caseload factor and the county income factor to determine the adjusted population.

344.1 (i) \$15,000 shall be allocated to each county.

344.2 (j) The remaining funds shall be allocated proportional to the county adjusted
344.3 population.

344.4 Sec. 17. Minnesota Statutes 2006, section 254B.02, subdivision 5, is amended to read:

344.5 Subd. 5. **Administrative adjustment.** The commissioner may make payments to
344.6 local agencies from money allocated under this section to support administrative activities
344.7 under sections 254B.03 and 254B.04. The administrative payment must not exceed
344.8 five percent of the first \$50,000, four percent of the next \$50,000, and three percent of
344.9 the remaining payments for services from the allocation. ~~Twenty-five percent of the~~
344.10 ~~administrative allowance shall be advanced at the beginning of each quarter, based on~~
344.11 ~~the payments for services made in the most recent quarter for which data is available.~~
344.12 ~~Adjustment of any overestimate or underestimate based on actual expenditures shall be~~
344.13 ~~made by the state agency by adjusting the administrative allowance for any succeeding~~
344.14 ~~quarter.~~

344.15 Sec. 18. Minnesota Statutes 2006, section 254B.03, subdivision 1, is amended to read:

344.16 Subdivision 1. **Local agency duties.** (a) Every local agency shall provide chemical
344.17 dependency services to persons residing within its jurisdiction who meet criteria
344.18 established by the commissioner for placement in a chemical dependency residential or
344.19 nonresidential treatment service. Chemical dependency money must be administered
344.20 by the local agencies according to law and rules adopted by the commissioner under
344.21 sections 14.001 to 14.69.

344.22 (b) In order to contain costs, the county board shall, with the approval of the
344.23 commissioner of human services, select eligible vendors of chemical dependency services
344.24 who can provide economical and appropriate treatment. Unless the local agency is a social
344.25 services department directly administered by a county or human services board, the local
344.26 agency shall not be an eligible vendor under section 254B.05. The commissioner may
344.27 approve proposals from county boards to provide services in an economical manner or to
344.28 control utilization, with safeguards to ensure that necessary services are provided. If a
344.29 county implements a demonstration or experimental medical services funding plan, the
344.30 commissioner shall transfer the money as appropriate. If a county selects a vendor located
344.31 in another state, the county shall ensure that the vendor is in compliance with the rules
344.32 governing licensure of programs located in the state.

344.33 ~~(c) The calendar year 2002 rate for vendors may not increase more than three~~
344.34 ~~percent above the rate approved in effect on January 1, 2001. The calendar year 2003~~

~~rate for vendors may not increase more than three percent above the rate in effect on January 1, 2002. The calendar years 2004 and 2005 rates may not exceed the rate in effect on January 1, 2003.~~

~~(d)~~ (c) A culturally specific vendor that provides assessments under a variance under Minnesota Rules, part 9530.6610, shall be allowed to provide assessment services to persons not covered by the variance.

Sec. 19. Minnesota Statutes 2006, section 254B.03, subdivision 3, is amended to read:

Subd. 3. **Local agencies to pay state for county share.** ~~Local agencies shall submit invoices to the state on forms supplied by the commissioner and according to procedures established by the commissioner. Local agencies shall pay the state for the county share of the invoiced services authorized by the local agency. Payments shall be made at the beginning of each month for services provided in the previous month. The commissioner shall bill the county monthly for services, based on the most recent month for which expenditure information is available. Adjustment of any overestimate or underestimate based on actual expenditures shall be made by the state agency by adjusting the estimate for any succeeding month.~~

Sec. 20. Minnesota Statutes 2006, section 254B.06, subdivision 3, is amended to read:

Subd. 3. **Payment; denial.** The commissioner shall pay eligible vendors for placements made by local agencies under section 254B.03, subdivision 1, and placements by tribal designated agencies according to section 254B.09. The commissioner may reduce or deny payment of the state share when services are not provided according to the placement criteria established by the commissioner. The commissioner may pay for all or a portion of improper county chemical dependency placements and bill the county for the entire payment made when the placement did not comply with criteria established by the commissioner. The commissioner may make payments to vendors and charge the county 100 percent of the payments if documentation of a county approved placement is received more than 30 working days, exclusive of weekends and holidays, after the date services began; ~~or if the county approved invoice is received by the commissioner more than 120 days after the last date of service provided.~~ The commissioner shall not pay vendors until private insurance company claims have been settled.

Sec. 21. Minnesota Statutes 2006, section 256.01, is amended by adding a subdivision to read:

346.1 Subd. 25. **Base budget detail.** The commissioner shall provide the commissioner
346.2 of finance with the information necessary to provide base budget detail to the legislature
346.3 under section 16A.10, subdivision 2a.

346.4 Sec. 22. Minnesota Statutes 2006, section 256B.0625, subdivision 23, is amended to
346.5 read:

346.6 Subd. 23. **Day treatment services.** Medical assistance covers day treatment
346.7 services as specified in sections 245.462, subdivision 8, and 245.4871, subdivision 10, that
346.8 are provided under contract with the county board. Notwithstanding Minnesota Rules,
346.9 part 9505.0323, subpart 15, the commissioner may set authorization thresholds for day
346.10 treatment for adults according to section 256B.0625, subdivision 25. Notwithstanding
346.11 Minnesota Rules, part 9505.0323, subpart 15, effective July 1, 2004, medical assistance
346.12 covers day treatment services for children as specified under section 256B.0943.

346.13 Sec. 23. **[256B.0636] PRESCRIBING OF CONTROLLED SUBSTANCES;**
346.14 **ABUSE PREVENTION.**

346.15 The commissioner shall develop and implement a plan to:

346.16 (1) monitor the prescribing of controlled substances listed in section 152.02,
346.17 subdivisions 3 and 4, and those substances defined by the Board of Pharmacy under
346.18 section 152.02, subdivisions 8 and 12, by enrolled providers and providers under contract
346.19 with participating managed care plans;

346.20 (2) require enrolled providers and providers under contract with participating
346.21 managed care plans to report information related to potential patient abuse of the
346.22 controlled substances to the commissioner, and the Board of Pharmacy; and

346.23 (3) provide education to Minnesota health care program enrollees on the proper use
346.24 of controlled substances.

346.25 Sec. 24. Minnesota Statutes 2006, section 256B.0943, subdivision 6, is amended to
346.26 read:

346.27 Subd. 6. **Provider entity clinical infrastructure requirements.** (a) To be
346.28 an eligible provider entity under this section, a provider entity must have a clinical
346.29 infrastructure that utilizes diagnostic assessment, an individualized treatment plan,
346.30 service delivery, and individual treatment plan review that are culturally competent,
346.31 child-centered, and family-driven to achieve maximum benefit for the client. The provider
346.32 entity must review and update the clinical policies and procedures every three years and

347.1 must distribute the policies and procedures to staff initially and upon each subsequent
347.2 update.

347.3 (b) The clinical infrastructure written policies and procedures must include policies
347.4 and procedures for:

347.5 (1) providing or obtaining a client's diagnostic assessment that identifies acute and
347.6 chronic clinical disorders, co-occurring medical conditions, sources of psychological and
347.7 environmental problems, and a functional assessment. The functional assessment must
347.8 clearly summarize the client's individual strengths and needs;

347.9 (2) developing an individual treatment plan that is:

347.10 (i) based on the information in the client's diagnostic assessment;

347.11 (ii) developed no later than the end of the first psychotherapy session after the
347.12 completion of the client's diagnostic assessment by the mental health professional who
347.13 provides the client's psychotherapy;

347.14 (iii) developed through a child-centered, family-driven planning process that
347.15 identifies service needs and individualized, planned, and culturally appropriate
347.16 interventions that contain specific treatment goals and objectives for the client and the
347.17 client's family or foster family;

347.18 (iv) reviewed at least once every 90 days and revised, if necessary; and

347.19 (v) signed by the client or, if appropriate, by the client's parent or other person
347.20 authorized by statute to consent to mental health services for the client;

347.21 (3) developing an individual behavior plan that documents services to be provided
347.22 by the mental health behavioral aide. The individual behavior plan must include:

347.23 (i) detailed instructions on the service to be provided;

347.24 (ii) time allocated to each service;

347.25 (iii) methods of documenting the child's behavior;

347.26 (iv) methods of monitoring the child's progress in reaching objectives; and

347.27 (v) goals to increase or decrease targeted behavior as identified in the individual
347.28 treatment plan;

347.29 (4) clinical supervision of the mental health practitioner and mental health behavioral
347.30 aide. A mental health professional must document the clinical supervision the professional
347.31 provides by cosigning individual treatment plans and making entries in the client's record
347.32 on supervisory activities. Clinical supervision does not include the authority to make or
347.33 terminate court-ordered placements of the child. A clinical supervisor must be available
347.34 for urgent consultation as required by the individual client's needs or the situation. Clinical
347.35 supervision may occur individually or in a small group to discuss treatment and review
347.36 progress toward goals. The focus of clinical supervision must be the client's treatment

348.1 needs and progress and the mental health practitioner's or behavioral aide's ability to
348.2 provide services;

348.3 (4a) CTSS certified provider entities providing day treatment programs must meet
348.4 the conditions in items (i) to (iii):

348.5 (i) the ~~provider~~ supervisor must be present and available on the premises more
348.6 than 50 percent of the time in a five-working-day period during which the supervisee is
348.7 providing a mental health service;

348.8 (ii) the diagnosis and the client's individual treatment plan or a change in the
348.9 diagnosis or individual treatment plan must be made by or reviewed, approved, and signed
348.10 by the ~~provider~~ supervisor; and

348.11 (iii) every 30 days, the supervisor must review and sign the record of the client's care
348.12 for all activities in the preceding 30-day period;

348.13 (4b) for all other services provided under CTSS, clinical supervision standards
348.14 provided in items (i) to (iii) must be used:

348.15 (i) medical assistance shall reimburse a mental health practitioner who maintains a
348.16 consulting relationship with a mental health professional who accepts full professional
348.17 responsibility and is present on site for at least one observation during the first 12 hours
348.18 in which the mental health practitioner provides the individual, family, or group skills
348.19 training to the child or the child's family;

348.20 (ii) thereafter, the mental health professional is required to be present on site for
348.21 observation as clinically appropriate when the mental health practitioner is providing
348.22 individual, family, or group skills training to the child or the child's family; and

348.23 (iii) the observation must be a minimum of one clinical unit. The on-site presence of
348.24 the mental health professional must be documented in the child's record and signed by the
348.25 mental health professional who accepts full professional responsibility;

348.26 (5) providing direction to a mental health behavioral aide. For entities that employ
348.27 mental health behavioral aides, the clinical supervisor must be employed by the provider
348.28 entity or other certified children's therapeutic supports and services provider entity to
348.29 ensure necessary and appropriate oversight for the client's treatment and continuity
348.30 of care. The mental health professional or mental health practitioner giving direction
348.31 must begin with the goals on the individualized treatment plan, and instruct the mental
348.32 health behavioral aide on how to construct therapeutic activities and interventions that
348.33 will lead to goal attainment. The professional or practitioner giving direction must also
348.34 instruct the mental health behavioral aide about the client's diagnosis, functional status,
348.35 and other characteristics that are likely to affect service delivery. Direction must also
348.36 include determining that the mental health behavioral aide has the skills to interact with

349.1 the client and the client's family in ways that convey personal and cultural respect and
349.2 that the aide actively solicits information relevant to treatment from the family. The aide
349.3 must be able to clearly explain the activities the aide is doing with the client and the
349.4 activities' relationship to treatment goals. Direction is more didactic than is supervision
349.5 and requires the professional or practitioner providing it to continuously evaluate the
349.6 mental health behavioral aide's ability to carry out the activities of the individualized
349.7 treatment plan and the individualized behavior plan. When providing direction, the
349.8 professional or practitioner must:

349.9 (i) review progress notes prepared by the mental health behavioral aide for accuracy
349.10 and consistency with diagnostic assessment, treatment plan, and behavior goals and the
349.11 professional or practitioner must approve and sign the progress notes;

349.12 (ii) identify changes in treatment strategies, revise the individual behavior plan,
349.13 and communicate treatment instructions and methodologies as appropriate to ensure
349.14 that treatment is implemented correctly;

349.15 (iii) demonstrate family-friendly behaviors that support healthy collaboration among
349.16 the child, the child's family, and providers as treatment is planned and implemented;

349.17 (iv) ensure that the mental health behavioral aide is able to effectively communicate
349.18 with the child, the child's family, and the provider; and

349.19 (v) record the results of any evaluation and corrective actions taken to modify the
349.20 work of the mental health behavioral aide;

349.21 (6) providing service delivery that implements the individual treatment plan and
349.22 meets the requirements under subdivision 9; and

349.23 (7) individual treatment plan review. The review must determine the extent to which
349.24 the services have met the goals and objectives in the previous treatment plan. The review
349.25 must assess the client's progress and ensure that services and treatment goals continue to
349.26 be necessary and appropriate to the client and the client's family or foster family. Revision
349.27 of the individual treatment plan does not require a new diagnostic assessment unless the
349.28 client's mental health status has changed markedly. The updated treatment plan must be
349.29 signed by the client, if appropriate, and by the client's parent or other person authorized by
349.30 statute to give consent to the mental health services for the child.

349.31 Sec. 25. Minnesota Statutes 2006, section 256B.0943, subdivision 9, is amended to
349.32 read:

349.33 Subd. 9. **Service delivery criteria.** (a) In delivering services under this section, a
349.34 certified provider entity must ensure that:

(1) each individual provider's caseload size permits the provider to deliver services to both clients with severe, complex needs and clients with less intensive needs. The provider's caseload size should reasonably enable the provider to play an active role in service planning, monitoring, and delivering services to meet the client's and client's family's needs, as specified in each client's individual treatment plan;

(2) site-based programs, including day treatment and preschool programs, provide staffing and facilities to ensure the client's health, safety, and protection of rights, and that the programs are able to implement each client's individual treatment plan;

(3) a day treatment program is provided to a group of clients by a multidisciplinary team under the clinical supervision of a mental health professional. The day treatment program must be provided in and by: (i) an outpatient hospital accredited by the Joint Commission on Accreditation of Health Organizations and licensed under sections 144.50 to 144.55; (ii) a community mental health center under section 245.62; and (iii) an entity that is under contract with the county board to operate a program that meets the requirements of sections 245.4712, subdivision 2, and 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475. The day treatment program must stabilize the client's mental health status while developing and improving the client's independent living and socialization skills. The goal of the day treatment program must be to reduce or relieve the effects of mental illness and provide training to enable the client to live in the community. The program must be available at least one day a week for a ~~minimum~~ three-hour time block. The three-hour time block must include at least one hour, but no more than two hours, of individual or group psychotherapy. The remainder of the three-hour time block may include recreation therapy, socialization therapy, or independent living skills therapy, but only if the therapies are included in the client's individual treatment plan. Day treatment programs are not part of inpatient or residential treatment services; and

(4) a preschool program is a structured treatment program offered to a child who is at least 33 months old, but who has not yet reached the first day of kindergarten, by a preschool multidisciplinary team in a day program licensed under Minnesota Rules, parts 9503.0005 to 9503.0175. The program must be available at least one day a week for a minimum two-hour time block. The structured treatment program may include individual or group psychotherapy and recreation therapy, socialization therapy, or independent living skills therapy, if included in the client's individual treatment plan.

(b) A provider entity must deliver the service components of children's therapeutic services and supports in compliance with the following requirements:

351.1 (1) individual, family, and group psychotherapy must be delivered as specified in
351.2 Minnesota Rules, part 9505.0323;

351.3 (2) individual, family, or group skills training must be provided by a mental health
351.4 professional or a mental health practitioner who has a consulting relationship with a
351.5 mental health professional who accepts full professional responsibility for the training;

351.6 (3) crisis assistance must be time-limited and designed to resolve or stabilize crisis
351.7 through arrangements for direct intervention and support services to the child and the
351.8 child's family. Crisis assistance must utilize resources designed to address abrupt or
351.9 substantial changes in the functioning of the child or the child's family as evidenced by
351.10 a sudden change in behavior with negative consequences for well being, a loss of usual
351.11 coping mechanisms, or the presentation of danger to self or others;

351.12 (4) medically necessary services that are provided by a mental health behavioral
351.13 aide must be designed to improve the functioning of the child and support the family in
351.14 activities of daily and community living. A mental health behavioral aide must document
351.15 the delivery of services in written progress notes. The mental health behavioral aide
351.16 must implement goals in the treatment plan for the child's emotional disturbance that
351.17 allow the child to acquire developmentally and therapeutically appropriate daily living
351.18 skills, social skills, and leisure and recreational skills through targeted activities. These
351.19 activities may include:

351.20 (i) assisting a child as needed with skills development in dressing, eating, and
351.21 toileting;

351.22 (ii) assisting, monitoring, and guiding the child to complete tasks, including
351.23 facilitating the child's participation in medical appointments;

351.24 (iii) observing the child and intervening to redirect the child's inappropriate behavior;

351.25 (iv) assisting the child in using age-appropriate self-management skills as related
351.26 to the child's emotional disorder or mental illness, including problem solving, decision
351.27 making, communication, conflict resolution, anger management, social skills, and
351.28 recreational skills;

351.29 (v) implementing deescalation techniques as recommended by the mental health
351.30 professional;

351.31 (vi) implementing any other mental health service that the mental health professional
351.32 has approved as being within the scope of the behavioral aide's duties; or

351.33 (vii) assisting the parents to develop and use parenting skills that help the child
351.34 achieve the goals outlined in the child's individual treatment plan or individual behavioral
351.35 plan. Parenting skills must be directed exclusively to the child's treatment; and

351.36 (5) direction of a mental health behavioral aide must include the following:

(i) a total of one hour of on-site observation by a mental health professional during the first 12 hours of service provided to a child;

(ii) ongoing on-site observation by a mental health professional or mental health practitioner for at least a total of one hour during every 40 hours of service provided to a child; and

(iii) immediate accessibility of the mental health professional or mental health practitioner to the mental health behavioral aide during service provision.

Sec. 26. Minnesota Statutes 2006, section 256B.0943, subdivision 11, is amended to read:

Subd. 11. **Documentation and billing.** (a) A provider entity must document the services it provides under this section. The provider entity must ensure that the entity's documentation standards meet the requirements of federal and state laws. Services billed under this section that are not documented according to this subdivision shall be subject to monetary recovery by the commissioner. The provider entity may not bill for anything other than direct service time.

(b) An individual mental health provider must promptly document the following in a client's record after providing services to the client:

(1) each occurrence of the client's mental health service, including the date, type, length, and scope of the service;

(2) the name of the person who gave the service;

(3) contact made with other persons interested in the client, including representatives of the courts, corrections systems, or schools. The provider must document the name and date of each contact;

(4) any contact made with the client's other mental health providers, case manager, family members, primary caregiver, legal representative, or the reason the provider did not contact the client's family members, primary caregiver, or legal representative, if applicable; and

(5) required clinical supervision, as appropriate.

Sec. 27. Minnesota Statutes 2006, section 256B.0943, subdivision 12, is amended to read:

Subd. 12. **Excluded services.** The following services are not eligible for medical assistance payment as children's therapeutic services and supports:

353.1 (1) service components of children's therapeutic services and supports
353.2 simultaneously provided by more than one provider entity unless prior authorization is
353.3 obtained;

353.4 (2) children's therapeutic services and supports provided in violation of medical
353.5 assistance policy in Minnesota Rules, part 9505.0220;

353.6 (3) mental health behavioral aide services provided by a personal care assistant who
353.7 is not qualified as a mental health behavioral aide and employed by a certified children's
353.8 therapeutic services and supports provider entity;

353.9 (4) service components of CTSS that are the responsibility of a residential or
353.10 program license holder, including foster care providers under the terms of a service
353.11 agreement or administrative rules governing licensure; ~~and~~

353.12 (5) adjunctive activities that may be offered by a provider entity but are not
353.13 otherwise covered by medical assistance, including:

353.14 (i) a service that is primarily recreation oriented or that is provided in a setting that
353.15 is not medically supervised. This includes sports activities, exercise groups, activities
353.16 such as craft hours, leisure time, social hours, meal or snack time, trips to community
353.17 activities, and tours;

353.18 (ii) a social or educational service that does not have or cannot reasonably be
353.19 expected to have a therapeutic outcome related to the client's emotional disturbance;

353.20 (iii) consultation with other providers or service agency staff about the care or
353.21 progress of a client;

353.22 (iv) prevention or education programs provided to the community; and

353.23 (v) treatment for clients with primary diagnoses of alcohol or other drug abuse; and

353.24 (6) activities that are not direct service time.

353.25 Sec. 28. **[256B.764] REIMBURSEMENT FOR FAMILY PLANNING SERVICES.**

353.26 Effective for services rendered on or after July 1, 2007, payment rates for family
353.27 planning services shall be increased by 25 percent over the rates in effect July 30, 2007,
353.28 when these services are provided by a community clinic as defined in section 145.9268,
353.29 subdivision 1.

353.30 Sec. 29. Minnesota Statutes 2006, section 256E.35, subdivision 2, is amended to read:

353.31 Subd. 2. **Definitions.** (a) The definitions in this subdivision apply to this section.

353.32 (b) "Family asset account" means a savings account opened by a household
353.33 participating in the Minnesota family assets for independence initiative.

353.34 (c) "Fiduciary organization" means:

354.1 (1) a community action agency that has obtained recognition under section ~~268.53~~
354.2 256E.31;

354.3 (2) a federal community development credit union serving the seven-county
354.4 metropolitan area; or

354.5 (3) a women-oriented economic development agency serving the seven-county
354.6 metropolitan area.

354.7 (d) "Financial institution" means a bank, bank and trust, savings bank, savings
354.8 association, or credit union, the deposits of which are insured by the Federal Deposit
354.9 Insurance Corporation or the National Credit Union Administration.

354.10 (e) "Permissible use" means:

354.11 (1) postsecondary educational expenses at an accredited public postsecondary
354.12 institution including books, supplies, and equipment required for courses of instruction;

354.13 (2) acquisition costs of acquiring, constructing, or reconstructing a residence,
354.14 including any usual or reasonable settlement, financing, or other closing costs;

354.15 (3) business capitalization expenses for expenditures on capital, plant, equipment,
354.16 working capital, and inventory expenses of a legitimate business pursuant to a business
354.17 plan approved by the fiduciary organization; and

354.18 (4) acquisition costs of a principal residence within the meaning of section 1034 of
354.19 the Internal Revenue Code of 1986 which do not exceed 100 percent of the average area
354.20 purchase price applicable to the residence determined according to section 143(e)(2) and
354.21 (3) of the Internal Revenue Code of 1986.

354.22 (f) "Household" means all individuals who share use of a dwelling unit as primary
354.23 quarters for living and eating separate from other individuals.

354.24 Sec. 30. [525A.01] SHORT TITLE.

354.25 This chapter may be cited as the "Darlene Luther Revised Uniform Anatomical
354.26 Gift Act."

354.27 Sec. 31. [525A.02] DEFINITIONS.

354.28 Subdivision 1. Scope. The definitions in this section apply to this chapter.

354.29 Subd. 2. Adult. "Adult" means an individual who is at least 18 years of age.

354.30 Subd. 3. Agent. "Agent" means an individual who is:

354.31 (1) authorized to make health care decisions on the principal's behalf by a power of
354.32 attorney for health care; or

354.33 (2) expressly authorized to make an anatomical gift on the principal's behalf by
354.34 any other record signed by the principal.

355.1 Subd. 4. **Anatomical gift.** "Anatomical gift" means a donation of all or part of
355.2 a human body to take effect after the donor's death for the purpose of transplantation,
355.3 therapy, research, or education.

355.4 Subd. 5. **Decedent.** "Decedent" means a deceased individual and includes a stillborn
355.5 infant or an embryo or fetus that has died of natural causes in utero.

355.6 Subd. 6. **Disinterested witness.** "Disinterested witness" means a witness other than
355.7 the spouse, child, parent, sibling, grandchild, grandparent, or guardian of the individual
355.8 who makes, amends, revokes, or refuses to make an anatomical gift, or another adult who
355.9 exhibited special care and concern for the individual. The term does not include a person
355.10 to which an anatomical gift could pass under section 525A.11.

355.11 Subd. 7. **Document of gift.** "Document of gift" means a donor card or other record
355.12 used to make an anatomical gift. The term includes a statement or symbol on a driver's
355.13 license, identification card, or donor registry.

355.14 Subd. 8. **Donor.** "Donor" means an individual whose body or part is the subject of
355.15 an anatomical gift.

355.16 Subd. 9. **Donor registry.** "Donor registry" means a database that contains records
355.17 of anatomical gifts and amendments to or revocations of anatomical gifts.

355.18 Subd. 10. **Driver's license.** "Driver's license" means a license or permit issued
355.19 under chapter 171 to operate a vehicle, whether or not conditions are attached to the
355.20 license or permit.

355.21 Subd. 11. **Eye bank.** "Eye bank" means a person that is licensed, accredited,
355.22 or regulated under federal or state law to engage in the recovery, screening, testing,
355.23 processing, storage, or distribution of human eyes or portions of human eyes.

355.24 Subd. 12. **Guardian.** "Guardian" means a person appointed by a court to make
355.25 decisions regarding the support, care, education, health, or welfare of an individual. The
355.26 term does not include a guardian ad litem.

355.27 Subd. 13. **Hospital.** "Hospital" means a facility licensed as a hospital under the
355.28 law of any state or a facility operated as a hospital by the United States, a state, or a
355.29 subdivision of a state.

355.30 Subd. 14. **Identification card.** "Identification card" means a Minnesota
355.31 identification card issued under chapter 171.

355.32 Subd. 15. **Know.** "Know" means to have actual knowledge.

355.33 Subd. 16. **Medical examiner.** "Medical examiner" includes coroner.

355.34 Subd. 17. **Minor.** "Minor" means an individual who is under 18 years of age.

356.1 Subd. 18. **Organ procurement organization.** "Organ procurement organization"
356.2 means a person designated by the secretary of the United States Department of Health and
356.3 Human Services as an organ procurement organization.

356.4 Subd. 19. **Parent.** "Parent" means a parent whose parental rights have not been
356.5 terminated.

356.6 Subd. 20. **Part.** "Part" means an organ, an eye, or tissue of a human being. The term
356.7 does not include the whole body.

356.8 Subd. 21. **Person.** "Person" means an individual, corporation, business trust, estate,
356.9 trust, partnership, limited liability company, association, joint venture, public corporation,
356.10 government or governmental subdivision, agency, or instrumentality, or any other legal or
356.11 commercial entity.

356.12 Subd. 22. **Physician.** "Physician" means an individual authorized to practice
356.13 medicine or osteopathy under the law of any state.

356.14 Subd. 23. **Procurement organization.** "Procurement organization" means an eye
356.15 bank, organ procurement organization, or tissue bank.

356.16 Subd. 24. **Prospective donor.** "Prospective donor" means an individual who is dead
356.17 or near death and has been determined by a procurement organization to have a part that
356.18 could be medically suitable for transplantation, therapy, research, or education. The term
356.19 does not include an individual who has made a refusal.

356.20 Subd. 25. **Reasonably available.** "Reasonably available" means able to be
356.21 contacted by a procurement organization without undue effort and willing and able to act
356.22 in a timely manner consistent with existing medical criteria necessary for the making of
356.23 an anatomical gift.

356.24 Subd. 26. **Recipient.** "Recipient" means an individual into whose body a decedent's
356.25 part has been or is intended to be transplanted.

356.26 Subd. 27. **Record.** "Record" means information that is inscribed on a tangible
356.27 medium or that is stored in an electronic or other medium and is retrievable in perceivable
356.28 form.

356.29 Subd. 28. **Refusal.** "Refusal" means a record created under section 525A.07 that
356.30 expressly states an intent to bar other persons from making an anatomical gift of an
356.31 individual's body or part.

356.32 Subd. 29. **Sign.** "Sign" means, with the present intent to authenticate or adopt
356.33 a record:

356.34 (1) to execute or adopt a tangible symbol; or

356.35 (2) to attach to or logically associate with the record an electronic symbol, sound,
356.36 or process.

357.1 Subd. 30. **State.** "State" means a state of the United States, the District of Columbia,
357.2 Puerto Rico, the United States Virgin Islands, or any territory or insular possession subject
357.3 to the jurisdiction of the United States.

357.4 Subd. 31. **Technician.** "Technician" means an individual determined to be qualified
357.5 to remove or process parts by an appropriate organization that is licensed, accredited, or
357.6 regulated under federal or state law. The term includes an enucleator.

357.7 Subd. 32. **Tissue.** "Tissue" means a portion of the human body other than an organ
357.8 or an eye. The term does not include blood unless the blood is donated for the purpose
357.9 of research or education.

357.10 Subd. 33. **Tissue bank.** "Tissue bank" means a person that is licensed, accredited,
357.11 or regulated under federal or state law to engage in the recovery, screening, testing,
357.12 processing, storage, or distribution of tissue.

357.13 Subd. 34. **Transplant hospital.** "Transplant hospital" means a hospital that
357.14 furnishes organ transplants and other medical and surgical specialty services required
357.15 for the care of transplant patients.

357.16 Sec. 32. **[525A.03] APPLICABILITY.**

357.17 This chapter applies to an anatomical gift or amendment to, revocation of, or refusal
357.18 to make an anatomical gift, whenever made.

357.19 Sec. 33. **[525A.04] WHO MAY MAKE ANATOMICAL GIFT BEFORE**
357.20 **DONOR'S DEATH.**

357.21 Subject to section 525A.08, an anatomical gift of a donor's body or part may be
357.22 made during the life of the donor for the purpose of transplantation, therapy, research, or
357.23 education in the manner provided in section 525A.05 by:

357.24 (1) the donor, if the donor is an adult or if the donor is a minor and is:

357.25 (i) emancipated; or

357.26 (ii) authorized under state law to apply for a driver's license because the donor is
357.27 at least 16 years of age;

357.28 (2) an agent of the donor, unless the power of attorney for health care or other record
357.29 prohibits the agent from making an anatomical gift;

357.30 (3) a parent of the donor, if the donor is an unemancipated minor; or

357.31 (4) the donor's guardian.

357.32 Sec. 34. **[525A.05] MANNER OF MAKING ANATOMICAL GIFT BEFORE**
357.33 **DONOR'S DEATH.**

- 358.1 (a) A donor may make an anatomical gift:
- 358.2 (1) by authorizing a statement or symbol indicating that the donor has made an
- 358.3 anatomical gift to be imprinted on the donor's driver's license or identification card;
- 358.4 (2) in a will;
- 358.5 (3) during a terminal illness or injury of the donor, by any form of communication
- 358.6 addressed to at least two adults, at least one of whom is a disinterested witness; or
- 358.7 (4) as provided in paragraph (b).
- 358.8 (b) A donor or other person authorized to make an anatomical gift under section
- 358.9 525A.04 may make a gift by a donor card or other record signed by the donor or other
- 358.10 person making the gift or by authorizing that a statement or symbol indicating that the
- 358.11 donor has made an anatomical gift be included on a donor registry. If the donor or
- 358.12 other person is physically unable to sign a record, the record may be signed by another
- 358.13 individual at the direction of the donor or other person and must:
- 358.14 (1) be witnessed by at least two adults, at least one of whom is a disinterested
- 358.15 witness, who have signed at the request of the donor or the other person; and
- 358.16 (2) state that it has been signed and witnessed as provided in clause (1).
- 358.17 (c) Revocation, suspension, expiration, or cancellation of a driver's license or
- 358.18 identification card upon which an anatomical gift is indicated does not invalidate the gift.
- 358.19 (d) An anatomical gift made by will takes effect upon the donor's death whether or
- 358.20 not the will is probated. Invalidation of the will after the donor's death does not invalidate
- 358.21 the gift.
- 358.22 (e) The making of an anatomical gift shall not itself authorize or direct the denial
- 358.23 of health care.

358.24 **Sec. 35. [525A.06] AMENDING OR REVOKING ANATOMICAL GIFT**

358.25 **BEFORE DONOR'S DEATH.**

- 358.26 (a) Subject to section 525A.08, a donor or other person authorized to make an
- 358.27 anatomical gift under section 525A.04 may amend or revoke an anatomical gift by:
- 358.28 (1) a record signed by:
- 358.29 (i) the donor;
- 358.30 (ii) the other person; or
- 358.31 (iii) subject to paragraph (b), another individual acting at the direction of the donor
- 358.32 or the other person if the donor or other person is physically unable to sign; or
- 358.33 (2) a later-executed document of gift that amends or revokes a previous anatomical
- 358.34 gift or portion of an anatomical gift, either expressly or by inconsistency.
- 358.35 (b) A record signed pursuant to paragraph (a), clause (1), item (iii), must:

(1) be witnessed by at least two adults, at least one of whom is a disinterested witness, who have signed at the request of the donor or the other person; and

(2) state that it has been signed and witnessed as provided in clause (1).

(c) Subject to section 525A.08, a donor or other person authorized to make an anatomical gift under section 525A.04 may revoke an anatomical gift by the destruction or cancellation of the document of gift, or the portion of the document of gift used to make the gift, with the intent to revoke the gift.

(d) A donor may amend or revoke an anatomical gift that was not made in a will by any form of communication during a terminal illness or injury addressed to at least two adults, at least one of whom is a disinterested witness.

(e) A donor who makes an anatomical gift in a will may amend or revoke the gift in the manner provided for amendment or revocation of wills or as provided in paragraph (a).

Sec. 36. **[525A.07] REFUSAL TO MAKE ANATOMICAL GIFT; EFFECT OF REFUSAL.**

(a) An individual may refuse to make an anatomical gift of the individual's body or part by:

(1) a record signed by:

(i) the individual; or

(ii) subject to paragraph (b), another individual acting at the direction of the individual if the individual is physically unable to sign;

(2) the individual's will, whether or not the will is admitted to probate or invalidated after the individual's death; or

(3) any form of communication made by the individual during the individual's terminal illness or injury addressed to at least two adults, at least one of whom is a disinterested witness.

(b) A record signed pursuant to paragraph (a), clause (1), item (ii), must:

(1) be witnessed by at least two adults, at least one of whom is a disinterested witness, who have signed at the request of the individual; and

(2) state that it has been signed and witnessed as provided in clause (1).

(c) An individual who has made a refusal may amend or revoke the refusal:

(1) in the manner provided in paragraph (a) for making a refusal;

(2) by subsequently making an anatomical gift pursuant to section 525A.05 that is inconsistent with the refusal; or

(3) by destroying or canceling the record evidencing the refusal, or the portion of the record used to make the refusal, with the intent to revoke the refusal.

(d) Except as otherwise provided in section 525A.08, paragraph (h), in the absence of an express, contrary indication by the individual set forth in the refusal, an individual's unrevoked refusal to make an anatomical gift of the individual's body or part bars all other persons from making an anatomical gift of the individual's body or part.

Sec. 37. **[525A.08] PRECLUSIVE EFFECT OF ANATOMICAL GIFT, AMENDMENT, OR REVOCATION.**

(a) Except as otherwise provided in paragraph (g) and subject to paragraph (f), in the absence of an express, contrary indication by the donor, a person other than the donor is barred from making, amending, or revoking an anatomical gift of a donor's body or part if the donor made an anatomical gift of the donor's body or part under section 525A.05 or an amendment to an anatomical gift of the donor's body or part under section 525A.06. An anatomical gift made in a will, a designation on a driver's license or identification card, or a health care directive under chapter 145C, and not revoked, establishes the intent of the person making the designation and may not be overridden by any other person.

(b) A donor's revocation of an anatomical gift of the donor's body or part under section 525A.06 is not a refusal and does not bar another person specified in section 525A.04 or 525A.09 from making an anatomical gift of the donor's body or part under section 525A.05 or 525A.10.

(c) If a person other than the donor makes an unrevoked anatomical gift of the donor's body or part under section 525A.05 or an amendment to an anatomical gift of the donor's body or part under section 525A.06, another person may not make, amend, or revoke the gift of the donor's body or part under section 525A.10.

(d) A revocation of an anatomical gift of a donor's body or part under section 525A.06 by a person other than the donor does not bar another person from making an anatomical gift of the body or part under section 525A.05 or 525A.10.

(e) In the absence of an express, contrary indication by the donor or other person authorized to make an anatomical gift under section 525A.04, an anatomical gift of a part is neither a refusal to give another part nor a limitation on the making of an anatomical gift of another part at a later time by the donor or another person.

(f) In the absence of an express, contrary indication by the donor or other person authorized to make an anatomical gift under section 525A.04, an anatomical gift of a part for one or more of the purposes set forth in section 525A.04 is not a limitation on the making of an anatomical gift of the part for any of the other purposes by the donor or any other person under section 525A.05 or 525A.10.

361.1 (g) If a donor who is an unemancipated minor dies, a parent of the donor who is
361.2 reasonably available may revoke or amend an anatomical gift of the donor's body or part.

361.3 (h) If an unemancipated minor who signed a refusal dies, a parent of the minor who
361.4 is reasonably available may revoke the minor's refusal.

361.5 Sec. 38. **[525A.09] WHO MAY MAKE ANATOMICAL GIFT OF DECEDENT'S**
361.6 **BODY OR PART.**

361.7 (a) Subject to paragraphs (b) and (c) and unless barred by section 525A.07 or
361.8 525A.08, an anatomical gift of a decedent's body or part for the purpose of transplantation,
361.9 therapy, research, or education may be made by any member of the following classes of
361.10 persons who is reasonably available, in the order of priority listed:

361.11 (1) an agent of the decedent at the time of death who could have made an anatomical
361.12 gift under section 525A.04, clause (2), immediately before the decedent's death;

361.13 (2) the spouse of the decedent;

361.14 (3) adult children of the decedent;

361.15 (4) parents of the decedent;

361.16 (5) adult siblings of the decedent;

361.17 (6) adult grandchildren of the decedent;

361.18 (7) grandparents of the decedent;

361.19 (8) an adult who exhibited special care and concern for the decedent;

361.20 (9) the persons who were acting as the guardians of the person of the decedent
361.21 at the time of death; and

361.22 (10) any other person having the authority to dispose of the decedent's body.

361.23 (b) If there is more than one member of a class listed in paragraph (a), clause (1),
361.24 (3), (4), (5), (6), (7), or (9), entitled to make an anatomical gift, an anatomical gift may
361.25 be made by a member of the class unless that member or a person to which the gift may
361.26 pass under section 525A.11 knows of an objection by another member of the class. If
361.27 an objection is known, the gift may be made only by a majority of the members of the
361.28 class who are reasonably available.

361.29 (c) A person may not make an anatomical gift if, at the time of the decedent's death,
361.30 a person in a prior class under paragraph (a) is reasonably available to make or to object to
361.31 the making of an anatomical gift.

361.32 Sec. 39. **[525A.10] MANNER OF MAKING, AMENDING, OR REVOKING**
361.33 **ANATOMICAL GIFT OF DECEDENT'S BODY OR PART.**

(a) A person authorized to make an anatomical gift under section 525A.09 may make an anatomical gift by a document of gift signed by the person making the gift or by that person's oral communication that is electronically recorded or is contemporaneously reduced to a record and signed by the individual receiving the oral communication.

(b) Subject to paragraph (c), an anatomical gift by a person authorized under section 525A.09 may be amended or revoked orally or in a record by any member of a prior class who is reasonably available. If more than one member of the prior class is reasonably available, the gift made by a person authorized under section 525A.09 may be:

(1) amended only if a majority of the reasonably available members agree to the amending of the gift; or

(2) revoked only if a majority of the reasonably available members agree to the revoking of the gift or if they are equally divided as to whether to revoke the gift.

(c) A revocation under paragraph (b) is effective only if, before an incision has been made to remove a part from the donor's body or before invasive procedures have begun to prepare the recipient, the procurement organization, transplant hospital, or physician or technician knows of the revocation.

Sec. 40. **[525A.11] PERSONS THAT MAY RECEIVE ANATOMICAL GIFT; PURPOSE OF ANATOMICAL GIFT.**

(a) An anatomical gift may be made to the following persons named in the document of gift:

(1) a hospital; accredited medical school, dental school, college, or university; organ procurement organization; or nonprofit organization in medical education or research, for research or education;

(2) subject to paragraph (b), an individual designated by the person making the anatomical gift if the individual is the recipient of the part; and

(3) an eye bank or tissue bank.

(b) If an anatomical gift to an individual under paragraph (a), clause (2), cannot be transplanted into the individual, the part passes in accordance with paragraph (g) in the absence of an express, contrary indication by the person making the anatomical gift.

(c) If an anatomical gift of one or more specific parts or of all parts is made in a document of gift that does not name a person described in paragraph (a) but identifies the purpose for which an anatomical gift may be used, the following rules apply:

(1) if the part is an eye and the gift is for the purpose of transplantation or therapy, the gift passes to the appropriate eye bank;

(2) if the part is tissue and the gift is for the purpose of transplantation or therapy, the gift passes to the appropriate tissue bank;

(3) if the part is an organ and the gift is for the purpose of transplantation or therapy, the gift passes to the appropriate organ procurement organization as custodian of the organ; and

(4) if the part is an organ, an eye, or tissue and the gift is for the purpose of research or education, the gift passes to the appropriate procurement organization.

(d) For the purpose of paragraph (c), if there is more than one purpose of an anatomical gift set forth in the document of gift but the purposes are not set forth in any priority, the gift must be used for transplantation or therapy, if suitable. If the gift cannot be used for transplantation or therapy, the gift may be used for research or education.

(e) If an anatomical gift of one or more specific parts is made in a document of gift that does not name a person described in paragraph (a) and does not identify the purpose of the gift, the gift may be used only for transplantation or therapy, and the gift passes in accordance with paragraph (g).

(f) If a document of gift specifies only a general intent to make an anatomical gift by words such as "donor," "organ donor," or "body donor," or by a symbol or statement of similar import, the gift may be used only for transplantation or therapy, and the gift passes in accordance with paragraph (g).

(g) For purposes of paragraphs (b), (e), and (f), the following rules apply:

(1) if the part is an eye, the gift passes to the appropriate eye bank;

(2) if the part is tissue, the gift passes to the appropriate tissue bank; and

(3) if the part is an organ, the gift passes to the appropriate organ procurement organization as custodian of the organ.

(h) An anatomical gift of an organ for transplantation or therapy, other than an anatomical gift under paragraph (a), clause (2), passes to the organ procurement organization as custodian of the organ.

(i) If an anatomical gift does not pass pursuant to paragraphs (a) to (h) or the decedent's body or part is not used for transplantation, therapy, research, or education, custody of the body or part passes to the person under obligation to dispose of the body or part.

(j) A person may not accept an anatomical gift if the person knows that the gift was not effectively made under section 525A.05 or 525A.10 or if the person knows that the decedent made a refusal under section 525A.07 that was not revoked. For purposes of this paragraph, if a person knows that an anatomical gift was made on a document of gift,

364.1 the person is deemed to know of any amendment or revocation of the gift or any refusal
364.2 to make an anatomical gift on the same document of gift.

364.3 (k) Except as otherwise provided in paragraph (a), clause (2), nothing in this chapter
364.4 affects the allocation of organs for transplantation or therapy.

364.5 Sec. 41. **[525A.12] SEARCH AND NOTIFICATION.**

364.6 (a) The following persons shall make a reasonable search of an individual who
364.7 the person reasonably believes is dead or near death for a document of gift or other
364.8 information identifying the individual as a donor or as an individual who made a refusal:

364.9 (1) a law enforcement officer, firefighter, paramedic, or other emergency rescuer
364.10 finding the individual; and

364.11 (2) if no other source of the information is immediately available, a hospital, as soon
364.12 as practical after the individual's arrival at the hospital.

364.13 (b) If a document of gift or a refusal to make an anatomical gift is located by the
364.14 search required by paragraph (a), clause (1), and the individual or deceased individual to
364.15 whom it relates is taken to a hospital, the person responsible for conducting the search
364.16 shall send the document of gift or refusal to the hospital. If a body is transferred to
364.17 the custody of the medical examiner, the person who discovered the body must notify
364.18 the person's dispatcher. A dispatcher notified under this section must notify the state's
364.19 federally designated organ procurement organization and inform the organization of the
364.20 deceased's name, donor status, and location.

364.21 (c) A person is not subject to criminal or civil liability for failing to discharge the
364.22 duties imposed by this section but may be subject to administrative sanctions.

364.23 Sec. 42. **[525A.13] DELIVERY OF DOCUMENT OF GIFT NOT REQUIRED;**
364.24 **RIGHT TO EXAMINE.**

364.25 (a) A document of gift need not be delivered during the donor's lifetime to be
364.26 effective.

364.27 (b) Upon or after an individual's death, a person in possession of a document of
364.28 gift or a refusal to make an anatomical gift with respect to the individual shall allow
364.29 examination and copying of the document of gift or refusal by a person authorized to
364.30 make or object to the making of an anatomical gift with respect to the individual or by a
364.31 person to which the gift could pass under section 525A.11.

364.32 Sec. 43. **[525A.14] RIGHTS AND DUTIES OF PROCUREMENT**
364.33 **ORGANIZATION AND OTHERS.**

365.1 (a) When a hospital refers an individual at or near death to a procurement
365.2 organization, the organization shall make a reasonable search of the records of the
365.3 Department of Public Safety and any donor registry that it knows exists for the
365.4 geographical area in which the individual resides to ascertain whether the individual has
365.5 made an anatomical gift.

365.6 (b) A procurement organization must be allowed reasonable access to information
365.7 in the records of the Department of Public Safety to ascertain whether an individual at
365.8 or near death is a donor.

