

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; regulating abortion procedures; 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, by adding a subdivision; 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, subdivisions 9, 10, 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; 145.412, by adding a subdivision; 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; 151.19, subdivision 2; 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,

2.1 subdivision 20; 245.465, by adding a subdivision; 245.4874; 245.50, subdivision
2.2 5; 245.98, subdivisions 2, 5; 245A.035; 245A.10, subdivision 2; 245A.16,
2.3 subdivisions 1, 3; 245C.02, by adding a subdivision; 245C.04, subdivision 1;
2.4 245C.05, subdivisions 1, 4, 5, 7, by adding a subdivision; 245C.08, subdivisions
2.5 1, 2; 245C.10, by adding a subdivision; 245C.11, subdivisions 1, 2; 245C.12;
2.6 245C.16, subdivision 1; 245C.17, by adding a subdivision; 245C.21, by adding a
2.7 subdivision; 245C.23, subdivision 2; 245C.24, subdivision 2; 246.54, subdivision
2.8 1; 252.27, subdivision 2a; 252.32, subdivision 3; 252.46, by adding a subdivision;
2.9 253B.185, subdivision 2; 254A.03, subdivision 3; 254A.16, subdivision 2;
2.10 254B.02, subdivisions 1, 5; 254B.03, subdivisions 1, 3; 254B.06, subdivision 3;
2.11 256.01, subdivisions 2, 2b, 4, 18, by adding subdivisions; 256.015, subdivision
2.12 7; 256.017, subdivisions 1, 9; 256.0471, subdivision 1; 256.476, subdivisions 1,
2.13 2, 3, 4, 5, 10; 256.482, subdivisions 1, 8; 256.969, subdivisions 3a, 9, by adding
2.14 a subdivision; 256.974; 256.9741, subdivisions 1, 3; 256.9742, subdivisions 3,
2.15 4, 6; 256.9744, subdivision 1; 256.975, subdivision 7; 256.984, subdivision 1;
2.16 256.9862, subdivision 2; 256B.04, subdivision 14, by adding a subdivision;
2.17 256B.055, subdivision 14; 256B.056, subdivisions 1a, 3, 5c, by adding a
2.18 subdivision; 256B.057, subdivision 8; 256B.059, subdivision 5; 256B.0621,
2.19 subdivision 11; 256B.0625, subdivisions 3f, 13c, 13d, 14, 17, 18a, 20, 23, 47, by
2.20 adding subdivisions; 256B.0644; 256B.0911, subdivisions 3a, 3b, 4b, 4c, 6, 7, by
2.21 adding subdivisions; 256B.0913, subdivisions 4, 5, 5a, 8, 9, 10, 11, 12, 13, 14;
2.22 256B.0915; 256B.0917, subdivision 8; 256B.0919, subdivision 3; 256B.0943,
2.23 subdivisions 6, 9, 11, 12; 256B.0945, subdivision 4; 256B.095; 256B.0951,
2.24 subdivision 1; 256B.199; 256B.431, subdivisions 1, 2e, 3f, 17e; 256B.434,
2.25 subdivision 4, by adding subdivisions; 256B.437, by adding a subdivision;
2.26 256B.438, subdivision 3; 256B.439, subdivision 1; 256B.441, subdivisions
2.27 1, 2, 5, 6, 10, 11, 13, 14, 17, 20, 24, 30, 31, 34, 38, by adding subdivisions;
2.28 256B.49, subdivision 11, by adding a subdivision; 256B.5012, by adding a
2.29 subdivision; 256B.69, subdivisions 5g, 5h, 23, 28; 256B.75; 256B.76; 256B.763;
2.30 256D.03, subdivision 4; 256D.44, subdivisions 2, 5; 256E.35, subdivision 2;
2.31 256I.04, subdivision 3; 256I.05, by adding subdivisions; 256J.01, by adding
2.32 a subdivision; 256J.02, subdivisions 1, 4; 256J.021; 256J.08, subdivision
2.33 65; 256J.21, subdivision 2; 256J.24, subdivision 10; 256J.39, by adding a
2.34 subdivision; 256J.42, subdivision 1; 256J.425, subdivisions 3, 4; 256J.46, by
2.35 adding a subdivision; 256J.49, subdivision 13; 256J.521, subdivisions 1, 2, by
2.36 adding a subdivision; 256J.53, subdivision 2; 256J.55, subdivision 1; 256J.626,
2.37 subdivisions 1, 2, 3, 4, 5, 6; 256J.751, subdivisions 2, 5; 256J.95, subdivisions
2.38 3, 13; 256K.45, by adding a subdivision; 256L.01, subdivision 4; 256L.03,
2.39 subdivisions 1, 5; 256L.035; 256L.04, subdivisions 1, 12; 256L.11, subdivision
2.40 7; 256L.12, subdivision 9a; 259.20, subdivision 2; 259.24, subdivision 3; 259.29,
2.41 subdivision 1; 259.41; 259.53, subdivisions 1, 2; 259.57, subdivisions 1, 2;
2.42 259.67, subdivisions 4, 7; 259.75, subdivision 8; 260.012; 260.755, subdivisions
2.43 12, 20; 260.761, subdivision 7; 260.765, subdivision 5; 260.771, subdivisions
2.44 1, 2; 260B.157, subdivision 1; 260C.152, subdivision 5; 260C.163, subdivision
2.45 1; 260C.201, subdivision 11; 260C.209; 260C.212, subdivisions 1, 2, 4, 9;
2.46 260C.317, subdivision 3; 260C.331, subdivision 1; 270B.14, subdivision 1;
2.47 609.115, subdivision 9; 626.556, subdivisions 2, 3, 10, 10a, 10c, 10f, by adding
2.48 subdivisions; Laws 2000, chapter 340, section 19; Laws 2005, chapter 98, article
2.49 3, section 25; Laws 2005, First Special Session chapter 4, article 9, section 3,
2.50 subdivision 2; Laws 2006, chapter 282, article 20, section 37; proposing coding
2.51 for new law in Minnesota Statutes, chapters 16A; 62A; 62J; 62Q; 144; 145; 148;
2.52 149A; 151; 152; 156; 245A; 245C; 254A; 256; 256B; 256C; 256D; 256F; 256J;
2.53 260; 325E; proposing coding for new law as Minnesota Statutes, chapters 146B;
2.54 256N; 525A; repealing Minnesota Statutes 2006, sections 62J.052, subdivision
2.55 1; 62J.17, subdivisions 1, 5a, 6a, 8; 119B.08, subdivision 4; 144.335; 252.21;
2.56 252.22; 252.23; 252.24; 252.25; 252.261; 252.275, subdivision 5; 254A.02,
2.57 subdivisions 7, 9, 12, 14, 15, 16; 254A.085; 254A.086; 254A.12; 254A.14;
2.58 254A.15; 254A.16, subdivision 5; 254A.175; 254A.18; 256.969, subdivision

27; 256.9743; 256B.0913, subdivisions 5b, 5c, 5d, 5e, 5f, 5g, 5h; 256B.441, subdivisions 12, 16, 21, 26, 28, 42, 45; 256J.29; 256J.37, subdivisions 3a, 3b; 256J.561, subdivision 1; 256J.62, subdivision 9; 256J.626, subdivisions 7, 9; 256J.65; 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; 525.9224; Laws 1997, chapter 8, section 1; Laws 2004, chapter 288, article 6, section 27; Minnesota Rules, parts 4610.2800; 9503.0035, subpart 2; 9560.0102, subpart 2, item C; 9585.0030.

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

ARTICLE 1

CHILDREN AND FAMILY

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

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

(1) according to section 13.05;

(2) according to court order;

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

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

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

(6) to administer federal funds or programs;

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

(8) to the Department of Revenue to administer and evaluate tax refund or tax credit programs and to identify individuals who may benefit from these programs. The following information may be disclosed under this paragraph: an individual's and their dependent's names, dates of birth, Social Security numbers, income, addresses, and other data as required, upon request by the Department of Revenue. Disclosures by the commissioner of revenue to the commissioner of human services for the purposes described in this clause are governed by section 270B.14, subdivision 1. Tax refund or tax credit programs include, but are not limited to, the dependent care credit under section 290.067, the Minnesota

working family credit under section 290.0671, the property tax refund and rental credit under section 290A.04, and the Minnesota education credit under section 290.0674;

(9) between the Department of Human Services, the Department of Education, and 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, 256D₂ 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 MFIP 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>

11.1	<u>245.00-249.99%</u>	<u>14.00%</u>
11.2	<u>250%</u>	<u>ineligible</u>

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

11.5 Subd. 2. **Parent fee.** A family must be assessed a parent fee for each service period.
11.6 A family's parent fee must be a fixed percentage of its annual gross income. Parent fees
11.7 must apply to families eligible for child care assistance under sections 119B.03 and
11.8 119B.05. Income must be as defined in section 119B.011, subdivision 15. The fixed
11.9 percent is based on the relationship of the family's annual gross income to 100 percent
11.10 of the annual federal poverty guidelines. Parent fees must begin at 75 percent of the
11.11 poverty level. The minimum parent fees for families between 75 percent and 100 percent
11.12 of poverty level must be ~~\$10~~ \$5 per month. Parent fees must provide for graduated
11.13 movement to full payment. Payment of part or all of a family's parent fee directly to the
11.14 family's child care provider on behalf of the family by a source other than the family shall
11.15 not affect the family's eligibility for child care assistance, and the amount paid shall be
11.16 excluded from the family's income. Child care providers who accept third-party payments
11.17 must maintain family specific documentation of payment source, amount, and time period
11.18 covered by the payment.