365.9 (c) When a hospital refers an individual at or near death to a procurement
365.10 organization, the organization may conduct any reasonable examination necessary to
365.11 ensure the medical suitability of a part that is or could be the subject of an anatomical gift
365.12 for transplantation, therapy, research, or education from a donor or a prospective donor.
365.13 During the examination period, measures necessary to ensure the medical suitability of the
365.14 part may not be withdrawn unless the hospital or procurement organization knows that
365.15 the individual expressed a contrary intent.

365.16 (d) Unless prohibited by law other than this chapter, at any time after a donor's death,
365.17 the person to which a part passes under section 525A.11 may conduct any reasonable
365.18 examination necessary to ensure the medical suitability of the body or part for its intended
365.19 purpose.

365.20 (e) Unless prohibited by law other than this chapter, an examination under paragraph
365.21 (c) or (d) may include an examination of all medical and dental records of the donor or
365.22 prospective donor.

365.23 (f) Upon the death of a minor who was a donor or had signed a refusal, unless a
365.24 procurement organization knows the minor is emancipated, the procurement organization
365.25 shall conduct a reasonable search for the parents of the minor and provide the parents with
365.26 an opportunity to revoke or amend the anatomical gift or revoke the refusal.

365.27 (g) Upon referral by a hospital under paragraph (a), a procurement organization shall
365.28 make a reasonable search for any person listed in section 525A.09 having priority to make
365.29 an anatomical gift on behalf of a prospective donor. If a procurement organization receives
365.30 information that an anatomical gift to any other person was made, amended, or revoked, it
365.31 shall promptly advise the other person of all relevant information.

365.32 (h) Subject to sections 525A.11, paragraph (i), and 525A.23, the rights of the person
365.33 to which a part passes under section 525A.11 are superior to the rights of all others with
365.34 respect to the part. The person may accept or reject an anatomical gift in whole or in part.
365.35 Subject to the terms of the document of gift and this chapter, a person that accepts an
365.36 anatomical gift of an entire body may allow embalming, burial, or cremation, and use of

366.1 remains in a funeral service. If the gift is of a part, the person to which the part passes
366.2 under section 525A.11, upon the death of the donor and before embalming, burial, or
366.3 cremation, shall cause the part to be removed without unnecessary mutilation.

366.4 (i) Neither the physician who attends the decedent at death nor the physician who
366.5 determines the time of the decedent's death may participate in the procedures for removing
366.6 or transplanting a part from the decedent.

366.7 (j) A physician or technician may remove a donated part from the body of a donor
366.8 that the physician or technician is qualified to remove.

366.9 Sec. 44. **[525A.15] COORDINATION OF PROCUREMENT AND USE.**

366.10 Each hospital in this state shall enter into agreements or affiliations with procurement
366.11 organizations for coordination of procurement and use of anatomical gifts.

366.12 Sec. 45. **[525A.16] SALE OR PURCHASE OF PARTS PROHIBITED; FELONY.**

366.13 (a) Except as otherwise provided in paragraph (b), a person that, for valuable
366.14 consideration, knowingly purchases or sells a part for transplantation or therapy if removal
366.15 of a part from an individual is intended to occur after the individual's death, commits a
366.16 felony and upon conviction is subject to a fine not exceeding \$10,000 or imprisonment
366.17 not exceeding five years, or both.

366.18 (b) A person may charge a reasonable amount for the removal, processing,
366.19 preservation, quality control, storage, transportation, implantation, or disposal of a part.

366.20 Sec. 46. **[525A.17] PROHIBITED ACTS; FELONY.**

366.21 A person that, in order to obtain a financial gain, intentionally falsifies, forges,
366.22 conceals, defaces, or obliterates a document of gift, an amendment or revocation of a
366.23 document of gift, or a refusal commits a felony and upon conviction is subject to a fine not
366.24 exceeding \$10,000 or imprisonment not exceeding five years, or both.

366.25 Sec. 47. **[525A.18] IMMUNITY.**

366.26 (a) A person that acts in accordance with this chapter or with the applicable
366.27 anatomical gift law of another state, or attempts in good faith to do so, is not liable for the
366.28 act in a civil action, criminal prosecution, or administrative proceeding.

366.29 (b) Neither the person making an anatomical gift nor the donor's estate is liable for
366.30 any injury or damage that results from the making or use of the gift.

366.31 (c) In determining whether an anatomical gift has been made, amended, or revoked
366.32 under this chapter, a person may rely upon representations of an individual listed in

367.1 section 525A.09, paragraph (a), clause (2), (3), (4), (5), (6), (7), or (8), relating to the
367.2 individual's relationship to the donor or prospective donor unless the person knows that
367.3 the representation is untrue.

367.4 (d) An anatomical gift under this chapter is not a sale of goods as that term is defined
367.5 in section 336.2-105, paragraph (1), or the sale of a product.

367.6 Sec. 48. **[525A.19] LAW GOVERNING VALIDITY; CHOICE OF LAW AS TO**
367.7 **EXECUTION OF DOCUMENT OF GIFT; PRESUMPTION OF VALIDITY.**

367.8 (a) A document of gift is valid if executed in accordance with:

367.9 (1) this chapter;

367.10 (2) the laws of the state or country where it was executed; or

367.11 (3) the laws of the state or country where the person making the anatomical gift
367.12 was domiciled, has a place of residence, or was a national at the time the document of
367.13 gift was executed.

367.14 (b) If a document of gift is valid under this section, the law of this state governs
367.15 the interpretation of the document of gift.

367.16 (c) A person may presume that a document of gift or amendment of an anatomical
367.17 gift is valid unless that person knows that it was not validly executed or was revoked.

367.18 Sec. 49. **[525A.20] DONOR REGISTRY.**

367.19 (a) The Department of Health may establish or contract for the establishment of a
367.20 donor registry.

367.21 (b) The Department of Public Safety shall cooperate with a person that administers
367.22 any donor registry that this state establishes, contracts for, or recognizes for the purpose
367.23 of transferring to the donor registry all relevant information regarding a donor's making,
367.24 amendment to, or revocation of an anatomical gift.

367.25 (c) A donor registry must:

367.26 (1) allow a donor or other person authorized under section 525A.04 to include on
367.27 the donor registry a statement or symbol that the donor has made, amended, or revoked
367.28 an anatomical gift;

367.29 (2) be accessible to a procurement organization to allow it to obtain relevant
367.30 information on the donor registry to determine, at or near death of the donor or a
367.31 prospective donor, whether the donor or prospective donor has made, amended, or revoked
367.32 an anatomical gift; and

367.33 (3) be accessible, for purposes of clauses (1) and (2), seven days a week on a
367.34 24-hour basis.

(d) Personally identifiable information on a donor registry about a donor or prospective donor may not be used or disclosed without the express consent of the donor, prospective donor, or person that made the anatomical gift for any purpose other than to determine, at or near death of the donor or prospective donor, whether the donor or prospective donor has made, amended, or revoked an anatomical gift.

(e) This section does not prohibit any person from creating or maintaining a donor registry that is not established by or under contract with the state. Any such registry must comply with paragraphs (c) and (d).

Sec. 50. **[525A.21] EFFECT OF ANATOMICAL GIFT ON ADVANCE HEALTH CARE DIRECTIVE.**

(a) In this section:

(1) "advance health care directive" means a power of attorney for health care or a record signed by a prospective donor containing the prospective donor's direction concerning a health care decision for the prospective donor;

(2) "declaration" means a record signed by a prospective donor specifying the circumstances under which a life support system may be withheld or withdrawn from the prospective donor; and

(3) "health care decision" means any decision made regarding the health care of the prospective donor.

(b) If a prospective donor has a declaration or advance health care directive, measures necessary to ensure the medical suitability of an organ for transplantation or therapy may not be withheld or withdrawn from the prospective donor, unless the declaration expressly provides to the contrary.

Sec. 51. **[525A.22] COOPERATION BETWEEN MEDICAL EXAMINER AND PROCUREMENT ORGANIZATION.**

(a) A medical examiner shall cooperate with procurement organizations to maximize the opportunity to recover anatomical gifts for the purpose of transplantation, therapy, research, or education.

(b) If a medical examiner receives notice from a procurement organization that an anatomical gift might be available or was made with respect to a decedent whose body is under the jurisdiction of the medical examiner and a postmortem examination is going to be performed, unless the medical examiner denies recovery in accordance with section 525A.23, the medical examiner or designee shall conduct a postmortem examination of

the body or the part in a manner and within a period compatible with its preservation for the purposes of the gift.

(c) A part may not be removed from the body of a decedent under the jurisdiction of a medical examiner for transplantation, therapy, research, or education unless the part is the subject of an anatomical gift. The body of a decedent under the jurisdiction of the medical examiner may not be delivered to a person for research or education unless the body is the subject of an anatomical gift. This paragraph does not preclude a medical examiner from performing the medicolegal investigation upon the body or parts of a decedent under the jurisdiction of the medical examiner.

Sec. 52. **[525A.23] FACILITATION OF ANATOMICAL GIFT FROM DECEDENT WHOSE BODY IS UNDER JURISDICTION OF MEDICAL EXAMINER.**

(a) Upon request of a procurement organization, a medical examiner shall release to the procurement organization the name, contact information, and available medical and social history of a decedent whose body is under the jurisdiction of the medical examiner. If the decedent's body or part is medically suitable for transplantation, therapy, research, or education, the medical examiner shall release postmortem examination results to the procurement organization. The procurement organization may make a subsequent disclosure of the postmortem examination results or other information received from the medical examiner only if relevant to transplantation or therapy.

(b) The medical examiner may conduct a medicolegal examination by reviewing all medical records, laboratory test results, x-rays, other diagnostic results, and other information that any person possesses about a donor or prospective donor whose body is under the jurisdiction of the medical examiner which the medical examiner determines may be relevant to the investigation.

(c) A person that has any information requested by a medical examiner pursuant to paragraph (b) shall provide that information as expeditiously as possible to allow the medical examiner to conduct the medicolegal investigation within a period compatible with the preservation of parts for the purpose of transplantation, therapy, research, or education.

(d) If an anatomical gift has been or might be made of a part of a decedent whose body is under the jurisdiction of the medical examiner and a postmortem examination is not required, or the medical examiner determines that a postmortem examination is required but that the recovery of the part that is the subject of an anatomical gift will not interfere with the examination, the medical examiner and procurement organization

shall cooperate in the timely removal of the part from the decedent for the purpose of transplantation, therapy, research, or education.

(e) If an anatomical gift of a part from the decedent under the jurisdiction of the medical examiner has been or might be made, but the medical examiner initially believes that the recovery of the part could interfere with the postmortem investigation into the decedent's cause or manner of death, the medical examiner shall consult with the procurement organization or physician or technician designated by the procurement organization about the proposed recovery. After consultation, the medical examiner may allow the recovery.

(f) Following the consultation under paragraph (e), in the absence of mutually agreed-upon protocols to resolve conflict between the medical examiner and the procurement organization, if the medical examiner intends to deny recovery of an organ for transplantation, the medical examiner or designee, at the request of the procurement organization, shall attend the removal procedure for the part before making a final determination not to allow the procurement organization to recover the part. During the removal procedure, the medical examiner or designee may allow recovery by the procurement organization to proceed, or, if the medical examiner or designee reasonably believes that the part may be involved in determining the decedent's cause or manner of death, deny recovery by the procurement organization.

(g) If the medical examiner or designee denies recovery under paragraph (f), the medical examiner or designee shall:

(1) explain in a record the specific reasons for not allowing recovery of the part;

(2) include the specific reasons in the records of the medical examiner; and

(3) provide a record with the specific reasons to the procurement organization.

(h) If the medical examiner or designee allows recovery of a part under paragraph (d), (e), or (f), the procurement organization, upon request, shall cause the physician or technician who removes the part to provide the medical examiner with a record describing the condition of the part, a biopsy, a photograph, and any other information and observations that would assist in the postmortem examination.

(i) If a medical examiner or designee is required to be present at a removal procedure under paragraph (f), upon request the procurement organization requesting the recovery of the part shall reimburse the medical examiner or designee for the additional costs incurred in complying with paragraph (f).

Sec. 53. **[525A.24] RELATION TO ELECTRONIC SIGNATURES IN GLOBAL AND NATIONAL COMMERCE ACT.**

371.1 This chapter modifies, limits, and supersedes the Electronic Signatures in Global and
371.2 National Commerce Act, United States Code, title 15, section 7001 et seq., but does not
371.3 modify, limit, or supersede section 101(a) of that act, United States Code, title 15, section
371.4 7001, or authorize electronic delivery of any of the notices described in section 103(b)
371.5 of that act, United States Code, title 15, section 7003(b).

371.6 Sec. 54. Laws 2005, chapter 98, article 3, section 25, is amended to read:

371.7 Sec. 25. **REPEALER.**

371.8 Minnesota Statutes 2004, sections 245.713, ~~subdivisions 2 and~~ subdivision 4;
371.9 245.716; and 626.5551, subdivision 4, are repealed.

371.10 **EFFECTIVE DATE.** This section is effective retroactively from August 1, 2005.

371.11 Sec. 55. **SOBER HOUSES.**

371.12 Subdivision 1. **Sober house defined.** For purposes of this section, a "sober house"
371.13 means a cooperative living residence that:

371.14 (1) provides temporary housing to persons with alcohol or other drug dependency
371.15 and abuse problems in exchange for compensation;

371.16 (2) stipulates residents must abstain from using alcohol or drugs and meet other
371.17 requirements as a condition of living in the residence; and

371.18 (3) does not provide counseling or treatment services to those residents within the
371.19 meaning of Minnesota Statutes, chapter 148C or 254A.

371.20 Subd. 2. **Work group creation; membership.** The commissioner of human services
371.21 shall convene a sober house work group which is comprised of the following members:

371.22 (1) sober house landlords;

371.23 (2) sober house residents;

371.24 (3) community members with knowledge of sober housing;

371.25 (4) representatives of cities and counties;

371.26 (5) a representative from the Department of Human Services, Chemical Health
371.27 Division;

371.28 (6) a representative from the Department of Human Services, Licensing Division;

371.29 (7) a representative of chemical dependency treatment providers; and

371.30 (8) a representative from the Department of Health.

371.31 Subd. 3. **Report.** The work group created in subdivision 2 is directed to study the
371.32 issue of sober houses in the state and determine whether state licensing or other regulation
371.33 of sober houses is appropriate. Based on findings of the work group, the commissioner of

human services shall submit a report of recommendations to the legislature by January 1, 2008.

Sec. 56. **INTERPRETER SERVICES WORK GROUP.**

(a) The commissioner of health shall, in consultation with the commissioners of commerce, human services, and employee relations, convene a work group to study the provision of interpreter services to patients in medical and dental care settings. The work group shall include one representative from each of the following groups:

- (1) consumers;
- (2) interpreters;
- (3) interpreter service providers or agencies;
- (4) health plan companies;
- (5) self-insured purchasers;
- (6) hospitals;
- (7) health care providers;
- (8) dental providers;
- (9) clinic administrators;
- (10) state agency staff from the Departments of Health, Human Services, and Employee Relations;
- (11) Minnesota Registry of Interpreters for the Deaf;
- (12) local county social services agencies;
- (13) local public health agencies;
- (14) interpreting stakeholders group;
- (15) one interpreter trainer; and
- (16) one interpreter certification examiner.

(b) The work group shall develop findings and recommendations on the following:

- (1) assuring access to interpreter services;
 - (2) compliance with requirements of federal law and guidance;
 - (3) developing a quality assurance program to ensure the quality of health care interpreting services, including requirements for training and establishing a certification process; and
 - (4) identifying broad-based funding mechanisms for interpreter services.
- (c) Based on the discussions of the work group, the commissioner shall make recommendations to the chairs of the health policy and finance committees in the house and senate by January 15, 2008, on how to ensure high quality interpreter services for

373.1 patients in medical and dental settings, and for a broad-based funding mechanism for
373.2 delivering these services.

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

373.4 Sec. 57. **FEDERAL GRANTS.**

373.5 The Board of Pharmacy shall apply for any applicable federal grants or other nonstate
373.6 funds to establish and fully implement the prescription electronic reporting system.

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

373.8 Sec. 58. **BOARD OF PHARMACY.**

373.9 The Board of Pharmacy shall not increase the license fees of pharmacists or
373.10 pharmacies in order to adequately fund the prescription electronic reporting system under
373.11 Minnesota Statutes, section 152.126, without specific authority from the legislature.

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

373.13 Sec. 59. **BOARD OF MEDICAL PRACTICE.**

373.14 The Board of Medical Practice shall convene a work group to discuss the appropriate
373.15 prescribing of controlled substances listed in Minnesota Statutes, section 152.02,
373.16 subdivisions 3 and 4, and those substances defined by the Board of Pharmacy under
373.17 Minnesota Statutes, section 152.02, subdivisions 7, 8, and 12, for pain management, and
373.18 shall report to the legislature by December 15, 2007.

373.19 Sec. 60. **AGRICULTURAL COOPERATIVE HEALTH PLAN FOR FARMERS.**

373.20 Subdivision 1. **Pilot project requirements.** The commissioner of commerce shall
373.21 authorize a joint self-insurance pilot project administered by a trust sponsored by one
373.22 or more agricultural cooperatives organized under Minnesota Statutes, chapter 308A,
373.23 or under a federal charter for the purpose of offering health coverage to members of
373.24 the cooperatives and their families, provided the project satisfies the requirements of
373.25 Minnesota Statutes, chapter 62H, except as follows:

373.26 (1) Minnesota Statutes, section 62H.02, paragraph (b), does not apply;

373.27 (2) the notice period required under Minnesota Statutes, section 62H.02, paragraph
373.28 (e), is 90 days;

373.29 (3) the commissioner shall grant necessary waivers and approve an alternative
373.30 arrangement that fully funds the plan's liability or incurred but unpaid claims under
373.31 Minnesota Statutes, section 62H.02, paragraph (f), unless the commissioner provides

evidence demonstrating that the insolvency protection proposed is substantially less than that typically provided by self-insured group plans of a similar size in Minnesota;

(4) notwithstanding Minnesota Statutes, section 62H.04, paragraph (a), the joint self-insurance plan shall be considered a large group and not subject to the small group insurance requirements in Minnesota Statutes, chapter 62L, even if some employer groups enrolled in the plan would be defined as small employers, except that the joint self-insurance plan may elect to treat the sale of a health plan to or for an employer that has only one eligible employee who has not waived coverage as the sale of an individual health plan as allowed under Minnesota Statutes, section 62L.02, subdivision 26;

(5) Minnesota Statutes, section 297I.05, subdivision 12, paragraph (c), does not apply; and

(6) the trust must pay the assessment for the Minnesota comprehensive health association as provided under Minnesota Statutes, section 62E.11.

Subd. 2. Evaluation and renewal. The pilot project authorized under this section is for a period of four years from the date of initial enrollment. The commissioner shall grant an extension of four additional years if the trust provides evidence that it remains in compliance with the requirements of this section and other applicable laws and rules. If the commissioner determines that the operation of the trust has not improved access, expanded health plan choices, or improved affordability of health coverage for farm families, or that it has significantly damaged access, choice, or affordability for other consumers not enrolled in the trust, the commissioner shall provide at least 180 days' advance written notice to the trust and to the chairs of the senate and house finance and policy committees with jurisdiction over health and insurance matters of the commissioner's intention not to renew the pilot project at the expiration of a four-year period.

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

Sec. 61. **HEALTH PLAN PURCHASING POOL STUDY GROUP.**

Subdivision 1. Creation; membership. A health care purchasing pool study group is created to study and make recommendations regarding the creation of a voluntary, statewide health care purchasing pool that would contract directly with providers to provide affordable health coverage to eligible Minnesota residents. The study group is composed of:

(1) the chief house and senate authors of this act;

(2) the chairs of the senate Committee on Health, Housing, and Family Security and the Health and Human Services Budget Division;

375.1 (3) the chairs of the house Health Care and Human Services Committee and the
375.2 Health Care and Human Services Division;

375.3 (4) the attorney general or the attorney general's designated representative;

375.4 (5) three representatives of health care providers appointed as follows:

375.5 (i) one member appointed by the governor;

375.6 (ii) one member appointed by the speaker of the house; and

375.7 (iii) one member appointed by the Subcommittee on Committees of the senate

375.8 Committee on Rules and Administration; and

375.9 (6) two consumers of health care appointed by the governor.

375.10 All appointments to be made under this subdivision must be made within 30 days
375.11 of the effective date of this act.

375.12 Subd. 2. **Study; report.** The study group shall study and make recommendations
375.13 on the following issues related to the creation, maintenance, and funding of a voluntary,
375.14 statewide health plan purchasing pool to provide comprehensive, cost-effective, and
375.15 medically appropriate health coverage to all public and private employees in Minnesota
375.16 and all Minnesota residents:

375.17 (1) the creation of an independent public entity to administer the pool;

375.18 (2) eligibility and participation requirements for existing public and private health
375.19 care purchasing pools, public and private employers, and residents of this state;

375.20 (3) how to contract directly with providers to provide comprehensive coverage for
375.21 preventive, mental health, dental and other medical services, and comprehensive drug
375.22 benefits to enrollees and maximize the cost savings and other efficiencies that a large
375.23 purchasing pool would be expected to generate without the need for a public subsidy;

375.24 (4) provisions that allow the pool to contract directly with health care providers
375.25 to provide coverage to enrollees;

375.26 (5) incentives designed to attract and retain the maximum number of enrollees;

375.27 (6) recommendations for the administration of the pool and the plans that will be
375.28 available to enrollees including, but not limited to, recommendations to keep the pool
375.29 solvent and profitable so that public subsidies are not necessary; and

375.30 (7) other elements the study group concludes are necessary or desirable for the
375.31 pool to possess.

375.32 The study group shall submit its report and the draft legislation necessary to
375.33 implement its recommendations to the chairs of the legislative committees and divisions
375.34 with jurisdiction over health care policy and finance, the Health Care Access Commission,
375.35 and the governor by February 1, 2008.

Subd. 3. **Staffing.** State agencies shall assist the study group with any requests for information the study group considers necessary to complete the study and report under subdivision 2.

Subd. 4. **Removal; vacancies; expenses.** Removal of members, vacancies, and expenses for members shall be as provided in Minnesota Statutes, section 15.059.

Subd. 5. **Expiration.** This section expires after the submission of the report as required in subdivision 2.

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

Sec. 62. **REPEALER.**

(a) Minnesota Statutes 2006, sections 254A.02, subdivisions 7, 9, 12, 14, 15, and 16; 254A.085; 254A.086; 254A.12; 254A.14; 254A.15; 254A.16, subdivision 5; 254A.175; 254A.18; 256J.561, subdivision 1; 256J.62, subdivision 9; and 256J.65, are repealed.

(b) Minnesota Rules, part 9503.0035, subpart 2, is repealed.

(c) Minnesota Statutes 2006, sections 525.921; 525.9211; 525.9212; 525.9213; 525.9214; 525.9215; 525.9216; 525.9217; 525.9218; 525.9219; 525.9221; 525.9222; 525.9223; and 525.9224, are repealed.

ARTICLE 8

CHILDREN'S HEALTH SECURITY PROGRAM

Section 1. **[16A.726] CHILDREN'S HEALTH SECURITY ACCOUNT.**

A children's health security account is created in a special revenue fund in the state treasury. The commissioner shall deposit to the credit of the account money made available to the account. Notwithstanding section 11A.20, any investment income attributable to the investment of the children's health security account not currently needed shall be credited to the children's health security account.

Sec. 2. Minnesota Statutes 2006, section 256B.057, subdivision 8, is amended to read:

Subd. 8. **Children under age two.** Medical assistance may be paid for a child under two years of age whose countable family income is above ~~275~~ 300 percent of the federal poverty guidelines for the same size family but less than or equal to ~~280~~ 305 percent of the federal poverty guidelines for the same size family.

EFFECTIVE DATE. This section is effective January 1, 2011, or upon federal approval, whichever is later.

Sec. 3. **[256N.01] CITATION.**

This chapter may be cited as the "Children's Health Security Act."

Sec. 4. **[256N.02] DEFINITIONS.**

Subdivision 1. **Applicability.** The terms used in this chapter have the following meanings unless otherwise provided for by text.

Subd. 2. **Child.** "Child" means an individual under age 21.

Subd. 3. **Commissioner.** "Commissioner" means the commissioner of human services.

Subd. 4. **Dependent child.** "Dependent child" means an unmarried child under age 25 who is claimed as a dependent for federal income tax purposes by a parent, grandparent, foster parent, relative caretaker, or legal guardian.

Sec. 5. **[256N.03] ESTABLISHMENT.**

The commissioner shall establish the children's health security program. The commissioner shall begin implementation of the program on October 1, 2008, or upon federal approval, whichever is later. The children's health security program must comply with title XIX of the federal Social Security Act, and waivers granted under title XIX.

Sec. 6. **[256N.05] ELIGIBILITY.**

Subdivision 1. **General requirements.** Children meeting the eligibility requirements of this section are eligible for the children's health security program.

Subd. 2. **Income limit.** (a) Effective October 1, 2008, children in families with gross household incomes equal to or less than 225 percent of the federal poverty guidelines are eligible for the children's health security program. In determining gross income, the commissioner shall use the income methodology applied to children under the MinnesotaCare program.

(b) Effective October 1, 2008, a dependent child who meets the program income limits under paragraph (a) and all other program eligibility requirements is eligible for state-funded benefits under this section.

(c) Effective January 1, 2011, or upon federal approval, whichever is later, children in families with household incomes equal to or less than 300 percent of the federal poverty guidelines must be included in the children's health security program.

(d) The Legislative Task Force On Children's Health Care Coverage established under section 19 shall develop recommendations on options for extending health insurance

378.1 coverage to children in families with household incomes in excess of 300 percent of the
378.2 federal poverty guidelines.

378.3 Subd. 3. **Residency.** Program participants must meet the residency requirements of
378.4 section 256B.056, subdivision 1.

378.5 Subd. 4. **Enrollment voluntary.** Enrollment in the children's health security
378.6 program is voluntary. Parents or guardians may retain private sector or Medicare coverage
378.7 for a child as the sole source of coverage. Parents or guardians who have private sector or
378.8 Medicare coverage for children may also enroll children in the children's health security
378.9 program. If private sector or Medicare coverage is available, coverage under the children's
378.10 health security program is secondary to the private sector or Medicare coverage.

378.11 Subd. 5. **Emergency services.** Payment must be made for care and services that
378.12 are furnished to noncitizens, regardless of immigration status, who otherwise meet the
378.13 eligibility requirements of this chapter, if the care and services are necessary for the
378.14 treatment of an emergency medical condition, except for organ transplants and related
378.15 care and services and routine prenatal care. For purposes of this subdivision, "emergency
378.16 medical condition" means a medical condition that meets the requirements of United
378.17 States Code, title 42, section 1396b(v).

378.18 Subd. 6. **Medical assistance standards and procedures.** (a) Unless otherwise
378.19 specified in this chapter, the commissioner shall use medical assistance procedures and
378.20 methodology when determining initial eligibility and redetermining eligibility for the
378.21 children's health security program.

378.22 (b) The procedures and income standard specified in section 256B.056, subdivisions
378.23 5 and 5c, paragraph (a), apply to children who would be eligible for the children's health
378.24 security program, except for excess income.

378.25 (c) Retroactive coverage for the children's health security program must be provided
378.26 as specified in section 256B.056, subdivision 7.

378.27 **Sec. 7. [256N.07] COVERED SERVICES.**

378.28 Covered services under the children's health security program must consist of all
378.29 covered services under chapter 256B.

378.30 **Sec. 8. [256N.09] NO ENROLLEE PREMIUMS OR COST SHARING.**

378.31 In order to ensure broad access to coverage, the children's health security program
378.32 has no enrollee premium or cost-sharing requirements.

Sec. 9. **[256N.11] APPLICATION PROCEDURES; ELIGIBILITY DETERMINATION.**

Subdivision 1. Application procedure. The application form for the program must be easily understandable and must not exceed two pages in length. Applications for the program must be made available to provider offices, local human services agencies, school districts, schools, community health offices, and other sites willing to cooperate in program outreach. These sites may accept applications and forward applications to the commissioner, and counties where applicable. Applications may also be made directly to the commissioner and to counties that determine eligibility.

Subd. 2. Eligibility determination. Counties that determine eligibility for MinnesotaCare as of March 1, 2007, shall determine eligibility for the children's health security program. The commissioner, and counties where applicable, shall determine an applicant's eligibility for the program within 30 days of the date the application is received, according to the procedures in Code of Federal Regulations, title 42, section 435.911.

Subd. 3. Presumptive eligibility. Coverage under the program is available during a presumptive eligibility period for children under age 19 whose family income does not exceed the applicable income standard. The presumptive eligibility period begins on the date on which a health care provider enrolled in the program, or other entity designated by the commissioner, determines, based on preliminary information, that the child's family income does not exceed the applicable income standard. The presumptive eligibility period ends the earlier of the day on which a determination is made of eligibility under this section or the last day of the month following the month presumptive eligibility was determined.

Subd. 4. Renewal of eligibility. The commissioner shall require enrollees to renew eligibility every 12 months.

Subd. 5. Continuous eligibility. Children under the age of 19 who are eligible under this section shall be continuously eligible until the earlier of the next renewal period, or the time that a child exceeds age 19.

Sec. 10. **[256N.12] COUNTY ROLE.**

Counties not required to determine eligibility under section 256N.11, subdivision 2, may choose to determine eligibility under that section. Counties may also choose to provide assistance to applicants under section 256N.17, subdivision 1, and provide ombudsperson services under section 256N.17, subdivision 2. This must not limit the ability of the commissioner to establish reasonable staffing standards that relate to the number of persons served, and that provide a county option to hire part-time staff or pursue multicounty implementation models. If a county chooses not to deliver these services, they

380.1 must be delivered by the commissioner. State and federal funding to support these services
380.2 must be the same, whether delivered by the state or by a county or group of counties.

380.3 Sec. 11. **[256N.13] SERVICE DELIVERY.**

380.4 Subdivision 1. **Contracts for service delivery.** The commissioner, within each
380.5 county, may contract with managed care organizations, including health maintenance
380.6 organizations licensed under chapter 62D, community integrated service networks licensed
380.7 under chapter 62N, accountable provider networks licensed under chapter 62T, and
380.8 county-based purchasing plans established under section 256B.692, to provide covered
380.9 health care services to program enrollees under a managed care system, and may contract
380.10 with health care and social service providers to provide services on a fee-for-service basis.
380.11 Section 256B.69, subdivision 26, applies to contracts with managed care organizations. In
380.12 determining the method for service delivery, the commissioner shall consider the cost and
380.13 quality of health care services; the breadth of services offered, including medical, dental
380.14 and mental health services; the breadth of choice of medical providers for enrollees; the
380.15 ease of access to quality medical care for enrollees; the efficiency and cost-effectiveness of
380.16 service delivery; and the integration of best medical practice standards into the children's
380.17 health security program.

380.18 Subd. 2. **Managed care organization requirements.** (a) Managed care
380.19 organizations under contract are responsible for coordinating covered health care services
380.20 provided to eligible individuals. Managed care organizations under contract:

380.21 (1) shall authorize and arrange for the provision of all needed covered health
380.22 services under chapter 256B, with the exception of services available only under a medical
380.23 assistance home and community-based waiver, in order to ensure appropriate health care
380.24 is delivered to enrollees;

380.25 (2) shall comply with the requirements of section 256B.69, subdivision 26;

380.26 (3) shall accept the prospective, per capita payment from the commissioner in return
380.27 for the provision of comprehensive and coordinated health care services for enrollees;

380.28 (4) may contract with health care and social service providers to provide covered
380.29 services to enrollees; and

380.30 (5) shall institute enrollee grievance procedures according to the method established
380.31 by the commissioner, utilizing applicable requirements of chapter 62D and Code of
380.32 Federal Regulations, title 42, section 438, subpart F. Disputes may also be appealed to
380.33 the commissioner using the procedures in section 256.045.

380.34 (b) Upon implementation of the children's health security program, the commissioner
380.35 shall withhold five percent of managed care organization payments pending completion

of performance targets, including lead screening, well child services, immunizations, vision screening, and customer service performance targets. Effective January 1, 2011, the commissioner shall add treatment of asthma and screening for mental health as new performance targets. Each performance target must apply uniformly to all managed care organizations, and be qualitative, objective, measurable, and reasonably attainable, except in the case of a performance target based on federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. The withheld funds must be returned no sooner than July of the following year if performance targets in the contract are achieved. The success of each managed care organization in reaching performance targets must be reported to the legislature annually.

Subd. 3. **Fee-for-service delivery.** Disputes related to services provided under the fee-for-service system may be appealed to the commissioner using the procedures in section 256.045.

Subd. 4. **Contracts for waiver services.** The commissioner, when services are delivered through managed care, may contract with health care and social service providers on a fee-for-service basis to provide program enrollees with covered services available only under a medical assistance home and community-based waiver. The commissioner shall determine eligibility for home and community-based waiver services using the criteria and procedures in chapter 256B. Disputes related to services provided on a fee-for-service basis may be appealed to the commissioner using the procedures in section 256.045.

Subd. 5. **Service delivery for Minnesota disabilities health option recipient.** Individuals who voluntarily enroll in the Minnesota Disability Health Option (MnDHO), established under section 256B.69, subdivision 23, shall continue to receive their home and community-based waiver services through MnDHO.

Subd. 6. **Disabled or blind children.** Children eligible for medical assistance due to blindness or disability as determined by the Social Security Administration or the state medical review team are exempt from enrolling in a managed care organization and shall be provided health benefits on a fee-for-service basis.

Sec. 12. **[256N.15] PAYMENT RATES.**

Subdivision 1. **Establishment.** The commissioner, in consultation with a health care actuary, shall establish the method and amount of payments for services. The commissioner shall annually contract with eligible entities to provide services to program enrollees. The commissioner, in consultation with the Risk Adjustment Association

established under section 62Q.03, subdivision 6, shall develop and implement a risk adjustment system for the program.

Subd. 2. **Provider rates.** In establishing the payment amount under subdivision 1, the commissioner shall ensure that fee-for-service payment rates for preventative care services provided on or after October 1, 2008, are at least five percent above the medical assistance rates for preventative services in effect on September 30, 2008, and shall ensure that fee-for-service payment rates for all other services provided on or after October 1, 2008, are at least three percent above the medical assistance rates for those services in effect on September 30, 2008. The commissioner shall adjust managed care capitation rates to reflect these increases, and shall require managed care organizations, as a condition of contract, to pass these increases on to providers under contract.

Sec. 13. **[256N.17] CONSUMER ASSISTANCE.**

Subdivision 1. **Assistance to applicants.** The commissioner shall assist applicants in choosing a managed care organization or fee-for-service provider by:

(1) establishing a Web site to provide information about managed care organizations and fee-for-service providers and to allow online enrollment;

(2) make information on managed care organizations and fee-for-service providers available at the sites specified in section 256N.11, subdivision 1;

(3) make applications and information on managed care organizations and fee-for-service providers available to applicants and enrollees according to Title VI of the Civil Rights Act and federal regulations adopted under that law or any guidance from the United States Department of Health and Human Services; and

(4) make benefit educators available to assist applicants in choosing a managed care organization or fee-for-service provider.

Subd. 2. **Ombudsperson.** The commissioner shall designate an ombudsperson to advocate for children enrolled in the children's health security program. The ombudsperson shall assist enrollees in understanding and making use of complaint and appeal procedures and ensure that necessary medical services are provided to enrollees. At the time of enrollment, the commissioner shall inform enrollees about the ombudsperson program, the right to a resolution of the enrollee's complaint by the managed care organization if the enrollee experiences a problem with the managed care organization or its providers, and appeal rights under section 256.045.

Sec. 14. **[256N.19] MONITORING AND EVALUATION OF QUALITY AND COSTS.**

383.1 (a) The commissioner, as a condition of contract, shall require each participating
383.2 managed care organization and participating provider to submit, in the form and manner
383.3 specified by the commissioner, data required for assessing enrollee satisfaction, quality
383.4 of care, cost, and utilization of services. The commissioner shall evaluate this data, in
383.5 order to:

383.6 (1) make summary information on the quality of care across managed care
383.7 organizations, medical clinics, and providers available to consumers;

383.8 (2) require managed care organizations and providers, as a condition of contract, to
383.9 implement quality improvement plans; and

383.10 (3) compare the cost and quality of services under the program to the cost and
383.11 quality of services provided to private sector enrollees.

383.12 (b) The commissioner shall implement this section to the extent allowed by federal
383.13 and state laws on data privacy.

383.14 Sec. 15. **[256N.21] FEDERAL APPROVAL.**

383.15 The commissioner shall seek all federal waivers and approvals necessary to
383.16 implement this chapter including, but not limited to, waivers and approvals necessary to:

383.17 (1) coordinate medical assistance and MinnesotaCare coverage for children with the
383.18 children's health security program;

383.19 (2) use federal medical assistance and MinnesotaCare dollars to pay for health care
383.20 services under the children's health security program;

383.21 (3) maximize receipt of the federal medical assistance match for covered children,
383.22 by increasing income standards through the use of more liberal income methodologies as
383.23 provided under United States Code, title 42, sections 1396a and 1396u-1;

383.24 (4) extend presumptive eligibility and continuous eligibility to children under age
383.25 21; and

383.26 (5) use federal medical assistance and MinnesotaCare dollars to provide benefits to
383.27 dependent children.

383.28 Sec. 16. **[256N.23] RULEMAKING.**

383.29 The commissioner shall adopt rules to implement this chapter.

383.30 Sec. 17. **[256N.25] CHILDREN'S HEALTH SECURITY PROGRAM**
383.31 **OUTREACH.**

383.32 Subdivision 1. **Grant awards.** The commissioner shall award grants to public or
383.33 private organizations to:

384.1 (1) provide information, in areas of the state with high uninsured populations, on the
384.2 importance of maintaining insurance coverage and on how to obtain coverage through
384.3 the children's health security program; and

384.4 (2) monitor and provide ongoing support to ensure enrolled children remain covered.

384.5 Subd. 2. **Criteria.** In awarding the grants, the commissioner shall consider the
384.6 following:

384.7 (1) geographic areas and populations with high uninsured rates;

384.8 (2) the ability to raise matching funds;

384.9 (3) the ability to contact, effectively communicate with, or serve eligible populations;

384.10 and

384.11 (4) the applicant's plan to monitor and provide support to ensure enrolled children
384.12 remain covered.

384.13 Subd. 3. **Monitoring and termination.** The commissioner shall monitor the grants
384.14 and may terminate a grant if the outreach effort does not increase enrollment in the
384.15 children's health security program.

384.16 Sec. 18. **IMPLEMENTATION PLAN.**

384.17 The commissioner of human services shall develop an implementation plan for the
384.18 children's health security program, which includes a health delivery plan based on the
384.19 criteria specified in Minnesota Statutes, section 256N.13, subdivision 1. The commissioner
384.20 shall present this plan, any necessary draft legislation, and a draft of proposed rules
384.21 to the legislature by December 15, 2007. The plan must include recommendations
384.22 for any additional legislative changes necessary to coordinate medical assistance and
384.23 MinnesotaCare coverage for children with the children's health security program. The
384.24 commissioner shall evaluate the provision of services under the program to children with
384.25 disabilities and shall present recommendations to the legislature by December 15, 2009,
384.26 for any program changes necessary to ensure the quality and continuity of care.

384.27 Sec. 19. **LEGISLATIVE TASK FORCE ON CHILDREN'S HEALTH CARE**
384.28 **COVERAGE.**

384.29 Subdivision 1. **Establishment; membership.** (a) The Legislative Task Force on
384.30 Children's Health Care Coverage is established. The task force is made up of 12 voting
384.31 members and six nonvoting members.

384.32 (b) The voting members are:

384.33 (1) six members of the house of representatives appointed by the speaker, three from
384.34 the majority party and three from the minority party; and

(2) six members of the senate appointed by the Subcommittee on Committees of the senate Committee on Rules and Administration, three from the majority party and three from the minority party.

(c) The nonvoting members are one representative selected by each of the following organizations:

(1) the American Academy of Pediatrics, Minnesota chapter;

(2) the Minnesota Nurses Association;

(3) the Minnesota Council of Health Plans;

(4) the Minnesota Children's Platform Coalition;

(5) the Minnesota Universal Health Care Coalition; and

(6) the Minnesota Business Partnership.

(d) The task force members must be appointed by September 1, 2007. The majority leader of the senate and the speaker of the house of representatives must each designate a chair from their appointments. The chair appointed by the speaker of the house of representatives shall convene and chair the first meeting of the task force. The chair appointed by the majority leader of the senate shall chair the next meeting of the task force. The chairs shall then alternate for the duration of the task force.

Subd. 2. **Study; staff support.** (a) The task force shall study viable options to extend coverage to all children as provided in Minnesota Statutes, section 256N.05, subdivision 2, paragraph (d), and provide recommendations to the legislature. The study must:

(1) evaluate methods to achieve universal coverage for children, including, but not limited to, changes to the employer-based coverage system and an expansion of eligibility for the children's health security program established under Minnesota Statutes, chapter 256N;

(2) examine health care reform and cost containment methods that will contain costs and increase access and improve health outcomes;

(3) examine how to increase access to preventive care and health care services; and

(4) examine how to reduce health disparities among minority populations.

(b) The task force, through the Legislative Coordinating Commission, may hire staff or contract for staff support for the study.

(c) The task force, in developing recommendations, shall hold meetings to hear public testimony at locations throughout the state, including locations outside of the seven-county metropolitan area.

Subd. 3. **Recommendations.** The task force shall report its recommendations to the legislature by December 15, 2009. Recommendations must be consistent with the following criteria:

387.1 (1) the geographic regions must be applied uniformly by the health carrier;

387.2 (2) each geographic region must be composed of no fewer than seven counties that
387.3 create a contiguous region; and

387.4 (3) the health carrier provides actuarial justification acceptable to the commissioner
387.5 for the proposed geographic variations in index rates, establishing that the variations are
387.6 based upon differences in the cost to the health carrier of providing coverage.

387.7 (d) Health carriers may use rate cells and must file with the commissioner the rate
387.8 cells they use. Rate cells must be based upon the number of adults or children covered
387.9 under the policy and may reflect the availability of Medicare coverage. The rates for
387.10 different rate cells must not in any way reflect generalized differences in expected costs
387.11 between principal insureds and their spouses.

387.12 (e) In developing its index rates and premiums for a health plan, a health carrier shall
387.13 take into account only the following factors:

387.14 (1) actuarially valid differences in rating factors permitted under paragraphs (a)
387.15 and (b); and

387.16 (2) actuarially valid geographic variations if approved by the commissioner as
387.17 provided in paragraph (c).

387.18 (f) All premium variations must be justified in initial rate filings and upon request of
387.19 the commissioner in rate revision filings. All rate variations are subject to approval by
387.20 the commissioner.

387.21 (g) The loss ratio must comply with the section 62A.021 requirements for individual
387.22 health plans.

387.23 (h) The rates must not be approved, unless the commissioner has determined that the
387.24 rates are reasonable. In determining reasonableness, the commissioner shall consider the
387.25 growth rates applied under section 62J.04, subdivision 1, paragraph (b), to the calendar
387.26 year or years that the proposed premium rate would be in effect, actuarially valid changes
387.27 in risks associated with the enrollee populations, and actuarially valid changes as a result
387.28 of statutory changes in Laws 1992, chapter 549.

387.29 (i) An insurer may, as part of a minimum lifetime loss ratio guarantee filing under
387.30 section 62A.02, subdivision 3a, include a rating practices guarantee as provided in this
387.31 paragraph. The rating practices guarantee must be in writing and must guarantee that
387.32 the policy form will be offered, sold, issued, and renewed only with premium rates and
387.33 premium rating practices that comply with subdivisions 2, 3, 4, and 5. The rating practices
387.34 guarantee must be accompanied by an actuarial memorandum that demonstrates that the
387.35 premium rates and premium rating system used in connection with the policy form will
387.36 satisfy the guarantee. The guarantee must guarantee refunds of any excess premiums to

policyholders charged premiums that exceed those permitted under subdivision 2, 3, 4, or 5. An insurer that complies with this paragraph in connection with a policy form is exempt from the requirement of prior approval by the commissioner under paragraphs (c), (f), and (h).

Sec. 2. [62A.67] MINNESOTA HEALTH INSURANCE EXCHANGE.

Subdivision 1. Title; citation. This section may be cited as the "Minnesota Health Insurance Exchange."

Subd. 2. Creation; tax exemption. The Minnesota Health Insurance Exchange is created for the limited purpose of providing individuals with greater access, choice, portability, and affordability of health insurance products. The Minnesota Health Insurance Exchange is a not-for-profit corporation under chapter 317A and section 501(c) of the Internal Revenue Code.

Subd. 3. Definitions. The following terms have the meanings given them unless otherwise provided in text.

(a) "Board" means the board of directors of the Minnesota Health Insurance Exchange under subdivision 13.

(b) "Commissioner" means:

(1) the commissioner of commerce for health insurers subject to the jurisdiction of the Department of Commerce;

(2) the commissioner of health for health insurers subject to the jurisdiction of the Department of Health; or

(3) either commissioner's designated representative.

(c) "Exchange" means the Minnesota Health Insurance Exchange.

(d) "HIPAA" means the Health Insurance Portability and Accountability Act of 1996.

(e) "Individual market health plans," unless otherwise specified, means individual market health plans defined in section 62A.011.

(f) "Section 125 Plan" means a cafeteria or Premium Only Plan under section 125 of the Internal Revenue Code that allows employees to pay for health insurance premiums with pretax dollars.

Subd. 4. Insurer and health plan participation. All health plans as defined in section 62A.011, subdivision 3, issued or renewed in the individual market shall participate in the exchange. No health plans in the individual market may be issued or renewed outside of the exchange. Group health plans as defined in section 62A.10 shall not be offered through the exchange. Health plans offered through the Minnesota Comprehensive Health Association as defined in section 62E.10 are offered through the exchange to

389.1 eligible enrollees as determined by the Minnesota Comprehensive Health Association.

389.2 Health plans offered through MinnesotaCare under chapter 256L are offered through the
389.3 exchange to eligible enrollees as determined by the commissioner of human services.

389.4 Subd. 5. **Approval of health plans.** No health plan may be offered through the
389.5 exchange unless the commissioner has first certified that:

389.6 (1) the insurer seeking to offer the health plan is licensed to issue health insurance in
389.7 the state; and

389.8 (2) the health plan meets the requirements of this section, and the health plan and the
389.9 insurer are in compliance with all other applicable health insurance laws.

389.10 Subd. 6. **Individual market health plans.** Individual market health plans offered
389.11 through the exchange continue to be regulated by the commissioner as specified in
389.12 chapters 62A, 62C, 62D, 62E, 62Q, and 72A, and must include the following provisions
389.13 that apply to all health plans issued or renewed through the exchange:

389.14 (1) premiums for children under the age of 19 shall not vary by age in the exchange;
389.15 and

389.16 (2) premiums for children under the age of 19 must be excluded from rating factors
389.17 under section 62A.65, subdivision 3, paragraph (b).

389.18 Subd. 7. **Individual participation and eligibility.** Individuals are eligible to
389.19 purchase health plans directly through the exchange or through an employer Section
389.20 125 Plan under section 62A.68. Nothing in this section requires guaranteed issue of
389.21 individual market health plans offered through the exchange. Individuals are eligible to
389.22 purchase individual market health plans through the exchange by meeting one or more
389.23 of the following qualifications:

389.24 (1) the individual is a Minnesota resident, meaning the individual is physically
389.25 residing on a permanent basis in a place that is the person's principal residence and from
389.26 which the person is absent only for temporary purposes;

389.27 (2) the individual is a student attending an institution outside of Minnesota and
389.28 maintains Minnesota residency;

389.29 (3) the individual is not a Minnesota resident but is employed by an employer
389.30 physically located within the state and the individual's employer is required to offer a
389.31 Section 125 Plan under section 62A.68;

389.32 (4) the individual is not a Minnesota resident but is self-employed and the
389.33 individual's principal place of business is in the state; or

389.34 (5) the individual is a dependent as defined in section 62L.02, of another individual
389.35 who is eligible to participate in the exchange.

Subd. 8. **Continuation of coverage.** Enrollment in a health plan may be canceled for nonpayment of premiums, fraud, or changes in eligibility for MinnesotaCare under chapter 256L. Enrollment in an individual market health plan may not be canceled or nonrenewed because of any change in employer or employment status, marital status, health status, age, residence, or any other change that does not affect eligibility as defined in this section.

Subd. 9. **Responsibilities of the exchange.** The exchange shall serve as the sole entity for enrollment and collection and transfer of premium payments for health plans sold to individuals through the exchange. The exchange shall be responsible for the following functions:

(1) publicize the exchange, including but not limited to its functions, eligibility rules, and enrollment procedures;

(2) provide assistance to employers to establish Section 125 Plans under section 62A.68;

(3) provide education and assistance to employers to help them understand the requirements of Section 125 Plans and compliance with applicable regulations;

(4) create a system to allow individuals to compare and enroll in health plans offered through the exchange;

(5) create a system to collect and transmit to the applicable plans all premium payments made by individuals, including developing mechanisms to receive and process automatic payroll deductions for individuals who purchase coverage through employer Section 125 Plans;

(6) not accept premium payments for individual market health plans from an employer Section 125 Plan if the employer offers a group health plan as defined in section 62A.10, or if the employer is a self-insurer as defined in section 62E.02;

(7) provide jointly with health insurers a cancellation notice directly to the primary insured at least ten days prior to termination of coverage for nonpayment of premium;

(8) bill the employer for the premiums payable by an employee, provided that the employer is not liable for payment except from payroll deductions for that purpose;

(9) refer individuals interested in MinnesotaCare under chapter 256L to the Department of Human Services to determine eligibility;

(10) establish a mechanism with the Department of Human Services to transfer premiums and subsidies for MinnesotaCare to qualify for federal matching payments;

(11) upon request, issue certificates of previous coverage according to the provisions of HIPAA and as referenced in section 62Q.181 to all such individuals who cease to be covered by a participating health plan through the exchange;

391.1 (12) establish procedures to account for all funds received and disbursed by the
391.2 exchange for individual participants of the exchange;

391.3 (13) make available to the public, at the end of each calendar year, a report of an
391.4 independent audit of the exchange's accounts; and

391.5 (14) provide copies of written and signed statements from employers stating that
391.6 the employer is not contributing to the employee's premiums for health plans purchased
391.7 by an employee through the exchange to all health insurers with enrolled employees of
391.8 the employer.

391.9 Health insurers may rely on the employer's statement in clause (4) provided by the
391.10 Minnesota Health Insurance Exchange and are not required to guarantee-issue individual
391.11 health plans to the employer's employees.

391.12 Subd. 10. **State not liable.** The state of Minnesota shall not be liable for the actions
391.13 of the Minnesota Health Insurance Exchange.

391.14 Subd. 11. **Powers of the exchange.** The exchange shall have the power to:

391.15 (1) contract with insurance producers licensed in accident and health insurance
391.16 under chapter 60K and vendors to perform one or more of the functions specified in
391.17 subdivision 10;

391.18 (2) contract with employers to collect premiums through a Section 125 Plan for
391.19 eligible individuals who purchase an individual market health plan through the exchange;

391.20 (3) establish and assess fees on health plan premiums of health plans purchased
391.21 through the exchange to fund the cost of administering the exchange;

391.22 (4) seek and directly receive grant funding from government agencies or private
391.23 philanthropic organizations to defray the costs of operating the exchange;

391.24 (5) establish and administer rules and procedures governing the operations of the
391.25 exchange;

391.26 (6) establish one or more service centers within Minnesota;

391.27 (7) sue or be sued or otherwise take any necessary or proper legal action;

391.28 (8) establish bank accounts and borrow money; and

391.29 (9) enter into agreements with the commissioners of commerce, health, human
391.30 services, revenue, employment and economic development, and other state agencies as
391.31 necessary for the exchange to implement the provisions of this section.

391.32 Subd. 12. **Dispute resolution.** The exchange shall establish procedures for
391.33 resolving disputes with respect to the eligibility of an individual to participate in the
391.34 exchange. The exchange does not have the authority or responsibility to intervene in or
391.35 resolve disputes between an individual and a health plan or health insurer. The exchange

shall refer complaints from individuals participating in the exchange to the commissioner to be resolved according to sections 62Q.68 to 62Q.73.

Subd. 13. Governance. The exchange shall be governed by a board of directors with 11 members. The board shall convene on or before July 1, 2007, after the initial board members have been selected. The initial board membership consists of the following:

(1) the commissioner of commerce;

(2) the commissioner of human services;

(3) the commissioner of health;

(4) four members appointed by a joint committee of the Minnesota senate and the Minnesota house of representatives to serve three-year terms; and
(5) four members appointed by the governor to serve three-year terms.

Subd. 14. Subsequent board membership. Ongoing membership of the exchange consists of the following effective July 1, 2010:

(1) the commissioner of commerce;

(2) the commissioner of human services;

(3) the commissioner of health;

(4) two members appointed by the governor with the approval of a joint committee of the senate and house of representatives to serve two-year terms; and
(5) six members elected by the membership of the exchange of which three

are elected to serve a two-year term and three are elected to serve a three-year term.

Appointed and elected members may serve more than one term.

Subd. 15. Operations of the board. Officers of the board of directors are elected by members of the board and serve one-year terms. Six members of the board constitutes a quorum, and the affirmative vote of six members of the board is necessary and sufficient for any action taken by the board. Board members serve without pay, but are reimbursed for actual expenses incurred in the performance of their duties.

Subd. 16. Operations of the exchange. The board of directors shall appoint an exchange director who shall:

(1) be a full-time employee of the exchange;

(2) administer all of the activities and contracts of the exchange; and

(3) hire and supervise the staff of the exchange.

Subd. 17. Insurance producers. An individual has the right to choose any insurance producer licensed in accident and health insurance under chapter 60K to assist them in purchasing an individual market health plan through the exchange. When a producer licensed in accident and health insurance under chapter 60K enrolls an eligible

393.1 individual in the exchange, the health plan chosen by an individual may pay the producer
393.2 a commission.

393.3 Subd. 18. **Implementation.** Health plan coverage through the exchange begins on
393.4 January 1, 2009. The exchange must be operational to assist employers and individuals
393.5 by September 1, 2008, and be prepared for enrollment by December 1, 2008. Enrollees
393.6 of individual market health plans, MinnesotaCare, and the Minnesota Comprehensive
393.7 Health Association as of December 2, 2008, are automatically enrolled in the exchange
393.8 on January 1, 2009, in the same health plan and at the same premium that they were
393.9 enrolled as of December 2, 2008, subject to the provisions of this section. As of January 1,
393.10 2009, all enrollees of individual market health plans, MinnesotaCare, and the Minnesota
393.11 Comprehensive Health Association shall make premium payments to the exchange.

393.12 Sec. 3. **[62A.68] SECTION 125 PLANS.**

393.13 Subdivision 1. **Definitions.** The following terms have the meanings given unless
393.14 otherwise provided in text:

393.15 (a) "Current employee" means an employee currently on an employer's payroll other
393.16 than a retiree or disabled former employee.

393.17 (b) "Employer" means a person, firm, corporation, partnership, association, business
393.18 trust, or other entity employing one or more persons, including a political subdivision of
393.19 the state, filing payroll tax information on such employed person or persons.

393.20 (c) "Section 125 Plan" means a cafeteria or Premium Only Plan under section 125
393.21 of the Internal Revenue Code that allows employees to purchase health insurance with
393.22 pretax dollars.

393.23 (d) "Exchange" means the Minnesota Health Insurance Exchange under section
393.24 62A.67.

393.25 (e) "Exchange director" means the appointed director under section 62A.67,
393.26 subdivision 16.

393.27 Subd. 2. **Section 125 Plan requirement.** (a) Effective January 1, 2009, all
393.28 employers with 11 or more current employees shall establish a Section 125 Plan to
393.29 allow their employees to purchase individual market health plan coverage with pretax
393.30 dollars. Nothing in this section requires or mandates employers to offer or purchase
393.31 health insurance coverage for their employees. The following employers are exempt
393.32 from the Section 125 Plan requirement:

393.33 (1) employers that offer a group health insurance plan as defined in 62A.10;

393.34 (2) employers that are self-insurers as defined in section 62E.02; and

(3) employers with fewer than 11 current employees, except that employers under this clause may voluntarily offer a Section 125 Plan.

(b) Employers that offer a Section 125 Plan may enter into an agreement with the exchange to administer the employer's Section 125 Plan.

Subd. 3. **Tracking compliance.** By July 1, 2008, the exchange, in consultation with the commissioners of commerce, health, employment and economic development, and revenue shall establish a method for tracking employer compliance with the Section 125 Plan requirement.

Subd. 4. **Employer requirements.** Employers that are required to offer or choose to offer a Section 125 Plan shall:

(1) allow employees to purchase any individual market health plan for themselves and their dependents through the exchange;

(2) allow employees to choose any insurance producer licensed in accident and health insurance under chapter 60K to assist them in purchasing an individual market health plan through the exchange;

(3) provide a written and signed statement to the exchange stating that the employer is not contributing to the employee's premiums for health plans purchased by an employee through the exchange;

(4) upon an employee's request, deduct premium amounts on a pretax basis in an amount not to exceed an employee's wages, and remit these employee payments to the exchange; and

(5) provide notice to employees that individual market health plans purchased through the exchange are not employer-sponsored or administered. Employers shall be held harmless from any and all liability claims related to the individual market health plans purchased through the exchange by employees under a Section 125 Plan.

Subd. 5. **Section 125 eligible health plans.** Individuals who are eligible to use an employer Section 125 Plan to pay for health insurance coverage purchased through the exchange may enroll in any health plan offered through the exchange for which the individual is eligible including individual market health plans, MinnesotaCare, and the Minnesota Comprehensive Health Association.

Sec. 4. Minnesota Statutes 2006, section 62E.141, is amended to read:

62E.141 INCLUSION IN EMPLOYER-SPONSORED PLAN.

No employee of an employer that offers a group health plan, under which the employee is eligible for coverage, is eligible to enroll, or continue to be enrolled, in the comprehensive health association, except for enrollment or continued enrollment

395.1 necessary to cover conditions that are subject to an unexpired preexisting condition
395.2 limitation, preexisting condition exclusion, or exclusionary rider under the employer's
395.3 health plan. This section does not apply to persons enrolled in the Comprehensive Health
395.4 Association as of June 30, 1993. With respect to persons eligible to enroll in the health
395.5 plan of an employer that has more than 29 current employees, as defined in section
395.6 62L.02, this section does not apply to persons enrolled in the Comprehensive Health
395.7 Association as of December 31, 1994.

395.8 Sec. 5. Minnesota Statutes 2006, section 62J.04, subdivision 3, is amended to read:

395.9 Subd. 3. **Cost containment duties.** The commissioner shall:

395.10 (1) establish statewide and regional cost containment goals for total health care
395.11 spending under this section ~~and~~, collect data as described in sections 62J.38 to 62J.41 to
395.12 monitor statewide achievement of the cost containment goals, and annually report to the
395.13 legislature on whether the goals were achieved and, if not, what action should be taken to
395.14 ensure that goals are achieved in the future;

395.15 (2) divide the state into no fewer than four regions, with one of those regions being
395.16 the Minneapolis/St. Paul metropolitan statistical area but excluding Chisago, Isanti,
395.17 Wright, and Sherburne Counties, for purposes of fostering the development of regional
395.18 health planning and coordination of health care delivery among regional health care
395.19 systems and working to achieve the cost containment goals;

395.20 (3) monitor the quality of health care throughout the state and take action as
395.21 necessary to ensure an appropriate level of quality;

395.22 (4) issue recommendations regarding uniform billing forms, uniform electronic
395.23 billing procedures and data interchanges, patient identification cards, and other uniform
395.24 claims and administrative procedures for health care providers and private and public
395.25 sector payers. In developing the recommendations, the commissioner shall review the
395.26 work of the work group on electronic data interchange (WEDI) and the American National
395.27 Standards Institute (ANSI) at the national level, and the work being done at the state and
395.28 local level. The commissioner may adopt rules requiring the use of the Uniform Bill
395.29 82/92 form, the National Council of Prescription Drug Providers (NCPDP) 3.2 electronic
395.30 version, the Centers for Medicare and Medicaid Services 1500 form, or other standardized
395.31 forms or procedures;

395.32 (5) undertake health planning responsibilities;

395.33 (6) authorize, fund, or promote research and experimentation on new technologies
395.34 and health care procedures;

(7) within the limits of appropriations for these purposes, administer or contract for statewide consumer education and wellness programs that will improve the health of Minnesotans and increase individual responsibility relating to personal health and the delivery of health care services, undertake prevention programs including initiatives to improve birth outcomes, expand childhood immunization efforts, and provide start-up grants for worksite wellness programs;

(8) undertake other activities to monitor and oversee the delivery of health care services in Minnesota with the goal of improving affordability, quality, and accessibility of health care for all Minnesotans; and

(9) make the cost containment goal data available to the public in a consumer-oriented manner.

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

Sec. 6. Minnesota Statutes 2006, section 62J.495, is amended to read:

**62J.495 HEALTH INFORMATION TECHNOLOGY AND
INFRASTRUCTURE ~~ADVISORY COMMITTEE.~~**

Subdivision 1. ~~Establishment; members; duties~~ **Implementation.** By January 1, 2012, all hospitals and health care providers must have in place an interoperable electronic health records system within their hospital system or clinical practice setting. The commissioner of health, in consultation with the Health Information Technology and Infrastructure Advisory Committee, shall develop a statewide plan to meet this goal, including the adoption of uniform standards to be used for the interoperable system for sharing and synchronizing patient data across systems. The standards must be compatible with federal efforts. The uniform standards must be refined and adopted for use when a standard development organization accredited by the American National Standards Institute completes the development of a standard for sharing and synchronizing patient data across systems.

Subd. 2. Health Information Technology and Infrastructure Advisory Committee. (a) The commissioner shall establish a Health Information Technology and Infrastructure Advisory Committee governed by section 15.059 to advise the commissioner on the following matters:

(1) assessment of the use of health information technology by the state, licensed health care providers and facilities, and local public health agencies;

(2) recommendations for implementing a statewide interoperable health information infrastructure, to include estimates of necessary resources, and for determining standards

for administrative data exchange, clinical support programs, patient privacy requirements, and maintenance of the security and confidentiality of individual patient data; and

(3) recommendations for encouraging use of innovative health care applications using information technology and systems to improve patient care and reduce the cost of care, including applications relating to disease management and personal health management that enable remote monitoring of patients' conditions, especially those with chronic conditions; and

~~(3)~~ (4) other related issues as requested by the commissioner.

(b) The members of the Health Information Technology and Infrastructure Advisory Committee shall include the commissioners, or commissioners' designees, of health, human services, administration, and commerce and additional members to be appointed by the commissioner to include persons representing Minnesota's local public health agencies, licensed hospitals and other licensed facilities and providers, private purchasers, the medical and nursing professions, health insurers and health plans, the state quality improvement organization, academic and research institutions, consumer advisory organizations with an interest and expertise in health information technology, and other stakeholders as identified by the Health Information Technology and Infrastructure Advisory Committee.

~~Subd. 2. Annual report.~~ (c) The commissioner shall prepare and issue an annual report not later than January 30 of each year outlining progress to date in implementing a statewide health information infrastructure and recommending future projects.

~~Subd. 3. Expiration.~~ (d) Notwithstanding section 15.059, this ~~section~~ subdivision expires June 30, ~~2009~~ 2012.

Sec. 7. [62J.496] ELECTRONIC HEALTH RECORD SYSTEM REVOLVING ACCOUNT AND LOAN PROGRAM.

Subdivision 1. Account establishment. The commissioner of finance shall establish and implement a revolving account in the state government special revenue fund to provide loans to eligible borrowers to assist in financing the installation or support of an interoperable health record system. The system must provide for the interoperable exchange of health care information between the applicant and, at a minimum, a hospital system, pharmacy, and a health care clinic or other physician group.

Subd. 2. Eligibility. (a) "Eligible borrower" means one of the following:

(1) community clinics, as defined under section 145.9268;

(2) hospitals eligible for rural hospital capital improvement grants, as defined in section 144.148;

(3) physician clinics located in a community with a population of less than 50,000 according to United States Census Bureau statistics and outside the seven-county metropolitan area;

(4) nursing facilities licensed under sections 144A.01 to 144A.27; and

(5) other providers of health or health care services approved by the commissioner for which interoperable electronic health record capability would improve quality of care, patient safety, or community health.

(b) To be eligible for a loan under this section, the applicant must submit a loan application to the commissioner of health on forms prescribed by the commissioner. The application must include, at a minimum:

(1) the amount of the loan requested and a description of the purpose or project for which the loan proceeds will be used;

(2) a quote from a vendor;

(3) a description of the health care entities and other groups participating in the project;

(4) evidence of financial stability and a demonstrated ability to repay the loan; and

(5) a description of how the system to be financed interconnects or plans in the future to interconnect with other health care entities and provider groups located in the same geographical area.

Subd. 3. **Loans.** (a) The commissioner of health may make a no interest loan to a provider or provider group who is eligible under subdivision 2 on a first-come, first-served basis provided that the applicant is able to comply with this section. The total accumulative loan principal must not exceed \$1,500,000 per loan. The commissioner of health has discretion over the size and number of loans made.

(b) The commissioner of health may prescribe forms and establish an application process and, notwithstanding section 16A.1283, may impose a reasonable nonrefundable application fee to cover the cost of administering the loan program.

(c) The borrower must begin repaying the principal no later than two years from the date of the loan. Loans must be amortized no later than six years from the date of the loan.

(d) Repayments must be credited to the account.

Subd. 4. **Data classification.** Data collected by the commissioner of health on the application to determine eligibility under subdivision 2 and to monitor borrowers' default risk or collect payments owed under subdivision 3 are (1) private data on individuals as defined in section 13.02, subdivision 12; and (2) nonpublic data as defined in section 13.02, subdivision 9. The names of borrowers and the amounts of the loans granted are public data.

Sec. 8. **[62J.536] UNIFORM ELECTRONIC TRANSACTIONS AND IMPLEMENTATION GUIDE STANDARDS.**

Subdivision 1. Electronic claims and eligibility transactions required. (a) Beginning January 15, 2009, all group purchasers must accept from health care providers the eligibility for a health plan transaction described under Code of Federal Regulations, title 45, part 162, subpart L. Beginning July 15, 2009, all group purchasers must accept from health care providers the health care claims or equivalent encounter information transaction described under Code of Federal Regulations, title 45, part 162, subpart K.

(b) Beginning January 15, 2009, all group purchasers must transmit to providers the eligibility for a health plan transaction described under Code of Federal Regulations, title 45, part 162, subpart L. Beginning December 1, 2009, all group purchasers must transmit to providers the health care payment and remittance advice transaction described under Code of Federal Regulations, title 45, part 162, subpart P.

(c) Beginning January 15, 2009, all health care providers must submit to group purchasers the eligibility for a health plan transaction described under Code of Federal Regulations, title 45, part 162, subpart L. Beginning July 15, 2009, all health care providers must submit to group purchasers the health care claims or equivalent encounter information transaction described under Code of Federal Regulations, title 45, part 162, subpart K.

(d) Beginning January 15, 2009, all health care providers must accept from group purchasers the eligibility for a health plan transaction described under Code of Federal Regulations, title 45, part 162, subpart L. Beginning December 15, 2009, all health care providers must accept from group purchasers the health care payment and remittance advice transaction described under Code of Federal Regulations, title 45, part 162, subpart P.

(e) Each of the transactions described in paragraphs (a) to (d) shall require the use of a single, uniform companion guide to the implementation guides described under Code of Federal Regulations, title 45, part 162. The companion guides will be developed pursuant to subdivision 2.

(f) Notwithstanding any other provisions in sections 62J.50 to 62J.61, all group purchasers and health care providers must exchange claims and eligibility information electronically using the transactions, companion guides, implementation guides, and timelines required under this subdivision. Group purchasers may not impose any fee on providers for the use of the transactions prescribed in this subdivision.

(g) Nothing in this subdivision shall prohibit group purchasers and health care providers from using a direct data entry, Web-based methodology for complying with

the requirements of this subdivision. Any direct data entry method for conducting the transactions specified in this subdivision must be consistent with the data content component of the single, uniform companion guides required in paragraph (e) and the implementation guides described under Code of Federal Regulations, title 45, part 162.

Subd. 2. Establishing uniform, standard companion guides. (a) At least 12 months prior to the timelines required in subdivision 1, the commissioner of health shall promulgate rules pursuant to section 62J.61 establishing and requiring group purchasers and health care providers to use the transactions and the uniform, standard companion guides required under subdivision 1, paragraph (e).

(b) The commissioner of health must consult with the Minnesota Administrative Uniformity Committee on the development of the single, uniform companion guides required under subdivision 1, paragraph (e), for each of the transactions in subdivision 1. The single uniform companion guides required under subdivision 1, paragraph (e), must specify uniform billing and coding standards. The commissioner of health shall base the companion guides required under subdivision 1, paragraph (e), billing and coding rules, and standards on the Medicare program, with modifications that the commissioner deems appropriate after consulting the Minnesota Administrative Uniformity Committee.

(c) No group purchaser or health care provider may add to or modify the single, uniform companion guides defined in subdivision 1, paragraph (e), through additional companion guides or other requirements.

(d) In promulgating the rules in paragraph (a), the commissioner shall not require data content that is not essential to accomplish the purpose of the transactions in subdivision 1.

Sec. 9. Minnesota Statutes 2006, section 62J.692, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** For purposes of this section, the following definitions apply:

(a) "Accredited clinical training" means the clinical training provided by a medical education program that is accredited through an organization recognized by the Department of Education, the Centers for Medicare and Medicaid Services, or another national body who reviews the accrediting organizations for multiple disciplines and whose standards for recognizing accrediting organizations are reviewed and approved by the commissioner of health in consultation with the Medical Education and Research Advisory Committee.

(b) "Commissioner" means the commissioner of health.

(c) "Clinical medical education program" means the accredited clinical training of physicians (medical students and residents), doctor of pharmacy practitioners, doctors of chiropractic, dentists, advanced practice nurses (clinical nurse specialists, certified registered nurse anesthetists, nurse practitioners, and certified nurse midwives), and physician assistants.

(d) "Sponsoring institution" means a hospital, school, or consortium located in Minnesota that sponsors and maintains primary organizational and financial responsibility for a clinical medical education program in Minnesota and which is accountable to the accrediting body.

(e) "Teaching institution" means a hospital, medical center, clinic, or other organization that conducts a clinical medical education program in Minnesota.

(f) "Trainee" means a student or resident involved in a clinical medical education program.

(g) "Eligible trainee FTEs" means the number of trainees, as measured by full-time equivalent counts, that are at training sites located in Minnesota with a currently active medical assistance provider number enrollment status and a National Provider Identification (NPI) number where training occurs in either an inpatient or ambulatory patient care setting and where the training is funded, in part, by patient care revenues.

Sec. 10. Minnesota Statutes 2006, section 62J.692, subdivision 4, is amended to read:

Subd. 4. **Distribution of funds.** (a) The commissioner shall annually distribute 90 percent of ~~available medical education~~ funds transferred according to section 256B.69, subdivision 5c, paragraph (a), clause (1), to all qualifying applicants based on a distribution formula that reflects a summation of two factors:

(1) an education factor, which is determined by the total number of eligible trainee FTEs and the total statewide average costs per trainee, by type of trainee, in each clinical medical education program; and

(2) a public program volume factor, which is determined by the total volume of public program revenue received by each training site as a percentage of all public program revenue received by all training sites in the fund pool.

In this formula, the education factor is weighted at 67 percent and the public program volume factor is weighted at 33 percent.

Public program revenue for the distribution formula includes revenue from medical assistance, prepaid medical assistance, general assistance medical care, and prepaid general assistance medical care. Training sites that receive no public program revenue are ineligible for funds available under this paragraph. Total statewide average costs per

trainee for medical residents is based on audited clinical training costs per trainee in primary care clinical medical education programs for medical residents. Total statewide average costs per trainee for dental residents is based on audited clinical training costs per trainee in clinical medical education programs for dental students. Total statewide average costs per trainee for pharmacy residents is based on audited clinical training costs per trainee in clinical medical education programs for pharmacy students.

(b) The commissioner shall annually distribute ten percent of ~~total available medical education~~ funds transferred according to section 256B.69, subdivision 5c, paragraph (a), clause (1), to all qualifying applicants based on the percentage received by each applicant under paragraph (a). These funds are to be used to offset clinical education costs at eligible clinical training sites based on criteria developed by the clinical medical education program. Applicants may choose to distribute funds allocated under this paragraph based on the distribution formula described in paragraph (a).

(c) The commissioner shall annually distribute \$5,000,000 of the funds dedicated to the commissioner under section 297F.10, subdivision 1, clause (2), plus any federal financial participation on these funds and on funds transferred under subdivision 10, to all qualifying applicants based on a distribution formula that gives 100 percent weight to a public program volume factor, which is determined by the total volume of public program revenue received by each training site as a percentage of all public program revenue received by all training sites in the fund pool. If federal approval is not obtained for federal financial participation on any portion of funds distributed under this paragraph, 90 percent of the unmatched funds shall be distributed by the commissioner based on the formula described in paragraph (a) and ten percent of the unmatched funds shall be distributed by the commissioner based on the formula described in paragraph (b).

(d) The commissioner shall annually distribute \$3,060,000 of funds dedicated to the commissioner under section 297F.10, subdivision 1, clause (2), through a formula giving 100 percent weight to an education factor, which is determined by the total number of eligible trainee full-time equivalents and the total statewide average costs per trainee, by type of trainee, in each clinical medical education program. If no matching funds are received on funds distributed under paragraph (c), funds distributed under this paragraph shall be distributed by the commissioner based on the formula described in paragraph (a).

(e) The commissioner shall annually distribute \$340,000 of funds dedicated to the commissioner under section 297F.10, subdivision 1, clause (2), to all qualifying applicants based on the percentage received by each applicant under paragraph (a). These funds are to be used to offset clinical education costs at eligible clinical training sites based on criteria developed by the clinical medical education program. Applicants may choose to

403.1 distribute funds allocated under this paragraph based on the distribution formula described
403.2 in paragraph (a). If no matching funds are received on funds distributed under paragraph
403.3 (c), funds distributed under this paragraph shall be distributed by the commissioner based
403.4 on the formula described in paragraph (b).

403.5 ~~(e)~~ (f) Funds distributed shall not be used to displace current funding appropriations
403.6 from federal or state sources.

403.7 ~~(d)~~ (g) Funds shall be distributed to the sponsoring institutions indicating the amount
403.8 to be distributed to each of the sponsor's clinical medical education programs based on
403.9 the criteria in this subdivision and in accordance with the commissioner's approval letter.
403.10 Each clinical medical education program must distribute funds allocated under paragraph
403.11 (a) to the training sites as specified in the commissioner's approval letter. Sponsoring
403.12 institutions, which are accredited through an organization recognized by the Department
403.13 of Education or the Centers for Medicare and Medicaid Services, may contract directly
403.14 with training sites to provide clinical training. To ensure the quality of clinical training,
403.15 those accredited sponsoring institutions must:

403.16 (1) develop contracts specifying the terms, expectations, and outcomes of the clinical
403.17 training conducted at sites; and

403.18 (2) take necessary action if the contract requirements are not met. Action may
403.19 include the withholding of payments under this section or the removal of students from
403.20 the site.

403.21 ~~(e)~~ (h) Any funds not distributed in accordance with the commissioner's approval
403.22 letter must be returned to the medical education and research fund within 30 days of
403.23 receiving notice from the commissioner. The commissioner shall distribute returned funds
403.24 to the appropriate training sites in accordance with the commissioner's approval letter.

403.25 ~~(f)~~ (i) The commissioner shall distribute by June 30 of each year an amount equal to
403.26 the funds transferred under subdivision 10, ~~plus five percent interest~~ to the University of
403.27 Minnesota Board of Regents for the instructional costs of health professional programs
403.28 at the Academic Health Center and for interdisciplinary academic initiatives within the
403.29 Academic Health Center.

403.30 ~~(g)~~ (j) A maximum of \$150,000 of the funds dedicated to the commissioner
403.31 under section 297F.10, subdivision 1, ~~paragraph (b)~~, clause (2), may be used by the
403.32 commissioner for administrative expenses associated with implementing this section.

403.33 Sec. 11. Minnesota Statutes 2006, section 62J.692, subdivision 7a, is amended to read:

403.34 Subd. 7a. **Clinical medical education innovations grants.** (a) The commissioner
403.35 shall award grants to teaching institutions and clinical training sites for projects that

404.1 increase dental access for underserved populations and promote innovative clinical
404.2 training of dental professionals.

404.3 (b) The commissioner shall award grants to teaching institutions and clinical training
404.4 sites for projects that increase mental health access for underserved populations, promote
404.5 innovative clinical training of mental health professionals, increase the number of mental
404.6 health providers in rural or underserved areas, and promote the incorporation of patient
404.7 safety principles into clinical medical education programs.

404.8 (c) In awarding the grants, the commissioner, in consultation with the commissioner
404.9 of human services, shall consider the following:

404.10 (1) potential to successfully increase access to an underserved population;

404.11 (2) the long-term viability of the project to improve access beyond the period
404.12 of initial funding;

404.13 (3) evidence of collaboration between the applicant and local communities;

404.14 (4) the efficiency in the use of the funding; ~~and~~

404.15 (5) the priority level of the project in relation to state clinical education, access,
404.16 patient safety, and workforce goals; and

404.17 (6) the potential of the project to impact the number or distribution of the health
404.18 care workforce.

404.19 ~~(b)~~ (d) The commissioner shall periodically evaluate the priorities in awarding the
404.20 innovations grants in order to ensure that the priorities meet the changing workforce
404.21 needs of the state.

404.22 Sec. 12. Minnesota Statutes 2006, section 62J.692, subdivision 8, is amended to read:

404.23 Subd. 8. **Federal financial participation.** (a) The commissioner of human
404.24 services shall seek to maximize federal financial participation in payments for medical
404.25 education and research costs. ~~If the commissioner of human services determines that~~
404.26 ~~federal financial participation is available for the medical education and research, the~~
404.27 ~~commissioner of health shall transfer to the commissioner of human services the amount~~
404.28 ~~of state funds necessary to maximize the federal funds available. The amount transferred~~
404.29 ~~to the commissioner of human services, plus the amount of federal financial participation,~~
404.30 ~~shall be distributed to medical assistance providers in accordance with the distribution~~
404.31 ~~methodology described in subdivision 4.~~

404.32 (b) For the purposes of paragraph (a), the commissioner shall use physician clinic
404.33 rates where possible to maximize federal financial participation.

404.34 Sec. 13. Minnesota Statutes 2006, section 62J.692, subdivision 10, is amended to read:

Subd. 10. **Transfers from University of Minnesota.** Of the funds dedicated to the Academic Health Center under section 297F.10, subdivision 1, clause (1), \$4,850,000 shall be transferred annually to the commissioner of health no later than April 15 of each year for distribution under subdivision 4, paragraph ~~(f)~~ (i).

Sec. 14. Minnesota Statutes 2006, section 62J.81, subdivision 1, is amended to read:

Subdivision 1. **Required disclosure of estimated payment.** (a) A health care provider, as defined in section 62J.03, subdivision 8, or the provider's designee as agreed to by that designee, shall, at the request of a consumer, provide that consumer with a good faith estimate of the ~~reimbursement~~ allowable payment the provider ~~expects to receive from the health plan company in which the consumer is enrolled~~ has agreed to accept from the consumer's health plan company for the services specified by the consumer, specifying the amount of the allowable payment due from the health plan company. Health plan companies must allow contracted providers, or their designee, to release this information. ~~A good faith estimate must also be made available at the request of a consumer who is not enrolled in a health plan company.~~ If a consumer has no applicable public or private coverage, the health care provider must give the consumer a good faith estimate of the average allowable reimbursement the provider accepts as payment from private third-party payers for the services specified by the consumer and the estimated amount the noncovered consumer will be required to pay. Payment information provided by a provider, or by the provider's designee as agreed to by that designee, to a patient pursuant to this subdivision does not constitute a legally binding estimate of the allowable charge for or cost to the consumer of services.

(b) A health plan company, as defined in section 62J.03, subdivision 10, shall, at the request of an enrollee or the enrollee's designee, provide that enrollee with a good faith estimate of the ~~reimbursement~~ allowable amount the health plan company ~~would expect to pay to~~ has contracted for with a specified provider within the network as total payment for a health care service specified by the enrollee and the portion of the allowable amount due from the enrollee and the enrollee's out-of-pocket costs. ~~If requested by the enrollee, the health plan company shall also provide to the enrollee a good faith estimate of the enrollee's out-of-pocket cost for the health care service.~~ An estimate provided to an enrollee under this paragraph is not a legally binding estimate of the ~~reimbursement~~ allowable amount or enrollee's out-of-pocket cost.

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

Sec. 15. Minnesota Statutes 2006, section 62J.82, is amended to read:

62J.82 HOSPITAL ~~CHARGE~~ INFORMATION REPORTING DISCLOSURE.

Subdivision 1. Required information. The Minnesota Hospital Association shall develop a Web-based system, available to the public free of charge, for reporting ~~charge information~~ the following, for Minnesota residents:

(1) hospital-specific performance on the measures of care developed under section 256B.072 for acute myocardial infarction, heart failure, and pneumonia;

(2) by January 1, 2009, hospital-specific performance on the public reporting measures for hospital-acquired infections as published by the National Quality Forum and collected by the Minnesota Hospital Association and Stratis Health in collaboration with infection control practitioners; and

(3) charge information, including, but not limited to, number of discharges, average length of stay, average charge, average charge per day, and median charge, for each of the 50 most common inpatient diagnosis-related groups and the 25 most common outpatient surgical procedures as specified by the Minnesota Hospital Association.

Subd. 2. Web site. The Web site must provide information that compares hospital-specific data to hospital statewide data. The Web site must be ~~established by October 1, 2006, and must be~~ updated annually. The commissioner shall provide a link to this reporting information on the department's Web site.

Subd. 3. Enforcement. The commissioner shall provide a link to this information on the department's Web site. If a hospital does not provide this information to the Minnesota Hospital Association, the commissioner of health may require the hospital to do so in accordance with section 144.55, subdivision 6. ~~The commissioner shall provide a link to this information on the department's Web site.~~

Sec. 16. [62J.84] HEALTH CARE TRANSFORMATION TASK FORCE.

Subdivision 1. Task force. The governor shall convene a health care transformation task force to advise and assist the governor and the Minnesota legislature. The task force shall consist of:

(1) four legislators from the house of representatives appointed by the speaker, two from the majority party and two from the minority party, and four legislators from the senate appointed by the Subcommittee on Committees of the senate Committee on Rules and Administration, two from the majority party and two from the minority party;

(2) four representatives of the governor and state agencies appointed by the governor;

(3) at least four persons appointed by the governor who have demonstrated leadership in health care organizations, health improvement initiatives, health care trade or professional associations, or other collaborative health system improvement activities; and

(4) at least two persons appointed by the governor who have demonstrated leadership in employer and group purchaser activities related to health system improvement, at least one of which must be from a labor organization.

Subd. 2. **Public input.** The commissioner of health shall review available research, and conduct statewide, regional, and local surveys, focus groups, and other activities as needed to fill gaps in existing research, to determine Minnesotans' values, preferences, opinions, and perceptions related to health care and to the issues confronting the task force, and shall report the findings to the task force.

Subd. 3. **Inventory and assessment of existing activities; action plan.** The task force shall complete an inventory and assessment of all public and private organized activities, coalitions, and collaboratives working on tasks relating to health system improvement including, but not limited to, patient safety, quality measurement and reporting, evidence-based practice, adoption of health information technology, disease management and chronic care coordination, medical homes, access to health care, cultural competence, prevention and public health, consumer incentives, price and cost transparency, nonprofit organization community benefits, education, research, and health care workforce.

Subd. 4. **Action plan.** By December 15, 2007, the governor, with the advice and assistance of the task force, shall develop and present to the legislature a statewide action plan for transforming the health care system to improve affordability, quality, and access. The plan shall include draft legislation needed to implement the plan. The plan may consist of legislative actions, administrative actions of governmental entities, collaborative actions, and actions of individuals and individual organizations. Among other things, the action plan must include the following, with specific and measurable goals and deadlines for each:

(1) proposed actions that will slow the rate of increase in health care costs to a rate that does not exceed the increase in the Consumer Price Index for urban consumers for the preceding calendar year plus two percentage points, plus an additional percentage based on the added costs necessary to implement legislation enacted in 2007;

(2) actions that will increase the affordable health coverage options for uninsured and underinsured Minnesotans and other strategies that will ensure that all Minnesotans will have health coverage by January 2011;

(3) actions to improve the quality and safety of health care and reduce racial and ethnic disparities in access and quality;

(4) actions that will reduce the rate of preventable chronic illness through prevention and public health and wellness initiatives; and

(5) proposed changes to state health care purchasing and payment strategies used for state health care programs and state employees that will promote higher quality, lower cost health care through incentives that reward prevention and early intervention, use of cost-effective primary care, effective care coordination, and management of chronic disease;

(6) actions that will promote the appropriate and cost-effective investment in new facilities, technologies, and drugs;

(7) actions to reduce administrative costs; and

(8) the results of the inventory completed under subdivision 3 and recommendations for how these activities can be coordinated and improved.

Subd. 5. **Options for small employers.** The task force shall study and report back to the legislature by December 15, 2007, on options for serving small employers and their employees, and self-employed individuals.

Sec. 17. Minnesota Statutes 2006, section 62L.12, subdivision 2, is amended to read:

Subd. 2. **Exceptions.** (a) A health carrier may sell, issue, or renew individual conversion policies to eligible employees otherwise eligible for conversion coverage under section 62D.104 as a result of leaving a health maintenance organization's service area.

(b) A health carrier may sell, issue, or renew individual conversion policies to eligible employees otherwise eligible for conversion coverage as a result of the expiration of any continuation of group coverage required under sections 62A.146, 62A.17, 62A.21, 62C.142, 62D.101, and 62D.105.

(c) A health carrier may sell, issue, or renew conversion policies under section 62E.16 to eligible employees.

(d) A health carrier may sell, issue, or renew individual continuation policies to eligible employees as required.

(e) A health carrier may sell, issue, or renew individual health plans if the coverage is appropriate due to an unexpired preexisting condition limitation or exclusion applicable to the person under the employer's group health plan or due to the person's need for health care services not covered under the employer's group health plan.

(f) A health carrier may sell, issue, or renew an individual health plan, if the individual has elected to buy the individual health plan not as part of a general plan to

409.1 substitute individual health plans for a group health plan nor as a result of any violation of
409.2 subdivision 3 or 4.

409.3 (g) Nothing in this subdivision relieves a health carrier of any obligation to provide
409.4 continuation or conversion coverage otherwise required under federal or state law.

409.5 (h) Nothing in this chapter restricts the offer, sale, issuance, or renewal of coverage
409.6 issued as a supplement to Medicare under sections 62A.3099 to 62A.44, or policies or
409.7 contracts that supplement Medicare issued by health maintenance organizations, or those
409.8 contracts governed by sections 1833, 1851 to 1859, 1860D, or 1876 of the federal Social
409.9 Security Act, United States Code, title 42, section 1395 et seq., as amended.

409.10 (i) Nothing in this chapter restricts the offer, sale, issuance, or renewal of individual
409.11 health plans necessary to comply with a court order.

409.12 (j) A health carrier may offer, issue, sell, or renew an individual health plan to
409.13 persons eligible for an employer group health plan, if the individual health plan is a high
409.14 deductible health plan for use in connection with an existing health savings account, in
409.15 compliance with the Internal Revenue Code, section 223. In that situation, the same or
409.16 a different health carrier may offer, issue, sell, or renew a group health plan to cover
409.17 the other eligible employees in the group.

409.18 (k) A health carrier may offer, sell, issue, or renew an individual health plan to one
409.19 or more employees of a small employer if the individual health plan is marketed ~~directly~~
409.20 through the Minnesota Health Insurance Exchange under section 62A.67 or 62A.68 to
409.21 all employees of the small employer and the small employer does not contribute directly
409.22 or indirectly to the premiums or facilitate the administration of the individual health
409.23 plan. The requirement to market an individual health plan to all employees through the
409.24 Minnesota Health Insurance Exchange under section 62A.67 or 62A.68 does not require
409.25 the health carrier to offer or issue an individual health plan to any employee. For purposes
409.26 of this paragraph, an employer is not contributing to the premiums or facilitating the
409.27 administration of the individual health plan if the employer does not contribute to the
409.28 premium and merely collects the premiums from an employee's wages or salary through
409.29 payroll deductions and submits payment for the premiums of one or more employees ~~in a~~
409.30 ~~lump sum to the health carrier~~ to the Minnesota Health Insurance Exchange under section
409.31 62A.67 or 62A.68. Except for coverage under section 62A.65, subdivision 5, paragraph
409.32 (b), or 62E.16, at the request of an employee, the ~~health carrier~~ Minnesota Health Insurance
409.33 Exchange under section 62A.67 or 62A.68 may bill the employer for the premiums
409.34 payable by the employee, provided that the employer is not liable for payment except
409.35 from payroll deductions for that purpose. If an employer is submitting payments under
409.36 this paragraph, the health carrier and the Minnesota Health Insurance Exchange under

section 62A.67 or 62A.68 shall jointly provide a cancellation notice directly to the primary insured at least ten days prior to termination of coverage for nonpayment of premium.

~~Individual coverage under this paragraph may be offered only if the small employer has not provided coverage under section 62L.03 to the employees within the past 12 months.~~

The employer must provide a written and signed statement to the ~~health carrier~~ Minnesota Health Insurance Exchange under section 62A.67 or 62A.68 that the employer is not contributing directly or indirectly to the employee's premiums. The Minnesota Health Insurance Exchange under section 62A.67 or 62A.68 shall provide all health carriers with enrolled employees of the employer with a copy of the employer's statement. The health carrier may rely on the employer's statement provided by the Minnesota Health Insurance Exchange under section 62A.67 or 62A.68 and is not required to guarantee-issue individual health plans to the employer's ~~other current or future~~ employees.

Sec. 18. Minnesota Statutes 2006, section 62L.12, subdivision 4, is amended to read:

Subd. 4. **Employer prohibition.** A small employer offering a health benefit plan shall not encourage or direct an employee or applicant to:

(1) refrain from filing an application for health coverage when other similarly situated employees may file an application for health coverage;

(2) file an application for health coverage during initial eligibility for coverage, the acceptance of which is contingent on health status, when other similarly situated employees may apply for health coverage, the acceptance of which is not contingent on health status;

(3) seek coverage from another health carrier, including, but not limited to, MCHA; or

(4) cause coverage to be issued on different terms because of the health status or claims experience of that person or the person's dependents.

Sec. 19. Minnesota Statutes 2006, section 62Q.165, subdivision 1, is amended to read:

Subdivision 1. **Definition.** It is the commitment of the state to achieve universal health coverage for all Minnesotans by the year 2011. Universal coverage is achieved when:

(1) every Minnesotan has access to a full range of quality health care services;

(2) every Minnesotan is able to obtain affordable health coverage which pays for the full range of services, including preventive and primary care; and

(3) every Minnesotan pays into the health care system according to that person's ability.