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

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

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

11.24 Subd. 2. **Persons who cannot be authorized.** (a) A person who meets any of the
11.25 conditions under paragraphs (b) to (n) must not be authorized as a legal nonlicensed
11.26 family child care provider. To determine whether any of the listed conditions exist,
11.27 the county must request information about the provider from the Bureau of Criminal
11.28 Apprehension, the juvenile courts, and social service agencies. When one of the listed
11.29 entities does not maintain information on a statewide basis, the county must contact the
11.30 entity in the county where the provider resides and any other county in which the provider
11.31 previously resided in the past year. For purposes of this subdivision, a finding that a
11.32 delinquency petition is proven in juvenile court must be considered a conviction in state
11.33 district court. If a county has determined that a provider is able to be authorized in that
11.34 county, and a family in another county later selects that provider, the provider is able to

12.1 be authorized in the second county without undergoing a new background investigation
12.2 unless one of the following conditions exists:

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

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

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

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

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

12.23 (c) Less than 15 years have passed since the discharge of the sentence imposed for
12.24 the offense and the person has received a felony conviction for one of the following
12.25 offenses, or the person has admitted to committing or a preponderance of the evidence
12.26 indicates that the person has committed an act that meets the definition of a felony
12.27 conviction for one of the following offenses: sections 609.20 to 609.205, manslaughter in
12.28 the first or second degree; 609.21, criminal vehicular homicide; 609.215, aiding suicide
12.29 or aiding attempted suicide; 609.221 to 609.2231, assault in the first, second, third, or
12.30 fourth degree; 609.224, repeat offenses of fifth degree assault; 609.228, great bodily
12.31 harm caused by distribution of drugs; 609.2325, criminal abuse of a vulnerable adult;
12.32 609.2335, financial exploitation of a vulnerable adult; 609.235, use of drugs to injure or
12.33 facilitate a crime; 609.24, simple robbery; 617.241, repeat offenses of obscene materials
12.34 and performances; 609.245, aggravated robbery; 609.25, kidnapping; 609.255, false
12.35 imprisonment; 609.2664 to 609.2665, manslaughter of an unborn child in the first or
12.36 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 degree; 609.378, neglect or endangerment of a child; 609.52, theft; 609.521, possession of shoplifting gear; 609.561 to 609.563, arson in the first, second, or third degree; 609.582, burglary in the first, second, third, or fourth degree; 609.625, aggravated forgery; 609.63, forgery; 609.631, check forgery, offering a forged check; 609.635, obtaining signature by false pretenses; 609.66, dangerous weapon; 609.665, setting a spring gun; 609.67, unlawfully owning, possessing, or operating a machine gun; 609.687, adulteration; 609.71, riot; 609.713, terrorist threats; 609.749, harassment, stalking; 260C.301, termination of parental rights; 152.021 to 152.022 and 152.0262, controlled substance crime in the first or second degree; 152.023, subdivision 1, clause (3) or (4), or 152.023, subdivision 2, clause (4), controlled substance crime in third degree; 152.024, subdivision 1, clause (2), (3), or (4), controlled substance crime in fourth degree; 617.23, repeat offenses of indecent exposure; 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.

(d) Less than ten years have passed since the discharge of the sentence imposed for the offense and the person has received a gross misdemeanor 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 gross misdemeanor conviction for one of the following offenses: sections 609.224, fifth degree assault; 609.2242 to 609.2243, domestic assault; 518B.01, subdivision 14, violation of an order for protection; 609.3451, fifth degree criminal sexual conduct; 609.746, repeat offenses of interference with privacy; 617.23, repeat offenses of indecent exposure; 617.241, obscene materials and performances; 617.243, indecent literature, distribution; 617.293, disseminating or displaying harmful material to minors; 609.71, riot; 609.66, dangerous weapons; 609.749, harassment, stalking; 609.224, subdivision 2, paragraph (c), fifth degree assault against a vulnerable adult by a caregiver; 609.23, mistreatment of persons confined; 609.231, mistreatment of residents or patients; 609.2325, criminal abuse of a vulnerable adult; 609.2335, financial exploitation of a vulnerable adult; 609.233, criminal neglect of a vulnerable adult; 609.234, failure to report maltreatment of a vulnerable adult; 609.72, subdivision 3, disorderly conduct against a vulnerable adult; 609.265, abduction; 609.378, neglect or endangerment of a child; 609.377, malicious punishment of a child; 609.324, subdivision 1a, other prohibited acts, minor engaged in prostitution; 609.33, disorderly house; 609.52, theft; 609.582, burglary in the first,

14.1 second, third, or fourth degree; 609.631, check forgery, offering a forged check; 609.275,
14.2 attempt to coerce; an attempt or conspiracy to commit any of these offenses as defined in
14.3 Minnesota Statutes; or an offense in any other state or country where the elements are
14.4 substantially similar to any of the offenses listed in this paragraph.

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

14.18 (f) The person has been identified by the child protection agency in the county where
14.19 the provider resides or a county where the provider has resided or by the statewide child
14.20 protection database as a person found by a preponderance of evidence under section
14.21 626.556 to be responsible for physical or sexual abuse of a child within the last seven years.

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

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

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

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

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

14.35 (l) The person has been convicted of the crime of theft by wrongfully obtaining
14.36 public assistance or has been found guilty of wrongfully obtaining public assistance by a

15.1 federal court, state court, or an administrative hearing determination or waiver, through a
15.2 disqualification consent agreement, as part of an approved diversion plan under section
15.3 401.065, or a court-ordered stay with probationary or other conditions.

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

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

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

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

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

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

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

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

15.32 (d) A rate which includes a special needs rate paid under subdivision 3 or under
15.33 a school readiness service agreement paid under section 95 may be in excess of the
15.34 maximum rate allowed under this subdivision.

(e) The department shall monitor the effect of this paragraph on provider rates. The 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:

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

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

19.6 (2) improving licensed child care facility programs;

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

19.11 (4) interim financing;

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

19.14 (6) emergency assistance for child care programs;

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

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

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

19.22 (1) licensed providers;

19.23 (2) providers in the process of being licensed;

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

19.25 (4) school-age care programs; or

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

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

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

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

19.31 Subd. 2. **Specific powers.** Subject to the provisions of section 241.021, subdivision
19.32 2, the commissioner of human services shall carry out the specific duties in paragraphs (a)
19.33 through (cc):

19.34 (a) Administer and supervise all forms of public assistance provided for by state law
19.35 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

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

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

21.8 (e) Assist and actively cooperate with other departments, agencies and institutions,
21.9 local, state, and federal, by performing services in conformity with the purposes of Laws
21.10 1939, chapter 431.

21.11 (f) Act as the agent of and cooperate with the federal government in matters of
21.12 mutual concern relative to and in conformity with the provisions of Laws 1939, chapter
21.13 431, including the administration of any federal funds granted to the state to aid in the
21.14 performance of any functions of the commissioner as specified in Laws 1939, chapter 431,
21.15 and including the promulgation of rules making uniformly available medical care benefits
21.16 to all recipients of public assistance, at such times as the federal government increases its
21.17 participation in assistance expenditures for medical care to recipients of public assistance,
21.18 the cost thereof to be borne in the same proportion as are grants of aid to said recipients.

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

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

21.35 (i) Act as coordinating referral and informational center on requests for service for
21.36 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. Minnesota Statutes 2006, section 256.9862, subdivision 2, is amended to read:

Subd. 2. **Transaction fee.** The commissioner ~~may~~ must charge transaction fees in accordance with this subdivision ~~up to a maximum of \$10 in transaction fees per cardholder per month. In a given month, the first four cash withdrawals made by an individual cardholder are free. For subsequent cash withdrawals, \$1 may be charged. No transaction fee can be charged if the card is used to purchase goods or services on a point of sale basis to cardholders.~~ A transaction fee subsequently set by the federal government may supersede a fee established under this subdivision. The fees shall be appropriated to the commissioner and used for electronic benefit purposes.