411.1 **EFFECTIVE DATE.** This section is effective July 1, 2007.

411.2 Sec. 20. Minnesota Statutes 2006, section 62Q.165, subdivision 2, is amended to read:

411.3 Subd. 2. **Goal.** It is the goal of the state to make continuous progress toward
411.4 reducing the number of Minnesotans who do not have health coverage so that by January
411.5 1, 2000, ~~fewer than four percent of the state's population will be without health coverage~~
411.6 2011, all Minnesota residents have access to affordable health care. The goal will be
411.7 achieved by improving access to private health coverage through insurance reforms and
411.8 market reforms, by making health coverage more affordable for low-income Minnesotans
411.9 through purchasing pools and state subsidies, and by reducing the cost of health coverage
411.10 through cost containment programs and methods of ensuring that all Minnesotans are
411.11 paying into the system according to their ability.

411.12 **EFFECTIVE DATE.** This section is effective July 1, 2007.

411.13 Sec. 21. Minnesota Statutes 2006, section 62Q.80, subdivision 3, is amended to read:

411.14 Subd. 3. **Approval.** (a) Prior to the operation of a community-based health care
411.15 coverage program, a community-based health initiative shall submit to the commissioner
411.16 of health for approval the community-based health care coverage program developed by
411.17 the initiative. ~~The commissioner shall only approve a program that has been awarded~~
411.18 ~~a community access program grant from the United States Department of Health and~~
411.19 ~~Human Services.~~ The commissioner shall ensure that the program meets the federal grant
411.20 requirements and any requirements described in this section and is actuarially sound based
411.21 on a review of appropriate records and methods utilized by the community-based health
411.22 initiative in establishing premium rates for the community-based health care coverage
411.23 program.

411.24 (b) Prior to approval, the commissioner shall also ensure that:

411.25 (1) the benefits offered comply with subdivision 8 and that there are adequate
411.26 numbers of health care providers participating in the community-based health network to
411.27 deliver the benefits offered under the program;

411.28 (2) the activities of the program are limited to activities that are exempt under this
411.29 section or otherwise from regulation by the commissioner of commerce;

411.30 (3) the complaint resolution process meets the requirements of subdivision 10; and

411.31 (4) the data privacy policies and procedures comply with state and federal law.

411.32 Sec. 22. Minnesota Statutes 2006, section 62Q.80, subdivision 4, is amended to read:

Subd. 4. **Establishment.** ~~(a)~~ The initiative shall establish and operate upon approval by the commissioner of health a community-based health care coverage program. The operational structure established by the initiative shall include, but is not limited to:

- (1) establishing a process for enrolling eligible individuals and their dependents;
- (2) collecting and coordinating premiums from enrollees and employers of enrollees;
- (3) providing payment to participating providers;
- (4) establishing a benefit set according to subdivision 8 and establishing premium rates and cost-sharing requirements;

(5) creating incentives to encourage primary care and wellness services; and

(6) initiating disease management services, as appropriate.

~~(b) The payments collected under paragraph (a), clause (2), may be used to capture available federal funds.~~

Sec. 23. Minnesota Statutes 2006, section 62Q.80, subdivision 13, is amended to read:

Subd. 13. **Report.** (a) The initiative shall submit quarterly status reports to the commissioner of health on January 15, April 15, July 15, and October 15 of each year, with the first report due January 15, ~~2007~~ 2008. The status report shall include:

(1) the financial status of the program, including the premium rates, cost per member per month, claims paid out, premiums received, and administrative expenses;

(2) a description of the health care benefits offered and the services utilized;

(3) the number of employers participating, the number of employees and dependents covered under the program, and the number of health care providers participating;

(4) a description of the health outcomes to be achieved by the program and a status report on the performance measurements to be used and collected; and

(5) any other information requested by the commissioner of health or commerce or the legislature.

(b) The initiative shall contract with an independent entity to conduct an evaluation of the program to be submitted to the commissioners of health and commerce and the legislature by January 15, ~~2009~~ 2010. The evaluation shall include:

(1) an analysis of the health outcomes established by the initiative and the performance measurements to determine whether the outcomes are being achieved;

(2) an analysis of the financial status of the program, including the claims to premiums loss ratio and utilization and cost experience;

(3) the demographics of the enrollees, including their age, gender, family income, and the number of dependents;

413.1 (4) the number of employers and employees who have been denied access to the
413.2 program and the basis for the denial;

413.3 (5) specific analysis on enrollees who have aggregate medical claims totaling over
413.4 \$5,000 per year, including data on the enrollee's main diagnosis and whether all the
413.5 medical claims were covered by the program;

413.6 (6) number of enrollees referred to state public assistance programs;

413.7 (7) a comparison of employer-subsidized health coverage provided in a comparable
413.8 geographic area to the designated community-based geographic area served by the
413.9 program, including, to the extent available:

413.10 (i) the difference in the number of employers with 50 or fewer employees offering
413.11 employer-subsidized health coverage;

413.12 (ii) the difference in uncompensated care being provided in each area; and

413.13 (iii) a comparison of health care outcomes and measurements established by the
413.14 initiative; and

413.15 (8) any other information requested by the commissioner of health or commerce.

413.16 Sec. 24. Minnesota Statutes 2006, section 62Q.80, subdivision 14, is amended to read:

413.17 Subd. 14. **Sunset.** This section expires December 31, ~~2011~~ 2012.

413.18 Sec. 25. Minnesota Statutes 2006, section 144.698, subdivision 1, is amended to read:

413.19 Subdivision 1. **Yearly reports.** (a) Each hospital and each outpatient surgical center,
413.20 which has not filed the financial information required by this section with a voluntary,
413.21 nonprofit reporting organization pursuant to section 144.702, shall file annually with the
413.22 commissioner of health after the close of the fiscal year:

413.23 (1) a balance sheet detailing the assets, liabilities, and net worth of the hospital or
413.24 outpatient surgical center;

413.25 (2) a detailed statement of income and expenses;

413.26 (3) a copy of its most recent cost report, if any, filed pursuant to requirements of
413.27 Title XVIII of the United States Social Security Act;

413.28 (4) a copy of all changes to articles of incorporation or bylaws;

413.29 (5) information on services provided to benefit the community, including services
413.30 provided at no cost or for a reduced fee to patients unable to pay, teaching and research
413.31 activities, or other community or charitable activities;

413.32 (6) information required on the revenue and expense report form set in effect on
413.33 July 1, 1989, or as amended by the commissioner in rule;

413.34 (7) information on changes in ownership or control; ~~and~~

414.1 (8) other information required by the commissioner in rule;

414.2 (9) information on the number of available hospital beds that are dedicated to certain
414.3 specialized services, as designated by the commissioner, and annual occupancy rates for
414.4 those beds, separately for adult and pediatric care;

414.5 (10) from outpatient surgical centers, the total number of surgeries; and

414.6 (11) a report on health care capital expenditures during the previous year, as required
414.7 by section 62J.17.

414.8 (b) Beginning with hospital fiscal year 2009, each nonprofit hospital shall report on
414.9 community benefits under paragraph (a), clause (5). "Community benefit" means the costs
414.10 of community care, underpayment for services provided under state health care programs,
414.11 research costs, community health services costs, financial and in-kind contributions, costs
414.12 of community building activities, costs of community benefit operations, education, and
414.13 the cost of operating subsidized services. The cost of bad debts and underpayment for
414.14 Medicare services are not included in the calculation of community benefit.

414.15 Sec. 26. Minnesota Statutes 2006, section 144.699, is amended by adding a subdivision
414.16 to read:

414.17 Subd. 5. **Annual reports on community benefit, community care amounts,**
414.18 **and state program underfunding.** (a) For each hospital reporting health care cost
414.19 information under section 144.698 or 144.702, the commissioner shall report annually
414.20 on the hospital's community benefit, community care, and underpayment for state public
414.21 health care programs.

414.22 (b) For purposes of this subdivision, "community benefits" has the definition given
414.23 in section 144.698, paragraph (b).

414.24 (c) For purposes of this subdivision, "community care" means the costs for medical
414.25 care for which a hospital has determined is charity care, as defined under Minnesota Rules,
414.26 part 4650.0115, or for which the hospital determines after billing for the services that there
414.27 is a demonstrated inability to pay. Any costs forgiven under a hospital's community care
414.28 plan or under section 62J.83 may be counted in the hospital's calculation of community
414.29 care. Bad debt expenses and discounted charges available to the uninsured shall not be
414.30 included in the calculation of community care. The amount of community care is the value
414.31 of costs incurred and not the charges made for services.

414.32 (d) For purposes of this subdivision, underpayment for services provided by state
414.33 public health care programs is the difference between hospital costs and public program
414.34 payments. The information shall be reported in terms of total dollars and as a percentage
414.35 of total operating costs for each hospital.

Sec. 27. Minnesota Statutes 2006, section 256.01, subdivision 2b, is amended to read:

Subd. 2b. **Performance payments.** (a) The commissioner shall develop and implement a pay-for-performance system to provide performance payments to:

(1) eligible medical groups and clinics that demonstrate optimum care in serving individuals with chronic diseases who are enrolled in health care programs administered by the commissioner under chapters 256B, 256D, and 256L;

(2) medical groups that implement effective medical home models of patient care that improve quality and reduce costs through effective primary and preventive care, care coordination, and management of chronic conditions; and

(3) eligible medical groups and clinics that evaluate medical provider usage patterns and provide feedback to individual medical providers on that provider's practice patterns relative to peer medical providers.

(b) The commissioner shall also develop and implement a patient incentive health program to provide incentives and rewards to patients who are enrolled in health care programs administered by the commissioner under chapters 256B, 256D, and 256L, and who have agreed to and meet personal health goals established with their primary care provider to manage a chronic disease or condition including, but not limited to, diabetes, high blood pressure, and coronary artery disease.

(c) The commissioner may receive any federal matching money that is made available through the medical assistance program for managed care oversight contracted through vendors including consumer surveys, studies, and external quality reviews as required by the Federal Balanced Budget Act of 1997, Code of Federal Regulations, title 42, part 438, subpart E. Any federal money received for managed care oversight is appropriated to the commissioner for this purpose. The commissioner may expend the federal money received in either year of the biennium.

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

Sec. 28. Minnesota Statutes 2006, section 256B.0625, is amended by adding a subdivision to read:

Subd. 49. **Provider-directed care coordination services.** The commissioner shall develop and implement a provider-directed care coordination program for medical assistance recipients who are not enrolled in the prepaid medical assistance program and who are receiving services on a fee-for-service basis. This program provides payment to primary care clinics for care coordination for people who have complex and chronic medical conditions. Clinics must meet certain criteria such as the capacity to develop care plans; have a dedicated care coordinator; and have an adequate number of fee-for-service

416.1 clients, evaluation mechanisms, and quality improvement processes to qualify for
416.2 reimbursement. For purposes of this subdivision, a primary care clinic is a medical clinic
416.3 designated as the patient's first point of contact for medical care, available 24 hours a
416.4 day, seven days a week, that provides or arranges for the patient's comprehensive health
416.5 care needs, and provides overall integration, coordination and continuity over time and
416.6 referrals for specialty care.

416.7 Sec. 29. **HEALTH CARE PAYMENT SYSTEM REFORM.**

416.8 Subdivision 1. **Payment reform plan.** The commissioners of employee relations,
416.9 human services, commerce, and health shall develop a plan for promoting and facilitating
416.10 changes in payment rates and methods for paying for health care services, drugs, devices,
416.11 supplies, and equipment in order to:

- 416.12 (1) reward the provision of cost-effective primary and preventive care;
416.13 (2) reward the use of evidence-based care;
416.14 (3) discourage underutilization, overuse, and misuse;
416.15 (4) reward the use of the most cost-effective settings, drugs, devices, providers,
416.16 and treatments; and
416.17 (5) encourage consumers to maintain good health and use the health care system
416.18 appropriately.

416.19 In developing the plan, the commissioners shall analyze existing data to determine
416.20 specific services and health conditions for which changes in payment rates and methods
416.21 would lead to significant improvements in quality of care.

416.22 Subd. 2. **Report.** The commissioners shall submit a report to the legislature by
416.23 December 15, 2007, describing the payment reform plan. The report must include
416.24 proposed legislation for implementing those components of the plan requiring legislative
416.25 action or appropriations of money.

416.26 **EFFECTIVE DATE.** This section is effective July 1, 2007.

416.27 Sec. 30. **COMMUNITY COLLABORATIVE PILOT PROJECTS TO COVER**
416.28 **THE UNINSURED.**

416.29 Subdivision 1. **Community collaboratives.** The commissioner of human services
416.30 shall provide grants to and authorization for up to three community collaboratives that
416.31 satisfy the requirements in this section. To be eligible to receive a grant and authorization
416.32 under this section, a community collaborative must include:

- 416.33 (1) one or more counties;
416.34 (2) one or more local hospitals;

417.1 (3) one or more local employers who collectively provide at least 300 jobs in the
417.2 community;

417.3 (4) one or more health care clinics or physician groups; and

417.4 (5) a third-party payer, which may be a county-based purchasing plan operating
417.5 under Minnesota Statutes, section 256B.692, a self-insured employer, or a health plan
417.6 company as defined in Minnesota Statutes, section 62Q.01, subdivision 4.

417.7 Subd. 2. **Pilot project requirements.** (a) Community collaborative pilot projects
417.8 must:

417.9 (1) identify and enroll persons in the community who are uninsured, and who have,
417.10 or are at risk of developing, one of the following chronic conditions: mental illness,
417.11 diabetes, asthma, hypertension, or other chronic condition designated by the project;

417.12 (2) assist uninsured persons to obtain private-sector health insurance coverage if
417.13 possible or to enroll in any public health care programs for which they are eligible. If the
417.14 uninsured individual is unable to obtain health coverage, the community collaborative
417.15 must enroll the individual in a local health care assistance program that provides specified
417.16 services to prevent or effectively manage the chronic condition;

417.17 (3) include components to help uninsured persons retain employment or to become
417.18 employable, if currently unemployed;

417.19 (4) ensure that each uninsured person enrolled in the program has a medical home
417.20 responsible for providing, or arranging for, health care services and assisting in the
417.21 effective management of the chronic condition;

417.22 (5) coordinate services between all providers and agencies serving an enrolled
417.23 individual; and

417.24 (6) be coordinated with the state's Q-Care initiative and improve the use of
417.25 evidence-based treatments and effective disease management programs in the broader
417.26 community, beyond those individuals enrolled in the project.

417.27 (b) Projects established under this section are not insurance and are not subject to
417.28 state-mandated benefit requirements or insurance regulations.

417.29 Subd. 3. **Criteria.** Proposals must be evaluated by actuarial, financial, and clinical
417.30 experts based on the likelihood that the project would produce a positive return on
417.31 investment for the community. In awarding grants, the commissioner of human services
417.32 shall give preference to proposals that:

417.33 (1) have broad community support from local businesses, provider counties, and
417.34 other public and private organizations;

417.35 (2) would provide services to uninsured persons who have, or are at risk of
417.36 developing, multiple, co-occurring chronic conditions;

(3) integrate or coordinate resources from multiple sources, such as employer contributions, county funds, social service programs, and provider financial or in-kind support;

(4) provide continuity of treatment and services when uninsured individuals in the program become eligible for public or private health insurance or when insured individuals lose their coverage;

(5) demonstrate how administrative costs for health plan companies and providers can be reduced through greater simplification, coordination, consolidation, standardization, reducing billing errors, or other methods; and

(6) involve local contributions to the cost of the pilot projects.

Subd. 4. **Grants.** The commissioner of human services shall provide implementation grants of up to one-half of the community collaborative's costs for planning, administration, and evaluation. The commissioner shall also provide grants to community collaboratives to develop a fund to pay up to 50 percent of the cost of the services provided to uninsured individuals. The remaining costs must be paid for through other sources or by agreement of a health care provider to contribute the cost as charity care.

Subd. 5. **Evaluation.** The commissioner of human services shall evaluate the effectiveness of each community collaborative project awarded a grant, by comparing actual costs for serving the identified uninsured persons to the predicted costs that would have been incurred in the absence of early intervention and consistent treatment to manage the chronic condition, including the costs to medical assistance, MinnesotaCare, and general assistance medical care. The commissioner shall require community collaborative projects, as a condition of receipt of a grant award, to provide the commissioner with all information necessary for this evaluation.

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

Sec. 31. HEALTH CARE PAYMENT REFORM PILOT PROJECTS.

Subdivision 1. **Pilot projects.** (a) The commissioners of health, human services, and employee relations shall develop and administer payment reform pilot projects for state employees and persons enrolled in medical assistance, MinnesotaCare, or general assistance medical care, to the extent permitted by federal requirements. The purpose of the projects is to promote and facilitate changes in payment rates and methods for paying for health care services, drugs, devices, supplies, and equipment in order to:

(1) reward the provision of cost-effective primary and preventive care;

(2) reward the use of evidence-based care;

419.1 (3) reward coordination of care for patients with chronic conditions;

419.2 (4) discourage overuse and misuse;

419.3 (5) reward the use of the most cost-effective settings, drugs, devices, providers,
419.4 and treatments;

419.5 (6) encourage consumers to maintain good health and use the health care system
419.6 appropriately.

419.7 (b) The pilot projects must involve the use of designated care professionals or
419.8 clinics to serve as a patient's medical home and be responsible for coordinating health
419.9 care services across the continuum of care. The pilot projects must evaluate different
419.10 payment reform models and must be coordinated with the Minnesota senior health options
419.11 program and the Minnesota disability health options program. To the extent possible, the
419.12 commissioners shall coordinate state purchasing activities with other public employers
419.13 and with private purchasers, self-insured groups, and health plan companies to promote
419.14 the use of pilot projects encompassing both public and private purchasers and markets.

419.15 Subd. 2. **Payment methods and incentives.** The commissioners shall modify
419.16 existing payment methods and rates for those enrollees and health care providers
419.17 participating in the pilot project in order to provide incentives for care management,
419.18 team-based care, and practice redesign, and increase resources for primary care, chronic
419.19 condition care, and care provided to complex patients. The commissioners may create
419.20 financial incentives for patients to select a medical home under the pilot project by
419.21 reducing, modifying, or eliminating deductibles and co-payments for certain services, or
419.22 through other incentives. The commissioners may require patients to remain with their
419.23 designated medical home for a specified period of time. Alternative payment methods
419.24 may include complete or partial capitation, fee-for-service payments, or other payment
419.25 methodologies. The payment methods may provide for the payment of bonuses to medical
419.26 home providers or other providers, or to patients, for the achievement of performance
419.27 goals. The payment methods may include allocating a portion of the payment that
419.28 would otherwise be paid to health plans under state prepaid health care programs to the
419.29 designated medical home for specified services.

419.30 Subd. 3. **Requirements.** In order to be designated a medical home under the pilot
419.31 project, health care professionals or clinics must demonstrate their ability to:

419.32 (1) be the patient's first point of contact by telephone or other means, 24 hours a
419.33 day, seven days a week;

419.34 (2) provide or arrange for patients' comprehensive health care needs, including the
419.35 ability to structure planned chronic disease visits and to manage chronic disease through
419.36 the use of disease registries;

- 420.1 (3) coordinate patients' care when care must be provided outside the medical home;
420.2 (4) provide longitudinal care, not just episodic care, including meeting long-term
420.3 and unique personal needs;
420.4 (5) utilize an electronic health record and incorporate a plan to develop and make
420.5 available to patients that choose a medical home an electronic personal health record that
420.6 is prepopulated with the patient's data, consumer-directed, connected to the provider,
420.7 24-hour accessible, and owned and controlled by the patient;
420.8 (6) systematically improve quality of care using, among other inputs, patient
420.9 feedback; and
420.10 (7) create a provider network that provides for increased reimbursement for a
420.11 medical home in a cost-neutral manner.
- 420.12 Subd. 4. **Evaluation.** Pilot projects must be evaluated based on patient satisfaction,
420.13 provider satisfaction, clinical process and outcome measures, program costs and savings,
420.14 and economic impact on health care providers. Pilot projects must be evaluated based
420.15 on the extent to which the medical home:
- 420.16 (1) coordinated health care services across the continuum of care and thereby
420.17 reduced duplication of services and enhanced communication across providers;
420.18 (2) provided safe and high-quality care by increasing utilization of effective
420.19 treatments, reduced use of ineffective treatments, reduced barriers to essential care and
420.20 services, and eliminated barriers to access;
420.21 (3) reduced unnecessary hospitalizations and emergency room visits and increased
420.22 use of cost-effective care and settings;
420.23 (4) encouraged long-term patient and provider relationships by shifting from
420.24 episodic care to consistent, coordinated communication and care with a specified team of
420.25 providers or individual providers;
420.26 (5) engaged and educated consumers by encouraging shared patient and provider
420.27 responsibility and accountability for disease prevention, health promotion, chronic
420.28 disease management, acute care, and overall well-being, encouraging informed medical
420.29 decision-making, ensuring the availability of accurate medical information, and facilitated
420.30 the transfer of accurate medical information;
420.31 (6) encouraged innovation in payment methodologies by using patient and provider
420.32 incentives to coordinate care and utilize medical home services and fostering the
420.33 expansion of a technology infrastructure that supports collaboration; and
420.34 (7) reduced overall health care costs as compared to conventional payment methods
420.35 for similar patient populations.

Subd. 5. **Rulemaking.** The commissioners are exempt from administrative rulemaking under chapter 14 for purposes of developing, administering, contracting for, and evaluating pilot projects under this section. The commissioner shall publish a proposed request for proposals in the State Register and allow 30 days for comment before issuing the final request for proposals.

Subd. 6. **Regulatory and payment barriers.** The commissioners shall study state and federal statutory and regulatory barriers to the creation of medical homes and provide a report and recommendations to the legislature by December 15, 2007.

Sec. 32. **HEALTH CARE SYSTEM CONSOLIDATION.**

(a) The commissioner of health shall study the effect of health care provider and health plan company consolidation in the four metropolitan statistical areas in Minnesota on: health care costs, including provider payment rates; quality of care; and access to care. The commissioner shall separately consider hospitals, specialty groups, and primary care groups. The commissioner shall present findings and recommendations to the legislature by December 15, 2007.

(b) For purposes of this study, health carriers, provider networks, and other health care providers shall provide data on network participation, contracted payment rates, charges, costs, payments received, patient referrals, and other information requested by the commissioner, in the form and manner specified by the commissioner. Provider-level information on contracted payment rates and payments from health plans provided to the commissioner of health for the purposes of this study are (1) private data on individuals as defined in Minnesota Statutes, section 13.02, subdivision 12, and (2) nonpublic data as defined in Minnesota Statutes, section 13.02, subdivision 9. The commissioner may not collect patient-identified data for purposes of this study. Data collected for purposes of this study may not be used for any other purposes.

Sec. 33. **REPEALER.**

Minnesota Statutes 2006, section 62J.052, subdivision 1, is repealed effective August 1, 2007.

ARTICLE 10
PUBLIC HEALTH

Section 1. Minnesota Statutes 2006, section 13.3806, is amended by adding a subdivision to read:

422.1 Subd. 21. **Birth defects registry system.** Data on individuals collected by the
422.2 birth defects registry system are private data on individuals and classified pursuant to
422.3 section 144.2215.

422.4 Sec. 2. Minnesota Statutes 2006, section 16B.61, is amended by adding a subdivision
422.5 to read:

422.6 Subd. 3b. **Window fall prevention device code.** The commissioner of labor and
422.7 industry shall adopt rules for window fall prevention devices as part of the state Building
422.8 Code. Window fall prevention devices include, but are not limited to, safety screens,
422.9 hardware, guards, and other devices that comply with the standards established by the
422.10 commissioner of labor and industry. The rules must require compliance with standards
422.11 for window fall prevention devices developed by ASTM International, contained in the
422.12 International Building Code as the model language with amendments deemed necessary to
422.13 coordinate with the other adopted building codes in Minnesota. The rules must establish a
422.14 scope that includes the applicable building occupancies, and the types, locations, and sizes
422.15 of windows that will require the installation of fall devices. The rules will be effective July
422.16 1, 2009. The commissioner shall report to the legislature on the status of the rulemaking
422.17 on or before February 15, 2008.

422.18 Sec. 3. Minnesota Statutes 2006, section 103I.101, subdivision 6, is amended to read:

422.19 Subd. 6. **Fees for variances.** The commissioner shall charge a nonrefundable
422.20 application fee of ~~\$175~~ \$215 to cover the administrative cost of processing a request for a
422.21 variance or modification of rules adopted by the commissioner under this chapter.

422.22 **EFFECTIVE DATE.** This section is effective July 1, 2008.

422.23 Sec. 4. Minnesota Statutes 2006, section 103I.208, subdivision 1, is amended to read:

422.24 Subdivision 1. **Well notification fee.** The well notification fee to be paid by a
422.25 property owner is:

422.26 (1) for a new water supply well, ~~\$175~~ \$215, which includes the state core function
422.27 fee;

422.28 (2) for a well sealing, ~~\$35~~ \$50 for each well, which includes the state core function
422.29 fee, except that for monitoring wells constructed on a single property, having depths
422.30 within a 25 foot range, and sealed within 48 hours of start of construction, a single fee of
422.31 ~~\$35~~ \$50; and

422.32 (3) for construction of a dewatering well, ~~\$175~~ \$215, which includes the state core
422.33 function fee, for each dewatering well except a dewatering project comprising five or

423.1 more dewatering wells shall be assessed a single fee of ~~\$875~~ \$1,075 for the dewatering
423.2 wells recorded on the notification.

423.3 **EFFECTIVE DATE.** This section is effective July 1, 2008.

423.4 Sec. 5. Minnesota Statutes 2006, section 103I.208, subdivision 2, is amended to read:

423.5 Subd. 2. **Permit fee.** The permit fee to be paid by a property owner is:

423.6 (1) for a water supply well that is not in use under a maintenance permit, ~~\$150~~ \$175
423.7 annually;

423.8 (2) for construction of a monitoring well, ~~\$175~~ \$215, which includes the state
423.9 core function fee;

423.10 (3) for a monitoring well that is unsealed under a maintenance permit, ~~\$150~~ \$175
423.11 annually;

423.12 (4) for monitoring wells used as a leak detection device at a single motor fuel retail
423.13 outlet, a single petroleum bulk storage site excluding tank farms, or a single agricultural
423.14 chemical facility site, the construction permit fee is ~~\$175~~ \$215, which includes the state
423.15 core function fee, per site regardless of the number of wells constructed on the site, and
423.16 the annual fee for a maintenance permit for unsealed monitoring wells is ~~\$150~~ \$175 per
423.17 site regardless of the number of monitoring wells located on site;

423.18 (5) for a groundwater thermal exchange device, in addition to the notification fee for
423.19 water supply wells, ~~\$175~~ \$215, which includes the state core function fee;

423.20 (6) for a vertical heat exchanger, ~~\$175~~ \$215;

423.21 (7) for a dewatering well that is unsealed under a maintenance permit, ~~\$150~~ \$175
423.22 annually for each dewatering well, except a dewatering project comprising more than five
423.23 dewatering wells shall be issued a single permit for ~~\$750~~ \$875 annually for dewatering
423.24 wells recorded on the permit; and

423.25 (8) for an elevator boring, ~~\$175~~ \$215 for each boring.

423.26 **EFFECTIVE DATE.** This section is effective July 1, 2008.

423.27 Sec. 6. Minnesota Statutes 2006, section 103I.235, subdivision 1, is amended to read:

423.28 Subdivision 1. **Disclosure of wells to buyer.** (a) Before signing an agreement to
423.29 sell or transfer real property, the seller must disclose in writing to the buyer information
423.30 about the status and location of all known wells on the property, by delivering to the buyer
423.31 either a statement by the seller that the seller does not know of any wells on the property,
423.32 or a disclosure statement indicating the legal description and county, and a map drawn
423.33 from available information showing the location of each well to the extent practicable.

424.1 In the disclosure statement, the seller must indicate, for each well, whether the well is in
424.2 use, not in use, or sealed.

424.3 (b) At the time of closing of the sale, the disclosure statement information, name and
424.4 mailing address of the buyer, and the quartile, section, township, and range in which each
424.5 well is located must be provided on a well disclosure certificate signed by the seller or a
424.6 person authorized to act on behalf of the seller.

424.7 (c) A well disclosure certificate need not be provided if the seller does not know
424.8 of any wells on the property and the deed or other instrument of conveyance contains
424.9 the statement: "The Seller certifies that the Seller does not know of any wells on the
424.10 described real property."

424.11 (d) If a deed is given pursuant to a contract for deed, the well disclosure certificate
424.12 required by this subdivision shall be signed by the buyer or a person authorized to act on
424.13 behalf of the buyer. If the buyer knows of no wells on the property, a well disclosure
424.14 certificate is not required if the following statement appears on the deed followed by the
424.15 signature of the grantee or, if there is more than one grantee, the signature of at least one
424.16 of the grantees: "The Grantee certifies that the Grantee does not know of any wells on the
424.17 described real property." The statement and signature of the grantee may be on the front
424.18 or back of the deed or on an attached sheet and an acknowledgment of the statement by
424.19 the grantee is not required for the deed to be recordable.

424.20 (e) This subdivision does not apply to the sale, exchange, or transfer of real property:

424.21 (1) that consists solely of a sale or transfer of severed mineral interests; or

424.22 (2) that consists of an individual condominium unit as described in chapters 515
424.23 and 515B.

424.24 (f) For an area owned in common under chapter 515 or 515B the association or other
424.25 responsible person must report to the commissioner by July 1, 1992, the location and
424.26 status of all wells in the common area. The association or other responsible person must
424.27 notify the commissioner within 30 days of any change in the reported status of wells.

424.28 (g) For real property sold by the state under section 92.67, the lessee at the time of
424.29 the sale is responsible for compliance with this subdivision.

424.30 (h) If the seller fails to provide a required well disclosure certificate, the buyer, or
424.31 a person authorized to act on behalf of the buyer, may sign a well disclosure certificate
424.32 based on the information provided on the disclosure statement required by this section
424.33 or based on other available information.

424.34 (i) A county recorder or registrar of titles may not record a deed or other instrument
424.35 of conveyance dated after October 31, 1990, for which a certificate of value is required
424.36 under section 272.115, or any deed or other instrument of conveyance dated after October

31, 1990, from a governmental body exempt from the payment of state deed tax, unless the deed or other instrument of conveyance contains the statement made in accordance with paragraph (c) or (d) or is accompanied by the well disclosure certificate containing all the information required by paragraph (b) or (d). The county recorder or registrar of titles must not accept a certificate unless it contains all the required information. The county recorder or registrar of titles shall note on each deed or other instrument of conveyance accompanied by a well disclosure certificate that the well disclosure certificate was received. The notation must include the statement "No wells on property" if the disclosure certificate states there are no wells on the property. The well disclosure certificate shall not be filed or recorded in the records maintained by the county recorder or registrar of titles. After noting "No wells on property" on the deed or other instrument of conveyance, the county recorder or registrar of titles shall destroy or return to the buyer the well disclosure certificate. The county recorder or registrar of titles shall collect from the buyer or the person seeking to record a deed or other instrument of conveyance, a fee of ~~\$40~~ \$45 for receipt of a completed well disclosure certificate. By the tenth day of each month, the county recorder or registrar of titles shall transmit the well disclosure certificates to the commissioner of health. By the tenth day after the end of each calendar quarter, the county recorder or registrar of titles shall transmit to the commissioner of health ~~\$32.50~~ \$37.50 of the fee for each well disclosure certificate received during the quarter. The commissioner shall maintain the well disclosure certificate for at least six years. The commissioner may store the certificate as an electronic image. A copy of that image shall be as valid as the original.

(j) No new well disclosure certificate is required under this subdivision if the buyer or seller, or a person authorized to act on behalf of the buyer or seller, certifies on the deed or other instrument of conveyance that the status and number of wells on the property have not changed since the last previously filed well disclosure certificate. The following statement, if followed by the signature of the person making the statement, is sufficient to comply with the certification requirement of this paragraph: "I am familiar with the property described in this instrument and I certify that the status and number of wells on the described real property have not changed since the last previously filed well disclosure certificate." The certification and signature may be on the front or back of the deed or on an attached sheet and an acknowledgment of the statement is not required for the deed or other instrument of conveyance to be recordable.

(k) The commissioner in consultation with county recorders shall prescribe the form for a well disclosure certificate and provide well disclosure certificate forms to county recorders and registrars of titles and other interested persons.

426.1 (l) Failure to comply with a requirement of this subdivision does not impair:

426.2 (1) the validity of a deed or other instrument of conveyance as between the parties
426.3 to the deed or instrument or as to any other person who otherwise would be bound by
426.4 the deed or instrument; or

426.5 (2) the record, as notice, of any deed or other instrument of conveyance accepted for
426.6 filing or recording contrary to the provisions of this subdivision.

426.7 **EFFECTIVE DATE.** This section is effective July 1, 2008.

426.8 Sec. 7. Minnesota Statutes 2006, section 144.123, is amended to read:

426.9 **144.123 FEES FOR DIAGNOSTIC LABORATORY SERVICES;**
426.10 **EXCEPTIONS.**

426.11 Subdivision 1. **Who must pay.** Except for the limitation contained in this section,
426.12 the commissioner of health shall charge a handling fee for each specimen submitted to
426.13 the Department of Health for analysis for diagnostic purposes by any hospital, private
426.14 laboratory, private clinic, or physician. No fee shall be charged to any entity which
426.15 receives direct or indirect financial assistance from state or federal funds administered by
426.16 the Department of Health, including any public health department, nonprofit community
426.17 clinic, ~~venereal~~ sexually transmitted disease clinic, ~~family planning clinic~~, or similar
426.18 entity. No fee will be charged for any biological materials submitted to the Department
426.19 of Health as a requirement of Minnesota Rules, part 4605.7040, or for those biological
426.20 materials requested by the department to gather information for disease prevention or
426.21 control purposes. The commissioner of health may establish ~~by rule~~ other exceptions to
426.22 the handling fee as may be necessary to ~~gather information for epidemiologic purposes~~
426.23 protect the public's health. All fees collected pursuant to this section shall be deposited in
426.24 the state treasury and credited to the state government special revenue fund.

426.25 Subd. 2. **Rules for Fee amounts.** The commissioner of health shall ~~promulgate~~
426.26 ~~rules, in accordance with chapter 14, which shall specify the amount of the charge a~~
426.27 ~~handling fee prescribed in subdivision 1. The fee shall approximate the costs to the~~
426.28 ~~department of handling specimens including reporting, postage, specimen kit preparation,~~
426.29 ~~and overhead costs. The fee prescribed in subdivision 1 shall be \$15 \$25 per specimen~~
426.30 ~~until the commissioner promulgates rules pursuant to this subdivision.~~

426.31 Sec. 8. Minnesota Statutes 2006, section 144.125, is amended to read:

426.32 **144.125 TESTS OF INFANTS FOR HERITABLE AND CONGENITAL**
426.33 **DISORDERS.**

Subdivision 1. **Duty to perform testing.** It is the duty of (1) the administrative officer or other person in charge of each institution caring for infants 28 days or less of age, (2) the person required in pursuance of the provisions of section 144.215, to register the birth of a child, or (3) the nurse midwife or midwife in attendance at the birth, to arrange to have administered to every infant or child in its care tests for heritable and congenital disorders according to subdivision 2 and rules prescribed by the state commissioner of health. Testing and the recording and reporting of test results shall be performed at the times and in the manner prescribed by the commissioner of health. The commissioner shall charge ~~laboratory service fees~~ a fee so that the total of fees collected will approximate the costs of conducting the tests and implementing and maintaining a system to follow-up infants with heritable or congenital disorders. The ~~laboratory service~~ fee is ~~\$61~~ \$101 per specimen. Costs associated with capital expenditures and the development of new procedures may be prorated over a three-year period when calculating the amount of the fees.

Subd. 2. **Determination of tests to be administered.** The commissioner shall periodically revise the list of tests to be administered for determining the presence of a heritable or congenital disorder. Revisions to the list shall reflect advances in medical science, new and improved testing methods, or other factors that will improve the public health. In determining whether a test must be administered, the commissioner shall take into consideration the adequacy of ~~laboratory~~ analytical methods to detect the heritable or congenital disorder, the ability to treat or prevent medical conditions caused by the heritable or congenital disorder, and the severity of the medical conditions caused by the heritable or congenital disorder. The list of tests to be performed may be revised if the changes are recommended by the advisory committee established under section 144.1255, approved by the commissioner, and published in the State Register. The revision is exempt from the rulemaking requirements in chapter 14, and sections 14.385 and 14.386 do not apply.

Subd. 3. **Objection of parents to test.** Persons with a duty to perform testing under subdivision 1 shall advise parents of infants (1) that the blood or tissue samples used to perform testing thereunder as well as the results of such testing may be retained by the Department of Health, (2) the benefit of retaining the blood or tissue sample, and (3) that the following options are available to them with respect to the testing: (i) to decline to have the tests, or (ii) to elect to have the tests but to require that all blood samples and records of test results be destroyed within 24 months of the testing. If the parents of an infant object in writing to testing for heritable and congenital disorders or elect to require that blood samples and test results be destroyed, the objection or election shall

428.1 be recorded on a form that is signed by a parent or legal guardian and made part of the
428.2 infant's medical record. A written objection exempts an infant from the requirements of
428.3 this section and section 144.128.

428.4 Sec. 9. Minnesota Statutes 2006, section 144.2215, subdivision 1, is amended to read:

428.5 Subdivision 1. **Establishment.** Within the limits of available appropriations, the
428.6 commissioner of health shall establish and maintain an information system containing data
428.7 on the cause, treatment, prevention, and cure of major birth defects. The commissioner
428.8 shall consult with representatives and experts in epidemiology, medicine, insurance,
428.9 health maintenance organizations, genetics, consumers, and voluntary organizations in
428.10 developing the system and may phase in the implementation of the system. After the
428.11 parents have provided informed consent under section 144.2216, subdivision 4, the
428.12 commissioner shall offer the parents with their informed consent a visit by a trained health
428.13 care worker to interview the parents about:

428.14 (1) all previous home addresses, occupations, and places of work including from
428.15 childhood;

428.16 (2) the time and place of any military service; and

428.17 (3) known occasions or sites of toxic exposures.

428.18 Sec. 10. Minnesota Statutes 2006, section 144.672, subdivision 1, is amended to read:

428.19 Subdivision 1. **Rule authority.** The commissioner of health shall collect cancer
428.20 incidence information, analyze the information, and conduct special studies designed to
428.21 determine the potential public health significance of an increase in cancer incidence.

428.22 The commissioner shall adopt rules to administer the system, collect information,
428.23 and distribute data. The rules must include, but not be limited to, the following:

428.24 (1) the type of data to be reported, which must include current and previous
428.25 occupational data;

428.26 (2) standards for reporting specific types of data;

428.27 (3) payments allowed to hospitals, pathologists, and registry systems to defray their
428.28 costs in providing information to the system;

428.29 (4) criteria relating to contracts made with outside entities to conduct studies using
428.30 data collected by the system. The criteria may include requirements for a written protocol
428.31 outlining the purpose and public benefit of the study, the description, methods, and
428.32 projected results of the study, peer review by other scientists, the methods and facilities
428.33 to protect the privacy of the data, and the qualifications of the researcher proposing to
428.34 undertake the study; and

429.1 (5) specification of fees to be charged under section 13.03, subdivision 3, for all
429.2 out-of-pocket expenses for data summaries or specific analyses of data requested by
429.3 public and private agencies, organizations, and individuals, and which are not otherwise
429.4 included in the commissioner's annual summary reports. Fees collected are appropriated
429.5 to the commissioner to offset the cost of providing the data.

429.6 Sec. 11. Minnesota Statutes 2006, section 144.9502, subdivision 3, is amended to read:

429.7 Subd. 3. **Reports of blood lead analysis required.** (a) Every hospital, medical
429.8 clinic, medical laboratory, other facility, or individual performing blood lead analysis
429.9 shall report the results after the analysis of each specimen analyzed, for both capillary
429.10 and venous specimens, and epidemiologic information required in this section to the
429.11 commissioner of health, within the time frames set forth in clauses (1) and (2):

429.12 (1) within two working days by telephone, fax, or electronic transmission, with
429.13 written or electronic confirmation within one month, for a venous blood lead level equal to
429.14 or greater than ~~15~~ ten micrograms of lead per deciliter of whole blood; or

429.15 (2) within one month in writing or by electronic transmission, for any capillary
429.16 result or for a venous blood lead level less than ~~15~~ ten micrograms of lead per deciliter of
429.17 whole blood.

429.18 (b) If a blood lead analysis is performed outside of Minnesota and the facility
429.19 performing the analysis does not report the blood lead analysis results and epidemiological
429.20 information required in this section to the commissioner, the provider who collected the
429.21 blood specimen must satisfy the reporting requirements of this section. For purposes of
429.22 this section, "provider" has the meaning given in section 62D.02, subdivision 9.

429.23 (c) The commissioner shall coordinate with hospitals, medical clinics, medical
429.24 laboratories, and other facilities performing blood lead analysis to develop a universal
429.25 reporting form and mechanism.

429.26 Sec. 12. Minnesota Statutes 2006, section 144.9504, subdivision 2, is amended to read:

429.27 Subd. 2. **Lead risk assessment.** (a) An assessing agency shall conduct a lead risk
429.28 assessment of a residence according to the venous blood lead level and time frame set
429.29 forth in clauses (1) to (4) for purposes of secondary prevention:

429.30 (1) within 48 hours of a child or pregnant female in the residence being identified to
429.31 the agency as having a venous blood lead level equal to or greater than ~~60~~ 45 micrograms
429.32 of lead per deciliter of whole blood;

(2) within five working days of a child or pregnant female in the residence being identified to the agency as having a venous blood lead level equal to or greater than ~~45~~ 15 micrograms of lead per deciliter of whole blood;

(3) within ten working days of a child in the residence being identified to the agency as having a venous blood lead level equal to or greater than ~~15~~ ten micrograms of lead per deciliter of whole blood; or

(4) within ten working days of a pregnant female in the residence being identified to the agency as having a venous blood lead level equal to or greater than ten micrograms of lead per deciliter of whole blood.

(b) Within the limits of available local, state, and federal appropriations, an assessing agency may also conduct a lead risk assessment for children with any elevated blood lead level.

(c) In a building with two or more dwelling units, an assessing agency shall assess the individual unit in which the conditions of this section are met and shall inspect all common areas accessible to a child. If a child visits one or more other sites such as another residence, or a residential or commercial child care facility, playground, or school, the assessing agency shall also inspect the other sites. The assessing agency shall have one additional day added to the time frame set forth in this subdivision to complete the lead risk assessment for each additional site.

(d) Within the limits of appropriations, the assessing agency shall identify the known addresses for the previous 12 months of the child or pregnant female with venous blood lead levels of at least ~~15~~ ten micrograms per deciliter ~~for the child or at least ten micrograms per deciliter for the pregnant female;~~ notify the property owners, landlords, and tenants at those addresses that an elevated blood lead level was found in a person who resided at the property; and give them primary prevention information. Within the limits of appropriations, the assessing agency may perform a risk assessment and issue corrective orders in the properties, if it is likely that the previous address contributed to the child's or pregnant female's blood lead level. The assessing agency shall provide the notice required by this subdivision without identifying the child or pregnant female with the elevated blood lead level. The assessing agency is not required to obtain the consent of the child's parent or guardian or the consent of the pregnant female for purposes of this subdivision. This information shall be classified as private data on individuals as defined under section 13.02, subdivision 12.

(e) The assessing agency shall conduct the lead risk assessment according to rules adopted by the commissioner under section 144.9508. An assessing agency shall have lead risk assessments performed by lead risk assessors licensed by the commissioner

according to rules adopted under section 144.9508. If a property owner refuses to allow a lead risk assessment, the assessing agency shall begin legal proceedings to gain entry to the property and the time frame for conducting a lead risk assessment set forth in this subdivision no longer applies. A lead risk assessor or assessing agency may observe the performance of lead hazard reduction in progress and shall enforce the provisions of this section under section 144.9509. Deteriorated painted surfaces, bare soil, and dust must be tested with appropriate analytical equipment to determine the lead content, except that deteriorated painted surfaces or bare soil need not be tested if the property owner agrees to engage in lead hazard reduction on those surfaces. The lead content of drinking water must be measured if another probable source of lead exposure is not identified. Within a standard metropolitan statistical area, an assessing agency may order lead hazard reduction of bare soil without measuring the lead content of the bare soil if the property is in a census tract in which soil sampling has been performed according to rules established by the commissioner and at least 25 percent of the soil samples contain lead concentrations above the standard in section 144.9508.

(f) Each assessing agency shall establish an administrative appeal procedure which allows a property owner to contest the nature and conditions of any lead order issued by the assessing agency. Assessing agencies must consider appeals that propose lower cost methods that make the residence lead safe. The commissioner shall use the authority and appeal procedure granted under sections 144.989 to 144.993.

(g) Sections 144.9501 to 144.9509 neither authorize nor prohibit an assessing agency from charging a property owner for the cost of a lead risk assessment.

Sec. 13. Minnesota Statutes 2006, section 144.9507, is amended by adding a subdivision to read:

Subd. 6. **Medical assistance.** Medical assistance reimbursement for lead risk assessment services under section 256B.0625, subdivision 49, shall not be used to replace or decrease existing state or local funding for lead services and lead-related activities.

Sec. 14. Minnesota Statutes 2006, section 144.9512, is amended to read:

144.9512 LEAD ABATEMENT PROGRAM.

Subdivision 1. **Definitions.** (a) The definitions in section 144.9501 and in this subdivision apply to this section.