Sec. 25. **[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. 26. **[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:

- 34.1 (1) being available 24 hours a day, seven days a week;
- 34.2 (2) providing services for children up to 72 hours at any one time;
- 34.3 (3) providing short-term case management to bridge the gap between crisis and
34.4 successful living;
- 34.5 (4) making referrals for parents to counseling services and other community
34.6 resources to help alleviate the underlying cause of the precipitating stress or crisis;
- 34.7 (5) providing services without a fee for a maximum of 30 days in any year;
- 34.8 (6) providing services to families with children from birth through 12 years of age,
34.9 as services are available;
- 34.10 (7) providing an immediate response to family needs and strengths with an initial
34.11 assessment and intake interview, making referrals to appropriate agencies or programs,
34.12 and providing temporary care of children, as needed;
- 34.13 (8) maintaining the clients' confidentiality to the extent required by law, and also
34.14 complying with statutory reporting requirements which may mandate a report to child
34.15 protective services;
- 34.16 (9) providing a volunteer component and support for volunteers;
- 34.17 (10) providing preservice training and ongoing training to providers and volunteers;
- 34.18 (11) evaluating the services provided by documenting use of services, the result of
34.19 family referrals made to community resources, and how the services reduced the risk of
34.20 maltreatment;
- 34.21 (12) providing developmental assessments;
- 34.22 (13) providing medical assessments as determined by using a risk screening tool;
- 34.23 (14) providing parent education classes or programs that include parent-child
34.24 interaction either on site or in collaboration with other community agencies; and
- 34.25 (15) having a multidisciplinary advisory board which may include one or more
34.26 parents who have used the crisis nursery services.
- 34.27 (b) The crisis nurseries are encouraged to provide opportunities for parents to
34.28 volunteer, if appropriate.
- 34.29 (c) Parents shall retain custody of their children during placement in a crisis facility.
- 34.30 Subd. 2. **Fund distribution.** In distributing funds, the commissioner shall give
34.31 priority consideration to agencies and organizations with experience in working with
34.32 abused or neglected children and their families, and with children at high risk of abuse and
34.33 neglect and their families, and serve communities which demonstrate the greatest need
34.34 for these services. Funds shall be distributed to crisis nurseries according to a formula
34.35 developed by the commissioner in consultation with the Minnesota Crisis Nursery
34.36 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. 27. 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. 28. 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. 29. 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. 30. 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. 31. 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

37.1 the payment month, who makes a written request for closure before the first of a payment
37.2 month and repays cash and food assistance electronically issued for that payment month
37.3 within that payment month, or who returns any uncashed assistance check and food
37.4 coupons and withdraws from the program.

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

37.6 Sec. 32. Minnesota Statutes 2006, section 256J.21, subdivision 2, is amended to read:

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

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

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

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

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

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

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

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

37.28 (ii) federal income tax refunds;

37.29 (8)(i) federal earned income credits;

37.30 (ii) Minnesota working family credits;

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

37.32 (iv) federal or state tax rebates;

37.33 (9) funds received for reimbursement, replacement, or rebate of personal or real
37.34 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;

(13) in-kind income, including any payments directly made by a third party to a provider of goods and services;

(14) assistance payments to correct underpayments, but only for the month in which the payment is received;

(15) payments for short-term emergency needs under section 256J.626, subdivision 2;

(16) funeral and cemetery payments as provided by section 256.935;

(17) nonrecurring cash gifts of \$30 or less, not exceeding \$30 per participant in a calendar month;

(18) any form of energy assistance payment made through Public Law 97-35, Low-Income Home Energy Assistance Act of 1981, payments made directly to energy providers by other public and private agencies, and any form of credit or rebate payment issued by energy providers;

(19) Supplemental Security Income (SSI), including retroactive SSI payments and other income of an SSI recipient, except as described in section 256J.37, subdivision 3b;

(20) Minnesota supplemental aid, including retroactive payments;

(21) proceeds from the sale of real or personal property;

(22) state adoption assistance payments under section 259.67, and up to an equal amount of county adoption assistance payments;

(23) state-funded family subsidy program payments made under section 252.32 to help families care for children with developmental disabilities, consumer support grant funds under section 256.476, and resources and services for a disabled household member under one of the home and community-based waiver services programs under chapter 256B;

(24) interest payments and dividends from property that is not excluded from and that does not exceed the asset limit;

(25) rent rebates;

- 39.1 (26) income earned by a minor caregiver, minor child through age 6, or a minor
39.2 child who is at least a half-time student in an approved elementary or secondary education
39.3 program;
- 39.4 (27) income earned by a caregiver under age 20 who is at least a half-time student in
39.5 an approved elementary or secondary education program;
- 39.6 (28) MFIP child care payments under section 119B.05;
- 39.7 (29) all other payments made through MFIP to support a caregiver's pursuit of
39.8 greater economic stability;
- 39.9 (30) income a participant receives related to shared living expenses;
- 39.10 (31) reverse mortgages;
- 39.11 (32) benefits provided by the Child Nutrition Act of 1966, United States Code, title
39.12 42, chapter 13A, sections 1771 to 1790;
- 39.13 (33) benefits provided by the women, infants, and children (WIC) nutrition program,
39.14 United States Code, title 42, chapter 13A, section 1786;
- 39.15 (34) benefits from the National School Lunch Act, United States Code, title 42,
39.16 chapter 13, sections 1751 to 1769e;
- 39.17 (35) relocation assistance for displaced persons under the Uniform Relocation
39.18 Assistance and Real Property Acquisition Policies Act of 1970, United States Code, title
39.19 42, chapter 61, subchapter II, section 4636, or the National Housing Act, United States
39.20 Code, title 12, chapter 13, sections 1701 to 1750jj;
- 39.21 (36) benefits from the Trade Act of 1974, United States Code, title 19, chapter
39.22 12, part 2, sections 2271 to 2322;
- 39.23 (37) war reparations payments to Japanese Americans and Aleuts under United
39.24 States Code, title 50, sections 1989 to 1989d;
- 39.25 (38) payments to veterans or their dependents as a result of legal settlements
39.26 regarding Agent Orange or other chemical exposure under Public Law 101-239, section
39.27 10405, paragraph (a)(2)(E);
- 39.28 (39) income that is otherwise specifically excluded from MFIP consideration in
39.29 federal law, state law, or federal regulation;
- 39.30 (40) security and utility deposit refunds;
- 39.31 (41) American Indian tribal land settlements excluded under Public Laws 98-123,
39.32 98-124, and 99-377 to the Mississippi Band Chippewa Indians of White Earth, Leech
39.33 Lake, and Mille Lacs reservations and payments to members of the White Earth Band,
39.34 under United States Code, title 25, chapter 9, section 331, and chapter 16, section 1407;

(42) all income of the minor parent's parents and stepparents when determining the grant for the minor parent in households that include a minor parent living with parents or stepparents on MFIP with other children;

(43) income of the minor parent's parents and stepparents equal to 200 percent of the federal poverty guideline for a family size not including the minor parent and the minor parent's child in households that include a minor parent living with parents or stepparents not on MFIP when determining the grant for the minor parent. The remainder of income is deemed as specified in section 256J.37, subdivision 1b;

(44) payments made to children eligible for relative custody assistance under section 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. 33. 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. 34. Minnesota Statutes 2006, section 256J.39, is amended by adding a subdivision to read:

Subd. 1a. **Prohibited purchases.** MFIP recipients are prohibited from using MFIP monthly cash assistance payments issued in the form of an electronic benefits transfer to purchase tobacco products or alcohol.

Sec. 35. 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.

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

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

Sec. 36. Minnesota Statutes 2006, section 256J.425, subdivision 3, is amended to read:

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

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

(2) a person who:

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

(ii) has an IQ below 80 who has been assessed by a vocational specialist or a county agency to be employable, but not at a level that makes the participant eligible for an extension under subdivision 4. The determination of IQ level must be made by a qualified professional. In the case of a non-English-speaking person: (A) the determination must be made by a qualified professional with experience conducting culturally appropriate assessments, whenever possible; (B) the county may accept reports that identify an

IQ range as opposed to a specific score; (C) these reports must include a statement of confidence in the results;

(3) a person who is determined by a qualified professional to be learning disabled, and the disability severely limits the person's ability to obtain, perform, or maintain suitable employment. For purposes of the initial approval of a learning disability extension, the determination must have been made or confirmed within the previous 12 months. In the case of a non-English-speaking person: (i) the determination must be made by a qualified professional with experience conducting culturally appropriate assessments, whenever possible; and (ii) these reports must include a statement of confidence in the results. If a rehabilitation plan for a participant extended as learning disabled is developed or approved by the county agency, the plan must be incorporated into the employment plan. However, a rehabilitation plan does not replace the requirement to develop and 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. 37. 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.~~

~~(c)~~ 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. 38. 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. 39. 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

45.1 unpaid work in return for cash assistance. The participant may terminate the unpaid
45.2 work arrangement, in writing, at any time;

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

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

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

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

45.15 (8) activities included in the employment plan that is developed under section
45.16 256J.521, subdivision 3; and

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

45.20 Sec. 40. Minnesota Statutes 2006, section 256J.521, subdivision 1, is amended to read:

45.21 Subdivision 1. **Assessments.** (a) For purposes of MFIP employment services,
45.22 assessment is a continuing process of gathering information related to employability
45.23 for the purpose of identifying both participant's strengths and strategies for coping with
45.24 issues that interfere with employment. The job counselor must use information from the
45.25 assessment process to develop and update the employment plan under subdivision 2 or 3,
45.26 as appropriate, ~~and~~ to determine whether the participant qualifies for a family violence
45.27 waiver including an employment plan under subdivision 3, and to determine whether the
45.28 participant should be referred to the family stabilization services program under section
45.29 256J.575.

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

45.31 (1) basic information about the participant's ability to obtain and retain employment,
45.32 including: a review of the participant's education level; interests, skills, and abilities; prior
45.33 employment or work experience; transferable work skills; child care and transportation
45.34 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. 41. 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.

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

Sec. 42. 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

49.1 plan must address issues interfering with employment, including physical and mental
49.2 health, substance use, and social service issues of the caregiver and the caregiver's family.
49.3 Job search and employment must also be included in the plan to the extent possible.

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

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

49.12 Sec. 43. Minnesota Statutes 2006, section 256J.53, subdivision 2, is amended to read:

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

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

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

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

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

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

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

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

49.31 ~~(d)~~ (b) Participants with an approved employment plan in place on July 1, 2003,
49.32 which includes more than 12 months of postsecondary education or training shall be
49.33 allowed to complete that plan provided that hourly requirements in section 256J.55,
49.34 subdivision 1, and conditions specified in paragraph ~~(b)~~ (a), and subdivisions 3 and 5 are
49.35 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. 44. 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. 45. **[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.

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

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

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

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

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

51.19 (1) obtaining and retaining unsubsidized employment;

51.20 (2) family stability;

51.21 (3) economic stability; and

51.22 (4) barrier reduction.

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

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

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

51.29 (1) a participant identified under section 256J.561, subdivision 2, paragraph (d), who
51.30 has or is eligible for an employment plan developed under section 256J.521, subdivision
51.31 2, paragraph (c);

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

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

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

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

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

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

52.10 (c) A participant under paragraph (a), clause (5), must be provided with English as a
52.11 second language opportunities and skills training for up to 12 months. After 12 months,
52.12 the case manager and participant must determine whether the participant should continue
52.13 with English as a second language classes or skills training, or both, or if the participant
52.14 should become an MFIP participant.

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

52.17 Subd. 5. **Case management; family stabilization plans; coordinated services.** (a)
52.18 The county agency shall provide family stabilization services to families through a case
52.19 management model. A case manager shall be assigned to each participating family within
52.20 30 days after the family begins to receive financial assistance as a participant of the family
52.21 stabilization services. The case manager, with the full involvement of the participant, shall
52.22 recommend, and the county agency shall establish and modify as necessary, a family
52.23 stabilization plan for each participating family. If a participant is already assigned to a
52.24 county case manager or a county-designated case manager in social services, disability
52.25 services, or housing services that case manager already assigned may be the case manager
52.26 for purposes of these services.

52.27 (b) The family stabilization plan must include:

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

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

52.33 (3) an identification of the services, supports, education, training, and
52.34 accommodations needed to reduce or overcome any barriers to enable the family to
52.35 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
- (6) the participant and case manager determine that the plan is no longer appropriate for any other reason.

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

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

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

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

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

Subd. 7. Sanctions. (a) The financial assistance grant of a participating family is reduced according to section 256J.46, if a participating adult fails without good cause to

54.1 comply or continue to comply with the family stabilization plan requirements in this
54.2 subdivision, unless compliance has been excused under subdivision 6, paragraph (e).

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

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

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

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

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

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

54.22 (4) explain the consequences of continuing noncompliance;

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

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

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

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

54.32 (e) After the requirements of paragraphs (c) and (d) are met and prior to imposition
54.33 of a sanction, the county agency shall provide a notice of intent to sanction under section
54.34 256J.57, subdivision 2, and, when applicable, a notice of adverse action under section
54.35 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. 46. 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. 47. 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. 48. 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. 49. 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 employment services with the city. Counties may collaborate to develop multicounty, multitribal, or regional service agreements.

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

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

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

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

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

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

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

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

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

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

Sec. 50. Minnesota Statutes 2006, section 256J.626, subdivision 5, is amended to read:

Subd. 5. **Innovation projects.** Beginning January 1, 2005, no more than \$3,000,000 of the funds annually appropriated to the commissioner for use in the consolidated fund shall be available to the commissioner for projects testing innovative approaches to improving outcomes for MFIP participants, family stabilization services program participants, and persons at risk of receiving MFIP as detailed in subdivision 3, and for providing incentives to counties and tribes that exceed performance. Projects shall be targeted to geographic areas with poor outcomes as specified in section 256J.751, subdivision 5, or to subgroups within the MFIP case load who are experiencing poor outcomes. For purposes of an incentive, a county or tribe exceeds performance if the county or tribe is above the top of the county's or tribe's annualized range of expected performance on the three-year self-support index under section 256J.751, subdivision 2, clause (7), and achieves a 50 percent TANF participation rate under section 256J.751, subdivision 2, clause (7), as averaged across the four quarterly measurements for the most recent year for which the measurements are available.

Sec. 51. Minnesota Statutes 2006, section 256J.626, subdivision 6, is amended to read:

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

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

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

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

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

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

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

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

(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. 52. 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. 53. 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. 54. 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. 55. 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. 56. 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. 57. 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. 58. 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. 59. 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. 60. 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. 61. 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 direct reimbursement is specified by the purchase of service agreement, and if the request for reimbursement is submitted by the local or tribal social services agency along with a verification that the service was provided.

Sec. 62. Minnesota Statutes 2006, section 259.75, subdivision 8, is amended to read:

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

- (a) the child is in an adoptive placement but is not legally adopted;
- (b) the child's foster parents or other individuals are now considering adoption;
- (c) diagnostic study or testing is required to clarify the child's problem and provide an adequate description; or
- (d) the child is currently in a hospital and continuing need for daily professional care will not permit placement in a family setting; ~~or,~~
- ~~(e) the child is 14 years of age or older and will not consent to an adoption plan.~~

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

Sec. 63. Minnesota Statutes 2006, section 260.012, is amended to read:

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

(a) Once a child alleged to be in need of protection or services is under the court's jurisdiction, the court shall ensure that reasonable efforts, including culturally appropriate services, by the social services agency are made to prevent placement or to eliminate the

68.1 need for removal and to reunite the child with the child's family at the earliest possible
68.2 time, and ~~when a child cannot be reunified with the parent or guardian from whom the~~
68.3 ~~child was removed~~, the court must ensure that the responsible social services agency
68.4 makes reasonable efforts to finalize an alternative permanent plan for the child as provided
68.5 in paragraph (e). In determining reasonable efforts to be made with respect to a child and
68.6 in making those reasonable efforts, the child's best interests, health, and safety must be of
68.7 paramount concern. Reasonable efforts to prevent placement and for rehabilitation and
68.8 reunification are always required except upon a determination by the court that a petition
68.9 has been filed stating a prima facie case that:

68.10 (1) the parent has subjected a child to egregious harm as defined in section
68.11 260C.007, subdivision 14;

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

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

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

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

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

68.26 (c) In the case of an Indian child, in proceedings under sections 260B.178 or
68.27 260C.178, 260C.201, and 260C.301 the juvenile court must make findings and conclusions
68.28 consistent with the Indian Child Welfare Act of 1978, United States Code, title 25, section
68.29 1901 et seq., as to the provision of active efforts. In cases governed by the Indian Child
68.30 Welfare Act of 1978, United States Code, title 25, section 1901, the responsible social
68.31 services agency must provide active efforts as required under United States Code, title
68.32 25, section 1911(d).

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

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

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

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

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

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

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

(4) when the child cannot return to the parent or guardian from whom the child was 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.

Sec. 64. Minnesota Statutes 2006, section 260.755, subdivision 12, is amended to read:

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

Sec. 65. Minnesota Statutes 2006, section 260.755, subdivision 20, is amended to read:

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

Sec. 66. Minnesota Statutes 2006, section 260.761, subdivision 7, is amended to read:

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

Sec. 67. Minnesota Statutes 2006, section 260.765, subdivision 5, is amended to read:

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

Sec. 68. Minnesota Statutes 2006, section 260.771, subdivision 1, is amended to read:

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

Sec. 69. 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. 70. **[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.

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

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

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

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

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

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

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

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

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

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

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

(d) "Timely interstate home study" means an interstate home study completed by a state if the state provides to the state that requested the study, within 30 days after receipt of the request, a report on the results of the study, except that there is no requirement for completion within the 30-day period of the parts of the home study involving the 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. 71. 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. 72. 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. 73. 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. 74. 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.

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

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

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

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

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

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

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

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

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

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

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

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

(i) the court may order a child into long-term foster care only if it approves the responsible social service 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) 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:

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

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

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

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

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

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

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

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

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

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

80.30 (v) if an adoption is not finalized by the identified prospective adoptive parent within
80.31 12 months of the execution of the consent to adopt under this clause, the commissioner of
80.32 human services or the commissioner's delegate shall pursue adoptive placement in another
80.33 home unless the commissioner certifies that the failure to finalize is not due to either an
80.34 action or a failure to act by the prospective adoptive parent;

80.35 (vi) notwithstanding item (v), the commissioner of human services or the
80.36 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 relatives and the child and other important persons with whom the child has resided or had significant contact. When the court has determined that permanent placement of the child away from the parent is necessary, the court shall consider permanent alternative homes that are available both inside and outside the state.