(b) ~~"Eligible organization" means a lead contractor, city, board of health, community health department, community action agency as defined in section 256E.30, or community development corporation.~~

~~(e) "Commissioner" means the commissioner of health, or the commissioner of the Minnesota Housing Finance Agency as authorized by section 462A.05, subdivision 15e.~~

Subd. 2. **Grants; administration.** Within the limits of the available appropriation, the commissioner ~~must develop a swab team services program which may~~ shall make ~~demonstration and training grants to eligible organizations~~ a nonprofit organization currently operating the CLEARCorps lead hazard reduction project to train workers to provide swab team services ~~and swab team services~~ for residential property. ~~Grants may be awarded to nonprofit organizations to provide technical assistance and training to ensure quality and consistency within the statewide program. Grants must be awarded to help ensure full-time employment to workers providing swab team services and must be awarded for a two-year period.~~

~~Grants awarded under this section must be made in consultation with the commissioner of the Housing Finance Agency and representatives of neighborhood groups from areas at high risk for toxic lead exposure, a labor organization, the lead coalition, community action agencies, and the legal aid society. The consulting team must review grant applications and recommend awards to eligible organizations that meet requirements for receiving a grant under this section.~~

Subd. 3. **Applicants.** ~~(a) Interested eligible organizations may apply to the commissioner for grants under this section. Two or more eligible organizations may jointly apply for a grant. Priority shall be given to community action agencies in greater Minnesota and to either community action agencies or neighborhood-based nonprofit organizations in cities of the first class. Of the total annual appropriation, 12.5 percent may be used for administrative purposes. The commissioner may deviate from this percentage if a grantee can justify the need for a larger administrative allowance. Of this amount, up to five percent may be used by the commissioner for state administrative purposes. Applications must provide information requested by the commissioner, including at least the information required to assess the factors listed in paragraph (d).~~

~~(b) The commissioner must consult with boards of health to provide swab team services for purposes of secondary prevention. The priority for swab teams created by grants to eligible organizations under this section must be work assigned by the commissioner of health, or by a board of health if so designated by the commissioner of health, to provide secondary prevention swab team services to fulfill the requirements of section 144.9504, subdivision 6, in response to a lead order. Swab teams assigned work under this section by the commissioner, that are not engaged daily in fulfilling the requirements of section 144.9504, subdivision 6, must deliver swab team services in response to elevated blood lead levels as defined in section 144.9501, subdivision 9;~~

433.1 ~~where lead orders were not issued, and for purposes of primary prevention in census~~
433.2 ~~tracts known to be in areas at high risk for toxic lead exposure as described in section~~
433.3 ~~144.9503, subdivision 2.~~

433.4 ~~(c) Any additional money must be used for grants to establish swab teams for~~
433.5 ~~primary prevention under section 144.9503, in census tracts in areas at high risk for toxic~~
433.6 ~~lead exposure as determined under section 144.9503, subdivision 2.~~

433.7 ~~(d) In evaluating grant applications, the commissioner must consider the following~~
433.8 ~~criteria:~~

433.9 ~~(1) the use of lead contractors and lead workers for residential swab team services;~~

433.10 ~~(2) the participation of neighborhood groups and individuals, as swab team workers,~~
433.11 ~~in areas at high risk for toxic lead exposure;~~

433.12 ~~(3) plans for the provision of swab team services for primary and secondary~~
433.13 ~~prevention as required under subdivision 4;~~

433.14 ~~(4) plans for supervision, training, career development, and postprogram placement~~
433.15 ~~of swab team members;~~

433.16 ~~(5) plans for resident and property owner education on lead safety;~~

433.17 ~~(6) plans for distributing cleaning supplies to area residents and educating residents~~
433.18 ~~and property owners on cleaning techniques;~~

433.19 ~~(7) sources of other funding and cost estimates for training, lead inspections, swab~~
433.20 ~~team services, equipment, monitoring, testing, and administration;~~

433.21 ~~(8) measures of program effectiveness;~~

433.22 ~~(9) coordination of program activities with other federal, state, and local public~~

433.23 ~~health, job training, apprenticeship, and housing renovation programs including programs~~
433.24 ~~under sections 116L.86 to 116L.881; and~~

433.25 ~~(10) prior experience in providing swab team services.~~

433.26 Subd. 4. ~~Lead supervisor or certified firm~~ Eligible grant activities. (a) ~~Eligible~~
433.27 ~~organizations and lead supervisors or certified firms may participate in the swab team~~
433.28 ~~program. An eligible organization~~ The nonprofit receiving a grant under this section
433.29 must ~~assure~~ ensure that all participating lead supervisors or certified firms are licensed
433.30 and that all swab team workers are certified by the Department of Health under section
433.31 144.9505. ~~Eligible organizations and lead supervisors or certified firms may distinguish~~
433.32 ~~between interior and exterior services in assigning duties and~~ The nonprofit organization
433.33 may participate in the program by:

433.34 (1) providing on-the-job training for swab team workers;

433.35 (2) providing swab team services to meet the requirements of sections 144.9503,
433.36 subdivision 4, and 144.9504, subdivision 6;

(3) providing a removal and replacement component using skilled craft workers under subdivision 7 lead hazard reduction to meet the requirements of section 144.9501, subdivision 17;

~~(4) providing lead testing according to subdivision 8;~~

~~(5)~~ (4) providing lead dust ~~cleaning supplies~~ cleanup equipment and materials, as described in section ~~144.9507~~ 144.9503, subdivision 4, ~~paragraph (c) 1~~, to residents; ~~or~~

~~(6)~~ (5) having a swab team worker instruct residents and property owners on appropriate lead control techniques, including the lead-safe directives developed by the commissioner of health;

(6) conducting blood lead testing events including screening children and pregnant women according to Department of Health screening guidelines;

(7) performing case management services according to Department of Health case management guidelines; or

(8) conducting mandated risk assessments under Minnesota Statutes, section 144.9504, subdivision 2.

~~(b) Participating lead supervisors or certified firms must:~~

~~(1) demonstrate proof of workers' compensation and general liability insurance coverage;~~

~~(2) be knowledgeable about lead abatement requirements established by the Department of Housing and Urban Development and the Occupational Safety and Health Administration and lead hazard reduction requirements and lead-safe directives of the commissioner of health;~~

~~(3) demonstrate experience with on-the-job training programs;~~

~~(4) demonstrate an ability to recruit employees from areas at high risk for toxic lead exposure; and~~

~~(5) demonstrate experience in working with low-income clients.~~

Subd. 5. **Swab team workers.** Each worker engaged in swab team services established under this section must have blood lead concentrations below 15 micrograms of lead per deciliter of whole blood as determined by a baseline blood lead screening. ~~Any~~ The nonprofit organization receiving a grant under this section is responsible for lead screening and must ~~assure~~ ensure that all swab team workers meet the standards established in this subdivision. ~~Grantees~~ The nonprofit organization must use appropriate workplace procedures including following the lead-safe directives developed by the commissioner of health to reduce risk of elevated blood lead levels. ~~Grantees~~ The nonprofit organization and participating contractors must report all employee blood lead levels that exceed 15 micrograms of lead per deciliter of whole blood to the commissioner of health.

435.1 ~~Subd. 6. **On-the-job training component.** (a) Programs established under this~~
435.2 ~~section must provide on-the-job training for swab team workers.~~

435.3 ~~(b) Swab team workers must receive monetary compensation equal to the prevailing~~
435.4 ~~wage as defined in section 177.42, subdivision 6, for comparable jobs in the licensed~~
435.5 ~~contractor's principal business.~~

435.6 ~~Subd. 7. **Removal and replacement component.** (a) Within the limits of the~~
435.7 ~~available appropriation and if a need is identified by a lead inspector, the commissioner~~
435.8 ~~may establish a component for removal and replacement of deteriorated paint in residential~~
435.9 ~~properties according to the following criteria:~~

435.10 ~~(1) components within a residence must have both deteriorated lead-based paint and~~
435.11 ~~substrate damage beyond repair or rotting wooden framework to be eligible for removal~~
435.12 ~~and replacement;~~

435.13 ~~(2) all removal and replacement must be done using least-cost methods and~~
435.14 ~~following lead-safe directives;~~

435.15 ~~(3) whenever windows and doors or other components covered with deteriorated~~
435.16 ~~lead-based paint have sound substrate or are not rotting, those components should be~~
435.17 ~~repaired, sent out for stripping, planed down to remove deteriorated lead-based paint, or~~
435.18 ~~covered with protective guards instead of being replaced, provided that such an activity is~~
435.19 ~~the least-cost method of providing the swab team service;~~

435.20 ~~(4) removal and replacement or repair must be done by lead contractors using skilled~~
435.21 ~~craft workers or trained swab team members; and~~

435.22 ~~(5) all craft work that requires a state license must be supervised by a person with~~
435.23 ~~a state license in the craft work being supervised. The grant recipient may contract for~~
435.24 ~~this supervision.~~

435.25 ~~(b) The program design must:~~

435.26 ~~(1) identify the need for on-the-job training of swab team workers to be removal and~~
435.27 ~~replacement workers; and~~

435.28 ~~(2) describe plans to involve appropriate groups in designing methods to meet the~~
435.29 ~~need for training swab team workers.~~

435.30 ~~Subd. 8. **Testing and evaluation.** (a) Testing of the environment is not necessary~~
435.31 ~~by swab teams whose work is assigned by the commissioner of health or a designated~~
435.32 ~~board of health under section 144.9504. The commissioner of health or designated board~~
435.33 ~~of health must share the analytical testing data collected on each residence for purposes~~
435.34 ~~of secondary prevention under section 144.9504 with the swab team workers in order to~~
435.35 ~~provide constructive feedback on their work and to the commissioner for the purposes~~
435.36 ~~set forth in paragraph (c).~~

~~(b) For purposes of primary prevention evaluation, the following samples must be collected: pretesting and posttesting of one noncarpeted floor dust lead sample and a notation of the extent and location of bare soil and of deteriorated lead-based paint. The analytical testing data collected on each residence for purposes of primary prevention under section 144.9503 must be shared with the swab team workers in order to provide constructive feedback on their work and to the commissioner for the purposes set forth in paragraph (c).~~

~~(c) The commissioner of health must establish a program to collect appropriate data as required under paragraphs (a) and (b), in order to conduct an ongoing evaluation of swab team services for primary and secondary prevention. Within the limits of available appropriations, the commissioner of health must conduct on up to 1,000 residences which have received primary or secondary prevention swab team services, a postremediation evaluation, on at least a quarterly basis for a period of at least two years for each residence. The evaluation must note the condition of the paint within the residence, the extent of bare soil on the grounds, and collect and analyze one noncarpeted floor dust lead sample. The data collected must be evaluated to determine the efficacy of providing swab team services as a method of reducing lead exposure in young children. In evaluating this data, the commissioner of health must consider city size, community location, historic traffic flow, soil lead level of the property by area or census tract, distance to industrial point sources that emit lead, season of the year, age of the housing, age and number of children living at the residence, the presence of pets that move in and out of the residence, and other relevant factors as the commissioner of health may determine.~~

Subd. 9. **Program benefits.** As a condition of providing swab team services under this section, ~~an~~ the nonprofit organization may require a property owner to not increase rents on a property solely as a result of a substantial improvement made with public funds under the programs in this section.

Subd. 10. **Requirements of ~~organizations receiving grants~~ the nonprofit organization.** ~~An eligible~~ The nonprofit organization that is awarded a ~~training and demonstration~~ grant under this section must prepare and submit a quarterly progress report to the commissioner beginning three months after receipt of the grant.

Sec. 15. [144.966] EARLY HEARING DETECTION AND INTERVENTION ACT.

Subdivision 1. Definitions. (a) "Child" means a person 18 years of age or younger.

437.1 (b) "False positive rate" means the proportion of infants identified as having a
437.2 significant hearing loss by the screening process who are ultimately found to not have a
437.3 significant hearing loss.

437.4 (c) "False negative rate" means the proportion of infants not identified as having
437.5 a significant hearing loss by the screening process who are ultimately found to have a
437.6 significant hearing loss.

437.7 (d) "Hearing screening test" means automated auditory brain stem response,
437.8 otoacoustic emissions, or another appropriate screening test approved by the Department
437.9 of Health.

437.10 (e) "Hospital" means a birthing health care facility or birthing center licensed in
437.11 this state that provides obstetrical services.

437.12 (f) "Infant" means a child who is not a newborn and has not attained the age of
437.13 one year.

437.14 (g) "Newborn" means an infant 28 days old or younger.

437.15 (h) "Parent" means a natural parent, stepparent, adoptive parent, guardian, or
437.16 custodian of a newborn or infant.

437.17 Subd. 2. Newborn Hearing Screening Advisory Committee. (a) The
437.18 commissioner of health shall appoint a Newborn Hearing Screening Advisory Committee
437.19 to advise and assist the Department of Health and the Department of Education in:

437.20 (1) developing protocols and timelines for screening, rescreening, and diagnostic
437.21 audiological assessment and early medical, audiological, and educational intervention
437.22 services for children who are deaf or hard-of-hearing;

437.23 (2) designing protocols for tracking children from birth through age three that may
437.24 have passed newborn screening but are at risk for delayed or late onset of permanent
437.25 hearing loss;

437.26 (3) designing a technical assistance program to support facilities implementing the
437.27 screening program and facilities conducting rescreening and diagnostic audiological
437.28 assessment;

437.29 (4) designing implementation and evaluation of a system of follow-up and tracking;
437.30 and

437.31 (5) evaluating program outcomes to increase effectiveness and efficiency and ensure
437.32 culturally appropriate services for children with a confirmed hearing loss and their families.

437.33 (b) Membership of the committee shall include at least one member from each of the
437.34 following groups with no less than two of the members being deaf or hard-of-hearing:

437.35 (1) a representative from a consumer organization representing culturally deaf
437.36 persons;

- 438.1 (2) a parent with a child with hearing loss representing a parent organization;
438.2 (3) a consumer from an organization representing oral communication options;
438.3 (4) a consumer from an organization representing cued speech communication
438.4 options;
438.5 (5) an audiologist who has experience in evaluation and intervention of infants
438.6 and young children;
438.7 (6) a speech-language pathologist who has experience in evaluation and intervention
438.8 of infants and young children;
438.9 (7) two primary care providers who have experience in the care of infants and young
438.10 children, one of which shall be a pediatrician;
438.11 (8) a representative from the early hearing detection intervention teams;
438.12 (9) a representative from the Department of Education resource center for the deaf
438.13 and hard-of-hearing or their designee;
438.14 (10) a representative of the Minnesota Commission Serving Deaf and Hard of
438.15 Hearing People;
438.16 (11) a representative from the Department of Human Services Deaf and Hard of
438.17 Hearing Services Division;
438.18 (12) one or more of the Part C coordinators from the Department of Education, the
438.19 Department of Health, or the Department of Human Services or their designee;
438.20 (13) the Department of Health early hearing detection and intervention coordinator;
438.21 (14) two birth hospital representatives from one rural and one urban hospital;
438.22 (15) a pediatric geneticist;
438.23 (16) an otolaryngologist;
438.24 (17) a representative from the Newborn Screening Advisory Committee under
438.25 this subdivision; and
438.26 (18) a representative of the Department of Education regional low-incidence
438.27 facilitators.
438.28 The Department of Health member shall chair the first meeting of the committee.
438.29 At the first meeting, the committee shall elect a chairperson from its membership. The
438.30 committee shall meet at the call of the chairperson, at least four times a year. The
438.31 committee shall adopt written bylaws to govern its activities. The Department of Health
438.32 shall provide technical and administrative support services as required by the committee.
438.33 These services shall include technical support from individuals qualified to administer
438.34 infant hearing screening, rescreening, and diagnostic audiological assessments.

439.1 Members of the committee shall receive no compensation for their service, but
439.2 shall be reimbursed for expenses incurred as a result of their duties as members of the
439.3 committee.

439.4 Subd. 3. **Newborn and infant hearing screening programs.** All hospitals shall
439.5 establish a Universal Newborn Hearing and Infant Screening (UNHS) program. Each
439.6 UNHS program shall:

439.7 (1) in advance of any hearing screening testing, provide to the newborn's or infant's
439.8 parents information concerning the nature of the screening procedure, applicable costs of
439.9 the screening procedure, the potential risks and effects of hearing loss, and the benefits of
439.10 early detection and intervention;

439.11 (2) comply with parental consent under section 144.125, subdivision 3;

439.12 (3) develop policies and procedures for screening and rescreening based on
439.13 Department of Health recommendations;

439.14 (4) provide appropriate training and monitoring of individuals responsible for
439.15 performing hearing screening tests as recommended by the Department of Health;

439.16 (5) test the newborn's hearing prior to discharge, or, if the newborn is expected to
439.17 remain in the hospital for a prolonged period, testing shall be performed prior to three
439.18 months of age, or when medically feasible;

439.19 (6) develop and implement procedures for documenting the results of all hearing
439.20 screening tests;

439.21 (7) inform the baby's parents or parent, primary care physician, and the Department
439.22 of Health according to recommendations of the Department of Health of the results of the
439.23 hearing screening test or rescreening if conducted, or if the newborn or infant was not
439.24 successfully tested. The hospital that discharges the baby to home is responsible for
439.25 the screening; and

439.26 (8) collect performance data specified by the Department of Health.

439.27 Subd. 4. **Notification and information.** (a) Notification to the parents, primary
439.28 care provider, and Department of Health shall occur prior to discharge or no later than ten
439.29 days following the date of testing. Notification shall include information recommended by
439.30 the Department of Health.

439.31 (b) A physician, nurse, midwife, or other health professional attending a birth outside
439.32 a hospital or institution shall provide information, orally and in writing, as established by
439.33 the Department of Health, to parents regarding places where the parents may have their
439.34 infants' hearing screened and the importance of such screening.

(c) The professional conducting the diagnostic procedure to confirm the hearing loss must report the results to the parents, primary care provider, and Department of Health according to the Department of Health recommendations.

Subd. 5. **Oversight responsibility.** The Department of Health shall exercise oversight responsibility for UNHS programs, including establishing a performance data set and reviewing performance data collected by each hospital.

Subd. 6. **Civil and criminal immunity and penalties.** (a) No physician or hospital shall be civilly or criminally liable for failure to conduct hearing screening testing.

(b) No physician, midwife, nurse, other health professional, or hospital acting in compliance with this section shall be civilly or criminally liable for any acts conforming with this section, including furnishing information required according to this section.

Subd. 7. **Laboratory service fees.** The commissioner shall charge laboratory service fees according to section 16A.1285 so that the total of fees collected will approximate the costs of implementing and maintaining a system to follow up infants, provide technical assistance, a tracking system, data management, and evaluation.

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

Sec. 16. **[144.967] ARSENIC HEALTH RISK STANDARD.**

Subdivision 1. **Arsenic health risk standard established.** The commissioner of health in cooperation with the commissioners of agriculture and the Pollution Control Agency responsible for monitoring land and water cleanup and soil contamination information shall determine a health risk standard for human exposure to arsenic. The commissioner of health shall ensure that the established arsenic health risk standard is included in all information provided to the public.

Subd. 2. **Information.** The commissioner of health, in consultation with the commissioners of agriculture and the Pollution Control Agency with jurisdiction over soil and water contamination, shall establish a central information source available to the public to provide accurate information on arsenic soil and water contamination in residential areas.

Subd. 3. **Testing for arsenic.** (a) The commissioner of health shall ensure access to medical testing for arsenical pesticide exposure to persons living within one mile of the CMC Heartland Lite Yard Superfund site who are not covered by health insurance or medical assistance.

(b) Through an agreement with the United States Environmental Protection Agency, the commissioner shall ensure soil testing is available to households within one mile of the CMC Heartland Lite Yard Superfund site at no cost to the residents.

441.1 Subd. 4. **Evaluation.** The commissioner of health shall evaluate the cumulative
441.2 health impact burdens of environmental toxins in the residential communities impacted by
441.3 arsenic-contaminated soil from the CMC Heartland Lite Yard Superfund site. The first
441.4 priority shall be to evaluate health burdens to those communities experiencing health
441.5 disparities as documented by the Minority and Multicultural Health Division of the
441.6 Minnesota Department of Health.

441.7 Sec. 17. **[144.995] DEFINITIONS.**

441.8 (a) For purposes of sections 144.995 to 144.998, the terms in this section have
441.9 the meanings given.

441.10 (b) "Advisory panel" means the Environmental Health Tracking and Biomonitoring
441.11 Advisory Panel established under section 144.998.

441.12 (c) "Biomonitoring" means the process by which chemicals and their metabolites are
441.13 identified and measured within a biospecimen.

441.14 (d) "Biospecimen" means a sample of human fluid, serum, or tissue that is reasonably
441.15 available as a medium to measure the presence and concentration of chemicals or their
441.16 metabolites in a human body.

441.17 (e) "Commissioner" means the commissioner of the Department of Health.

441.18 (f) "Community" means geographically or nongeographically-based populations
441.19 that may participate in the biomonitoring program. A "nongeographical community"
441.20 includes, but is not limited to, populations that may share a common chemical exposure
441.21 through similar occupations, populations experiencing a common health outcome that
441.22 may be linked to chemical exposures, or populations that may experience similar chemical
441.23 exposures because of comparable consumption, lifestyle, product use, or subpopulations
441.24 that share ethnicity, age, or gender.

441.25 (g) "Department" means the Department of Health.

441.26 (h) "Designated chemicals" means those chemicals that are known to, or strongly
441.27 suspected of, adversely impacting human health or development, based upon scientific,
441.28 peer-reviewed animal, human, or in vitro studies, and baseline human exposure data,
441.29 and consists of chemical families or metabolites that are included in the federal Centers
441.30 for Disease Control and Prevention studies that are known collectively as the National
441.31 Reports on Human Exposure to Environmental Chemicals program and any substances
441.32 specified under section 144.998, subdivision 3, clause (6).

441.33 (i) "Environmental hazard" means a chemical, metal, or other substance for which
441.34 scientific, peer-reviewed studies of humans, animals, or cells have demonstrated that the
441.35 chemical is known or reasonably anticipated to adversely impact human health.

442.1 (j) "Environmental health tracking" means collection, integration, analysis, and
442.2 dissemination of data on human exposures to chemicals in the environment and on
442.3 diseases potentially caused or aggravated by those chemicals.

442.4 Sec. 18. **[144.996] ENVIRONMENTAL HEALTH TRACKING;**
442.5 **BIOMONITORING.**

442.6 Subdivision 1. Environmental health tracking. In cooperation with the
442.7 commissioner of the Pollution Control Agency, the commissioner shall establish an
442.8 environmental health tracking program to:

442.9 (1) coordinate data collection activities with the Pollution Control Agency,
442.10 Department of Agriculture, University of Minnesota, and any other relevant state agency
442.11 and work to promote the sharing of and access to health and environmental databases
442.12 in order to develop an environmental health tracking system for Minnesota, consistent
442.13 with applicable data practices laws;

442.14 (2) facilitate the dissemination of public health tracking data to the public and
442.15 researchers in accessible format and provide technical assistance on interpreting the data;

442.16 (3) develop written data sharing agreements with the Minnesota Pollution Control
442.17 Agency, Department of Agriculture, and other relevant state agencies and organizations,
442.18 and develop additional procedures as needed to protect individual privacy;

442.19 (4) develop a strategic plan that includes a mission statement, the identification of
442.20 core priorities for research and epidemiologic surveillance, the identification of internal
442.21 and external stakeholders, and a work plan describing future program development;

442.22 (5) organize, analyze, and interpret available data, in order to:

442.23 (i) characterize statewide and localized trends and geographic patterns of prevalence
442.24 and incidence of chronic diseases, including, but not limited to, cancer, respiratory
442.25 diseases, reproductive problems, birth defects, neurologic diseases, and developmental
442.26 disorders;

442.27 (ii) recommend to the commissioner methods to improve data collection on
442.28 statewide population rates of chronic diseases and the occurrence of environmental
442.29 hazards and exposures;

442.30 (iii) characterize statewide and localized trends and geographic patterns in the
442.31 occurrence of environmental hazards and exposures;

442.32 (iv) assess the level of correlation with disease rate data and indicators of exposure
442.33 such as biomonitoring data, and other health and environmental data;

443.1 (v) incorporate newly collected and existing health tracking and biomonitoring
443.2 data into efforts to identify communities with elevated rates of chronic disease, higher
443.3 likelihood of exposure to environmental pollutants, or both;

443.4 (vi) analyze occurrence of environmental hazards, exposures, and diseases with
443.5 relation to socioeconomic status, race, and ethnicity;

443.6 (vii) develop and implement targeted plans to conduct more intensive health tracking
443.7 and biomonitoring among communities;

443.8 (viii) work with the Pollution Control Agency, the Department of Agriculture, and
443.9 other relevant state agency personnel and organizations to develop, implement, and
443.10 evaluate preventive measures to reduce elevated rates of diseases and exposures identified
443.11 through activities performed under sections 144.995 to 144.998; and

443.12 (ix) provide baseline data and present descriptive information relevant to policy
443.13 formation that are consistent with existing goals of the department; and

443.14 (6) submit a biennial report to the legislature by January 15, beginning January
443.15 15, 2009, on the status of environmental health tracking activities and related research
443.16 programs, and making recommendations regarding the continuation and improvement of
443.17 the programs.

443.18 Subd. 2. **Biomonitoring.** The commissioner shall:

443.19 (1) conduct biomonitoring of communities on a voluntary basis by collecting and
443.20 analyzing biospecimens, as appropriate, to assess environmental exposures to designated
443.21 chemicals;

443.22 (2) conduct biomonitoring of pregnant women and minors on a voluntary basis,
443.23 when scientifically appropriate;

443.24 (3) communicate findings to the public, and plan ensuing stages of biomonitoring
443.25 and disease tracking work to further develop and refine the integrated analysis;

443.26 (4) share analytical results with the advisory panel and work with the panel
443.27 to interpret results, communicate findings to the public, and plan ensuing stages of
443.28 biomonitoring work; and

443.29 (5) submit a biennial report to the legislature by January 15, beginning January
443.30 15, 2009, on the status of the biomonitoring program and any recommendations for
443.31 improvement.

443.32 Subd. 3. **Health data.** Data collected under the biomonitoring program are health
443.33 data under section 13.3805.

443.34 Sec. 19. **[144.997] BIOMONITORING PILOT PROGRAM.**

444.1 Subdivision 1. **Pilot program.** With advice from the advisory panel, the
444.2 commissioner shall develop a biomonitoring pilot program. The program shall collect
444.3 one biospecimen from each of the voluntary participants. The biospecimen selected must
444.4 be the biospecimen that most accurately represents body concentration of the chemical
444.5 of interest. Each biospecimen from the voluntary participants must be analyzed for one
444.6 type or class of related chemicals or metals, based on recommendations from the advisory
444.7 panel. The panel shall determine the chemical or class of chemicals that community
444.8 members were most likely exposed to. The program shall collect and assess biospecimens
444.9 in accordance with the following:

444.10 (1) 30 voluntary participants from each of three communities that the advisory panel
444.11 identifies as likely to have been exposed to a designated chemical;

444.12 (2) 100 voluntary participants from each of two communities: (i) that the advisory
444.13 panel identifies as likely to have been exposed to arsenic and (ii) that the advisory panel
444.14 identifies as likely to have been exposed to mercury; and

444.15 (3) 100 voluntary participants from each of two communities that the advisory panel
444.16 identifies as likely to have been exposed to perfluorinated chemicals.

444.17 Subd. 2. **Base program.** Following the conclusion of the pilot program and within
444.18 the appropriations available, the program shall:

444.19 (1) collect and assess biospecimens from at least as many voluntary participants and
444.20 communities as identified in subdivision 1, clause (1); and

444.21 (2) work with the advisory panel to assess the usefulness of continuing biomonitoring
444.22 among members of communities assessed during the initial phase of the program,
444.23 and to identify other communities and other designated chemicals to be assessed via
444.24 biomonitoring.

444.25 Subd. 3. **Participation.** (a) Participation in the biomonitoring program by providing
444.26 biospecimens is voluntary and requires written, informed consent. Minors may participate
444.27 in the program if a written consent is signed by the minor's parent or legal guardian.
444.28 The written consent must include the information required to be provided under this
444.29 subdivision to all voluntary participants.

444.30 (b) All participants shall be evaluated for the presence of the designated chemical
444.31 of interest as a component of the biomonitoring process. Participants shall be provided
444.32 with information and fact sheets about the program's activities and its findings.
444.33 Individual participants shall, if requested, receive their complete results. Any results
444.34 provided to participants shall be subject to the Department of Health Institutional
444.35 Review Board protocols and guidelines. When either physiological or chemical data
444.36 obtained from a participant indicate a significant known health risk, program staff

experienced in communicating biomonitoring results shall consult with the individual and recommend follow-up steps, as appropriate. Program administrators shall receive training in administering the program in an ethical, culturally sensitive, participatory, and community-based manner.

Subd. 4. **Program guidelines.** (a) The commissioner, in consultation with the advisory panel, shall develop:

(1) protocols or program guidelines that address the science and practice of biomonitoring to be utilized and procedures for changing those protocols to incorporate new and more accurate or efficient technologies as they become available. The protocols shall be developed utilizing a peer-review process in a manner that is participatory and community-based in design, implementation, and evaluation;

(2) guidelines for ensuring the privacy of information; informed consent; follow-up counseling and support; and communicating findings to participants, communities, and the general public. The informed consent used for the program must meet the informed consent protocols developed by the National Institutes of Health;

(3) educational and outreach materials that are culturally appropriate for dissemination to program participants and communities. Priority shall be given to the development of materials specifically designed to ensure that parents are informed about all of the benefits of breastfeeding so that the program does not result in an unjustified fear of toxins in breast milk, which might inadvertently lead parents to avoid breastfeeding. The materials shall communicate relevant scientific findings; data on the accumulation of pollutants to community health; and the required responses by local, state, and other governmental entities in regulating toxicant exposures;

(4) a training program that is culturally sensitive specifically for health care providers, health educators, and other program administrators;

(5) a designation process for state and private laboratories that are qualified to analyze biospecimens and report the findings; and

(6) a method for informing affected communities and local governments representing those communities concerning biomonitoring activities and for receiving comments from citizens concerning those activities.

(b) The commissioner may enter into contractual agreements with health clinics, community-based organizations, or experts in a particular field to perform any of the activities described under this section.

Sec. 20. [144.998] ENVIRONMENTAL HEALTH TRACKING AND BIOMONITORING ADVISORY PANEL.

Subdivision 1. **Creation.** The commissioner shall establish the Environmental Health Tracking and Biomonitoring Advisory Panel. The commissioner shall appoint, from the panel's membership, a chair. The panel shall meet as often as it deems necessary but, at a minimum, on a quarterly basis. Members of the panel shall serve without compensation but shall be reimbursed for travel and other necessary expenses incurred through performance of their duties. Members appointed under this subdivision are appointed for a three-year term and may be reappointed.

Subd. 2. **Members.** The commissioner shall appoint eight members, none of whom may be lobbyists registered under chapter 10A, who have backgrounds or training in designing, implementing, and interpreting health tracking and biomonitoring studies or in related fields of science, including epidemiology, biostatistics, environmental health, laboratory sciences, occupational health, industrial hygiene, toxicology, and public health, including:

(1) two scientists who represent nongovernmental organizations with a focus on environmental health, environmental justice, children's health, or on specific chronic diseases; and

(2) one scientist who is a representative of the University of Minnesota.

In addition, the commissioner shall appoint one member representing each of the following departments or divisions: the department's health promotion and chronic disease division, the Pollution Control Agency, and the Department of Agriculture.

Subd. 3. **Duties.** The advisory panel shall make recommendations to the commissioner and the legislature on:

(1) priorities for health tracking;

(2) priorities for biomonitoring that are based on sound science and practice, and that will advance the state of public health in Minnesota;

(3) specific chronic diseases to study under the environmental health tracking system;

(4) specific environmental pollutant exposures to study under the environmental health tracking system, with the agreement of at least seven of the advisory panel members;

(5) specific communities and geographic areas on which to focus environmental health tracking and biomonitoring efforts;

(6) specific chemicals and metals to study under the biomonitoring program that meet the following criteria, with the agreement of at least seven of the advisory panel members:

(i) the degree of potential exposure to the public or specific subgroups, including, but not limited to, occupational;

(ii) the likelihood of a chemical being a carcinogen or toxicant based on peer-reviewed health data, the chemical structure, or the toxicology of chemically related compounds;

(iii) the limits of laboratory detection for the chemical, including the ability to detect the chemical at low enough levels that could be expected in the general population;

(iv) exposure or potential exposure to the public or specific subgroups;

(v) the known or suspected health effects resulting from the same level of exposure based on peer-reviewed scientific studies;

(vi) the need to assess the efficacy of public health actions to reduce exposure to a chemical;

(vii) the availability of a biomonitoring analytical method with adequate accuracy, precision, sensitivity, specificity, and speed;

(viii) the availability of adequate biospecimen samples; and

(ix) other criteria that the panel may agree to; and

(7) other aspects of the design, implementation, and evaluation of the environmental health tracking and biomonitoring system, including, but not limited to:

(i) identifying possible community partners and sources of additional public or private funding;

(ii) developing outreach and educational methods and materials; and

(iii) disseminating environmental health tracking and biomonitoring findings to the public.

Subd. 4. **Liability.** No member of the panel shall be held civilly or criminally liable for an act or omission by that person if the act or omission was in good faith and within the scope of the member's responsibilities under sections 144.995 to 144.998.

Sec. 21. Minnesota Statutes 2006, section 144E.101, subdivision 6, is amended to read:

Subd. 6. **Basic life support.** (a) Except as provided in paragraph (e), a basic life support ambulance shall be staffed by at least two ambulance service personnel, at least one of which must be an EMT, who provide a level of care so as to ensure that:

(1) life-threatening situations and potentially serious injuries are recognized;

(2) patients are protected from additional hazards;

(3) basic treatment to reduce the seriousness of emergency situations is administered;

and

(4) patients are transported to an appropriate medical facility for treatment.

(b) A basic life support service shall provide basic airway management.

(c) By January 1, 2001, a basic life support service shall provide automatic defibrillation, as provided in section 144E.103, subdivision 1, paragraph (b).

(d) A basic life support service licensee's medical director may authorize the ambulance service personnel to carry and to use medical antishock trousers and to perform intravenous infusion if the ambulance service personnel have been properly trained.

(e) Upon application from an ambulance service that includes evidence demonstrating hardship, the board may grant a ~~temporary~~ variance from the staff requirements in paragraph (a) and may authorize a basic life support ambulance to be staffed by one EMT and one first responder. The variance shall apply to basic life support ambulances operated by the ambulance service ~~for up to one year from the date of the variance's issuance~~ until the ambulance service renews its license. When a variance expires, an ambulance service may apply for a new variance under this paragraph. For purposes of this paragraph, "ambulance service" means either an ambulance service whose primary service area is located outside the metropolitan counties listed in section 473.121, subdivision 4, and outside the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud; or an ambulance service based in a community with a population of less than 1,000.

Sec. 22. Minnesota Statutes 2006, section 144E.127, is amended to read:

144E.127 INTERHOSPITAL; INTERFACILITY TRANSFER.

Subdivision 1. Interhospital transfers. When transporting a patient from one licensed hospital to another, a licensee may substitute for one of the required ambulance service personnel, a physician, a registered nurse, or physician's assistant who has been trained to use the equipment in the ambulance and is knowledgeable of the licensee's ambulance service protocols.

Subd. 2. Interfacility transfers. In an interfacility transport, a licensee whose primary service area is located outside the metropolitan counties listed in section 473.121, subdivision 4, and outside the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud; or an ambulance service based in a community with a population of less than 1,000, may substitute one EMT with a registered first responder if an EMT or EMT-paramedic, physician, registered nurse, or physician's assistant is in the patient compartment. If using a physician, registered nurse, or physician's assistant as the sole provider in the patient compartment, the individual must be trained to use the equipment in the ambulance and be knowledgeable of the ambulance service protocols.

Sec. 23. Minnesota Statutes 2006, section 144E.35, subdivision 1, is amended to read:

Subdivision 1. **Repayment for volunteer training.** ~~Any political subdivision, or nonprofit hospital or nonprofit corporation operating~~ A licensed ambulance service shall be reimbursed by the board for the necessary expense of the initial training of a volunteer ambulance attendant upon successful completion by the attendant of a basic emergency care course, or a continuing education course for basic emergency care, or both, which has been approved by the board, pursuant to section 144E.285. Reimbursement may include tuition, transportation, food, lodging, hourly payment for the time spent in the training course, and other necessary expenditures, except that in no instance shall a volunteer ambulance attendant be reimbursed more than ~~\$450~~ \$600 for successful completion of a basic course, and ~~\$225~~ \$275 for successful completion of a continuing education course.

Sec. 24. **[145.958] BISPHENOL-A IN PRODUCTS FOR CHILDREN.**

Subdivision. 1. **Bisphenol-A and phthalates committee.** The commissioner of health shall create a committee under the direction of the environmental health division of the Department of Health to study the scientific literature and make recommendations to the legislature on the health impact of bisphenol-A and phthalates on children in products intended for use by young children, including, but not limited to, toys, pacifiers, baby bottles, and teethingers, and report back by January 15, 2008. The committee shall also identify least harmful alternatives. Of the seven committee members at least one shall be a representative of the Department of Health, one shall be a representative of environmental health sciences research, one shall be a representative of the Minnesota Nurses Association, one shall be a representative of environmental health consumer advocates, one shall be a member of a children's product manufacturer's association, and one shall be a representative of the University of Minnesota, chemical plastics research department.

Subd. 2. **Definitions.** For the purposes of this section, the following terms have the meanings given them:

(a) "Toy" means all products designed or intended by the manufacturer to be used by children when they play.

(b) "Child care article" means all products designed or intended by the manufacturer to facilitate sleep, relaxation, or the feeding of children or to help children with sucking or teething.

Sec. 25. Minnesota Statutes 2006, section 145A.17, is amended to read:

145A.17 FAMILY HOME VISITING PROGRAMS.

Subdivision 1. **Establishment; goals.** The commissioner shall establish a program to fund family home visiting programs designed to foster a healthy beginning for children

~~in families at or below 200 percent of the federal poverty guidelines~~ beginnings, improve pregnancy outcomes, promote school readiness, prevent child abuse and neglect, reduce juvenile delinquency, promote positive parenting and resiliency in children, and promote family health and economic self-sufficiency for children and families. The commissioner shall promote partnerships, collaboration, and multidisciplinary visiting done by teams of professionals and paraprofessionals from the fields of public health nursing, social work, and early childhood education. A program funded under this section must serve families at or below 200 percent of the federal poverty guidelines, and other families determined to be at risk, including but not limited to being at risk for child abuse, child neglect, or juvenile delinquency. ~~Programs must give priority for services to families considered to be in need of services, including but not limited to~~ begin prenatally whenever possible and must be targeted to families with:

- (1) adolescent parents;
- (2) a history of alcohol or other drug abuse;
- (3) a history of child abuse, domestic abuse, or other types of violence;
- (4) a history of domestic abuse, rape, or other forms of victimization;
- (5) reduced cognitive functioning;
- (6) a lack of knowledge of child growth and development stages;
- (7) low resiliency to adversities and environmental stresses; ~~or~~
- (8) insufficient financial resources to meet family needs;
- (9) a history of homelessness;
- (10) a risk of long-term welfare dependence or family instability due to employment barriers; or
- (11) other risk factors as determined by the commissioner.

Subd. 3. **Requirements for programs; process.** ~~(a) Before a community health board or tribal government may receive an allocation under subdivision 2, a community health board or tribal government must submit a proposal to the commissioner that includes identification, based on a community assessment, of the populations at or below 200 percent of the federal poverty guidelines that will be served and the other populations that will be served. Each program that receives funds must~~ Community health boards and tribal governments that receive funding under this section must submit a plan to the commissioner describing a multidisciplinary approach to targeted home visiting for families. The plan must be submitted on forms provided by the commissioner. At a minimum, the plan must include the following:

- (1) a description of outreach strategies to families prenatally or at birth;
- (2) provisions for the seamless delivery of health, safety, and early learning services;

- 451.1 (3) methods to promote continuity of services when families move within the state;
451.2 (4) a description of the community demographics;
451.3 (5) a plan for meeting outcome measures; and
451.4 (6) a proposed work plan that includes:
451.5 (i) coordination to ensure nonduplication of services for children and families;
451.6 (ii) a description of the strategies to ensure that children and families at greatest risk
451.7 receive appropriate services; and
451.8 (iii) collaboration with multidisciplinary partners including public health,
451.9 ECFE, Head Start, community health workers, social workers, community home
451.10 visiting programs, school districts, and other relevant partners. Letters of intent from
451.11 multidisciplinary partners must be submitted with the plan.
451.12 (b) Each program that receives funds must accomplish the following program
451.13 requirements:
451.14 (1) use ~~either a broad community-based or selective community-based~~ strategy to
451.15 provide preventive and early intervention home visiting services;
451.16 (2) offer a home visit by a trained home visitor. If a home visit is accepted, the first
451.17 home visit must occur prenatally or as soon after birth as possible and must include a
451.18 public health nursing assessment by a public health nurse;
451.19 (3) offer, at a minimum, information on infant care, child growth and development,
451.20 positive parenting, preventing diseases, preventing exposure to environmental hazards,
451.21 and support services available in the community;
451.22 (4) provide information on and referrals to health care services, if needed, including
451.23 information on and assistance in applying for health care coverage for which the child or
451.24 family may be eligible; and provide information on preventive services, developmental
451.25 assessments, and the availability of public assistance programs as appropriate;
451.26 (5) provide youth development programs when appropriate;
451.27 (6) recruit home visitors who will represent, to the extent possible, the races,
451.28 cultures, and languages spoken by families that may be served;
451.29 (7) train and supervise home visitors in accordance with the requirements established
451.30 under subdivision 4;
451.31 (8) maximize resources and minimize duplication by coordinating ~~activities or~~
451.32 contracting with local social and human services organizations, education organizations,
451.33 and other appropriate governmental entities and community-based organizations and
451.34 agencies; ~~and~~
451.35 (9) utilize appropriate racial and ethnic approaches to providing home visiting
451.36 services; and

452.1 (10) connect eligible families, as needed, to additional resources available in the
452.2 community, including, but not limited to, early care and education programs, health or
452.3 mental health services, family literacy programs, employment agencies, social services,
452.4 and child care resources and referral agencies.

452.5 (c) When available, programs that receive funds under this section must offer or
452.6 provide the family with a referral to center-based or group meetings that meet at least
452.7 once per month for those families identified with additional needs. The meetings must
452.8 focus on further enhancing the information, activities, and skill-building addressed during
452.9 home visitation; offering opportunities for parents to meet with and support each other;
452.10 and offering infants and toddlers a safe, nurturing, and stimulating environment for
452.11 socialization and supervised play with qualified teachers.

452.12 ~~(b)~~ (d) Funds available under this section shall not be used for medical services. The
452.13 commissioner shall establish an administrative cost limit for recipients of funds. The
452.14 outcome measures established under subdivision 6 must be specified to recipients of
452.15 funds at the time the funds are distributed.

452.16 ~~(e)~~ (e) Data collected on individuals served by the home visiting programs must
452.17 remain confidential and must not be disclosed by providers of home visiting services
452.18 without a specific informed written consent that identifies disclosures to be made.
452.19 Upon request, agencies providing home visiting services must provide recipients with
452.20 information on disclosures, including the names of entities and individuals receiving the
452.21 information and the general purpose of the disclosure. Prospective and current recipients
452.22 of home visiting services must be told and informed in writing that written consent for
452.23 disclosure of data is not required for access to home visiting services.

452.24 Subd. 4. **Training.** The commissioner shall establish training requirements for
452.25 home visitors and minimum requirements for supervision ~~by a public health nurse~~. The
452.26 requirements for nurses must be consistent with chapter 148. The commissioner must
452.27 provide training for home visitors. Training must include ~~child development, positive~~
452.28 ~~parenting techniques, screening and referrals for child abuse and neglect, and diverse~~
452.29 ~~cultural practices in child rearing and family systems~~ the following:

452.30 (1) effective relationships for engaging and retaining families and ensuring family
452.31 health, safety, and early learning;

452.32 (2) effective methods of implementing parent education, conducting home visiting,
452.33 and promoting quality early childhood development;

452.34 (3) early childhood development from birth to age five;

452.35 (4) diverse cultural practices in child rearing and family systems;

452.36 (5) recruiting, supervising, and retaining qualified staff;

453.1 (6) increasing services for underserved populations; and
453.2 (7) relevant issues related to child welfare and protective services, with information
453.3 provided being consistent with state child welfare agency training.

453.4 Subd. 5. **Technical assistance.** The commissioner shall provide administrative
453.5 and technical assistance to each program, including assistance in data collection and
453.6 other activities related to conducting short- and long-term evaluations of the programs
453.7 as required under subdivision 7. The commissioner may request research and evaluation
453.8 support from the University of Minnesota.

453.9 Subd. 6. **Outcome and performance measures.** The commissioner shall establish
453.10 ~~outcomes~~ measures to determine the impact of family home visiting programs funded
453.11 under this section on the following areas:

453.12 (1) appropriate utilization of preventive health care;
453.13 (2) rates of substantiated child abuse and neglect;
453.14 (3) rates of unintentional child injuries;
453.15 (4) rates of children who are screened and who pass early childhood screening; ~~and~~
453.16 (5) rates of children accessing early care and educational services;
453.17 (6) program retention rates;
453.18 (7) number of home visits provided compared to the number of home visits planned;
453.19 (8) participant satisfaction;
453.20 (9) rates of at-risk populations reached; and
453.21 (10) any additional qualitative goals and quantitative measures established by the
453.22 commissioner.

453.23 Subd. 7. **Evaluation.** Using the qualitative goals and quantitative outcome and
453.24 performance measures established under subdivisions 1 and 6, the commissioner shall
453.25 conduct ongoing evaluations of the programs funded under this section. Community
453.26 health boards and tribal governments shall cooperate with the commissioner in the
453.27 evaluations and shall provide the commissioner with the information necessary to conduct
453.28 the evaluations. As part of the ongoing evaluations, the commissioner shall rate the impact
453.29 of the programs on the outcome measures listed in subdivision 6, and shall periodically
453.30 determine whether home visiting programs are the best way to achieve the qualitative
453.31 goals established under subdivisions 1 and 6. If the commissioner determines that home
453.32 visiting programs are not the best way to achieve these goals, the commissioner shall
453.33 provide the legislature with alternative methods for achieving them.

453.34 Subd. 8. **Report.** By January 15, 2002, and January 15 of each even-numbered
453.35 year thereafter, the commissioner shall submit a report to the legislature on the family

home visiting programs funded under this section and on the results of the evaluations conducted under subdivision 7.

Subd. 9. **No supplanting of existing funds.** Funding available under this section may be used only to supplement, not to replace, nonstate funds being used for home visiting services as of July 1, 2001.

Sec. 26. Minnesota Statutes 2006, section 156.001, is amended by adding a subdivision to read:

Subd. 10a. **Program for the Assessment of Veterinary Education Equivalence; PAVE certificate.** A "Program for the Assessment of Veterinary Education Equivalence" or "PAVE" certificate is issued by the American Association of Veterinary State Boards, indicating that the holder has demonstrated knowledge and skill equivalent to that possessed by a graduate of an accredited or approved college of veterinary medicine.

Sec. 27. **[156.015] FEES.**

Subdivision 1. **Verification of licensure.** The board may charge a fee of \$25 per license verification to a licensee for verification of licensure status provided to other veterinary licensing boards.

Subd. 2. **Continuing education review.** The board may charge a fee of \$50 per submission to a sponsor for review and approval of individual continuing education seminars, courses, wet labs, and lectures. This fee does not apply to continuing education sponsors that already meet the criteria for preapproval under Minnesota Rules, part 9100.1000, subpart 3, item A.

Sec. 28. Minnesota Statutes 2006, section 156.02, subdivision 1, is amended to read:

Subdivision 1. **License application.** Application for a license to practice veterinary medicine in this state shall be made in writing to the Board of Veterinary Medicine upon a form furnished by the board, accompanied by satisfactory evidence that the applicant is at least 18 years of age, is of good moral character, and has one of the following:

(1) a diploma conferring the degree of doctor of veterinary medicine, or an equivalent degree, from an accredited or approved college of veterinary medicine;

(2) an ECFVG or PAVE certificate; or

(3) a certificate from the dean of an accredited or approved college of veterinary medicine stating that the applicant is a student in good standing expecting to be graduated at the completion of the current academic year of the college in which the applicant is enrolled.

455.1 The application shall contain the information and material required by subdivision
455.2 2 and any other information that the board may, in its sound judgment, require. The
455.3 application shall be filed with the board at least 60 days before the date of the examination.
455.4 If the board deems it advisable, it may require that such application be verified by the
455.5 oath of the applicant.

455.6 Sec. 29. Minnesota Statutes 2006, section 156.02, subdivision 2, is amended to read:

455.7 Subd. 2. **Required with application.** Every application shall contain the following
455.8 information and material:

455.9 (1) the application fee set by the board in the form of a check or money order payable
455.10 to the board, which fee is not returnable in the event permission to take the examination
455.11 is denied for good cause;

455.12 (2) a copy of a diploma from an accredited or approved college of veterinary
455.13 medicine or a certificate from the dean or secretary of an accredited or approved college of
455.14 veterinary medicine showing the time spent in the school and the date when the applicant
455.15 was duly and regularly graduated or will duly and regularly graduate or verification of
455.16 ECFVG or PAVE certification;

455.17 (3) affidavits of at least two veterinarians and three adults who are not related to
455.18 the applicant setting forth how long a time, when, and under what circumstances they
455.19 have known the applicant, and any other facts as may be proper to enable the board to
455.20 determine the qualifications of the applicant; and

455.21 (4) if the applicant has served in the armed forces, a copy of discharge papers.

455.22 Sec. 30. Minnesota Statutes 2006, section 156.04, is amended to read:

455.23 **156.04 BOARD TO ISSUE LICENSE.**

455.24 The Board of Veterinary Medicine shall issue to every applicant who has successfully
455.25 passed the required examination, who has received a diploma conferring the degree of
455.26 doctor of veterinary medicine or an equivalent degree from an accredited or approved
455.27 college of veterinary medicine or an ECFVG or PAVE certificate, and who shall have been
455.28 adjudged to be duly qualified to practice veterinary medicine, a license to practice.

455.29 Sec. 31. Minnesota Statutes 2006, section 156.072, subdivision 2, is amended to read:

455.30 Subd. 2. **Required with application.** Such doctor of veterinary medicine shall
455.31 accompany the application by the following:

455.32 (1) a copy of a diploma from an accredited or approved college of veterinary
455.33 medicine or certification from the dean, registrar, or secretary of an accredited or approved

college of veterinary medicine attesting to the applicant's graduation from an accredited or approved college of veterinary medicine, or a certificate of satisfactory completion of the ECFVG or PAVE program.

(2) affidavits of two licensed practicing doctors of veterinary medicine residing in the United States or Canadian licensing jurisdiction in which the applicant is currently practicing, attesting that they are well acquainted with the applicant, that the applicant is a person of good moral character, and has been actively engaged in practicing or teaching in such jurisdiction for the period above prescribed;

(3) a certificate from the regulatory agency having jurisdiction over the conduct of practice of veterinary medicine that such applicant is in good standing and is not the subject of disciplinary action or pending disciplinary action;

(4) a certificate from all other jurisdictions in which the applicant holds a currently active license or held a license within the past ten years, stating that the applicant is and was in good standing and has not been subject to disciplinary action;

(5) in lieu of clauses (3) and (4), certification from the Veterinary Information Verification Agency that the applicant's licensure is in good standing;

(6) a fee as set by the board in form of check or money order payable to the board, no part of which shall be refunded should the application be denied;

(7) score reports on previously taken national examinations in veterinary medicine, certified by the Veterinary Information Verification Agency; and

(8) if requesting waiver of examination, provide evidence of meeting licensure requirements in the state of the applicant's original licensure that were substantially equal to the requirements for licensure in Minnesota in existence at that time.

Sec. 32. Minnesota Statutes 2006, section 156.073, is amended to read:

156.073 TEMPORARY PERMIT.

The board may issue without examination a temporary permit to practice veterinary medicine in this state to a person who has submitted an application approved by the board for license pending examination, and holds a doctor of veterinary medicine degree or an equivalent degree from an approved or accredited college of veterinary medicine or an ECFVG or PAVE certification. The temporary permit shall expire the day after publication of the notice of results of the first examination given after the permit is issued. No temporary permit may be issued to any applicant who has previously failed the national examination and is currently not licensed in any licensing jurisdiction of the United States or Canada or to any person whose license has been revoked or suspended

457.1 or who is currently subject to a disciplinary order in any licensing jurisdiction of the
457.2 United States or Canada.

457.3 Sec. 33. Minnesota Statutes 2006, section 156.12, subdivision 2, is amended to read:

457.4 Subd. 2. **Authorized activities.** No provision of this chapter shall be construed to
457.5 prohibit:

457.6 (a) a person from rendering necessary gratuitous assistance in the treatment of any
457.7 animal when the assistance does not amount to prescribing, testing for, or diagnosing,
457.8 operating, or vaccinating and when the attendance of a licensed veterinarian cannot be
457.9 procured;

457.10 (b) a person who is a regular student in an accredited or approved college of
457.11 veterinary medicine from performing duties or actions assigned by instructors or
457.12 preceptors or working under the direct supervision of a licensed veterinarian;

457.13 (c) a veterinarian regularly licensed in another jurisdiction from consulting with a
457.14 licensed veterinarian in this state;

457.15 (d) the owner of an animal and the owner's regular employee from caring for and
457.16 administering to the animal belonging to the owner, except where the ownership of the
457.17 animal was transferred for purposes of circumventing this chapter;

457.18 (e) veterinarians who are in compliance with subdivision 6 and who are employed by
457.19 the University of Minnesota from performing their duties with the College of Veterinary
457.20 Medicine, College of Agriculture, Agricultural Experiment Station, Agricultural Extension
457.21 Service, Medical School, School of Public Health, or other unit within the university; or
457.22 a person from lecturing or giving instructions or demonstrations at the university or in
457.23 connection with a continuing education course or seminar to veterinarians or pathologists
457.24 at the University of Minnesota Veterinary Diagnostic Laboratory;

457.25 (f) any person from selling or applying any pesticide, insecticide or herbicide;

457.26 (g) any person from engaging in bona fide scientific research or investigations which
457.27 reasonably requires experimentation involving animals;

457.28 (h) any employee of a licensed veterinarian from performing duties other than
457.29 diagnosis, prescription or surgical correction under the direction and supervision of the
457.30 veterinarian, who shall be responsible for the performance of the employee;

457.31 (i) a graduate of a foreign college of veterinary medicine from working under the
457.32 direct personal instruction, control, or supervision of a veterinarian faculty member of
457.33 the College of Veterinary Medicine, University of Minnesota in order to complete the
457.34 requirements necessary to obtain an ECFVG or PAVE certificate.

Sec. 34. Minnesota Statutes 2006, section 156.12, subdivision 4, is amended to read:

Subd. 4. **Titles.** It is unlawful for a person who has not received a professional degree from an accredited or approved college of veterinary medicine, or ECFVG or PAVE certification, to use any of the following titles or designations: Veterinary, veterinarian, animal doctor, animal surgeon, animal dentist, animal chiropractor, animal acupuncturist, or any other title, designation, word, letter, abbreviation, sign, card, or device tending to indicate that the person is qualified to practice veterinary medicine.

Sec. 35. Minnesota Statutes 2006, section 156.12, subdivision 6, is amended to read:

Subd. 6. **Faculty licensure.** (a) Veterinary Medical Center clinicians at the College of Veterinary Medicine, University of Minnesota, who are engaged in the practice of veterinary medicine as defined in subdivision 1 and who treat animals owned by clients of the Veterinary Medical Center must possess the same license required by other veterinary practitioners in the state of Minnesota except for persons covered by paragraphs (b) and (c).

(b) A specialty practitioner in a hard-to-fill faculty position who has been employed at the College of Veterinary Medicine, University of Minnesota, for five years or more prior to 2003 or is specialty board certified by the American Veterinary Medical Association or the European Board of Veterinary Specialization may be granted a specialty faculty Veterinary Medical Center clinician license which will allow the licensee to practice veterinary medicine in the state of Minnesota in the specialty area of the licensee's training and only within the scope of employment at the Veterinary Medical Center.

(c) A specialty practitioner in a hard-to-fill faculty position at the College of Veterinary Medicine, University of Minnesota, who has graduated from a board-approved foreign veterinary school may be granted a temporary faculty Veterinary Medical Center clinician license. The temporary faculty Veterinary Medical Center clinician license expires in two years and allows the licensee to practice veterinary medicine as defined in subdivision 1 and treat animals owned by clients of the Veterinary Medical Center. The temporary faculty Veterinary Medical Center clinician license allows the licensee to practice veterinary medicine in the state of Minnesota in the specialty area of the licensee's training and only within the scope of employment at the Veterinary Medical Center while under the direct supervision of a veterinarian currently licensed and actively practicing veterinary medicine in Minnesota, as defined in section 156.04. The direct supervising veterinarian shall not have any current or past conditions, restrictions, or probationary status imposed on the veterinarian's license by the board within the past five years. The holder of a temporary faculty Veterinary Medical Center clinician license who is enrolled in a PhD program may apply for up to two additional consecutive two-year extensions

of an expiring temporary faculty Veterinary Medical Center clinician license. Any other holder of a temporary faculty Veterinary Medical Center clinician license may apply for one two-year extension of the expiring temporary faculty Veterinary Medical Center clinician license. Temporary faculty Veterinary Medical Center clinician licenses that are allowed to expire may not be renewed. The board shall grant an extension to a licensee who demonstrates suitable progress toward completing the requirements of their academic program, specialty board certification, or full licensure in Minnesota by a graduate of a foreign veterinary college.

(d) Temporary and specialty faculty Veterinary Medical Center clinician licensees must abide by all the laws governing the practice of veterinary medicine in the state of Minnesota and are subject to the same disciplinary action as any other veterinarian licensed in the state of Minnesota.

(e) The fee for a license issued under this subdivision is the same as for a regular license to practice veterinary medicine in Minnesota. License payment deadlines, late payment fees, and other license requirements are also the same as for regular licenses.

Sec. 36. Minnesota Statutes 2006, section 156.15, subdivision 2, is amended to read:

Subd. 2. **Service.** Service of an order under this section is effective if the order is served on the person or counsel of record personally or by ~~certified~~ United States mail to the most recent address provided to the board for the person or counsel of record.

Sec. 37. Minnesota Statutes 2006, section 156.16, subdivision 3, is amended to read:

Subd. 3. **Dispensing.** "Dispensing" means distribution of veterinary prescription drugs or over-the-counter drugs for extra-label use or human drugs for extra-label use by a person licensed as a pharmacist by the Board of Pharmacy or a person licensed by the Board of Veterinary Medicine.

Sec. 38. Minnesota Statutes 2006, section 156.16, subdivision 10, is amended to read:

Subd. 10. **Prescription.** "Prescription" means an order from a veterinarian to a pharmacist or another veterinarian authorizing the dispensing of ~~a~~ veterinary prescription drug, human drugs for extra-label use, or over-the-counter drugs for extra-label use to a client for use on or in a patient.

Sec. 39. Minnesota Statutes 2006, section 156.18, subdivision 1, is amended to read:

Subdivision 1. **Prescription.** (a) A person may not dispense a veterinary prescription drug to a client without a prescription or other veterinary authorization. A

person may not make extra-label use of an animal or human drug for an animal without a prescription from a veterinarian. A veterinarian or the veterinarian's authorized employee may dispense a veterinary prescription ~~drug to~~ drugs, human drugs for extra-label use, or an over-the-counter drug for extra-label use by a client ~~or oversee the extra-label use of a veterinary drug directly by a client~~ without a separate written prescription, providing there is documentation of the prescription in the medical record and there is an existing veterinarian-client-patient relationship. The prescribing veterinarian must monitor the use of veterinary prescription drugs, human drugs for extra-label use, or over-the-counter drugs for extra-label use by a client.

(b) A veterinarian may dispense prescription veterinary drugs and prescribe and dispense extra-label use drugs to a client without personally examining the animal if a bona fide veterinarian-client-patient relationship exists and in the judgment of the veterinarian the client has sufficient knowledge to use the drugs properly.

(c) A veterinarian may issue a prescription or other veterinary authorization by oral or written communication to the dispenser, or by computer connection. If the communication is oral, the veterinarian must enter it into the patient's record. The dispenser must record the veterinarian's prescription or other veterinary authorization within 72 hours.

(d) A prescription or other veterinary authorization must include:

- (1) the name, address, and, if written, the signature of the prescriber;
- (2) the name and address of the client;
- (3) identification of the species for which the drug is prescribed or ordered;
- (4) the name, strength, and quantity of the drug;
- (5) the date of issue;
- (6) directions for use; ~~and~~
- (7) withdrawal time-, if applicable; and
- (8) number of authorized refills.

(e) A veterinarian may, in the course of professional practice and an existing veterinarian-client-patient relationship, prepare medicaments that combine drugs approved by the United States Food and Drug Administration and other legally obtained ingredients with appropriate vehicles.

(f) A veterinarian or a bona fide employee of a veterinarian may dispense veterinary prescription drugs to a person on the basis of a prescription issued by a licensed veterinarian. The provisions of paragraphs (c) and (d) apply.

(g) This section does not limit the authority of the Minnesota Racing Commission to regulate veterinarians providing services at a licensed racetrack.

Sec. 40. Minnesota Statutes 2006, section 156.18, subdivision 2, is amended to read:

Subd. 2. **Label of dispensed veterinary drugs.** (a) A veterinarian or the veterinarian's authorized agent or employee dispensing a veterinary prescription drug ~~or prescribing the extra-label use of an over-the-counter drug, an over-the-counter drug~~ for extra-label use, or a human drug for extra-label use must provide written information which includes the name and address of the veterinarian, date of filling, species of patient, name or names of drug, strength of drug or drugs, directions for use, withdrawal time, and cautionary statements, if any, appropriate for the drug.

(b) If the veterinary drug has been prepared, mixed, formulated, or packaged by the dispenser, all of the information required in paragraph (a) must be provided on a label affixed to the container.

(c) If the veterinary drug is in the manufacturer's original package, the information required in paragraph (a) must be supplied in writing but need not be affixed to the container. Information required in paragraph (a) that is provided by the manufacturer on the original package does not need to be repeated in the separate written information. Written information required by this paragraph may be written on the sales invoice.

Sec. 41. Minnesota Statutes 2006, section 156.19, is amended to read:

156.19 EXTRA-LABEL USE.

A person, other than a veterinarian or ~~a person working under the control of an~~ employee of a veterinarian, must not make extra-label use of a veterinary drug in or on a food-producing animal, unless permitted by the prescription of a veterinarian. A veterinarian may prescribe the extra-label use of a ~~veterinary~~ drug if:

(1) the veterinarian makes a careful medical diagnosis within the context of a valid veterinarian-client-patient relationship;

(2) the veterinarian determines that there is no marketed drug specifically labeled to treat the condition diagnosed, or that drug therapy as recommended by the labeling has, in the judgment of the attending veterinarian, been found to be clinically ineffective;

(3) the veterinarian recommends procedures to ensure that the identity of the treated animal will be carefully maintained; ~~and~~

(4) the veterinarian prescribes a significantly extended time period for drug withdrawal before marketing meat, milk, or eggs; and

(5) the veterinarian has met the criteria established in Code of Federal Regulations, title 21, part 530, which define the extra-label use of medication in or on animals.

Sec. 42. Minnesota Statutes 2006, section 198.075, is amended to read:

198.075 MINNESOTA VETERANS HOME EMPLOYEES; EXCLUDED FROM COMMISSARY PRIVILEGES.

Except as provided in this section, no commissary privileges including food, laundry service, janitorial service, and household supplies shall be furnished to any employee of the Minnesota veterans homes. An employee of the Minnesota veterans homes who works a second shift that is consecutive with a regularly scheduled shift may be allowed one free meal at the veterans home on the day of that extra shift.

Sec. 43. Minnesota Statutes 2006, section 256B.0625, subdivision 14, is amended to read:

Subd. 14. **Diagnostic, screening, and preventive services.** (a) Medical assistance covers diagnostic, screening, and preventive services.

(b) "Preventive services" include services related to pregnancy, including:

(1) services for those conditions which may complicate a pregnancy and which may be available to a pregnant woman determined to be at risk of poor pregnancy outcome;

(2) prenatal HIV risk assessment, education, counseling, and testing; and

(3) alcohol abuse assessment, education, and counseling on the effects of alcohol usage while pregnant. Preventive services available to a woman at risk of poor pregnancy outcome may differ in an amount, duration, or scope from those available to other individuals eligible for medical assistance.

(c) "Screening services" include, but are not limited to, blood lead tests. Screening services also include, for children with blood lead levels equal to or greater than five micrograms of lead per deciliter of whole blood, environmental investigations to determine the source of lead exposure. Reimbursement is limited to a health professional's time and activities during an on-site investigation of a child's home or primary residence.

Sec. 44. Minnesota Statutes 2006, section 256B.0625, is amended by adding a subdivision to read:

Subd. 49. **Lead risk assessments.** (a) Effective October 1, 2007, or six months after federal approval, whichever is later, medical assistance covers lead risk assessments provided by a lead risk assessor who is licensed by the commissioner of health under section 144.9505 and employed by an assessing agency as defined in section 144.9501. Medical assistance covers a onetime on-site investigation of a recipient's home or primary residence to determine the existence of lead so long as the recipient is under the age

of 21 and has a venous blood lead level specified in section 144.9504, subdivision 2, paragraph (a).

(b) Medical assistance reimbursement covers the lead risk assessor's time to complete the following activities:

(1) gathering samples;

(2) interviewing family members;

(3) gathering data, including meter readings; and

(4) providing a report with the results of the investigation and options for reducing lead-based paint hazards.

Medical assistance coverage of lead risk assessment does not include testing of environmental substances such as water, paint, or soil or any other laboratory services.

Medical assistance coverage of lead risk assessments is not included in the capitated services for children enrolled in health plans through the prepaid medical assistance program and the MinnesotaCare program.

(c) Payment for lead risk assessment must be cost-based and must meet the criteria for federal financial participation under the Medicaid program. The rate must be based on allowable expenditures from cost information gathered. Under section 144.9507, subdivision 5, federal medical assistance funds may not replace existing funding for lead-related activities. The nonfederal share of costs for services provided under this subdivision must be from state or local funds and is the responsibility of the agency providing the risk assessment. Eligible expenditures for the nonfederal share of costs may not be made from federal funds or funds used to match other federal funds. Any federal disallowances are the responsibility of the agency providing risk assessment services.

Sec. 45. **[325E.385] PRODUCTS CONTAINING POLYBROMINATED DIPHENYL ETHER.**

Subdivision 1. Definitions. For the purposes of sections 325E.386 to 325E.388, the terms in this section have the meanings given them.

Subd. 2. Commercial decabromodiphenyl ether. "Commercial decabromodiphenyl ether" means the chemical mixture of decabromodiphenyl ether, including associated polybrominated diphenyl ether impurities not intentionally added.

Subd. 3. Commissioner. "Commissioner" means the commissioner of the Pollution Control Agency.

Subd. 4. Manufacturer. "Manufacturer" means any person, firm, association, partnership, corporation, governmental entity, organization, or joint venture that produces

a product containing polybrominated diphenyl ethers or an importer or domestic distributor of a noncombustible product containing polybrominated diphenyl ethers.

Subd. 5. **Polybrominated diphenyl ethers or PBDE's.** "Polybrominated diphenyl ethers" or "PBDE's" means chemical forms that consist of diphenyl ethers bound with bromine atoms. Polybrominated diphenyl ethers include, but are not limited to, the three primary forms of the commercial mixtures known as pentabromodiphenyl ether, octabromodiphenyl ether, and decabromodiphenyl ether.

Subd. 6. **Retailer.** "Retailer" means a person who offers a product for sale at retail through any means, including, but not limited to, remote offerings such as sales outlets, catalogs, or the Internet, but does not include a sale that is a wholesale transaction with a distributor or a retailer.

Subd. 7. **Used product.** "Used product" means any product that has been previously owned, purchased, or sold in commerce. Used product does not include any product manufactured after January 1, 2008.

Sec. 46. [325E.386] PRODUCTS CONTAINING CERTAIN POLYBROMINATED DIPHENYL ETHERS BANNED; EXEMPTIONS.

Subdivision 1. **Penta- and octabromodiphenyl ethers.** Except as provided in subdivision 3, beginning January 1, 2008, a person may not manufacture, process, or distribute in commerce a product or flame-retardant part of a product containing more than one-tenth of one percent of pentabromodiphenyl ether or octabromodiphenyl ether by mass.

Subd. 2. **Exemptions.** The following products containing polybrominated diphenyl ethers are exempt from subdivision 1:

(1) the sale or distribution of any used transportation vehicle with component parts containing polybrominated diphenyl ethers;

(2) the sale or distribution of any used transportation vehicle parts or new transportation vehicle parts manufactured before January 1, 2008, that contain polybrominated diphenyl ethers;

(3) the manufacture, sale, repair, distribution, maintenance, refurbishment, or modification of equipment containing polybrominated diphenyl ethers and used primarily for military or federally funded space program applications. This exemption does not cover consumer-based goods with broad applicability;

(4) the sale or distribution by a business, charity, public entity, or private party of any used product containing polybrominated diphenyl ethers;

(5) the manufacture, sale, or distribution of new carpet cushion made from recycled foam containing more than one-tenth of one percent penta polybrominated diphenyl ether; or

(6) medical devices.

In-state retailers in possession of products on January 1, 2008, that are banned for sale under subdivision 1 may exhaust their stock through sales to the public. Nothing in this section restricts the ability of a manufacturer, importer, or distributor from transporting products containing polybrominated diphenyl ethers through the state, or storing such products in the state for later distribution outside the state.

Sec. 47. **[325E.387] REVIEW OF DECABROMODIPHENYL ETHER.**

Subdivision 1. Commissioner duties. The commissioner in consultation with the commissioners of health and public safety shall review uses of commercial decabromodiphenyl ether, availability of technically feasible and safer alternatives, fire safety and any evidence regarding the potential harm to public health and the environment posed by commercial decabromodiphenyl ether and the alternatives. The commissioner must consult with key stakeholders. The commissioner must also review the findings from similar state and federal agencies and must report their findings and recommendations to the appropriate committees of the legislature no later than January 15, 2008.

Subd. 2. State procurement. By January 1, 2008, the commissioner of administration shall make available for purchase and use by all state agencies only equipment, supplies, and other products that do not contain polybrominated diphenyl ethers, unless exempted under section 325E.386, subdivision 2.

Sec. 48. **[325E.388] PENALTIES.**

A manufacturer who violates sections 325E.386 to 325E.388 is subject to a civil penalty not to exceed \$1,000 for each violation in the case of a first offense. A manufacturer is subject to a civil penalty not to exceed \$5,000 for each repeat offense. Penalties collected under this section must be deposited in an account in the special revenue fund and are appropriated in fiscal years 2008 and 2009 to the commissioner to implement and enforce this section.

Sec. 49. Laws 2005, First Special Session chapter 4, article 9, section 3, subdivision 2, is amended to read:

Subd. 2. Community and Family Health Improvement

466.1	Summary by Fund		
466.2	General	40,413,000	40,382,000
466.3	State Government		
466.4	Special Revenue	141,000	128,000
466.5	Health Care Access	3,510,000	3,516,000
466.6	Federal TANF	6,000,000	6,000,000

466.7 ~~**Family Planning Base Reduction.** Base~~
466.8 ~~level funding for the family planning~~
466.9 ~~special projects grant program is reduced~~
466.10 ~~by \$1,877,000 each year of the biennium~~
466.11 ~~beginning July 1, 2007, provided that~~
466.12 ~~this reduction shall only take place~~
466.13 ~~upon full implementation of the family~~
466.14 ~~planning project section of the 1115 waiver.~~
466.15 ~~Notwithstanding Minnesota Statutes, section~~
466.16 ~~145.925, the commissioner shall give priority~~
466.17 ~~to community health care clinics providing~~
466.18 ~~family planning services that either serve a~~
466.19 ~~high number of women who do not qualify~~
466.20 ~~for medical assistance or are unable to~~
466.21 ~~participate in the medical assistance program~~
466.22 ~~as a medical assistance provider when~~
466.23 ~~allocating the remaining appropriations.~~
466.24 ~~Notwithstanding section 15, this paragraph~~
466.25 ~~shall not expire.~~

466.26 **Shaken Baby Video.** Of the state
466.27 government special revenue fund
466.28 appropriation, \$13,000 in 2006 is
466.29 appropriated to the commissioner of health
466.30 to provide a video to hospitals on shaken
466.31 baby syndrome. The commissioner of health
466.32 shall assess a fee to hospitals to cover the
466.33 cost of the approved shaken baby video and
466.34 the revenue received is to be deposited in the
466.35 state government special revenue fund.

Sec. 50. **FUNDING FOR ENVIRONMENTAL JUSTICE MAPPING.**

The commissioner of health, in conjunction with the commissioner of the Pollution Control Agency, shall establish an environmental justice mapping program and shall apply for federal funding to renew and expand the state's environmental justice mapping capacity in order to promote public health tracking. The commissioner shall coordinate the project with the Pollution Control Agency and the Department of Agriculture in order to explore possible links between environmental health and toxic exposures and to help create a system for environmental public health tracking. The commissioner shall also make recommendations to the legislature for additional sources of funding within the state.

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

Sec. 51. **LEGISLATIVE FINDINGS AND PURPOSE.**

The legislature hereby finds that hearing loss occurs in newborn infants more frequently than any other health condition for which newborn infant screening is required. Early detection of hearing loss in a child and early intervention and treatment has been demonstrated to be highly effective in facilitating a child's healthy development in a manner consistent with the child's age, language acquisition, and cognitive ability. Without early hearing detection and intervention, children with hearing loss experience serious delays in language acquisition and social and cognitive development. With appropriate testing and identification of newborn infants, hearing loss screening will facilitate early intervention and treatment and will serve the public purpose of promoting the healthy development of children.

For these reasons, the legislature hereby determines that it is beneficial and in the best interests of the development of the children of the state of Minnesota that newborn infants' hearing be screened.

Sec. 52. **INFORMATION SHARING.**

By August 1, 2007, the commissioner of health, the Pollution Control Agency, the commissioner of agriculture, and the University of Minnesota are requested to jointly develop and sign a memorandum of understanding declaring their intent to share new and existing environmental hazard, exposure, and health outcome data, consistent with applicable data practices laws, and to cooperate and communicate effectively to ensure sufficient clarity and understanding of the data between these organizations.

Sec. 53. **COMMISSIONER OF HEALTH REPORT; ROUTINE RADIATION EMISSIONS.**

468.1 The commissioner of health, within the limits of available appropriations, in
468.2 cooperation with the utilities that own the Monticello and Prairie Island nuclear plants,
468.3 shall issue a report detailing where routine radiation releases go and the health impacts of
468.4 the radiation emissions on affected communities. By April 1, 2008, the report must be
468.5 distributed to house and senate committees having jurisdiction over public health and to
468.6 all communities that are part of the emergency response planning.

468.7 Sec. 54. **FRAGRANCE-FREE SCHOOLS EDUCATION PILOT PROJECT.**

468.8 Subdivision 1. **Purpose.** Recognizing that scented products may trigger asthma or
468.9 chemical sensitivity reactions in students and school staff, which can contribute to learning
468.10 and breathing problems, the commissioner of health shall develop a fragrance-free schools
468.11 education pilot project.

468.12 Subd. 2. **Education.** The commissioner of health, in collaboration with the
468.13 commissioner of education and the Minneapolis Board of Education, shall establish a
468.14 working group composed of at least three students, two teachers, one school administrator,
468.15 and one member of the Minneapolis Board of Education to recommend an education
468.16 campaign in Minneapolis public schools to inform students and parents about the
468.17 potentially harmful effects of the use of fragrance products on sensitive students and
468.18 school personnel in Minneapolis schools. The commissioner shall report findings to the
468.19 legislature by February 1, 2008.

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

468.21 Sec. 55. **LINDANE COMMITTEE.**

468.22 The commissioner of health shall create a committee of stakeholders, including
468.23 at least one environmental health research scientist and at least one parent consumer
468.24 advocate, to review the scientific literature and make recommendations to the legislature
468.25 on the health impact of Lindane on children and report back by January 15, 2008.

468.26 Sec. 56. **MEDICAL ASSISTANCE COVERAGE FOR ARSENIC TESTING.**

468.27 The commissioner of human services shall ensure that testing for arsenic under
468.28 Minnesota Statutes, section 144.967, is covered under medical assistance.

468.29 Sec. 57. **BLOOD LEAD TESTING STUDY.**

468.30 The commissioner of health, in consultation with the Department of Human
468.31 Services; cities of the first class; health care providers; and other interested parties shall

469.1 conduct a study to evaluate blood lead testing methods used to confirm elevated blood
469.2 lead status. The study shall examine and/or develop:

469.3 (1) the false positive rate of capillary tests for children less than 72 months old;

469.4 (2) current protocols for conducting capillary testing, including filter paper
469.5 methodology;

469.6 (3) existing guidelines and regulations from other states and federal agencies
469.7 regarding lead testing;

469.8 (4) recommendations regarding the use of capillary tests to initiate environmental
469.9 investigations and case management, including number and timing of tests and fiscal
469.10 implications for state and local lead programs; and

469.11 (5) recommendations regarding reducing the state mandatory intervention to ten
469.12 micrograms of lead per deciliter of whole blood.

469.13 The commissioner shall submit the results of the study and any recommendations,
469.14 including any necessary legislative changes, to the legislature by February 15, 2008.

469.15 Sec. 58. **WINDOW SAFETY EDUCATION.**

469.16 The commissioner of health shall create in the department's current educational
469.17 safety program a component targeted at parents and caregivers of young children to
469.18 provide awareness of the need to take precautions to prevent children from falling
469.19 through open windows. The commissioner of health shall consult with representatives
469.20 of the residential building industry, the window products industry, the child safety
469.21 advocacy community, and the Department of Labor and Industry to create the window
469.22 safety program component. The program must include the gathering of data about
469.23 falls from windows that result in severe injury in order to measure the effectiveness of
469.24 the safety program. The commissioner of health may consult with other child safety
469.25 advocacy groups, experts, and interested parties in the development and implementation
469.26 of the window safety program. The commissioner of health shall prepare and submit
469.27 a final report on the window safety program to the legislature by March 1, 2011. The
469.28 commissioner shall prepare and submit a yearly progress report to the legislature by
469.29 March 1 of each year beginning in 2008 until the submission of the final report. The
469.30 final report must include a summary of the safety program, the impact of the program on
469.31 children falling from windows, and any recommendations for further study or action.

469.32 Sec. 59. **REVISOR'S INSTRUCTION.**

470.1 The revisor of statutes shall change the range reference "144.9501 to 144.9509"
470.2 to "144.9501 to 144.9512" wherever the reference appears in Minnesota Statutes and
470.3 Minnesota Rules.

470.4 Sec. 60. **REPEALER.**

470.5 Laws 2004, chapter 288, article 6, section 27, is repealed.

ARTICLE 11

HUMAN SERVICES FORECAST ADJUSTMENTS

470.8 Section 1. SUMMARY OF APPROPRIATIONS; DEPARTMENT OF HUMAN
470.9 SERVICES FORECAST ADJUSTMENT.

470.10 The dollar amounts shown are added to or, if shown in parentheses, are subtracted
470.11 from the appropriations in Laws 2006, chapter 282, from the general fund, or any other
470.12 fund named, to the Department of Human Services for the purposes specified in this
470.13 article, to be available for the fiscal year indicated for each purpose. The figure "2007"
470.14 used in this article means that the appropriation or appropriations listed are available
470.15 for the fiscal year ending June 30, 2007.

470.16		<u>2007</u>
470.17	<u>General Fund</u>	\$ (25,226,000)
470.18	<u>Health Care Access</u>	\$ (53,980,000)
470.19	<u>TANF</u>	\$ (24,805,000)
470.20	Total	\$ (104,011,000)

470.21 Sec. 2. **COMMISSIONER OF HUMAN**
470.22 **SERVICES**

470.23	Subdivision 1. Total Appropriation	\$ (104,011,000)

470.24 Appropriations by Fund

470.25		<u>2007</u>
470.26	<u>General</u>	<u>(25,226,000)</u>
470.27	<u>Health Care Access</u>	<u>(53,980,000)</u>
470.28	TANF	(24,805,000)

470.29 Subd. 2. Revenue and Pass Through

470.30 TANF (106,000)

470.31 Subd. 3. Children and Economic Assistance
470.32 Grants

470.33	<u>General</u>	<u>3,221,000</u>
470.34	TANF	(24,699,000)

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471.1	<u>The amounts that may be spent from this</u>	
471.2	<u>appropriation for each purpose are as follows:</u>	
471.3	<u>(a) MFIP/DWP Grants</u>	
471.4	<u>General</u>	<u>13,827,000</u>
471.5	<u>TANF</u>	<u>(24,699,000)</u>
471.6	<u>(b) MFIP Child Care Assistance Grants</u>	
471.7	<u>General</u>	<u>(4,733,000)</u>
471.8	<u>(c) General Assistance Grants</u>	
471.9	<u>General</u>	<u>1,081,000</u>
471.10	<u>(d) Minnesota Supplemental Aid Grants</u>	
471.11	<u>General</u>	<u>(1,099,000)</u>
471.12	<u>(e) Group Residential Housing Grants</u>	
471.13	<u>General</u>	<u>(5,855,000)</u>
471.14	<u>Subd. 4. Basic Health Care Grants</u>	
471.15	<u>General</u>	<u>17,592,000</u>
471.16	<u>Health Care Access</u>	<u>(53,980,000)</u>
471.17	<u>The amounts that may be spent from this</u>	
471.18	<u>appropriation for each purpose are as follows:</u>	
471.19	<u>(a) MinnesotaCare Health Care Access</u>	<u>(53,980,000)</u>
471.20	<u>(b) MA Basic Health Care - Families and Children</u>	
471.21	<u>General</u>	<u>15,729,000</u>
471.22	<u>(c) MA Basic Health Care - Elderly and Disabled</u>	
471.23	<u>General</u>	<u>(4,540,000)</u>
471.24	<u>(d) General Assistance Medical Care</u>	
471.25	<u>General</u>	<u>6,403,000</u>
471.26	<u>Subd. 5. Continuing Care Grants</u>	
471.27	<u>General</u>	<u>(46,039,000)</u>
471.28	<u>The amounts that may be spent from this</u>	
471.29	<u>appropriation for each purpose are as follows:</u>	
471.30	<u>(a) MA Long-Term Care Facilities</u>	
471.31	<u>General</u>	<u>(15,028,000)</u>
471.32	<u>(b) MA Long-Term Care Waivers</u>	
471.33	<u>General</u>	<u>(20,677,000)</u>

472.1 (c) Chemical Dependency Entitlement Grants

472.2 General (10,334,000)

472.3 Sec. 3. EFFECTIVE DATE.

472.4 Sections 1 and 2 are effective the day following final enactment.

472.5 **ARTICLE 12**

472.6 **HUMAN SERVICES APPROPRIATIONS**

472.7 Section 1. SUMMARY OF APPROPRIATIONS.

472.8 The amounts shown in this section summarize direct appropriations, by fund, made

472.9 in this article.

472.10		<u>2008</u>		<u>2009</u>		<u>Total</u>
472.11	<u>General</u>	\$ 4,836,759,000	\$	5,194,751,000	\$	10,031,510,000
472.12	<u>State Government Special</u>					
472.13	<u>Revenue</u>	55,737,000		56,428,000		112,165,000
472.14	<u>Health Care Access</u>	436,050,000		549,573,000		985,623,000
472.15	<u>Federal TANF</u>	266,864,000		277,866,000		544,730,000
472.16	<u>Environment Fund</u>	300,000		300,000		600,000
472.17	<u>Lottery Prize Fund</u>	2,184,000		1,787,000		3,971,000
472.18	<u>Total</u>	\$ 5,597,894,000	\$	6,080,705,000	\$	11,678,599,000

472.19 Sec. 2. HEALTH AND HUMAN SERVICES APPROPRIATIONS.

472.20 The sums shown in the columns marked "Appropriations" are appropriated to the

472.21 agencies and for the purposes specified in this article. The appropriations are from the

472.22 general fund, or another named fund, and are available for the fiscal years indicated

472.23 for each purpose. The figures "2008" and "2009" used in this article mean that the

472.24 appropriations listed under them are available for the fiscal year ending June 30, 2008, or

472.25 June 30, 2009, respectively. "The first year" is fiscal year 2008. "The second year" is fiscal

472.26 year 2009. "The biennium" is fiscal years 2008 and 2009. Appropriations for the fiscal

472.27 year ending June 30, 2007, are effective the day following final enactment.

472.28		<u>APPROPRIATIONS</u>	
472.29		<u>Available for the Year</u>	
472.30		<u>Ending June 30</u>	
472.31		<u>2008</u>	<u>2009</u>

472.32 Sec. 3. HUMAN SERVICES

472.33 Subdivision 1. Total Appropriation \$ 5,356,970,000 \$ 5,848,682,000

473.1	<u>Appropriations by Fund</u>		
473.2		<u>2008</u>	<u>2009</u>
473.3	<u>General</u>	<u>4,688,475,000</u>	<u>5,050,169,000</u>
473.4	<u>State Government</u>		
473.5	<u>Special Revenue</u>	<u>545,000</u>	<u>555,000</u>
473.6	<u>Health Care Access</u>	<u>409,602,000</u>	<u>529,655,000</u>
473.7	<u>Federal TANF</u>	<u>255,514,000</u>	<u>265,866,000</u>
473.8	<u>Lottery Prize Fund</u>	<u>2,184,000</u>	<u>1,787,000</u>

473.9 The amounts that may be spent for each
473.10 purpose are specified in the following
473.11 subdivisions.

473.12 **Receipts for Systems Projects.**
473.13 Appropriations and federal receipts for
473.14 information system projects for MAXIS,
473.15 PRISM, MMIS, and SSIS must be deposited
473.16 in the state system account authorized in
473.17 Minnesota Statutes, section 256.014. Money
473.18 appropriated for computer projects approved
473.19 by the Minnesota Office of Enterprise
473.20 Technology, funded by the legislature, and
473.21 approved by the commissioner of finance,
473.22 may be transferred from one project to
473.23 another and from development to operations
473.24 as the commissioner of human services
473.25 considers necessary. Any unexpended
473.26 balance in the appropriation for these
473.27 projects does not cancel but is available for
473.28 ongoing development and operations.

473.29 **Systems Continuity.** In the event of
473.30 disruption of technical systems or computer
473.31 operations, the commissioner may use
473.32 available grant appropriations to ensure
473.33 continuity of payments for maintaining the
473.34 health, safety, and well-being of clients
473.35 served by programs administered by the
473.36 Department of Human Services. Grant funds

474.1 must be used in a manner consistent with the
474.2 original intent of the appropriation.

474.3 **Nonfederal Share Transfers.** The
474.4 nonfederal share of activities for which
474.5 federal administrative reimbursement is
474.6 appropriated to the commissioner may be
474.7 transferred to the special revenue fund.

474.8 **Gifts.** Notwithstanding Minnesota
474.9 Statutes, sections 16A.013 to 16A.016, the
474.10 commissioner may accept, on behalf of the
474.11 state, additional funding from sources other
474.12 than state funds for the purpose of financing
474.13 the cost of assistance program grants or
474.14 nongrant administration. All additional
474.15 funding is appropriated to the commissioner
474.16 for use as designated by the grantor of
474.17 funding.

474.18 **TANF Funds Appropriated to Other**
474.19 **Entities.** Any expenditures from the TANF
474.20 block grant shall be expended according
474.21 to the requirements and limitations of part
474.22 A of title IV of the Social Security Act, as
474.23 amended, and any other applicable federal
474.24 requirement or limitation. Prior to any
474.25 expenditure of these funds, the commissioner
474.26 shall ensure that funds are expended in
474.27 compliance with the requirements and
474.28 limitations of federal law and that any
474.29 reporting requirements of federal law are
474.30 met. It shall be the responsibility of any entity
474.31 to which these funds are appropriated to
474.32 implement a memorandum of understanding
474.33 with the commissioner that provides the
474.34 necessary assurance of compliance prior to
474.35 any expenditure of funds. The commissioner

475.1 shall receipt TANF funds appropriated
475.2 to other state agencies and coordinate all
475.3 related interagency accounting transactions
475.4 necessary to implement these appropriations.
475.5 Unexpended TANF funds appropriated to
475.6 any state, local, or nonprofit entity cancel
475.7 at the end of the state fiscal year unless
475.8 appropriating or statutory language permits
475.9 otherwise.

475.10 **TANF Block Grant.** Of this amount,
475.11 \$750,000 the first year and \$750,000 the
475.12 second year are onetime appropriations
475.13 from the state's federal TANF block grant
475.14 under Title I of Public Law 104-193. If the
475.15 appropriation in either year is insufficient, the
475.16 appropriation for the other year is available.

475.17 **TANF Maintenance of Effort.** (a) In
475.18 order to meet the basic maintenance of
475.19 effort (MOE) requirements of the TANF
475.20 block grant specified under Code of Federal
475.21 Regulations, title 45, section 263.1, the
475.22 commissioner may only report nonfederal
475.23 money expended for allowable activities
475.24 listed in the following clauses as TANF/MOE
475.25 expenditures:

475.26 (1) MFIP cash, diversionary work program,
475.27 and food assistance benefits under Minnesota
475.28 Statutes, chapter 256J;

475.29 (2) the child care assistance programs
475.30 under Minnesota Statutes, sections 119B.03
475.31 and 119B.05, and county child care
475.32 administrative costs under Minnesota
475.33 Statutes, section 119B.15;

476.1 (3) state and county MFIP administrative
476.2 costs under Minnesota Statutes, chapters
476.3 256J and 256K;

476.4 (4) state, county, and tribal MFIP
476.5 employment services under Minnesota
476.6 Statutes, chapters 256J and 256K;

476.7 (5) expenditures made on behalf of
476.8 noncitizen MFIP recipients who qualify
476.9 for the medical assistance without federal
476.10 financial participation program under
476.11 Minnesota Statutes, section 256B.06,
476.12 subdivision 4, paragraphs (d), (e), and (j);
476.13 and

476.14 (6) qualifying working family credit
476.15 expenditures under Minnesota Statutes,
476.16 section 290.0671.

476.17 (b) The commissioner shall ensure that
476.18 sufficient qualified nonfederal expenditures
476.19 are made each year to meet the state's
476.20 TANF/MOE requirements. For the activities
476.21 listed in paragraph (a), clauses (2) to
476.22 (6), the commissioner may only report
476.23 expenditures that are excluded from the
476.24 definition of assistance under Code of
476.25 Federal Regulations, title 45, section 260.31.