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

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

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

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

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

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

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

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

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

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

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

82.7 (h) In the event it is necessary for a child that has been ordered into foster care for a
82.8 specified period of time to be in foster care longer than one year after the permanency
82.9 hearing held under this section, not later than 12 months after the time the child was
82.10 ordered into foster care for a specified period of time, the matter must be returned to
82.11 court for a review of the appropriateness of continuing the child in foster care and of the
82.12 responsible social services agency's reasonable efforts to finalize a permanent plan for
82.13 the child; if it is in the child's best interests to continue the order for foster care for a
82.14 specified period of time past a total of 12 months, the court shall set objectives for the
82.15 child's continuation in foster care, specify any further amount of time the child may be in
82.16 foster care, and review the plan for the safe return of the child to the parent.

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

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

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

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

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

82.27 (j) An order for permanent legal and physical custody of a child may be modified
82.28 under sections 518.18 and 518.185. The social services agency is a party to the proceeding
82.29 and must receive notice. A parent may only seek modification of an order for long-term
82.30 foster care upon motion and a showing by the parent of a substantial change in the parent's
82.31 circumstances such that the parent could provide appropriate care for the child and that
82.32 removal of the child from the child's permanent placement and the return to the parent's
82.33 care would be in the best interest of the child. The responsible social services agency may
82.34 ask the court to vacate an order for long-term foster care upon a prima facie showing
82.35 that there is a factual basis for the court to order another permanency option under this
82.36 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.

(l) 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. 75. 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.

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

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

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

84.14 (2) ordered by the court, either as presented or modified after hearing, under section
84.15 260C.178, subdivision 7, or 260C.201, subdivision 6; and

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

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

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

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

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

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

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

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

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

(6) documentation of steps to finalize the adoption or legal guardianship of the child 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. 76. 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. 77. 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.

~~(e)~~ (d) Whenever a petition for review is brought pursuant to this subdivision, a guardian ad litem shall be appointed for the child.

Sec. 78. 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.

91.1 Sec. 79. Minnesota Statutes 2006, section 260C.331, subdivision 1, is amended to read:

91.2 Subdivision 1. **Care, examination, or treatment.** (a) Except where parental rights
91.3 are terminated,

91.4 (1) whenever legal custody of a child is transferred by the court to a responsible
91.5 social services agency,

91.6 (2) whenever legal custody is transferred to a person other than the responsible social
91.7 services agency, but under the supervision of the responsible social services agency, or

91.8 (3) whenever a child is given physical or mental examinations or treatment under
91.9 order of the court, and no provision is otherwise made by law for payment for the care,
91.10 examination, or treatment of the child, these costs are a charge upon the welfare funds of
91.11 the county in which proceedings are held upon certification of the judge of juvenile court.

91.12 (b) The court shall order, and the responsible social services agency shall require,
91.13 the parents or custodian of a child, while the child is under the age of 18, to use the
91.14 total income and resources attributable to the child for the period of care, examination,
91.15 or treatment, except for clothing and personal needs allowance as provided in section
91.16 256B.35, to reimburse the county for the cost of care, examination, or treatment. Income
91.17 and resources attributable to the child include, but are not limited to, Social Security
91.18 benefits, supplemental security income (SSI), veterans benefits, railroad retirement
91.19 benefits and child support. When the child is over the age of 18, and continues to receive
91.20 care, examination, or treatment, the court shall order, and the responsible social services
91.21 agency shall require, reimbursement from the child for the cost of care, examination, or
91.22 treatment from the income and resources attributable to the child less the clothing and
91.23 personal needs allowance. Income does not include earnings from a child over the age of
91.24 18 who is working as part of a plan under section 260C.212, subdivision 1, paragraph (c),
91.25 clause (8), to transition from foster care.

91.26 (c) If the income and resources attributable to the child are not enough to reimburse
91.27 the county for the full cost of the care, examination, or treatment, the court shall inquire
91.28 into the ability of the parents to support the child and, after giving the parents a reasonable
91.29 opportunity to be heard, the court shall order, and the responsible social services agency
91.30 shall require, the parents to contribute to the cost of care, examination, or treatment of
91.31 the child. When determining the amount to be contributed by the parents, the court shall
91.32 use a fee schedule based upon ability to pay that is established by the responsible social
91.33 services agency and approved by the commissioner of human services. The income of
91.34 a stepparent who has not adopted a child shall be excluded in calculating the parental
91.35 contribution under this section.

92.1 (d) The court shall order the amount of reimbursement attributable to the parents
92.2 or custodian, or attributable to the child, or attributable to both sources, withheld under
92.3 chapter 518A from the income of the parents or the custodian of the child. A parent or
92.4 custodian who fails to pay without good reason may be proceeded against for contempt, or
92.5 the court may inform the county attorney, who shall proceed to collect the unpaid sums,
92.6 or both procedures may be used.

92.7 (e) If the court orders a physical or mental examination for a child, the examination
92.8 is a medically necessary service for purposes of determining whether the service is
92.9 covered by a health insurance policy, health maintenance contract, or other health
92.10 coverage plan. Court-ordered treatment shall be subject to policy, contract, or plan
92.11 requirements for medical necessity. Nothing in this paragraph changes or eliminates
92.12 benefit limits, conditions of coverage, co-payments or deductibles, provider restrictions,
92.13 or other requirements in the policy, contract, or plan that relate to coverage of other
92.14 medically necessary services.

92.15 Sec. 80. Minnesota Statutes 2006, section 270B.14, subdivision 1, is amended to read:

92.16 Subdivision 1. **Disclosure to commissioner of human services.** (a) On the request
92.17 of the commissioner of human services, the commissioner shall disclose return information
92.18 regarding taxes imposed by chapter 290, and claims for refunds under chapter 290A, to
92.19 the extent provided in paragraph (b) and for the purposes set forth in paragraph (c).

92.20 (b) Data that may be disclosed are limited to data relating to the identity,
92.21 whereabouts, employment, income, and property of a person owing or alleged to be owing
92.22 an obligation of child support.

92.23 (c) The commissioner of human services may request data only for the purposes of
92.24 carrying out the child support enforcement program and to assist in the location of parents
92.25 who have, or appear to have, deserted their children. Data received may be used only
92.26 as set forth in section 256.978.

92.27 (d) The commissioner shall provide the records and information necessary to
92.28 administer the supplemental housing allowance to the commissioner of human services.

92.29 (e) At the request of the commissioner of human services, the commissioner of
92.30 revenue shall electronically match the Social Security numbers and names of participants
92.31 in the telephone assistance plan operated under sections 237.69 to 237.711, with those of
92.32 property tax refund filers, and determine whether each participant's household income is
92.33 within the eligibility standards for the telephone assistance plan.

92.34 (f) The commissioner may provide records and information collected under sections
92.35 295.50 to 295.59 to the commissioner of human services for purposes of the Medicaid

93.1 Voluntary Contribution and Provider-Specific Tax Amendments of 1991, Public Law
93.2 102-234. Upon the written agreement by the United States Department of Health and
93.3 Human Services to maintain the confidentiality of the data, the commissioner may provide
93.4 records and information collected under sections 295.50 to 295.59 to the Centers for
93.5 Medicare and Medicaid Services section of the United States Department of Health and
93.6 Human Services for purposes of meeting federal reporting requirements.

93.7 (g) The commissioner may provide records and information to the commissioner of
93.8 human services as necessary to administer the early refund of refundable tax credits.

93.9 (h) The commissioner may disclose information to the commissioner of human
93.10 services necessary to verify income for eligibility and premium payment under the
93.11 MinnesotaCare program, under section 256L.05, subdivision 2.

93.12 (i) The commissioner may disclose information to the commissioner of human
93.13 services necessary to verify whether applicants or recipients for the Minnesota family
93.14 investment program, general assistance, food support, ~~and~~ Minnesota supplemental aid
93.15 program, and child care assistance have claimed refundable tax credits under chapter 290
93.16 and the property tax refund under chapter 290A, and the amounts of the credits.

93.17 Sec. 81. Minnesota Statutes 2006, section 626.556, subdivision 2, is amended to read:

93.18 Subd. 2. **Definitions.** As used in this section, the following terms have the meanings
93.19 given them unless the specific content indicates otherwise:

93.20 (a) "Family assessment" means a comprehensive assessment of child safety, risk
93.21 of subsequent child maltreatment, and family strengths and needs that is applied to a
93.22 child maltreatment report that does not allege substantial child endangerment. Family
93.23 assessment does not include a determination as to whether child maltreatment occurred
93.24 but does determine the need for services to address the safety of family members and the
93.25 risk of subsequent maltreatment.

93.26 (b) "Investigation" means fact gathering related to the current safety of a child
93.27 and the risk of subsequent maltreatment that determines whether child maltreatment
93.28 occurred and whether child protective services are needed. An investigation must be used
93.29 when reports involve substantial child endangerment, and for reports of maltreatment in
93.30 facilities required to be licensed under chapter 245A or 245B; under sections 144.50 to
93.31 144.58 and 241.021; in a school as defined in sections 120A.05, subdivisions 9, 11, and
93.32 13, and 124D.10; or in a nonlicensed personal care provider association as defined in
93.33 sections 256B.04, subdivision 16, and 256B.0625, subdivision 19a.