476.26 (c) The commissioner shall ensure that
476.27 the maintenance of effort used by the
476.28 commissioner of finance for the February
476.29 and November forecasts required under
476.30 Minnesota Statutes, section 16A.103,
476.31 contains expenditures under paragraph (a),
476.32 clause (1), equal to at least 25 percent of
476.33 the total required under Code of Federal
476.34 Regulations, title 45, section 263.1.

477.1 (d) Minnesota Statutes, section 256.011,
477.2 subdivision 3, which requires that federal
477.3 grants or aids secured or obtained under that
477.4 subdivision be used to reduce any direct
477.5 appropriations provided by law, does not
477.6 apply if the grants or aids are federal TANF
477.7 funds.

477.8 (e) Notwithstanding section 13, this rider
477.9 expires June 30, 2011.

477.10 **Working Family Credit Expenditures**
477.11 **as TANF/MOE.** The commissioner may
477.12 claim as TANF maintenance of effort up
477.13 to \$6,707,000 per year for fiscal year 2008
477.14 through fiscal year 2011. Notwithstanding
477.15 section 13, this rider expires June 30, 2011.

477.16 **Additional Working Family Credit**
477.17 **Expenditures to be Claimed for**
477.18 **TANF/MOE.** In addition to the amounts
477.19 provided in this section, the commissioner
477.20 may count the following amounts of working
477.21 family credit expenditure as TANF/MOE:

477.22 (1) fiscal year 2008, \$4,269,000; and

477.23 (2) fiscal year 2009, \$4,889,000.

477.24 Notwithstanding section 13, this rider expires
477.25 June 30, 2011.

477.26 **Capitation Rate Increase.** Of the health care
477.27 access fund appropriations to the University
477.28 of Minnesota in the higher education
477.29 omnibus appropriation bill, \$2,157,000 in
477.30 fiscal year 2008 and \$2,157,000 in fiscal year
477.31 2009 are to be used to increase the capitation
477.32 payments under Minnesota Statutes, section
477.33 256B.69.

478.1	<u>Health Care Access Fund Transfer.</u>		
478.2	<u>Notwithstanding Minnesota Statutes, section</u>		
478.3	<u>295.581, in addition to the transfers in</u>		
478.4	<u>Minnesota Statutes, section 16A.724,</u>		
478.5	<u>subdivision 2, the commissioner of finance</u>		
478.6	<u>shall transfer up to the following amounts</u>		
478.7	<u>from the health care access fund to the</u>		
478.8	<u>general fund on June 30 of each fiscal year:</u>		
478.9	<u>(1) fiscal year 2008, \$6,416,000;</u>		
478.10	<u>(2) fiscal year 2009, \$5,643,000;</u>		
478.11	<u>(3) fiscal year 2010, \$6,677,000; and</u>		
478.12	<u>(4) fiscal year 2011, \$7,866,000.</u>		
478.13	<u>Notwithstanding section 13, this rider expires</u>		
478.14	<u>June 30, 2011.</u>		
478.15	<u>Subd. 2. Agency Management</u>	<u>57,727,000</u>	<u>58,161,000</u>
478.16	<u>Appropriations by Fund</u>		
478.17	<u>General</u>	<u>48,413,000</u>	<u>48,882,000</u>
478.18	<u>State Government</u>		
478.19	<u>Special Revenue</u>	<u>424,000</u>	<u>432,000</u>
478.20	<u>Health Care Access</u>	<u>8,018,000</u>	<u>7,975,000</u>
478.21	<u>Federal TANF</u>	<u>222,000</u>	<u>222,000</u>
478.22	<u>The amounts that may be spent from the</u>		
478.23	<u>appropriation for each purpose are as follows:</u>		
478.24	<u>(a) Financial Operations</u>		
478.25	<u>Appropriations by Fund</u>		
478.26	<u>General</u>	<u>7,102,000</u>	<u>7,523,000</u>
478.27	<u>Health Care Access</u>	<u>889,000</u>	<u>880,000</u>
478.28	<u>Federal TANF</u>	<u>122,000</u>	<u>122,000</u>
478.29	<u>(b) Legal and Regulation Operations</u>		
478.30	<u>Appropriations by Fund</u>		
478.31	<u>General</u>	<u>13,037,000</u>	<u>13,138,000</u>
478.32	<u>State Government</u>		
478.33	<u>Special Revenue</u>	<u>424,000</u>	<u>432,000</u>
478.34	<u>Health Care Access</u>	<u>891,000</u>	<u>908,000</u>
478.35	<u>Federal TANF</u>	<u>100,000</u>	<u>100,000</u>

479.1 **Base Adjustment.** The general fund base is
479.2 decreased by \$177,000 in fiscal year 2010
479.3 and \$353,000 in fiscal year 2011 for legal
479.4 and regulatory.

479.5 **Child Care Licensing.** \$697,000 is
479.6 appropriated from the general fund to
479.7 the commissioner of human services for
479.8 the biennium beginning July 1, 2007, for
479.9 purposes of completing background studies
479.10 for family and group family child care
479.11 providers under Minnesota Statutes, chapter
479.12 245C. This appropriation will be \$288,000 in
479.13 fiscal year 2010 and \$112,000 in fiscal year
479.14 2011.

479.15 **(c) Management Operations**

479.16	<u>Appropriations by Fund</u>		
479.17	<u>General</u>	<u>4,390,000</u>	<u>4,433,000</u>
479.18	<u>Health Care Access</u>	<u>234,000</u>	<u>238,000</u>

479.19 **(d) Information Technology Operations**

479.20	<u>Appropriations by Fund</u>		
479.21	<u>General</u>	<u>23,884,000</u>	<u>23,788,000</u>
479.22	<u>Health Care Access</u>	<u>6,004,000</u>	<u>5,949,000</u>

479.23	<u>Subd. 3. Revenue and Pass-Through</u>		
479.24	<u>Expenditures</u>	<u>66,842,000</u>	<u>69,723,000</u>

479.25	<u>Federal TANF</u>	<u>66,842,000</u>	<u>69,723,000</u>

479.26 **TANF Transfer to Federal Child Care**
479.27 **and Development Fund.** The following
479.28 TANF fund amounts are appropriated to
479.29 the commissioner for the purposes of MFIP
479.30 transition year child care under MFIP,
479.31 Minnesota Statutes, section 119B.05:

479.32 (1) fiscal year 2008, \$10,333,000

479.33 (2) fiscal year 2009, \$12,826,000

479.34 (3) fiscal year 2010, \$4,104,000 and

480.1	<u>(4) fiscal year 2011, \$5,460,000.</u>		
480.2	<u>The commissioner shall authorize transfer</u>		
480.3	<u>of sufficient TANF funds to the federal</u>		
480.4	<u>child care and development fund to meet</u>		
480.5	<u>this appropriation and shall ensure that all</u>		
480.6	<u>transferred funds are expended according</u>		
480.7	<u>the federal child care and development fund</u>		
480.8	<u>regulations.</u>		
480.9	<u>Subd. 4. Children and Economic Assistance</u>		
480.10	<u>Grants</u>	<u>749,318,000</u>	<u>730,623,000</u>
480.11	<u>Appropriations by Fund</u>		
480.12	<u>General</u>	<u>561,814,000</u>	<u>535,898,000</u>
480.13	<u>Federal TANF</u>	<u>187,254,000</u>	<u>194,725,000</u>
480.14	<u>Health Care Access</u>	<u>250,000</u>	<u>-0-</u>
480.15	<u>The amounts that may be spent from this</u>		
480.16	<u>appropriation for each purpose are as follows:</u>		
480.17	<u>(a) MFIP/DWP Grants</u>		
480.18	<u>Appropriations by Fund</u>		
480.19	<u>General</u>	<u>62,000,000</u>	<u>61,911,000</u>
480.20	<u>Federal TANF</u>	<u>82,532,000</u>	<u>90,003,000</u>
480.21	<u>(b) Support Services Grants</u>		
480.22	<u>Appropriations by Fund</u>		
480.23	<u>General</u>	<u>8,815,000</u>	<u>9,465,000</u>
480.24	<u>Federal TANF</u>	<u>103,382,000</u>	<u>103,382,000</u>
480.25	<u>TANF Prior Appropriation Cancellation.</u>		
480.26	<u>Notwithstanding Laws 2001, First Special</u>		
480.27	<u>Session chapter 9, article 17, section</u>		
480.28	<u>2, subdivision 11, paragraph (b), any</u>		
480.29	<u>unexpended TANF funds appropriated to the</u>		
480.30	<u>commissioner to contract with the Board of</u>		
480.31	<u>Trustees of Minnesota State Colleges and</u>		
480.32	<u>Universities, to provide tuition waivers to</u>		
480.33	<u>employees of health care and human service</u>		
480.34	<u>providers that are members of qualifying</u>		
480.35	<u>consortia operating under Minnesota</u>		

481.1 Statutes, sections 116L.10 to 116L.15, must
481.2 cancel at the end of fiscal year 2007.

481.3 **MFIP Pilot Program.** Of the general fund
481.4 appropriation, \$100,000 in fiscal year 2008
481.5 and \$750,000 in fiscal year 2009 are for a
481.6 grant to the Stearns-Benton Employment and
481.7 Training Council for the Workforce U pilot
481.8 program.

481.9 **Work Study.** \$750,000 in fiscal year
481.10 2008 and \$750,000 in fiscal year 2009 are
481.11 appropriated from the TANF reserve account
481.12 to the Minnesota Office of Higher Education
481.13 for work study grants under Minnesota
481.14 Statutes, section 136A.233, specifically
481.15 for low-income individuals who receive
481.16 assistance under Minnesota Statutes, chapter
481.17 256J.

481.18 **(c) MFIP Child Care Assistance Grants**

481.19 <u>General</u>	<u>74,797,000</u>	<u>73,699,000</u>

481.20 **(d) Basic Sliding Fee Child Care Assistance**
481.21 **Grants**

481.22 <u>General</u>	<u>43,012,000</u>	<u>45,432,000</u>

481.23 **Base Adjustment.** The general fund base
481.24 is increased by \$1,262,000 in fiscal year
481.25 2010 and decreased by \$951,000 in fiscal
481.26 year 2011 for basic sliding fee child care
481.27 assistance grants.

481.28 **(e) Child Care Development Grants**

481.29 <u>General</u>	<u>5,865,000</u>	<u>5,865,000</u>

481.30 **Child Care Services Grants.** \$5,000,000
481.31 is appropriated from the general fund to
481.32 the commissioner of human services for
481.33 the biennium beginning July 1, 2007, for
481.34 purposes of providing child care services

482.1 grants under Minnesota Statutes, section
482.2 119B.21, subdivision 5. This appropriation
482.3 is for the 2008-2009 biennium only, and does
482.4 not increase the base funding.

482.5 **Early Childhood Professional**
482.6 **Development System.** \$2,000,000 is
482.7 appropriated from the general fund to
482.8 the commissioner of human services for
482.9 the biennium beginning July 1, 2007, for
482.10 purposes of the early childhood professional
482.11 development system, which increases the
482.12 quality and continuum of professional
482.13 development opportunities for child care
482.14 practitioners. This appropriation is for the
482.15 2008-2009 biennium only, and does not
482.16 increase the base funding.

482.17 **Family, Friend, and Neighbor Grant**
482.18 **Program.** \$750,000 in fiscal year 2008 and
482.19 \$750,000 in fiscal year 2009 are appropriated
482.20 from the general fund to the commissioner
482.21 of human services for the family, friend,
482.22 and neighbor grant program in section 31.
482.23 Any balance in the first year does not cancel
482.24 but is available in the second year. This
482.25 appropriation is for the 2008-2009 biennium
482.26 only, and does not increase the base funding.

482.27 **(f) Increased Child Care Provider**
482.28 **Connections.** (1) \$200,000 is appropriated
482.29 from the general fund to the commissioner of
482.30 human services for the biennium beginning
482.31 July 1, 2007, for the following purposes:
482.32 \$100,000 each year is for a grant to Hennepin
482.33 County, and \$100,000 each year is for a grant
482.34 to Ramsey County. The two counties shall
482.35 each contract with a nonprofit organization

483.1 to work with the contracting county
483.2 and county-based licensed family child
483.3 care providers to facilitate county-based
483.4 information regarding family and children's
483.5 resources and to make training and peer
483.6 support available to licensed family child
483.7 care providers consistent with clause (2).
483.8 These appropriations are available until
483.9 June 30, 2009, and shall not become part
483.10 of base-level funding for the biennium
483.11 beginning July 1, 2009.

483.12 (2) Programs to improve child care provider
483.13 connections to county services shall be
483.14 established in Hennepin and Ramsey
483.15 counties to:

483.16 (i) improve county contact activities
483.17 with county-licensed family child care
483.18 providers that facilitate utilization of county
483.19 educational, social service, public health,
483.20 and economic assistance services by eligible
483.21 families, parents, and children using licensed
483.22 family child care; and

483.23 (ii) support licensed family child care
483.24 providers to qualify as quality-rated child
483.25 care providers through peer support and
483.26 coaching networks.

483.27 Hennepin and Ramsey Counties shall
483.28 contract with a nonprofit organization under
483.29 clause (1) that utilizes licensed family child
483.30 care providers as contacts for families using
483.31 licensed family child care and to provide
483.32 peer support to licensed family child care
483.33 providers.

483.34 (3) Hennepin and Ramsey Counties must
483.35 report back on successful strategies for

484.1 increasing contact with county-based
484.2 licensed family child care providers and
484.3 report their findings to the appropriate
484.4 legislative committees by February 15, 2010.

484.5 **Base Adjustment.** The general fund base
484.6 is \$1,515,000 for each of fiscal years 2010
484.7 and 2011.

484.8 **(g) Child Support Enforcement Grants**

484.9	<u>General</u>	<u>9,038,000</u>	<u>3,705,000</u>

484.10 **Child Support Enforcement.** \$5,333,000
484.11 for fiscal year 2008 is to make grants to
484.12 counties for child support enforcement
484.13 programs to make up for the loss under the
484.14 2006 federal Deficit Reduction Act of federal
484.15 matching funds for federal incentive funds
484.16 passed on to the counties by the state.

484.17 This appropriation is available until spent.

484.18 **(h) Children's Services Grants**

484.19	<u>Appropriations by Fund</u>		
484.20	<u>General</u>	<u>62,745,000</u>	<u>73,133,000</u>
484.21	<u>Health Care Access</u>	<u>250,000</u>	<u>-0-</u>

484.22 **Base Adjustment.** The general fund base
484.23 is decreased by \$673,000 in fiscal year
484.24 2010 and \$670,000 in fiscal year 2011 for
484.25 children's services grants.

484.26 **Privatized Adoption Grants.** Federal
484.27 reimbursement for privatized adoption grant
484.28 and foster care recruitment grant expenditures
484.29 is appropriated to the commissioner for
484.30 adoption grants and foster care and adoption
484.31 administrative purposes.

484.32 **Adoption Assistance Incentive Grants.**
484.33 Federal funds available during fiscal year
484.34 2008 and fiscal year 2009 for the adoption

485.1 incentive grants are appropriated to the
485.2 commissioner for these purposes.

485.3 **Adoption Assistance and Relative Custody**
485.4 **Assistance.** The commissioner may transfer
485.5 unencumbered appropriation balances for
485.6 adoption assistance and relative custody
485.7 assistance between fiscal years and between
485.8 programs.

485.9 **Adoption Assistance and Relative**
485.10 **Custody Assistance Subsidy Payment**
485.11 **Increase.** Notwithstanding Minnesota
485.12 Rules, part 9560.0083, subparts 5 and 6, the
485.13 commissioner shall increase the payment
485.14 schedules for basic and supplemental
485.15 maintenance needs subsidies by 3.95 percent
485.16 effective July 1, 2007. The commissioner
485.17 may make cost-neutral adjustments between
485.18 schedules and between brackets within
485.19 schedules to allow for whole-dollar bracket
485.20 levels and account for differential cost
485.21 increases in caring for children with special
485.22 needs. Counties have until December 31,
485.23 2007, to implement the relative custody
485.24 assistance payment increases and shall make
485.25 payment adjustments retroactive to July 1,
485.26 2007.

485.27 **Crisis Nurseries.** \$1,100,000 in fiscal year
485.28 2008 and \$1,100,000 in fiscal year 2009 are
485.29 appropriated from the general fund for the
485.30 crisis nurseries program. Of this amount,
485.31 \$100,000 each year is to be made available
485.32 for capacity development and technical
485.33 support for crisis nurseries.

485.34 **Respite Care.** Of the general fund
485.35 appropriation, \$1,250,000 in fiscal year

486.1 2008 and \$2,500,000 in fiscal year 2009 are
486.2 to the commissioner of human services to
486.3 fund respite care for children who have a
486.4 diagnosis of emotional disturbance or severe
486.5 emotional disturbance.

486.6 **Childhood Trauma; Grants.** Of the general
486.7 fund appropriation, \$125,000 in fiscal year
486.8 2008 and \$250,000 in fiscal year 2009 are
486.9 to the commissioner of human services to
486.10 make grants for the purpose of maintaining
486.11 and expanding evidence-based practices that
486.12 support children and youth who have been
486.13 exposed to violence or who are refugees.

486.14 **Collaborative Services for High-Risk**
486.15 **Children.** Of the general fund appropriation,
486.16 \$2,632,000 in fiscal year 2008 and
486.17 \$6,150,000 in fiscal year 2009 are to the
486.18 commissioner of human services to fund
486.19 early intervention collaborative programs.

486.20 **Evidence-Based Practice.** Of the general
486.21 fund appropriation, \$2,175,000 in fiscal year
486.22 2008 and \$4,350,000 in fiscal year 2009
486.23 are to the commissioner of human services
486.24 to develop and implement evidence-based
486.25 practice in children's mental health care and
486.26 treatment.

486.27 **MFIP and Children's Mental Health Pilot**
486.28 **Project.** Of the general fund appropriation,
486.29 \$100,000 in fiscal year 2008 and \$200,000
486.30 in fiscal year 2009 are to the commissioner
486.31 of human services to fund the MFIP and
486.32 children's mental health pilot project.

486.33 **Regional Children's Mental Health**
486.34 **Initiative.** \$700,000 in fiscal year 2008 and
486.35 \$700,000 in fiscal year 2009 are appropriated

487.1 to the commissioner of human services to
487.2 fund the Regional Children's Mental Health
487.3 Initiative pilot project. This is a onetime
487.4 appropriation.

487.5 **Child Safety Efforts.** \$1,000,000 in fiscal
487.6 year 2008 and \$1,000,000 in fiscal year 2009
487.7 are appropriated to counties based on their
487.8 population of residents under age 18. Funds
487.9 are to be used to maintain and improve child
487.10 safety services. By February 1, 2008, each
487.11 county shall submit a report regarding current
487.12 child safety efforts, child safety funding, and
487.13 unmet needs including investments needed.

487.14 The report shall also include methods and
487.15 community partners available to ensure
487.16 early identification of at-risk families. The
487.17 Association of Minnesota Counties and
487.18 county agencies shall develop a uniform
487.19 report structure so that statewide data can
487.20 be easily summarized. This is a onetime
487.21 appropriation.

487.22 **Fetal Alcohol Syndrome.** Of the general
487.23 fund appropriation, \$75,000 in fiscal year
487.24 2008 and \$75,000 in fiscal year 2009 are
487.25 for three programs that provide services
487.26 to reduce fetal alcohol syndrome under
487.27 Minnesota Statutes, section 145.9266. The
487.28 three program grantees are the University
487.29 of Minnesota, the Meeker-McLeod-Sibley
487.30 Community, and the American Indian Family
487.31 Center. This appropriation shall become part
487.32 of the base appropriation.

487.33 **Base Adjustment.** The general fund base is
487.34 increased by \$366,000 in fiscal year 2010 and

488.1 \$369,000 in fiscal year 2011 for children's
488.2 services grants.

488.3 **(i) Children and Community Services Grants**

488.4 General 110,802,000 69,567,000

488.5 **Base Adjustment.** The general fund base is
488.6 increased by \$99,000 in each of fiscal years
488.7 2010 and 2011 for children and community
488.8 services grants.

488.9 **Targeted Case Management Temporary**
488.10 **Funding.** Of the general fund appropriation,
488.11 \$40,000,000 in fiscal year 2008 is allocated to
488.12 counties and tribes affected by reductions in
488.13 targeted case management federal Medicaid
488.14 revenue as a result of the provisions in
488.15 the federal Deficit Reduction Act of 2005,
488.16 Public Law 109-171. The commissioner
488.17 shall distribute the funds proportionate
488.18 to each affected county or tribe's targeted
488.19 case management federal earnings for
488.20 calendar year 2005. Prior to distribution
488.21 of funds, the commissioner shall estimate
488.22 and certify the amount by which the federal
488.23 regulations will reduce case management
488.24 revenue over the 2008-2009 biennium. The
488.25 commissioner may provide grants up to the
488.26 amount of the estimated reduction, not to
488.27 exceed \$40,000,000 for the biennium. The
488.28 commissioner may determine the timing and
488.29 frequency of payments to counties. These
488.30 funds are available in either year of the
488.31 biennium. Counties shall use these funds to
488.32 pay for social service-related costs, but the
488.33 funds are not subject to provisions of the
488.34 Children and Community Services Act grant
488.35 under Minnesota Statutes, chapter 256M.

489.1 **Child Welfare Project.** Of the general fund
489.2 appropriation, \$2,000,000 for the biennium
489.3 beginning July 1, 2007, is for expanding
489.4 the American Indian chid welfare project
489.5 under Minnesota Statutes, section 256.01,
489.6 subdivision 14b, to include the Red Lake
489.7 Band of Chippewa Indians Tribe, provided
489.8 the tribe meets the criteria in Minnesota
489.9 Statutes, section 256.01, subdivision 14b.
489.10 **(j) General Assistance Grants**

489.11

<u>General</u>	<u>37,876,000</u>	<u>38,253,000</u>

489.12 **General Assistance Standard.** The
489.13 commissioner shall set the monthly standard
489.14 of assistance for general assistance units
489.15 consisting of an adult recipient who is
489.16 childless and unmarried or living apart
489.17 from parents or a legal guardian at \$203.
489.18 The commissioner may reduce this amount
489.19 according to Laws 1997, chapter 85, article
489.20 3, section 54.

489.21 **Emergency General Assistance.** The
489.22 amount appropriated for emergency general
489.23 assistance funds is limited to no more
489.24 than \$7,889,812 in fiscal year 2008 and
489.25 \$7,889,812 in fiscal year 2009. Funds
489.26 to counties must be allocated by the
489.27 commissioner using the allocation method
489.28 specified in Minnesota Statutes, section
489.29 256D.06.

489.30 **(k) Minnesota Supplemental Aid Grants**

489.31

<u>General</u>	<u>30,798,000</u>	<u>31,439,000</u>

489.32 **Emergency Minnesota Supplemental**
489.33 **Aid Funds.** The amount appropriated for
489.34 emergency Minnesota supplemental aid

490.1 funds is limited to no more than \$1,100,000
490.2 in fiscal year 2008 and \$1,100,000 in fiscal
490.3 year 2009. Funds to counties must be
490.4 allocated by the commissioner using the
490.5 allocation method specified in Minnesota
490.6 Statutes, section 256D.46.

490.7 **(l) Group Residential Housing Grants**

490.8	<u>General</u>	<u>91,441,000</u>	<u>99,304,000</u>

490.9 **Base Adjustment.** The general fund base is
490.10 increased by \$6,665,000 in fiscal year 2010
490.11 and \$13,419,000 in fiscal year 2011.

490.12 **People Incorporated.** \$460,000 in fiscal
490.13 year 2008 and \$460,000 in fiscal year 2009
490.14 are appropriated from the general fund to the
490.15 commissioner of human services to augment
490.16 community support and mental health
490.17 services provided to individuals residing in
490.18 facilities under Minnesota Statutes, section
490.19 256I.05, subdivision 1h.

490.20 **(m) Other Children and Economic Assistance**
490.21 **Grants**

490.22	<u>General</u>	<u>24,625,000</u>	<u>24,125,000</u>

490.23	<u>Federal TANF</u>	<u>1,340,000</u>	<u>1,340,000</u>

490.24 **Base Adjustment.** The general fund base
490.25 shall be \$20,447,000 in each of fiscal years
490.26 2010 and 2011.

490.27 **New Chance.** \$140,000 in fiscal year
490.28 2008 and \$140,000 in fiscal year 2009 are
490.29 appropriated from federal TANF funds to the
490.30 Hennepin County new chance program.

490.31 **Mothers First.** Of the TANF appropriation,
490.32 \$450,000 in fiscal year 2008 and \$450,000
490.33 in fiscal year 2009 are to fund the Ramsey
490.34 County mothers first program. The

491.1 appropriations are available until spent and
491.2 are a onetime appropriation.

491.3 **Homeless and Runaway Youth. \$3,500,000**
491.4 in the first year and \$3,500,000 in the second
491.5 year are for the Runaway and Homeless
491.6 Youth Act under Minnesota Statutes, section
491.7 256K.45. Funds shall be spent in each area
491.8 of the continuum of care to ensure that
491.9 programs are meeting the greatest need. The
491.10 base is decreased by \$2,000,000 each year in
491.11 fiscal year 2010 and fiscal year 2011.

491.12 **Transitional Housing and Emergency**
491.13 **Services.**

491.14 (1) \$750,000 each year from the federal
491.15 TANF fund is for transitional housing
491.16 programs under Minnesota Statutes, section
491.17 256E.33. The TANF appropriations
491.18 are onetime. The general fund base for
491.19 transitional housing is increased by \$422,000
491.20 each year for the fiscal 2010-2011 biennium.
491.21 Up to ten percent of this appropriation may
491.22 be used for housing and services which
491.23 extend beyond 24 months. \$300,000 in each
491.24 year of this amount is for grants for safe
491.25 housing pilot projects for battered women
491.26 and families in Anoka County, Houston
491.27 County, and Beltrami County; and

491.28 (2) \$527,000 each year is added to the
491.29 base for emergency services grants under
491.30 Laws 1997, chapter 162, article 3, section
491.31 7. The base for emergency services grants
491.32 is decreased each year by \$300,000 in fiscal
491.33 year 2010 and fiscal year 2011.

491.34 **Foodshelf Programs. \$575,000 each year**
491.35 **is added to the base for foodshelf programs**

492.1 under Minnesota Statutes, section 256E.34.
492.2 The base is decreased by \$250,000 each year
492.3 in fiscal year 2010 and fiscal year 2011.

492.4 **Long-term Homeless Services. \$2,440,000**
492.5 each year is added to the base for the
492.6 long-term homeless services under
492.7 Minnesota Statutes, section 256K.26. The
492.8 base is decreased by \$1,000,000 each year in
492.9 fiscal year 2010 and fiscal year 2011.

492.10 **Minnesota Community Action Grants.**
492.11 \$1,500,000 each year is added to the base for
492.12 the purposes of Minnesota community action
492.13 grants under Minnesota Statutes, sections
492.14 256E.30 to 256E.32. The base is reduced by
492.15 \$500,000 each year in fiscal year 2010 and
492.16 fiscal year 2011.

492.17 **Tenant Hotline Services Program. \$50,000**
492.18 each year is added to the base for a grant to
492.19 HOME Line for the tenant hotline services
492.20 program. This is a onetime appropriation.

492.21 <u>Subd. 5. Children and Economic Assistance</u>		
492.22 <u>Management</u>	<u>47,035,000</u>	<u>46,884,000</u>

492.23	<u>Appropriations by Fund</u>		
492.24 <u>General</u>	<u>45,492,000</u>	<u>45,335,000</u>	
492.25 <u>Health Care Access</u>	<u>347,000</u>	<u>354,000</u>	
492.26 <u>Federal TANF</u>	<u>1,196,000</u>	<u>1,196,000</u>	

492.27 The amounts that may be spent from the
492.28 appropriation for each purpose are as follows:

492.29 **(a) Children and Economic Assistance**
492.30 **Administration**

492.31	<u>Appropriations by Fund</u>		
492.32 <u>General</u>	<u>9,725,000</u>	<u>9,612,000</u>	
492.33 <u>Federal TANF</u>	<u>1,196,000</u>	<u>1,196,000</u>	

493.1 **Base Adjustment.** The general fund base is
493.2 \$9,574,000 in each of fiscal years 2010 and
493.3 2011.

493.4 **(b) Children and Economic Assistance**
493.5 **Operations**

493.6	<u>Appropriations by Fund</u>		
493.7	<u>General</u>	<u>35,767,000</u>	<u>35,722,000</u>
493.8	<u>Health Care Access</u>	<u>347,000</u>	<u>354,000</u>

493.9 **Spending Authority for Food Stamps**

493.10 **Bonus Awards.** In the event that Minnesota
493.11 qualifies for the United States Department
493.12 of Agriculture Food and Nutrition Services
493.13 Food Stamp Program performance bonus
493.14 awards, the funding is appropriated to the
493.15 commissioner. The commissioner shall
493.16 retain 25 percent of the funding, with the
493.17 other 75 percent divided among the counties
493.18 according to a formula that takes into account
493.19 each county's impact on state performance in
493.20 the applicable bonus categories.

493.21 **Child Support Payment Center.** Payments
493.22 to the commissioner from other governmental
493.23 units, private enterprises, and individuals
493.24 for services performed by the child support
493.25 payment center must be deposited in the state
493.26 systems account authorized under Minnesota
493.27 Statutes, section 256.014. These payments
493.28 are appropriated to the commissioner for the
493.29 operation of the child support payment center
493.30 or system, according to Minnesota Statutes,
493.31 section 256.014.

493.32 **Financial Institution Data Match and**
493.33 **Payment of Fees.** The commissioner is
493.34 authorized to allocate up to \$310,000 each
493.35 year in fiscal years 2008 and 2009 from the
493.36 PRISM special revenue account to make

494.1 payments to financial institutions in exchange
494.2 for performing data matches between account
494.3 information held by financial institutions
494.4 and the public authority's database of child
494.5 support obligors as authorized by Minnesota
494.6 Statutes, section 13B.06, subdivision 7.

494.7 **Base Adjustment.** The general fund base is
494.8 decreased by \$22,000 in each of fiscal years
494.9 2010 and 2011.

494.10 **Subd. 6. Basic Health Care Grants** 2,397,260,000 2,739,194,000

494.11 Appropriations by Fund

494.12 <u>General</u>	<u>2,019,435,000</u>	<u>2,246,743,000</u>
494.13 <u>Health Care Access</u>	<u>377,825,000</u>	<u>492,451,000</u>

494.14 The amounts that may be spent from the
494.15 appropriation for each purpose are as follows:

494.16 **(a) MinnesotaCare Grants**

494.17 <u>Health Care Access</u>	<u>376,938,000</u>	<u>459,891,000</u>

494.18 **MinnesotaCare Federal Receipts.** Receipts
494.19 received as a result of federal participation
494.20 in administering costs of the Minnesota
494.21 health care reform waiver must be deposited
494.22 as nondedicated revenue in the health care
494.23 access fund. Receipts received as a result of
494.24 federal participation in making grants must
494.25 be deposited in the federal fund and must
494.26 offset health care access funds for payments
494.27 to providers.

494.28 **MinnesotaCare Funding.** The
494.29 commissioner may expend money
494.30 appropriated from the health care access fund
494.31 for MinnesotaCare in either fiscal year of the
494.32 biennium.

494.33 **HealthMatch Delay.** Of this appropriation,
494.34 \$2,560,000 in fiscal year 2008 and

495.1 \$29,647,000 in fiscal year 2009 are for
495.2 MinnesotaCare program costs related to
495.3 implementation of the HealthMatch program.

495.4 **(b) MA Basic Health Care - Families and**
495.5 **Children**

495.6	<u>Appropriations by Fund</u>		
495.7	<u>General</u>	<u>758,212,000</u>	<u>847,163,000</u>
495.8	<u>Health Care Access</u>	<u>-0-</u>	<u>31,661,000</u>

495.9 **(c) MA Basic Health Care - Elderly and**
495.10 **Disabled**

495.11	<u>General</u>	<u>1,019,297,000</u>	<u>1,145,789,000</u>

495.12 **Provider-Directed Care Coordination. In**
495.13 addition to medical assistance reimbursement
495.14 under Minnesota Statutes, sections
495.15 256B.0625 and 256B.76, clinics participating
495.16 in provider-directed care coordination under
495.17 Minnesota Statutes, section 256B.0625, also
495.18 receive a monthly payment per client when
495.19 the clinic serves an eligible client. The
495.20 payments across the program must average
495.21 \$50 per month per client.

495.22 **Services for Developmentally Disabled.**
495.23 The commissioner must serve: an additional
495.24 200 persons in the MR/RC waiver program;
495.25 an additional 200 persons in the family
495.26 support grant program under Minnesota
495.27 Statutes, section 252.32; and an additional
495.28 200 persons in the semi-independent living
495.29 services program under Minnesota Statutes,
495.30 section 252.275.

495.31 **County CADI allocation adjustment. (1)**
495.32 The commissioner shall adjust 2007 home
495.33 and community-based allocations under
495.34 section 256B.49 to qualifying counties
495.35 that transferred persons to the community

496.1 alternatives for disabled individuals
496.2 (CADI) waiver program under Laws 2006,
496.3 chapter 282, article 20, section 35. The
496.4 adjustment shall reflect the amount that
496.5 county-authorized funding for CADI waiver
496.6 services exceeded the allowable amount
496.7 as shown in the Medicaid Management
496.8 Information System (MMIS) on March 1,
496.9 2007.

496.10 (2) A county that may qualify under
496.11 paragraph (1) shall apply to the commissioner
496.12 by June 10, 2007. Following a review of the
496.13 county request and the MMIS documentation,
496.14 the commissioner shall adjust the county
496.15 allocation, as appropriate, by June 25, 2007.

496.16 (3) The amounts provided to a county under
496.17 this section shall become part of the county's
496.18 base level state allocation for the CADI
496.19 waiver for the biennium beginning July 1,
496.20 2007.

496.21 (4) This rider is effective the day following
496.22 final enactment.

496.23 **(d) General Assistance Medical Care Grants**

496.24 <u>General</u>	<u>238,887,000</u>	<u>251,082,000</u>

496.25 **(e) Other Health Care Grants**

496.26 <u>General</u>	<u>3,039,000</u>	<u>2,709,000</u>
496.27 <u>Health Care Access</u>	<u>887,000</u>	<u>899,000</u>

496.28 **Care Coordination.** Of the general fund
496.29 appropriation, \$500,000 in fiscal year 2008
496.30 and \$1,000,000 in fiscal year 2009 are for
496.31 the commissioner of human services for
496.32 contracting for care coordination with the
496.33 U special kids program under Minnesota
496.34 Statutes, section 256B.0751.

497.1 **Community-Based Health Care.** Of the
497.2 general fund appropriation, \$1,050,000
497.3 for the biennium beginning July 1, 2007,
497.4 is to the commissioner of human services
497.5 for the demonstration project grant
497.6 described in Minnesota Statutes, section
497.7 62Q.80, subdivision 1a. This is a onetime
497.8 appropriation and is available until June 30,
497.9 2012.

497.10 **Health Care Payment Reform Pilot.** Of
497.11 the general fund appropriation, \$1,018,000
497.12 in fiscal year 2008 and \$1,027,000 in fiscal
497.13 year 2009 are for the health care payment
497.14 reform pilot project. These are onetime
497.15 appropriations.

497.16 **Patient Incentive Programs.** Of the general
497.17 fund appropriation, \$500,000 in fiscal year
497.18 2008 and \$500,000 in fiscal year 2009 are
497.19 for patient incentive programs.

497.20 **State Health Policies Grant.** Of the general
497.21 fund appropriation, \$300,000 in fiscal year
497.22 2008 is to provide a grant to a research center
497.23 associated with a safety net hospital and
497.24 county-affiliated health system to develop
497.25 the capabilities necessary for evaluating the
497.26 effects of changes in state health policies
497.27 on low-income and uninsured individuals,
497.28 including the impact on state health care
497.29 program costs, health outcomes, cost-shifting
497.30 to different units and levels of government,
497.31 and utilization patterns including use of
497.32 emergency room care and hospitalization
497.33 rates.

497.34 **Neighborhood Health Care Network.** Of
497.35 the general fund appropriation, \$150,000 in

498.1	<u>fiscal year 2008 and \$150,000 in fiscal year</u>		
498.2	<u>2009 are for a grant to the Neighborhood</u>		
498.3	<u>Health Care Network to maintain and staff a</u>		
498.4	<u>toll-free health care access telephone number.</u>		
498.5	<u>Subd. 7. Health Care Management</u>	<u>54,536,000</u>	<u>58,696,000</u>
498.6	<u>Appropriations by Fund</u>		
498.7	<u>General</u>	<u>32,416,000</u>	<u>30,571,000</u>
498.8	<u>Health Care Access</u>	<u>22,120,000</u>	<u>28,125,000</u>
498.9	<u>The amounts that may be spent from the</u>		
498.10	<u>appropriation for each purpose are as follows:</u>		
498.11	<u>(a) Health Care Policy Administration</u>		
498.12	<u>Appropriations by Fund</u>		
498.13	<u>General</u>	<u>10,236,000</u>	<u>8,813,000</u>
498.14	<u>Health Care Access</u>	<u>2,323,000</u>	<u>10,074,000</u>
498.15	<u>Minnesota Senior Health Options</u>		
498.16	<u>Reimbursement.</u> <u>Federal administrative</u>		
498.17	<u>reimbursement resulting from the Minnesota</u>		
498.18	<u>senior health options project is appropriated</u>		
498.19	<u>to the commissioner for this activity.</u>		
498.20	<u>Utilization Review.</u> <u>Federal administrative</u>		
498.21	<u>reimbursement resulting from prior</u>		
498.22	<u>authorization and inpatient admission</u>		
498.23	<u>certification by a professional review</u>		
498.24	<u>organization is dedicated to the commissioner</u>		
498.25	<u>for these purposes. A portion of these funds</u>		
498.26	<u>must be used for activities to decrease</u>		
498.27	<u>unnecessary pharmaceutical costs in medical</u>		
498.28	<u>assistance.</u>		
498.29	<u>Dental Access for Persons with Disabilities.</u>		
498.30	<u>Of the general fund appropriation, \$82,000</u>		
498.31	<u>in fiscal year 2008 is for a study on access to</u>		
498.32	<u>dental services for persons with disabilities.</u>		
498.33	<u>Base Adjustment.</u> <u>The health care access</u>		
498.34	<u>fund base is \$10,716,000 in fiscal year 2010</u>		

499.1 and \$8,870,000 in fiscal year 2011, for health
499.2 care administration.

499.3 **(b) Health Care Operations**

499.4	<u>Appropriations by Fund</u>		
499.5	<u>General</u>	<u>22,180,000</u>	<u>21,758,000</u>
499.6	<u>Health Care Access</u>	<u>19,797,000</u>	<u>18,051,000</u>

499.7 **Base Adjustment.** The general fund base is
499.8 decreased by \$214,000 in fiscal year 2010
499.9 for health care operations.

499.10	<u>Subd. 8. Continuing Care Grants</u>	<u>1,697,359,000</u>	<u>1,858,283,000</u>

499.11	<u>Appropriations by Fund</u>		
499.12	<u>General</u>	<u>1,694,876,000</u>	<u>1,855,900,000</u>
499.13	<u>Health Care Access</u>	<u>750,000</u>	<u>750,000</u>
499.14	<u>Lottery Prize</u>	<u>1,733,000</u>	<u>1,633,000</u>

499.15 The amounts that may be spent from the
499.16 appropriation for each purpose are as follows:

499.17 **(a) Aging and Adult Services Grants**

499.18	<u>General</u>	<u>15,986,000</u>	<u>16,605,000</u>

499.19 **Information and Assistance**

499.20 **Reimbursement.** Federal administrative
499.21 reimbursement obtained from information
499.22 and assistance services provided by the
499.23 Senior LinkAge Line to people who are
499.24 identified as eligible for medical assistance
499.25 are appropriated to the commissioner for this
499.26 activity.

499.27 **Senior Companion Program.** Of the
499.28 general fund appropriation, \$191,000 in
499.29 fiscal year 2008 and \$191,000 in fiscal year
499.30 2009 are for the senior companion program
499.31 under Minnesota Statutes, section 256.977.

499.32 **Volunteer Senior Citizens.** Of the general
499.33 fund appropriation, \$192,000 in fiscal year
499.34 2008 and \$192,000 in fiscal year 2009 are

500.1 for the volunteer programs for retired senior
500.2 citizens under Minnesota Statutes, section
500.3 256.9753.

500.4 **Foster Grandparent Program.** Of the
500.5 general fund appropriation, \$192,000 in
500.6 fiscal year 2008 and \$192,000 in fiscal year
500.7 2009 are for the foster grandparent program
500.8 in Minnesota Statutes, section 256.976.

500.9 **Senior Nutrition.** Of the general fund
500.10 appropriation, \$250,000 in fiscal year
500.11 2008 and \$250,000 in fiscal year 2009 are
500.12 for the senior nutrition programs under
500.13 Minnesota Statutes, section 256.9752.

500.14 The commissioner shall give priority to
500.15 increase services to: (1) persons facing
500.16 language or cultural barriers, (2) persons with
500.17 special diets, (3) persons living in isolated
500.18 rural areas, and (4) other hard-to-serve
500.19 populations.

500.20 **Living At Home/Block Nurse Program.** Of
500.21 the general fund appropriation, \$580,000 in
500.22 fiscal year 2008 and \$655,000 in fiscal year
500.23 2009 are for the living at home/block nurse
500.24 program. The purpose of the appropriation is
500.25 to increase base funding levels to \$25,000
500.26 per program year, provide base funding for
500.27 nine programs currently operating without
500.28 base funding, provide base funding for five
500.29 new programs beginning July 1, 2007, and
500.30 provide base funding for six additional
500.31 programs beginning July 1, 2008.

500.32 \$76,000 in fiscal year 2008 and \$62,000 in
500.33 fiscal year 2009 are for increased staff for
500.34 the ombudsman for older Minnesotans and
500.35 related costs.

501.1 \$150,000 in fiscal year 2008 and \$150,000 in
501.2 fiscal year 2009 are to increase the base of
501.3 the Senior LinkAge line program.

501.4 **Minnesota Kinship Caregivers**

501.5 **Association.** (1) Of the general fund
501.6 appropriation, \$175,000 in fiscal year
501.7 2008 and \$175,000 in fiscal year 2009
501.8 are transferred to a nonprofit organization
501.9 experienced in kinship caregiver programs,
501.10 with at least 50 percent of its board
501.11 composed of kinship caregivers for purposes
501.12 of providing support to grandparents or
501.13 relatives who are raising kinship children.

501.14 (2) The demonstration grant sites must
501.15 include the Minnesota Kinship Caregivers
501.16 Association central site in the metropolitan
501.17 area and another site in the Bemidji region.
501.18 The support must provide a one-stop services
501.19 program. The services that may be provided
501.20 include but are not limited to legal services,
501.21 education, information, family activities,
501.22 support groups, mental health access,
501.23 advocacy, mentors, and information related
501.24 to foster care licensing. The funds may also
501.25 be used for a media campaign to inform
501.26 kinship families about available information
501.27 and services, support sites, and other program
501.28 development. The general fund base for the
501.29 program shall be \$160,000 in fiscal year
501.30 2010 and \$160,000 in fiscal year 2011.

501.31 **Base Adjustment.** The general fund base
501.32 is increased by \$72,000 in fiscal year 2010
501.33 and \$72,000 in fiscal year 2011 for aging and
501.34 adult services grants.

501.35 **(b) Alternative Care Grants**

502.1	<u>General</u>	<u>50,063,000</u>	<u>52,511,000</u>
502.2	<u>Alternative Care Transfer. Any money</u>		
502.3	<u>allocated to the alternative care program that</u>		
502.4	<u>is not spent for the purposes indicated does</u>		
502.5	<u>not cancel but is transferred to the medical</u>		
502.6	<u>assistance account.</u>		
502.7	<u>Base Adjustment. The general fund base is</u>		
502.8	<u>increased by \$547,000 in fiscal year 2010 and</u>		
502.9	<u>\$784,000 in fiscal year 2011 for alternative</u>		
502.10	<u>care grants.</u>		
502.11	<u>(c) Medical Assistance Grants - Long-Term</u>		
502.12	<u>Care Facilities</u>		
502.13	<u>General</u>	<u>499,278,000</u>	<u>513,016,000</u>
502.14	<u>New Nursing Facility Reimbursement</u>		
502.15	<u>System Delay. Notwithstanding Minnesota</u>		
502.16	<u>Statutes, section 256B.441, subdivision 1,</u>		
502.17	<u>paragraph (c), the commissioner shall begin</u>		
502.18	<u>to phase in the new reimbursement system</u>		
502.19	<u>for nursing facilities on or after October 1,</u>		
502.20	<u>2009.</u>		
502.21	<u>Long-Term Care Consultation Funding</u>		
502.22	<u>Increase. For the rate year beginning</u>		
502.23	<u>October 1, 2008, the county long-term</u>		
502.24	<u>care consultation allocations in Minnesota</u>		
502.25	<u>Statutes, section 256B.0911, subdivision</u>		
502.26	<u>6, must be increased based on the number</u>		
502.27	<u>of transitional long-term care consultation</u>		
502.28	<u>visits projected by the commissioner in</u>		
502.29	<u>each county. For the rate year beginning</u>		
502.30	<u>October 1, 2009, final allocations must be</u>		
502.31	<u>determined based on the average between</u>		
502.32	<u>the actual number of transitional long-term</u>		
502.33	<u>care visits that were conducted in the prior</u>		
502.34	<u>12-month period and the projected number</u>		

503.1 of consultations that will be provided in
503.2 the rate year beginning October 1, 2009.
503.3 Notwithstanding section 7, this rider expires
503.4 June 30, 2010.

503.5 **Life Safety Code Compliance.** Of the
503.6 general fund appropriation, \$1,000,000 in
503.7 fiscal year 2008 is for payments to nursing
503.8 facilities for life safety code compliance
503.9 under Minnesota Statutes, section 256B.434,
503.10 subdivision 4, paragraph (e). This is a
503.11 onetime appropriation and available until
503.12 spent.

503.13 **(d) Medical Assistance Grants - Long-Term**
503.14 **Care Waivers and Home Care Grants**

503.15	<u>General</u>	<u>966,623,000</u>	<u>1,099,540,000</u>

503.16 **(e) Mental Health Grants**

503.17	<u>Appropriations by Fund</u>		
503.18	<u>General</u>	<u>57,522,000</u>	<u>60,678,000</u>
503.19	<u>Health Care Access</u>	<u>750,000</u>	<u>750,000</u>
503.20	<u>Lottery Prize</u>	<u>1,733,000</u>	<u>1,633,000</u>

503.21 **Dual Diagnosis; Demonstration Project.**
503.22 Of the general fund appropriation, \$800,000
503.23 in fiscal year 2008 and \$1,600,000 in fiscal
503.24 year 2009 are to the commissioner of
503.25 human services to fund the dual diagnosis
503.26 demonstration project.

503.27 **Mobile Mental Health Crisis Services.** Of
503.28 the general fund appropriation, \$2,500,000
503.29 in fiscal year 2008 and \$3,625,000 in fiscal
503.30 year 2009 are to the commissioner of human
503.31 services for statewide funding of adult mobile
503.32 mental health crisis services. Providers must
503.33 utilize all available funding streams.

503.34 **National Council on Problem Gambling.**
503.35 (1) \$225,000 in fiscal year 2008 and \$225,000

504.1 in fiscal year 2009 are appropriated from
504.2 the lottery prize fund to the commissioner
504.3 of human services for a grant to the state
504.4 affiliate recognized by the National Council
504.5 on Problem Gambling. The affiliate must
504.6 provide services to increase public awareness
504.7 of problem gambling, education, and training
504.8 for individuals and organizations providing
504.9 effective treatment services to problem
504.10 gamblers and their families, and research
504.11 relating to problem gambling. These
504.12 services must be complementary to and not
504.13 duplicative of the services provided through
504.14 the problem gambling program administered
504.15 by the commissioner of human services. This
504.16 grant does not prevent the commissioner
504.17 from regular monitoring and oversight of the
504.18 grant or the ability to reallocate the funds to
504.19 other services within the problem gambling
504.20 program for nonperformance of duties by
504.21 the grantee.

504.22 (2) Of this appropriation, \$100,000 in
504.23 fiscal year 2008 and \$100,000 in fiscal year
504.24 2009 are contingent on the contribution
504.25 of nonstate matching funds. Matching
504.26 funds may be either cash or qualifying
504.27 in-kind contributions. The commissioner of
504.28 finance may disburse the state portion of the
504.29 matching funds in increments of \$25,000
504.30 upon receipt of a commitment for an equal
504.31 amount of matching nonstate funds. The
504.32 general fund base shall be \$100,000 in fiscal
504.33 year 2010 and \$100,000 in fiscal year 2011

504.34 (3) \$100,000 in fiscal year 2008 is
504.35 appropriated from the lottery prize fund to
504.36 the commissioner of human services for a

505.1 grant or grants to be awarded competitively
505.2 to develop programs and services for
505.3 problem gambling treatment, prevention,
505.4 and education in immigrant communities.
505.5 This appropriation is available until June
505.6 30, 2009, at which time the project must
505.7 be completed and final products delivered,
505.8 unless an earlier completion date is specified
505.9 in the work program.

505.10 **Compulsive Gambling.** \$300,000 in fiscal
505.11 year 2008 and \$100,000 in fiscal year 2009
505.12 are appropriated from the lottery prize fund
505.13 to the commissioner of human services for
505.14 purposes of compulsive gambling education,
505.15 assessment, and treatment under Minnesota
505.16 Statutes, section 245.98.

505.17 **Compulsive Gambling Study.** \$100,000
505.18 in fiscal year 2008 is to continue the
505.19 study currently being done on compulsive
505.20 gambling treatment effectiveness and
505.21 long-term effects of gambling.

505.22 **Base Adjustment.** The general fund base is
505.23 increased by \$266,000 in fiscal year 2010.

505.24 **(f) Deaf and Hard-of-Hearing Grants**

505.25	<u>General</u>	<u>1,932,000</u>	<u>2,380,000</u>

505.26 **Hearing Loss Mentors.** Of the general fund
505.27 appropriation, \$80,000 is to provide mentors
505.28 who have a hearing loss to parents of newly
505.29 identified infants and children with hearing
505.30 loss.

505.31 **Base Adjustment.** The general fund base
505.32 is increased by \$7,000 in fiscal year 2010
505.33 and \$7,000 in fiscal year 2011 for deaf and
505.34 hard-of-hearing grants.

506.1 (g) Chemical Dependency Entitlement Grants

506.2	<u>General</u>	<u>78,749,000</u>	<u>89,946,000</u>

506.3 (h) Chemical Dependency Nonentitlement
506.4 Grants

506.5	<u>General</u>	<u>1,055,000</u>	<u>1,055,000</u>

506.6 (i) Other Continuing Care Grants

506.7	<u>Appropriations by Fund</u>		

506.8	<u>General</u>	<u>23,668,000</u>	<u>20,169,000</u>

506.9 Native American Juvenile Treatment

506.10 Center. Of the general fund appropriation,

506.11 \$50,000 is to conduct a feasibility study

506.12 of and to predesign a Native American

506.13 juvenile treatment center on or near the

506.14 White Earth Reservation. The facility must

506.15 house and treat Native American juveniles

506.16 and provide culturally specific programming

506.17 to juveniles placed in the treatment center.

506.18 The commissioner of human services may

506.19 contract with parties who have experience

506.20 in the design and construction of juvenile

506.21 treatment centers to assist in the feasibility

506.22 study and predesign. On or before January

506.23 15, 2008, the commissioner shall present

506.24 the results of the feasibility study and the

506.25 predesign of the facility to the chairs of house

506.26 of representatives and senate committees

506.27 having jurisdiction over human services

506.28 finance, public safety finance, and capital

506.29 investment.

506.30 Leech Lake Youth Treatment Center. Of

506.31 the general fund appropriation, \$75,000 in

506.32 fiscal year 2008 and \$75,000 in fiscal year

506.33 2009 are for a grant to the Leech Lake Youth

506.34 Treatment Center project partners, in order

507.1 to pay the salaries and other directly related
507.2 costs associated with the development of this
507.3 project.

507.4 **Assistive Technology.** Of the general fund
507.5 appropriation, \$300,000 in fiscal year 2008 is
507.6 to the Minnesota State Council on Disability
507.7 for the purposes of providing \$100,000
507.8 in financial support to the Minnesota
507.9 Regions Assistive Technology Collaborative
507.10 and \$200,000 in fiscal year 2008 is for
507.11 a local match required to access the
507.12 federal Technology-Related Assistance for
507.13 Individuals with Disabilities Act, alternate
507.14 finance project.

507.15 **Repayment.** For the fiscal year ending June
507.16 30, 2008, \$5,287,000 is appropriated to the
507.17 commissioner of human services to repay
507.18 the amount of overspending in the waiver
507.19 program for persons with developmental
507.20 disabilities incurred by affected counties in
507.21 calendar years 2004 and 2005.

507.22 **Base Adjustment.** The general fund base
507.23 is \$20,276,000 in fiscal year 2010 and
507.24 \$20,332,000 in fiscal year 2011 for other
507.25 continuing care grants.

507.26 **Subd. 9. Continuing Care Management** 20,248,000 19,400,000

507.27	<u>Appropriations by Fund</u>		
507.28	<u>General</u>	<u>19,384,000</u>	<u>19,123,000</u>
507.29	<u>State Government</u>		
507.30	<u>Special Revenue</u>	<u>121,000</u>	<u>123,000</u>
507.31	<u>Health Care Access</u>	<u>292,000</u>	<u>-0-</u>
507.32	<u>Lottery Prize</u>	<u>451,000</u>	<u>154,000</u>

507.33 **Community Trainee and Consultation.**
507.34 Of the general fund appropriation, \$125,000
507.35 in fiscal year 2008 is to the commissioner

508.1 of human services to contract for training
508.2 and consultation for clinical supervisors and
508.3 staff of community mental health centers
508.4 who provide services to children and adults.
508.5 The purpose of the training and consultation
508.6 is to improve clinical supervision of
508.7 staff, strengthen compliance with federal
508.8 and state rules and regulations, and to
508.9 recommend strategies for standardization and
508.10 simplification of administrative functions
508.11 among community mental health centers.

508.12 **Mental Health Tracking System.** Of the
508.13 general fund appropriation, \$448,000 in fiscal
508.14 year 2008 and \$324,000 in fiscal year 2009
508.15 are to the commissioner of human services
508.16 to fund implementation of the mental health
508.17 services outcomes and tracking system.

508.18 **Quality Management; Assurance; and**
508.19 **Improvement System for Minnesotans**
508.20 **Receiving Disability Services.** Of the
508.21 general fund appropriation, up to \$300,000
508.22 for the biennium beginning July 1, 2007,
508.23 may be used for the purposes of the quality
508.24 management, assurance, and improvement
508.25 system for Minnesotans receiving disability
508.26 services. Federal Medicaid matching funds
508.27 obtained for this purpose shall be dedicated
508.28 to the commissioner for this purpose.

508.29 **Base Adjustment.** The health care access
508.30 fund base is \$0 in each of the fiscal years 2010
508.31 and 2011 for continuing care management.

508.32 **Disability Linkage Line.** Of the general
508.33 fund appropriation, \$650,000 in fiscal year
508.34 2008 and \$626,000 in fiscal year 2009 are to

509.1	<u>establish and maintain the disability linkage</u>		
509.2	<u>line.</u>		
509.3	<u>Subd. 10. State-Operated Services</u>	<u>266,645,000</u>	<u>267,718,000</u>
509.4	<u>General</u>	<u>266,645,000</u>	<u>267,718,000</u>
509.5	<u>Remembering With Dignity Project. (1)</u>		
509.6	<u>\$200,000 is appropriated from the general</u>		
509.7	<u>fund to the commissioner of human services</u>		
509.8	<u>to be available until September 30, 2008, to</u>		
509.9	<u>make a grant to Advocating Change Together</u>		
509.10	<u>for the purposes of the Remembering With</u>		
509.11	<u>Dignity project in paragraph (2).</u>		
509.12	<u>(2) As part of the Remembering With Dignity</u>		
509.13	<u>project, the grant recipient shall:</u>		
509.14	<u>(i) conduct necessary research on persons</u>		
509.15	<u>buried in state cemeteries who were residents</u>		
509.16	<u>of state hospitals or regional treatment</u>		
509.17	<u>centers and buried in numbered or unmarked</u>		
509.18	<u>graves;</u>		
509.19	<u>(ii) purchase and install headstones that are</u>		
509.20	<u>properly inscribed with their names on the</u>		
509.21	<u>graves of those persons; and</u>		
509.22	<u>(iii) collaborate with community groups</u>		
509.23	<u>and state and local government agencies to</u>		
509.24	<u>build community involvement and public</u>		
509.25	<u>awareness, ensure public access to the</u>		
509.26	<u>graves, and ensure appropriate perpetual</u>		
509.27	<u>maintenance of state cemeteries.</u>		
509.28	<u>(3) This rider is effective the day following</u>		
509.29	<u>final enactment.</u>		
509.30	<u>Transfer Authority Related to</u>		
509.31	<u>State-Operated Services. Money</u>		
509.32	<u>appropriated to finance state-operated</u>		
509.33	<u>services programs and administrative</u>		
509.34	<u>services may be transferred between fiscal</u>		

510.1 years of the biennium with the approval of
510.2 the commissioner of finance.

510.3 The amounts that may be spent from the
510.4 appropriation for each purpose are as follows:

510.5 **(a) Mental Health Services**

510.6 General 116,270,000 120,095,000

510.7 **Appropriation Limitation.** No part of
510.8 the appropriation in this article to the
510.9 commissioner for mental health treatment
510.10 services at the regional treatment centers
510.11 shall be used for the Minnesota sex offender
510.12 program.

510.13 **(b) Minnesota Sex Offender Services**

510.14 General 67,719,000 62,787,000

510.15 **(c) Minnesota Security Hospital and METO**
510.16 **Services**

510.17 General 82,656,000 84,836,000

510.18 **Minnesota Security Hospital.** For the
510.19 purposes of enhancing the safety of
510.20 the public, improving supervision, and
510.21 enhancing community-based mental health
510.22 treatment, state-operated services may
510.23 establish additional community capacity
510.24 for providing treatment and supervision
510.25 of clients who have been ordered into a
510.26 less restrictive alternative care from the
510.27 state-operated services transitional services
510.28 program consistent with Minnesota Statutes,
510.29 section 246.014.

510.30 Sec. 4. **COMMISSIONER OF HEALTH**

510.31 **Subdivision 1. Total Appropriation** **\$** **176,686,000** **\$** **165,689,000**

510.32 Appropriations by Fund
510.33 2008 2009

511.1	<u>General</u>	<u>98,737,000</u>	<u>92,829,000</u>
511.2	<u>State Government</u>		
511.3	<u>Special Revenue</u>	<u>39,851,000</u>	<u>40,642,000</u>
511.4	<u>Health Care Access</u>	<u>26,448,000</u>	<u>19,918,000</u>
511.5	<u>Federal TANF</u>	<u>11,350,000</u>	<u>12,000,000</u>
511.6	<u>Environment</u>	<u>300,000</u>	<u>300,000</u>

511.7 Subd. 2. **Community and Family Health**
511.8 **Promotion**

511.9	<u>Appropriations by Fund</u>		
511.10	<u>General</u>	<u>59,881,000</u>	<u>59,978,000</u>
511.11	<u>State Government</u>		
511.12	<u>Special Revenue</u>	<u>468,000</u>	<u>471,000</u>
511.13	<u>Health Care Access</u>	<u>3,539,000</u>	<u>3,562,000</u>
511.14	<u>Federal TANF</u>	<u>8,667,000</u>	<u>9,002,000</u>

511.15 **TANF Appropriations.** (a) \$3,579,000 of
511.16 the TANF funds is appropriated in each year
511.17 of the biennium to the commissioner for
511.18 home visiting and nutritional services listed
511.19 under Minnesota Statutes, section 145.882,
511.20 subdivision 7, clauses (6) and (7). Funding
511.21 shall be distributed to community health
511.22 boards based on Minnesota Statutes, section
511.23 145A.131, subdivision 1.

511.24 (b) \$5,088,000 in the first year and \$5,423,000
511.25 in the second year are appropriated to the
511.26 commissioner of health for the family home
511.27 visiting grant program. The commissioner
511.28 shall distribute funds to community health
511.29 boards using a formula developed in
511.30 conjunction with the state Community
511.31 Health Services Advisory Committee. The
511.32 commissioner may use five percent of the
511.33 funds appropriated in each fiscal year to
511.34 conduct the ongoing evaluations required
511.35 under Minnesota Statutes, section 145A.17,
511.36 subdivision 7, and may use ten percent of
511.37 the funds appropriated each fiscal year to

512.1 provide training and technical assistance as
512.2 required under Minnesota Statutes, section
512.3 145A.17, subdivisions 4 and 5.

512.4 **TANF Carryforward.** Any unexpended
512.5 balance of the TANF appropriation in the
512.6 first year of the biennium does not cancel but
512.7 is available for the second year.

512.8 **Loan Forgiveness.** \$605,000 the first year
512.9 and \$775,000 the second year and thereafter
512.10 are for the loan forgiveness program under
512.11 Minnesota Statutes, section 144.1501. This
512.12 funding is in addition to the loan forgiveness
512.13 program base.

512.14 **MN ENABL.** Base level funding for the MN
512.15 ENABL program, under Minnesota Statutes,
512.16 section 145.9255, is reduced by \$220,000
512.17 each year of the biennium beginning July 1,
512.18 2007.

512.19 **Fetal Alcohol Spectrum Disorder. (a)**
512.20 \$900,000 each year is added to the base for
512.21 fetal alcohol spectrum disorder. On July 1
512.22 each fiscal year, the portion of the general
512.23 fund appropriation to the commissioner of
512.24 health for fetal alcohol spectrum disorder
512.25 administration and grants shall be transferred
512.26 to a statewide organization that focuses
512.27 solely on prevention of and intervention with
512.28 fetal alcohol spectrum disorder as follows:

512.29 (1) on July 1, 2007, \$2,090,000; and
512.30 (2) on July 2, 2008, and annually thereafter,
512.31 \$2,090,000.

512.32 **(b) The money shall be used for prevention**
512.33 **and intervention services and programs,**
512.34 **including, but not limited to, community**

513.1 grants, professional education, public
513.2 awareness, and diagnosis. The organization
513.3 may retain \$60,000 of the transferred money
513.4 for administrative costs. The organization
513.5 shall report to the commissioner annually
513.6 by January 15 on the services and programs
513.7 funded by the appropriation.

513.8 **Deaf or Hearing Loss Support. \$100,000**
513.9 for the first year and \$100,000 for the second
513.10 year is for the purpose of providing family
513.11 support and assistance to families with
513.12 children who are deaf or have a hearing
513.13 loss. The family support provided must
513.14 include direct parent-to-parent assistance and
513.15 information on communication, educational,
513.16 and medical options. The commissioner
513.17 may contract with a nonprofit organization
513.18 that has the ability to provide these services
513.19 throughout the state.

513.20 **Heart Disease and Stroke Prevention.**
513.21 \$200,000 is appropriated in the first year for
513.22 the heart disease and stroke prevention unit
513.23 of the Department of Health to fund data
513.24 collection and other activities to improve
513.25 cardiovascular health and reduce the burden
513.26 of heart disease and stroke in Minnesota.
513.27 This is a onetime appropriation.

513.28 **Family Planning Grants. \$1,000,000 each**
513.29 year is for family planning grants under
513.30 Minnesota Statutes, section 145.925.

513.31 **Bright Smiles Pilot Project. (a) \$384,000**
513.32 in the first year and \$50,000 in the second
513.33 year is to fund a grant for the Bright Smiles
513.34 pilot project.

514.1 (b) Of these amounts, \$50,000 each year is to
514.2 fund a dental health coordinator position at
514.3 the Minnesota Department of Health.

514.4 (c) The commissioner of health shall
514.5 establish a pilot project to fund a Bright
514.6 Smiles program designed to increase access
514.7 to oral health care for low-income and
514.8 immigrant children, ages birth to five
514.9 years, and their families and to build the
514.10 knowledge and ability of parents to care
514.11 for the oral health of their children. Under
514.12 this pilot project, a Bright Smiles program
514.13 shall serve the medically underserved areas
514.14 in Minneapolis and the Bemidji area, as
514.15 determined by the commissioner of health.

514.16 (d) A grant shall be used to fund costs related
514.17 to improving oral health outreach, education,
514.18 screening, and access to care for families
514.19 with children, ages birth to five years.

514.20 (e) Grant applicants shall submit to
514.21 the commissioner a written plan that
514.22 demonstrates the ability to provide the
514.23 following:

514.24 (1) new programs or continued expansion
514.25 of current access programs that have
514.26 demonstrated success in providing dental
514.27 services in underserved areas of Minneapolis
514.28 and the Bemidji area;

514.29 (2) programs for screening children entering
514.30 the Minneapolis and the Bemidji area public
514.31 school systems and facilitating access to care
514.32 for their families;

514.33 (3) programs testing new models of care
514.34 that are sensitive to cultural needs of the
514.35 recipients;

515.1 (4) programs creating new educational
515.2 campaigns that inform individuals of the
515.3 importance of good oral health and the
515.4 link between dental diseases, overall health
515.5 status, and success in school; and
515.6 (5) programs testing new delivery models
515.7 by creating partnerships between local early
515.8 childhood and school-age education and
515.9 community clinic dental providers.
515.10 (f) Qualified applicants are partnerships
515.11 among early childhood experts, Minneapolis
515.12 or Bemidji area public schools, and nonprofit
515.13 clinics that are established to provide health
515.14 services to low-income patients, provide
515.15 preventive and dental care services, and
515.16 utilize a sliding-scale fee or other method of
515.17 providing charity care that ensures that no
515.18 person is denied services because of inability
515.19 to pay.
515.20 (g) Applicants shall submit to the
515.21 commissioner an application and supporting
515.22 documentation, in the form and manner
515.23 specified by the commissioner. Applicants
515.24 must be able to provide culturally appropriate
515.25 outreach, screenings, and access to dental
515.26 care for children, ages birth to five years,
515.27 their parents, and pregnant women most at
515.28 risk of poor oral health due to lack of access
515.29 to dental care. Applicants must also meet the
515.30 following criteria:
515.31 (1) have the potential to successfully increase
515.32 access to families with children, ages birth
515.33 to five years;
515.34 (2) incorporate quality program evaluation;
515.35 (3) maximize use of grant funds; and

516.1 (4) have experience in providing services to
516.2 the target populations of this program.

516.3 (h) The commissioner shall evaluate the
516.4 effectiveness of this pilot program on the
516.5 oral health of children and their families and
516.6 report to the house of representatives and
516.7 senate committees with jurisdiction over
516.8 public health policy and finance by January
516.9 1, 2009, with recommendations as to how to
516.10 develop programs throughout Minnesota that
516.11 provide education and access to oral health
516.12 care for low-income and immigrant children.

516.13 **Suicide prevention programs. \$600,000**
516.14 each year is to fund the suicide prevention
516.15 program. The base for fiscal years 2010 and
516.16 2011 is reduced by \$300,000.

516.17 **Hearing Aid Loan Bank.** Of the general
516.18 fund appropriation, \$70,000 in fiscal year
516.19 2008 and \$70,000 in fiscal year 2009 are
516.20 for the purpose of providing a statewide
516.21 hearing aid and instrument loan bank to
516.22 families with children newly diagnosed with
516.23 hearing loss from birth to the age of ten. This
516.24 appropriation shall cover the administrative
516.25 costs of the program.

516.26 **Medical Home Learning Collaborative.**
516.27 Of the general fund appropriation, \$500,000
516.28 in fiscal year 2008 and \$500,000 in fiscal
516.29 year 2009 are to expand the medical
516.30 home learning collaborative initiative in
516.31 collaboration with the commissioner of
516.32 human services. Services provided under this
516.33 funding must support a medical home model
516.34 for children with special health care needs.
516.35 The collaborative shall report back to the

517.1 legislature on use of the funds by January 15,
517.2 2010. This appropriation shall not become
517.3 part of the base funding for the 2010-2011
517.4 biennium.

517.5 **Community Collaboratives.** Of the general
517.6 fund appropriation, \$330,000 in fiscal year
517.7 2008 and \$850,000 in fiscal year 2009 are to
517.8 provide grants to community collaboratives
517.9 to cover the uninsured. These are onetime
517.10 appropriations.

517.11 **Base Adjustment.** General fund base is
517.12 \$46,143,000 in each of fiscal years 2010 and
517.13 2011.

517.14 **Subd. 3. Policy, Quality, and Compliance** 51,209,000 45,590,000

517.15	<u>Appropriations by Fund</u>		
517.16	<u>General</u>	<u>14,897,000</u>	<u>15,737,000</u>
517.17	<u>State Government</u>		
517.18	<u>Special Revenue</u>	<u>13,403,000</u>	<u>13,497,000</u>
517.19	<u>Health Care Access</u>	<u>22,909,000</u>	<u>16,356,000</u>

517.20 **Health Care Access Survey.** Of the
517.21 health care access fund appropriation,
517.22 \$600,000 in fiscal year 2008 is appropriated
517.23 to the commissioner to conduct a health
517.24 insurance survey of Minnesota households,
517.25 in partnership with the State Health Access
517.26 Data Assistance Center at the University
517.27 of Minnesota. The commissioner shall
517.28 contract with the State Health Access Data
517.29 Assistance Center to conduct a survey that
517.30 provides information on the characteristics
517.31 of the uninsured in Minnesota and the
517.32 reasons for changing patterns of insurance
517.33 coverage and access to health care services.
517.34 This appropriation shall become part of the
517.35 agency's base budget for even-numbered
517.36 fiscal years.

518.1 **MERC.** Of the general fund appropriation,
518.2 \$8,000,000 each fiscal year is for distribution
518.3 of MERC grants as follows:
518.4 (1) \$5,000,000 according to Minnesota
518.5 Statutes, section 62J.692, subdivision 4,
518.6 paragraph (c);
518.7 (2) \$900,000 according to Minnesota
518.8 Statutes, section 62J.692, subdivision 4,
518.9 paragraph (d);
518.10 (3) \$100,000 according to Minnesota
518.11 Statutes, section 62J.692, subdivision 4,
518.12 paragraph (e); and
518.13 (4) \$2,000,000 according to Minnesota
518.14 Statutes, section 62J.692, subdivision 7a,
518.15 paragraph (b).
518.16 **Health Information Technology.** Of
518.17 the health care access fund appropriation,
518.18 \$6,750,000 each fiscal year is to implement
518.19 Minnesota Statutes, section 144.3345. Up
518.20 to \$350,000 each fiscal year is available for
518.21 grant administration and health information
518.22 technology technical assistance and
518.23 \$6,400,000 each year is to be transferred
518.24 to the commissioner of finance to establish
518.25 and implement a revolving account under
518.26 Minnesota Statutes, section 62J.496. This
518.27 appropriation shall not be included in the
518.28 agency's base budget for the fiscal year
518.29 beginning July 1, 2009.
518.30 **Health Insurance Exchange.** Of the health
518.31 care access fund appropriation, \$6,000,000
518.32 in fiscal year 2008 is appropriated to
518.33 the commissioner to establish the health
518.34 insurance exchange in Minnesota Statutes,
518.35 section 62A.76. Up to \$50,000 in fiscal year

519.1 2008 is available for administrative costs
519.2 incurred by the Department of Health in
519.3 establishing and providing grant funding to
519.4 the legal entity responsible for implementing
519.5 the health insurance exchange. This is a
519.6 onetime appropriation.

519.7 **Uncompensated Care Fund.** Of the general
519.8 fund appropriation, \$65,000 in fiscal year
519.9 2008 is for the commissioner of health to
519.10 study and present recommendations to the
519.11 governor and the legislature by January
519.12 15, 2008, on the design, operation, and
519.13 funding of an uncompensated care fund to
519.14 be used to provide subsidies to hospitals,
519.15 community clinics, federally qualified health
519.16 centers, community mental health centers,
519.17 and other health care providers that serve
519.18 a disproportionately large percentage of
519.19 uninsured patients. An organization must not
519.20 provide or perform abortion services under
519.21 this program.

519.22 **Community Collaboratives.** Of the
519.23 general fund appropriation, \$300,000 for the
519.24 biennium beginning July 1, 2007, is to the
519.25 commissioner of health to provide grants
519.26 to community collaboratives to cover the
519.27 uninsured. This is a onetime appropriation.

519.28 **Uniform Electronic Transactions.** Of the
519.29 general fund appropriation, \$146,000 in fiscal
519.30 year 2008 is for development of uniform
519.31 electronic transactions and implementation
519.32 guide standards under Minnesota Statutes,
519.33 section 62J.536.

519.34 **Federally Qualified Health Centers.** Of the
519.35 general fund appropriation, \$3,000,000 in

520.1 fiscal year 2008 and \$3,900,000 in fiscal year
520.2 2009 are for subsidies to federally qualified
520.3 health centers under Minnesota Statutes,
520.4 section 145.9269.

520.5 **Base Adjustment.** The general fund base
520.6 is reduced \$500,000 in each of fiscal years
520.7 2010 and 2011. The health care access fund
520.8 base is \$3,456,000 in fiscal year 2010 and
520.9 \$2,856,000 in fiscal year 2011.

520.10 **Subd. 4. Health Protection**

520.11	<u>Appropriations by Fund</u>		
520.12	<u>General</u>	<u>20,544,000</u>	<u>13,900,000</u>
520.13	<u>State Government</u>		
520.14	<u>Special Revenue</u>	<u>25,980,000</u>	<u>26,674,000</u>
520.15	<u>Environment</u>	<u>300,000</u>	<u>300,000</u>

520.16 **Pandemic Influenza Preparedness.** Of
520.17 the general fund appropriation to the
520.18 commissioner, \$6,035,000 in fiscal year 2008
520.19 is for preparation, planning, and response
520.20 to a pandemic influenza outbreak. This
520.21 appropriation is available until June 30, 2009.

520.22 Base funding for the 2010-2011 biennium is
520.23 \$0 each fiscal year.

520.24 **Environmental Health Tracking and**
520.25 **Biomonitoring.** (a) \$500,000 in the first
520.26 year and \$900,000 in the second year are
520.27 for the environmental health tracking and
520.28 biomonitoring program. The base for fiscal
520.29 year 2010 and fiscal year 2011 is increased
520.30 by \$300,000 each year.

520.31 (b) \$300,000 each year is from the
520.32 environmental fund to the Pollution Control
520.33 Agency for transfer to the Department
520.34 of Health for the health tracking and
520.35 biomonitoring program. The base for the

521.1 environmental fund is \$0 in fiscal year 2010
521.2 and after.

521.3 **AIDS Prevention Initiative Focusing**
521.4 **on African-born Residents. \$300,000 in**
521.5 **2008 is for an AIDS prevention initiative**
521.6 **focusing on African-born residents. This**
521.7 **appropriation is a onetime appropriation**
521.8 **and shall not become part of the base-level**
521.9 **funding for the 2010-2011 biennium.**

521.10 The commissioner of health shall award
521.11 grants in accordance with Minnesota Statutes,
521.12 section 145.924, paragraph (b), for a public
521.13 education and awareness campaign targeting
521.14 communities of African-born Minnesota
521.15 residents. The grants shall be designed to
521.16 promote knowledge and understanding about
521.17 HIV and to increase knowledge in order
521.18 to eliminate and reduce the risk for HIV
521.19 infection; to encourage screening and testing
521.20 for HIV; and to link individuals to public
521.21 health and health care resources. The grants
521.22 must be awarded to collaborative efforts that
521.23 bring together nonprofit community-based
521.24 groups with demonstrated experience in
521.25 addressing the public health, health care,
521.26 and social service needs of African-born
521.27 communities.

521.28 **Arsenic Health Risk Standard. \$920,000 in**
521.29 **the first year and \$461,000 in the second year**
521.30 **is to fund the study relating to arsenic health**
521.31 **risk standards, under Minnesota Statutes,**
521.32 **section 144.967.**

521.33 **Lindane and Bisphenol-A Studies.**
521.34 **\$114,000 in the first year is for the Lindane**
521.35 **committee and the study of bisphenol-A,**

522.1 under Minnesota Statutes, section 145.958.

522.2 This is a onetime appropriation.

522.3 **Decabromodiphenyl Ether Study.**

522.4 \$118,000 in the first year is for transfer to the

522.5 commissioner of the pollution control agency

522.6 for the study of decabromodiphenyl ether

522.7 under Minnesota Statutes, section 325E.387.

522.8 This is a onetime appropriation.

522.9 **Radiation Study.** \$45,000 in the first year

522.10 from the general fund and \$15,000 in the

522.11 first year from the state government special

522.12 revenue fund are for the radiation study in

522.13 section 62. This is a onetime appropriation.

522.14 **Lead Abatement.** \$925,000 in the first

522.15 year and \$950,000 in the second year are

522.16 for changes in lead abatement requirements.

522.17 Of this amount, \$6,000 in the first year and

522.18 \$11,000 in the second year are for transfer

522.19 to the commissioner of human services for

522.20 increased medical assistance costs. A portion

522.21 of this amount may be used to reimburse

522.22 local governments for costs of implementing

522.23 the new requirements.

522.24 **Water Treatment.** \$40,000 in fiscal year

522.25 2008 is to augment any appropriation from the

522.26 remediation fund to conduct an evaluation of

522.27 point of use water treatment units at removing

522.28 perfluorooctanoic acid, perfluorooctane

522.29 sulfonate, and perfluorobutanoic acid from

522.30 known concentrations of these compounds

522.31 in drinking water. The evaluation shall be

522.32 completed by December 31, 2007, and the

522.33 commissioner may contract for services to

522.34 complete the evaluation. This is a onetime

522.35 appropriation.

523.1 **Environmental Justice Mapping.** \$137,000
523.2 in the first year and \$53,000 in the second
523.3 year is for environmental justice mapping.

523.4 **HIV Information.** \$80,000 each year
523.5 is to fund a community-based nonprofit
523.6 organization with demonstrated capacity to
523.7 operate a statewide HIV information and
523.8 referral service using telephone, Internet, and
523.9 other appropriate technologies.

523.10 **Lead Hazard Reduction.** \$250,000 is
523.11 appropriated each year of the biennium for a
523.12 grant to a nonprofit organization operating
523.13 the CLEARCorps to conduct a pilot project
523.14 to determine the incidence of lead hazards in
523.15 pre-1978 rental property. Any balance in the
523.16 first year does not cancel but is available in
523.17 the second year.

523.18 **Minnesota Birth Defects Information**
523.19 **System.** \$750,000 each year is to maintain
523.20 the birth defects information system that was
523.21 established by Minnesota Statutes, section
523.22 144.2215.

523.23 Subd. 5. **Minority and Multicultural Health**

523.24	<u>Appropriations by Fund</u>		
523.25	<u>General</u>	<u>5,042,000</u>	<u>5,052,000</u>
523.26	<u>Federal TANF</u>	<u>2,683,000</u>	<u>2,998,000</u>

523.27 **TANF Appropriations.** (a) \$2,421,000 of
523.28 the TANF funds is appropriated in each year
523.29 of the biennium to the commissioner for
523.30 home visiting and nutritional services listed
523.31 under Minnesota Statutes, section 145.882,
523.32 subdivision 7, clauses (6) and (7). Funding
523.33 shall be distributed to tribal governments
523.34 based on Minnesota Statutes, section
523.35 145A.14, subdivision 2a, paragraph (b).

524.1 (b) \$262,000 in the first year and \$577,000
524.2 in the second year are appropriated
524.3 to the commissioner of health for the
524.4 family home visiting grant program. The
524.5 commissioner shall distribute funds to tribal
524.6 governments using a formula developed in
524.7 conjunction with tribal governments. The
524.8 commissioner may use five percent of the
524.9 funds appropriated in each fiscal year to
524.10 conduct the ongoing evaluations required
524.11 under Minnesota Statutes, section 145A.17,
524.12 subdivision 7, and may use ten percent of
524.13 the funds appropriated each fiscal year to
524.14 provide training and technical assistance as
524.15 required under Minnesota Statutes, section
524.16 145A.17, subdivisions 4 and 5.

524.17 **TANF Carryforward.** Any unexpended
524.18 balance of the TANF appropriation in the
524.19 first year of the biennium does not cancel but
524.20 is available for the second year.

524.21 **Subd. 6. Administrative Support Services**

524.22	<u>Appropriations by Fund</u>		
524.23	<u>General</u>	<u>11,047,000</u>	<u>11,197,000</u>

524.24 **Disease Surveillance.** \$2,000,000 each fiscal
524.25 year is for redesigning and implementing
524.26 coordinated and modern disease surveillance
524.27 systems for the department, ensuring that
524.28 occupational and residential histories are
524.29 included in the database. Base level funding
524.30 for the 2012-2013 biennium will be \$600,000
524.31 each fiscal year for maintaining and operating
524.32 the systems.

524.33	<u>Sec. 5. VETERANS NURSING HOMES</u>			
524.34	<u>BOARD</u>	<u>\$</u>	<u>44,124,000</u>	<u>\$ 46,244,000</u>

525.1 **Veterans Homes Special Revenue Account.**
525.2 The general fund appropriations made to
525.3 the board may be transferred to a veterans
525.4 homes special revenue account in the
525.5 special revenue fund in the same manner
525.6 as other receipts are deposited according to
525.7 Minnesota Statutes, section 198.34, and are
525.8 appropriated to the board for the operation of
525.9 board facilities and programs.

525.10 **Repair and Betterment.** Of this
525.11 appropriation, \$4,000,000 in fiscal year
525.12 2008 and \$4,000,000 in fiscal year 2009
525.13 are to be used for repair, maintenance,
525.14 rehabilitation, and betterment activities at
525.15 facilities statewide.

525.16 **Base Adjustment.** The general fund base is
525.17 decreased by \$2,000,000 in fiscal year 2010
525.18 and \$2,000,000 in fiscal year 2011.

525.19 Sec. 6. **HEALTH-RELATED BOARDS**

525.20 Subdivision 1. <u>Total Appropriation; State</u>			
525.21 <u>Government Special Revenue Fund</u>	<u>\$</u>	<u>14,654,000</u>	<u>\$ 14,527,000</u>

525.22 The commissioner of finance shall not permit
525.23 the allotment, encumbrance, or expenditure
525.24 of money appropriated in this section in
525.25 excess of the anticipated biennial revenues
525.26 or accumulated surplus revenues from fees
525.27 collected by the boards.

525.28 Subd. 2. <u>Board of Chiropractic Examiners</u>	<u>450,000</u>	<u>447,000</u>

525.29 Subd. 3. <u>Board of Dentistry</u>	<u>987,000</u>	<u>1,009,000</u>

525.30 Subd. 4. <u>Board of Dietetic and Nutrition</u>		
525.31 <u>Practice</u>	<u>103,000</u>	<u>119,000</u>

525.32 **Base Adjustment.** Of this appropriation in
525.33 fiscal year 2009, \$14,000 is onetime.

526.1	Subd. 5. <u>Board of Marriage and Family</u>		
526.2	<u>Therapy</u>	<u>134,000</u>	<u>154,000</u>
526.3	<u>Base Adjustment. Of this appropriation in</u>		
526.4	<u>fiscal year 2009, \$17,000 is onetime.</u>		
526.5	Subd. 6. <u>Board of Medical Practice</u>	<u>4,120,000</u>	<u>3,674,000</u>
526.6	Subd. 7. <u>Board of Nursing</u>	<u>3,985,000</u>	<u>4,146,000</u>
526.7	Subd. 8. <u>Board of Nursing Home</u>		
526.8	<u>Administrators</u>	<u>633,000</u>	<u>647,000</u>
526.9	<u>Administrative Services Unit. Of this</u>		
526.10	<u>appropriation, \$430,000 in fiscal year</u>		
526.11	<u>2008 and \$439,000 in fiscal year 2009 are</u>		
526.12	<u>for the administrative services unit. The</u>		
526.13	<u>administrative services unit may receive</u>		
526.14	<u>and expend reimbursements for services</u>		
526.15	<u>performed by other agencies.</u>		
526.16	Subd. 9. <u>Board of Optometry</u>	<u>98,000</u>	<u>114,000</u>
526.17	<u>Base Adjustment. Of this appropriation in</u>		
526.18	<u>fiscal year 2009, \$13,000 is onetime.</u>		
526.19	Subd. 10. <u>Board of Pharmacy</u>	<u>1,375,000</u>	<u>1,442,000</u>
526.20	<u>Base Adjustment. Of this appropriation in</u>		
526.21	<u>fiscal year 2009, \$29,000 is onetime.</u>		
526.22	Subd. 11. <u>Board of Physical Therapy</u>	<u>306,000</u>	<u>295,000</u>
526.23	Subd. 12. <u>Board of Podiatry</u>	<u>54,000</u>	<u>63,000</u>
526.24	<u>Base Adjustment. Of this appropriation in</u>		
526.25	<u>fiscal year 2009, \$7,000 is onetime.</u>		
526.26	Subd. 13. <u>Board of Psychology</u>	<u>788,000</u>	<u>806,000</u>
526.27	Subd. 14. <u>Board of Social Work</u>	<u>997,000</u>	<u>1,022,000</u>
526.28	Subd. 15. <u>Board of Veterinary Medicine</u>	<u>230,000</u>	<u>195,000</u>
526.29	Subd. 16. <u>Board of Behavioral Health and</u>		
526.30	<u>Therapy</u>	<u>394,000</u>	<u>394,000</u>
526.31	Sec. 7. <u>EMERGENCY MEDICAL SERVICES</u>		
526.32	<u>BOARD</u>	<u>\$ 4,617,000</u>	<u>\$ 4,645,000</u>

527.1	<u>Appropriations by Fund</u>		
527.2		<u>2008</u>	<u>2009</u>
527.3	<u>General</u>	<u>3,023,000</u>	<u>3,041,000</u>
527.4	<u>State Government</u>		
527.5	<u>Special Revenue</u>	<u>687,000</u>	<u>704,000</u>
527.6	<u>Regional Emergency Medical Services</u>		
527.7	<u>Programs.</u> \$400,000 each year is for		
527.8	<u>regional emergency medical services</u>		
527.9	<u>programs, to be distributed equally to the</u>		
527.10	<u>eight emergency medical service regions.</u>		
527.11	<u>This amount shall be added to the base</u>		
527.12	<u>funding. Notwithstanding Minnesota</u>		
527.13	<u>Statutes, section 144E.50, 100 percent of</u>		
527.14	<u>the appropriation shall be passed on to the</u>		
527.15	<u>emergency medical service regions.</u>		
527.16	<u>Health Professional Services Program.</u>		
527.17	<u>\$687,000 in fiscal year 2008 and \$704,000 in</u>		
527.18	<u>fiscal year 2009 from the state government</u>		
527.19	<u>special revenue fund are for the health</u>		
527.20	<u>professional services program.</u>		
527.21	Sec. 8. <u>COUNCIL ON DISABILITY</u>	<u>\$</u>	<u>582,000 \$</u> <u>590,000</u>
527.22	<u>Options Too.</u> (a) \$75,000 for the first		
527.23	<u>year and \$75,000 for the second year are</u>		
527.24	<u>to continue the work of the Options Too</u>		
527.25	<u>disability services interagency work group</u>		
527.26	<u>established under Laws 2005, First Special</u>		
527.27	<u>Session chapter 4, article 7, section 57.</u>		
527.28	<u>Funds shall be used to monitor and assist the</u>		
527.29	<u>work group and the Options Too Steering</u>		
527.30	<u>Committee in the implementation of the</u>		
527.31	<u>recommendations in the Options Too report</u>		
527.32	<u>dated February 15, 2007.</u>		
527.33	<u>(b) For purposes of this section, the Options</u>		
527.34	<u>Too Steering Committee shall consist of the</u>		
527.35	<u>following members:</u>		

528.1 (1) a representative from the Minnesota
528.2 Housing Finance Agency;
528.3 (2) a representative from the Minnesota State
528.4 Council on Disability;
528.5 (3) a representative from the Department of
528.6 Veterans Affairs;
528.7 (4) a representative from the Department of
528.8 Transportation;
528.9 (5) a representative from the Department of
528.10 Human Services; and
528.11 (6) representatives from interested
528.12 stakeholders including counties, local
528.13 public housing authorities, the Metropolitan
528.14 Council, disability service providers, and
528.15 disability advocacy organizations who are
528.16 appointed by the Minnesota State Council on
528.17 Disability for two-year terms.
528.18 (c) Notwithstanding Laws 2005, First Special
528.19 Session chapter 4, article 7, section 57, the
528.20 interagency work group shall be administered
528.21 by the Minnesota Housing Finance Agency,
528.22 the Minnesota State Council on Disability,
528.23 Department of Human Services, and the
528.24 Department of Transportation.
528.25 (d) The Options Too Steering Committee
528.26 shall report to the chairs of the health
528.27 and human services policy and finance
528.28 committees of the senate and house of
528.29 representatives by October 15, 2007, and
528.30 October 15, 2008, on the continued progress
528.31 of the work group towards implementing the
528.32 recommendations in the Options Too report
528.33 dated February 15, 2007.

529.1 Sec. 9. OMBUDSMAN FOR MENTAL
529.2 HEALTH AND DEVELOPMENTAL
529.3 DISABILITIES \$ 1,567,000 \$ 1,621,000

529.4 Sec. 10. OMBUDSMAN FOR FAMILIES \$ 251,000 \$ 257,000

529.5 Sec. 11. TRANSFERS.

529.6 Subdivision 1. Grants. The commissioner of human services, with the approval
529.7 of the commissioner of finance and after notifying the chairs of the senate and house
529.8 committees with jurisdiction, may transfer unencumbered appropriation balances for the
529.9 biennium ending June 30, 2009, within fiscal years among the MFIP; general assistance;
529.10 general assistance medical care; medical assistance; MFIP child care assistance under
529.11 Minnesota Statutes, section 119B.05; Minnesota supplemental aid and group residential
529.12 housing programs; and the entitlement portion of the chemical dependency consolidated
529.13 treatment fund and between fiscal years of the biennium.

529.14 Subd. 2. Administration. Positions, salary money, and nonsalary administrative
529.15 money may be transferred within the Departments of Human Services and Health and
529.16 within the programs operated by the Veterans Nursing Homes Board as the commissioners
529.17 and the board consider necessary, with the advance approval of the commissioner of
529.18 finance. The commissioner or the board shall inform the chairs of the house and senate
529.19 committees with jurisdiction quarterly about transfers made under this provision.

529.20 Sec. 12. INDIRECT COSTS NOT TO FUND PROGRAMS.

529.21 The commissioners of health and of human services shall not use indirect cost
529.22 allocations to pay for the operational costs of any program for which they are responsible.

529.23 Sec. 13. SUNSET OF UNCODIFIED LANGUAGE.

529.24 All uncodified language contained in this article expires on June 30, 2009, unless a
529.25 different expiration date is explicit.

529.26 Sec. 14. EFFECTIVE DATE.

529.27 The provisions in this article are effective July 1, 2007, unless a different effective
529.28 date is specified.