93.34 (c) "Substantial child endangerment" means a person responsible for a child's care,
93.35 and in the case of sexual abuse includes a person who has a significant relationship to the

child as defined in section 609.341, or a person in a position of authority as defined in section 609.341, who by act or omission commits or attempts to commit an act against a child under their care that constitutes any of the following:

- (1) egregious harm as defined in section 260C.007, subdivision 14;
- (2) sexual abuse as defined in paragraph (d);
- (3) abandonment under section 260C.301, subdivision 2;
- (4) neglect as defined in paragraph (f), clause (2), that substantially endangers the child's physical or mental health, including a growth delay, which may be referred to as failure to thrive, that has been diagnosed by a physician and is due to parental neglect;
- (5) murder in the first, second, or third degree under section 609.185, 609.19, or 609.195;
- (6) manslaughter in the first or second degree under section 609.20 or 609.205;
- (7) assault in the first, second, or third degree under section 609.221, 609.222, or 609.223;
- (8) solicitation, inducement, and promotion of prostitution under section 609.322;
- (9) criminal sexual conduct under sections 609.342 to 609.3451;
- (10) solicitation of children to engage in sexual conduct under section 609.352;
- (11) malicious punishment or neglect or endangerment of a child under section 609.377 or 609.378;
- (12) use of a minor in sexual performance under section 617.246; or
- (13) parental behavior, status, or condition which mandates that the county attorney file a termination of parental rights petition under section 260C.301, subdivision 3, paragraph (a).

(d) "Sexual abuse" means the subjection of a child by a person responsible for the child's care, by a person who has a significant relationship to the child, as defined in section 609.341, or by a person in a position of authority, as defined in section 609.341, subdivision 10, to any act which constitutes a violation of section 609.342 (criminal sexual conduct in the first degree), 609.343 (criminal sexual conduct in the second degree), 609.344 (criminal sexual conduct in the third degree), 609.345 (criminal sexual conduct in the fourth degree), or 609.3451 (criminal sexual conduct in the fifth degree). Sexual abuse also includes any act which involves a minor which constitutes a violation of prostitution offenses under sections 609.321 to 609.324 or 617.246. Sexual abuse includes threatened sexual abuse.

(e) "Person responsible for the child's care" means (1) an individual functioning within the family unit and having responsibilities for the care of the child such as a parent, guardian, or other person having similar care responsibilities, or (2) an individual

95.1 functioning outside the family unit and having responsibilities for the care of the child
95.2 such as a teacher, school administrator, other school employees or agents, or other lawful
95.3 custodian of a child having either full-time or short-term care responsibilities including,
95.4 but not limited to, day care, babysitting whether paid or unpaid, counseling, teaching,
95.5 and coaching.

95.6 (f) "Neglect" means:

95.7 (1) failure by a person responsible for a child's care to supply a child with necessary
95.8 food, clothing, shelter, health, medical, or other care required for the child's physical or
95.9 mental health when reasonably able to do so;

95.10 (2) failure to protect a child from conditions or actions that seriously endanger the
95.11 child's physical or mental health when reasonably able to do so, including a growth delay,
95.12 which may be referred to as a failure to thrive, that has been diagnosed by a physician and
95.13 is due to parental neglect;

95.14 (3) failure to provide for necessary supervision or child care arrangements
95.15 appropriate for a child after considering factors as the child's age, mental ability, physical
95.16 condition, length of absence, or environment, when the child is unable to care for the
95.17 child's own basic needs or safety, or the basic needs or safety of another child in their care;

95.18 (4) failure to ensure that the child is educated as defined in sections 120A.22 and
95.19 260C.163, subdivision 11, which does not include a parent's refusal to provide the parent's
95.20 child with sympathomimetic medications, consistent with section 125A.091, subdivision 5;

95.21 (5) nothing in this section shall be construed to mean that a child is neglected solely
95.22 because the child's parent, guardian, or other person responsible for the child's care in
95.23 good faith selects and depends upon spiritual means or prayer for treatment or care of
95.24 disease or remedial care of the child in lieu of medical care; except that a parent, guardian,
95.25 or caretaker, or a person mandated to report pursuant to subdivision 3, has a duty to report
95.26 if a lack of medical care may cause serious danger to the child's health. This section does
95.27 not impose upon persons, not otherwise legally responsible for providing a child with
95.28 necessary food, clothing, shelter, education, or medical care, a duty to provide that care;

95.29 (6) prenatal exposure to a controlled substance, as defined in section 253B.02,
95.30 subdivision 2, used by the mother for a nonmedical purpose, as evidenced by withdrawal
95.31 symptoms in the child at birth, results of a toxicology test performed on the mother at
95.32 delivery or the child at birth, or medical effects or developmental delays during the child's
95.33 first year of life that medically indicate prenatal exposure to a controlled substance;

95.34 (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;

(2) striking a child with a closed fist;

(3) shaking a child under age three;

(4) striking or other actions which result in any nonaccidental injury to a child under 18 months of age;

(5) unreasonable interference with a child's breathing;

(6) threatening a child with a weapon, as defined in section 609.02, subdivision 6;

(7) striking a child under age one on the face or head;

(8) purposely giving a child poison, alcohol, or dangerous, harmful, or controlled substances which were not prescribed for the child by a practitioner, in order to control or punish the child; or other substances that substantially affect the child's behavior, motor coordination, or judgment or that results in sickness or internal injury, or subjects the child to medical procedures that would be unnecessary if the child were not exposed to the substances;

(9) unreasonable physical confinement or restraint not permitted under section 609.379, including but not limited to tying, caging, or chaining; or

(10) in a school facility or school zone, an act by a person responsible for the child's care that is a violation under section 121A.58.

97.1 (h) "Report" means any report received by the local welfare agency, police
97.2 department, county sheriff, or agency responsible for assessing or investigating
97.3 maltreatment pursuant to this section.

97.4 (i) "Facility" means:

97.5 (1) a licensed or unlicensed day care facility, residential facility, agency, hospital,
97.6 sanitarium, or other facility or institution required to be licensed under sections 144.50 to
97.7 144.58, 241.021, or 245A.01 to 245A.16, or chapter 245B;

97.8 (2) a school as defined in sections 120A.05, subdivisions 9, 11, and 13; and
97.9 124D.10; or

97.10 (3) a nonlicensed personal care provider organization as defined in sections 256B.04,
97.11 subdivision 16, and 256B.0625, subdivision 19a.

97.12 (j) "Operator" means an operator or agency as defined in section 245A.02.

97.13 (k) "Commissioner" means the commissioner of human services.

97.14 (l) "Practice of social services," for the purposes of subdivision 3, includes but is
97.15 not limited to employee assistance counseling and the provision of guardian ad litem and
97.16 parenting time expeditor services.

97.17 (m) "Mental injury" means an injury to the psychological capacity or emotional
97.18 stability of a child as evidenced by an observable or substantial impairment in the child's
97.19 ability to function within a normal range of performance and behavior with due regard to
97.20 the child's culture.

97.21 (n) "Threatened injury" means a statement, overt act, condition, or status that
97.22 represents a substantial risk of physical or sexual abuse or mental injury. Threatened
97.23 injury includes, but is not limited to, exposing a child to a person responsible for the
97.24 child's care, as defined in paragraph (e), clause (1), who has:

97.25 (1) subjected a child to, or failed to protect a child from, an overt act or condition
97.26 that constitutes egregious harm, as defined in section 260C.007, subdivision 14, or a
97.27 similar law of another jurisdiction;

97.28 (2) been found to be palpably unfit under section 260C.301, paragraph (b), clause
97.29 (4), or a similar law of another jurisdiction;

97.30 (3) committed an act that has resulted in an involuntary termination of parental rights
97.31 under section 260C.301, or a similar law of another jurisdiction; or

97.32 (4) committed an act that has resulted in the involuntary transfer of permanent legal
97.33 and physical custody of a child to a relative under section 260C.201, subdivision 11,
97.34 paragraph (d), clause (1), or a similar law of another jurisdiction.

97.35 (o) Persons who conduct assessments or investigations under this section shall take
97.36 into account accepted child-rearing practices of the culture in which a child participates

98.1 and accepted teacher discipline practices, which are not injurious to the child's health,
98.2 welfare, and safety.

98.3 Sec. 82. Minnesota Statutes 2006, section 626.556, subdivision 3, is amended to read:

98.4 Subd. 3. **Persons mandated to report.** (a) A person who knows or has reason
98.5 to believe a child is being neglected or physically or sexually abused, as defined in
98.6 subdivision 2, or has been neglected or physically or sexually abused within the preceding
98.7 three years, shall immediately report the information to the local welfare agency, agency
98.8 responsible for assessing or investigating the report, police department, or the county
98.9 sheriff if the person is:

98.10 (1) a professional or professional's delegate who is engaged in the practice of
98.11 the healing arts, social services, hospital administration, psychological or psychiatric
98.12 treatment, child care, education, correctional supervision, probation and correctional
98.13 services, or law enforcement; or

98.14 (2) employed as a member of the clergy and received the information while
98.15 engaged in ministerial duties, provided that a member of the clergy is not required by
98.16 this subdivision to report information that is otherwise privileged under section 595.02,
98.17 subdivision 1, paragraph (c).

98.18 The police department or the county sheriff, upon receiving a report, shall
98.19 immediately notify the local welfare agency or agency responsible for assessing or
98.20 investigating the report, orally and in writing. The local welfare agency, or agency
98.21 responsible for assessing or investigating the report, upon receiving a report, shall
98.22 immediately notify the local police department or the county sheriff orally and in writing.
98.23 The county sheriff and the head of every local welfare agency, agency responsible
98.24 for assessing or investigating reports, and police department shall each designate a
98.25 person within their agency, department, or office who is responsible for ensuring that
98.26 the notification duties of this paragraph and paragraph (b) are carried out. Nothing in
98.27 this subdivision shall be construed to require more than one report from any institution,
98.28 facility, school, or agency.

98.29 (b) Any person may voluntarily report to the local welfare agency, agency
98.30 responsible for assessing or investigating the report, police department, or the county
98.31 sheriff if the person knows, has reason to believe, or suspects a child is being or has been
98.32 neglected or subjected to physical or sexual abuse. The police department or the county
98.33 sheriff, upon receiving a report, shall immediately notify the local welfare agency or
98.34 agency responsible for assessing or investigating the report, orally and in writing. The
98.35 local welfare agency or agency responsible for assessing or investigating the report, upon

receiving a report, shall immediately notify the local police department or the county sheriff orally and in writing.

(c) A person mandated to report physical or sexual child abuse or neglect occurring within a licensed facility shall report the information to the agency responsible for licensing the facility under sections 144.50 to 144.58; 241.021; 245A.01 to 245A.16; or chapter 245B; or a nonlicensed personal care provider organization as defined in sections 256B.04, subdivision 16; and 256B.0625, subdivision 19. A health or corrections agency receiving a report may request the local welfare agency to provide assistance pursuant to subdivisions 10, 10a, and 10b. A board or other entity whose licensees perform work within a school facility, upon receiving a complaint of alleged maltreatment, shall provide information about the circumstances of the alleged maltreatment to the commissioner of education. Section 13.03, subdivision 4, applies to data received by the commissioner of education from a licensing entity.

(d) Any person mandated to report shall receive a summary of the disposition of any report made by that reporter, including whether the case has been opened for child protection or other services, or if a referral has been made to a community organization, unless release would be detrimental to the best interests of the child. Any person who is not mandated to report shall, upon request to the local welfare agency, receive a concise summary of the disposition of any report made by that reporter, unless release would be detrimental to the best interests of the child.

(e) For purposes of this ~~subdivision~~ section, "immediately" means as soon as possible but in no event longer than 24 hours.

Sec. 83. Minnesota Statutes 2006, section 626.556, is amended by adding a subdivision to read:

Subd. 3e. **Agency responsibility for assessing or investigating reports of sexual abuse.** The local welfare agency is the agency responsible for investigating allegations of sexual abuse if the alleged offender is the parent, guardian, sibling, or an individual functioning within the family unit as a person responsible for the child's care, or a person with a significant relationship to the child if that person resides in the child's household.

Sec. 84. Minnesota Statutes 2006, section 626.556, is amended by adding a subdivision to read:

Subd. 3f. **Law enforcement agency responsibility for investigating maltreatment.** The local law enforcement agency has responsibility for investigating any report of child maltreatment if a violation of a criminal statute is alleged. Law enforcement

100.1 and the responsible agency must coordinate their investigations or assessments as required
100.2 under subdivision 10.

100.3 Sec. 85. Minnesota Statutes 2006, section 626.556, subdivision 10, is amended to read:

100.4 Subd. 10. **Duties of local welfare agency and local law enforcement agency upon**
100.5 **receipt of a report.** (a) Upon receipt of a report, the local welfare agency shall determine
100.6 whether to conduct a family assessment or an investigation as appropriate to prevent or
100.7 provide a remedy for child maltreatment. The local welfare agency:

100.8 (1) shall conduct an investigation on reports involving substantial child
100.9 endangerment;

100.10 (2) shall begin an immediate investigation if, at any time when it is using a family
100.11 assessment response, it determines that there is reason to believe that substantial child
100.12 endangerment or a serious threat to the child's safety exists;

100.13 (3) may conduct a family assessment for reports that do not allege substantial child
100.14 endangerment. In determining that a family assessment is appropriate, the local welfare
100.15 agency may consider issues of child safety, parental cooperation, and the need for an
100.16 immediate response; and

100.17 (4) may conduct a family assessment on a report that was initially screened and
100.18 assigned for an investigation. In determining that a complete investigation is not required,
100.19 the local welfare agency must document the reason for terminating the investigation and
100.20 notify the local law enforcement agency if the local law enforcement agency is conducting
100.21 a joint investigation.

100.22 If the report alleges neglect, physical abuse, or sexual abuse by a parent, guardian,
100.23 or individual functioning within the family unit as a person responsible for the child's
100.24 care, or sexual abuse by a person with a significant relationship to the child when that
100.25 person resides in the child's household or by a sibling, the local welfare agency shall
100.26 immediately conduct a family assessment or investigation as identified in clauses (1) to
100.27 (4). In conducting a family assessment or investigation, the local welfare agency shall
100.28 gather information on the existence of substance abuse and domestic violence and offer
100.29 services for purposes of preventing future child maltreatment, safeguarding and enhancing
100.30 the welfare of the abused or neglected minor, and supporting and preserving family
100.31 life whenever possible. If the report alleges a violation of a criminal statute involving
100.32 sexual abuse, physical abuse, or neglect or endangerment, under section 609.378, the
100.33 local law enforcement agency and local welfare agency shall coordinate the planning and
100.34 execution of their respective investigation and assessment efforts to avoid a duplication of
100.35 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

102.1 Minnesota Rules of Procedure for Juvenile Courts, the juvenile court may, after hearing on
102.2 an ex parte motion by the local welfare agency, order that, where reasonable cause exists,
102.3 the agency withhold notification of this interview from the parent, legal custodian, or
102.4 guardian. If the interview took place or is to take place on school property, the order shall
102.5 specify that school officials may not disclose to the parent, legal custodian, or guardian the
102.6 contents of the notification of intent to interview the child on school property, as provided
102.7 under this paragraph, and any other related information regarding the interview that may
102.8 be a part of the child's school record. A copy of the order shall be sent by the local welfare
102.9 or law enforcement agency to the appropriate school official.

102.10 (d) When the local welfare, local law enforcement agency, or the agency responsible
102.11 for assessing or investigating a report of maltreatment determines that an interview should
102.12 take place on school property, written notification of intent to interview the child on school
102.13 property must be received by school officials prior to the interview. The notification
102.14 shall include the name of the child to be interviewed, the purpose of the interview, and
102.15 a reference to the statutory authority to conduct an interview on school property. For
102.16 interviews conducted by the local welfare agency, the notification shall be signed by the
102.17 chair of the local social services agency or the chair's designee. The notification shall be
102.18 private data on individuals subject to the provisions of this paragraph. School officials
102.19 may not disclose to the parent, legal custodian, or guardian the contents of the notification
102.20 or any other related information regarding the interview until notified in writing by the
102.21 local welfare or law enforcement agency that the investigation or assessment has been
102.22 concluded, unless a school employee or agent is alleged to have maltreated the child.
102.23 Until that time, the local welfare or law enforcement agency or the agency responsible
102.24 for assessing or investigating a report of maltreatment shall be solely responsible for any
102.25 disclosures regarding the nature of the assessment or investigation.

102.26 Except where the alleged offender is believed to be a school official or employee,
102.27 the time and place, and manner of the interview on school premises shall be within the
102.28 discretion of school officials, but the local welfare or law enforcement agency shall have
102.29 the exclusive authority to determine who may attend the interview. The conditions as to
102.30 time, place, and manner of the interview set by the school officials shall be reasonable and
102.31 the interview shall be conducted not more than 24 hours after the receipt of the notification
102.32 unless another time is considered necessary by agreement between the school officials and
102.33 the local welfare or law enforcement agency. Where the school fails to comply with the
102.34 provisions of this paragraph, the juvenile court may order the school to comply. Every
102.35 effort must be made to reduce the disruption of the educational program of the child, other
102.36 students, or school staff when an interview is conducted on school premises.

103.1 (e) Where the alleged offender or a person responsible for the care of the alleged
103.2 victim or other minor prevents access to the victim or other minor by the local welfare
103.3 agency, the juvenile court may order the parents, legal custodian, or guardian to produce
103.4 the alleged victim or other minor for questioning by the local welfare agency or the local
103.5 law enforcement agency outside the presence of the alleged offender or any person
103.6 responsible for the child's care at reasonable places and times as specified by court order.

103.7 (f) Before making an order under paragraph (e), the court shall issue an order to
103.8 show cause, either upon its own motion or upon a verified petition, specifying the basis for
103.9 the requested interviews and fixing the time and place of the hearing. The order to show
103.10 cause shall be served personally and shall be heard in the same manner as provided in
103.11 other cases in the juvenile court. The court shall consider the need for appointment of a
103.12 guardian ad litem to protect the best interests of the child. If appointed, the guardian ad
103.13 litem shall be present at the hearing on the order to show cause.

103.14 (g) The commissioner of human services, the ombudsman for mental health and
103.15 developmental disabilities, the local welfare agencies responsible for investigating reports,
103.16 the commissioner of education, and the local law enforcement agencies have the right to
103.17 enter facilities as defined in subdivision 2 and to inspect and copy the facility's records,
103.18 including medical records, as part of the investigation. Notwithstanding the provisions of
103.19 chapter 13, they also have the right to inform the facility under investigation that they are
103.20 conducting an investigation, to disclose to the facility the names of the individuals under
103.21 investigation for abusing or neglecting a child, and to provide the facility with a copy of
103.22 the report and the investigative findings.

103.23 (h) The local welfare agency responsible for conducting a family assessment or
103.24 investigation shall collect available and relevant information to determine child safety,
103.25 risk of subsequent child maltreatment, and family strengths and needs and share not public
103.26 information with an Indian's tribal social services agency without violating any law of the
103.27 state that may otherwise impose duties of confidentiality on the local welfare agency in
103.28 order to implement the tribal state agreement. The local welfare agency or the agency
103.29 responsible for investigating the report shall collect available and relevant information
103.30 to ascertain whether maltreatment occurred and whether protective services are needed.
103.31 Information collected includes, when relevant, information with regard to the person
103.32 reporting the alleged maltreatment, including the nature of the reporter's relationship to the
103.33 child and to the alleged offender, and the basis of the reporter's knowledge for the report;
103.34 the child allegedly being maltreated; the alleged offender; the child's caretaker; and other
103.35 collateral sources having relevant information related to the alleged maltreatment. The
103.36 local welfare agency or the agency responsible for assessing or investigating the report

104.1 may make a determination of no maltreatment early in an assessment, and close the case
104.2 and retain immunity, if the collected information shows no basis for a full assessment or
104.3 investigation.

104.4 Information relevant to the assessment or investigation must be asked for, and
104.5 may include:

104.6 (1) the child's sex and age, prior reports of maltreatment, information relating
104.7 to developmental functioning, credibility of the child's statement, and whether the
104.8 information provided under this clause is consistent with other information collected
104.9 during the course of the assessment or investigation;

104.10 (2) the alleged offender's age, a record check for prior reports of maltreatment, and
104.11 criminal charges and convictions. The local welfare agency or the agency responsible for
104.12 assessing or investigating the report must provide the alleged offender with an opportunity
104.13 to make a statement. The alleged offender may submit supporting documentation relevant
104.14 to the assessment or investigation;

104.15 (3) collateral source information regarding the alleged maltreatment and care of the
104.16 child. Collateral information includes, when relevant: (i) a medical examination of the
104.17 child; (ii) prior medical records relating to the alleged maltreatment or the care of the
104.18 child maintained by any facility, clinic, or health care professional and an interview with
104.19 the treating professionals; and (iii) interviews with the child's caretakers, including the
104.20 child's parent, guardian, foster parent, child care provider, teachers, counselors, family
104.21 members, relatives, and other persons who may have knowledge regarding the alleged
104.22 maltreatment and the care of the child; and

104.23 (4) information on the existence of domestic abuse and violence in the home of
104.24 the child, and substance abuse.

104.25 Nothing in this paragraph precludes the local welfare agency, the local law
104.26 enforcement agency, or the agency responsible for assessing or investigating the report
104.27 from collecting other relevant information necessary to conduct the assessment or
104.28 investigation. Notwithstanding section 13.384 or 144.335, the local welfare agency has
104.29 access to medical data and records for purposes of clause (3). Notwithstanding the data's
104.30 classification in the possession of any other agency, data acquired by the local welfare
104.31 agency or the agency responsible for assessing or investigating the report during the course
104.32 of the assessment or investigation are private data on individuals and must be maintained
104.33 in accordance with subdivision 11. Data of the commissioner of education collected
104.34 or maintained during and for the purpose of an investigation of alleged maltreatment
104.35 in a school are governed by this section, notwithstanding the data's classification as
104.36 educational, licensing, or personnel data under chapter 13.

105.1 In conducting an assessment or investigation involving a school facility as defined
105.2 in subdivision 2, paragraph (i), the commissioner of education shall collect investigative
105.3 reports and data that are relevant to a report of maltreatment and are from local law
105.4 enforcement and the school facility.

105.5 (i) Upon receipt of a report, the local welfare agency shall conduct a face-to-face
105.6 contact with the child reported to be maltreated and with the child's primary caregiver
105.7 sufficient to complete a safety assessment and ensure the immediate safety of the child.
105.8 The face-to-face contact with the child and primary caregiver shall occur immediately
105.9 if substantial child endangerment is alleged and within five calendar days for all other
105.10 reports. If the alleged offender was not already interviewed as the primary caregiver, the
105.11 local welfare agency shall also conduct a face-to-face interview with the alleged offender
105.12 in the early stages of the assessment or investigation. At the initial contact, the local child
105.13 welfare agency or the agency responsible for assessing or investigating the report must
105.14 inform the alleged offender of the complaints or allegations made against the individual in
105.15 a manner consistent with laws protecting the rights of the person who made the report.
105.16 The interview with the alleged offender may be postponed if it would jeopardize an active
105.17 law enforcement investigation.

105.18 (j) When conducting an investigation, the local welfare agency shall use a question
105.19 and answer interviewing format with questioning as nondirective as possible to elicit
105.20 spontaneous responses. For investigations only, the following interviewing methods and
105.21 procedures must be used whenever possible when collecting information:

- 105.22 (1) audio recordings of all interviews with witnesses and collateral sources; and
105.23 (2) in cases of alleged sexual abuse, audio-video recordings of each interview with
105.24 the alleged victim and child witnesses.

105.25 (k) In conducting an assessment or investigation involving a school facility as
105.26 defined in subdivision 2, paragraph (i), the commissioner of education shall collect
105.27 available and relevant information and use the procedures in paragraphs (i), (k), and
105.28 subdivision 3d, except that the requirement for face-to-face observation of the child
105.29 and face-to-face interview of the alleged offender is to occur in the initial stages of the
105.30 assessment or investigation provided that the commissioner may also base the assessment
105.31 or investigation on investigative reports and data received from the school facility and
105.32 local law enforcement, to the extent those investigations satisfy the requirements of
105.33 paragraphs (i) and (k), and subdivision 3d.

105.34 Sec. 86. Minnesota Statutes 2006, section 626.556, subdivision 10a, is amended to
105.35 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.

Sec. 87. Minnesota Statutes 2006, section 626.556, subdivision 10c, is amended to read:

Subd. 10c. **Duties of local social service agency upon receipt of a report of medical neglect.** If the report alleges medical neglect as defined in section 260C.007, subdivision ~~4~~ 6, clause (5), the local welfare agency shall, in addition to its other duties under this section, immediately consult with designated hospital staff and with the parents of the infant to verify that appropriate nutrition, hydration, and medication are being provided; and shall immediately secure an independent medical review of the infant's medical charts and records and, if necessary, seek a court order for an independent medical examination of the infant. If the review or examination leads to a conclusion of medical neglect, the agency shall intervene on behalf of the infant by initiating legal proceedings under section 260C.141 and by filing an expedited motion to prevent the withholding of medically indicated treatment.

Sec. 88. Minnesota Statutes 2006, section 626.556, subdivision 10f, is amended to read:

Subd. 10f. **Notice of determinations.** Within ten working days of the conclusion of a family assessment, the local welfare agency shall notify the parent or guardian of the child of the need for services to address child safety concerns or significant risk of subsequent child maltreatment. The local welfare agency and the family may also jointly agree that family support and family preservation services are needed. Within ten working

107.1 days of the conclusion of an investigation, the local welfare agency or agency responsible
107.2 for assessing or investigating the report shall notify the parent or guardian of the child, the
107.3 person determined to be maltreating the child, and if applicable, the director of the facility,
107.4 of the determination and a summary of the specific reasons for the determination. The
107.5 notice must also include a certification that the information collection procedures under
107.6 subdivision 10, paragraphs (h), (i), and (j), were followed and a notice of the right of a
107.7 data subject to obtain access to other private data on the subject collected, created, or
107.8 maintained under this section. In addition, the notice shall include the length of time that
107.9 the records will be kept under subdivision 11c. The investigating agency shall notify the
107.10 parent or guardian of the child who is the subject of the report, and any person or facility
107.11 determined to have maltreated a child, of their appeal or review rights under this section
107.12 or section 256.022. The notice must also state that a finding of maltreatment may result
107.13 in denial of a license application or background study disqualification under chapter
107.14 245C related to employment or services that are licensed by the Department of Human
107.15 Services under chapter 245A, the Department of Health under chapter 144 or 144A, the
107.16 Department of Corrections under section 241.021, and from providing services related to
107.17 an unlicensed personal care provider organization under chapter 256B.

107.18 Sec. 89. **KINSHIP NAVIGATOR PROGRAM; DEMONSTRATION GRANT.**

107.19 (a) The commissioner of human services shall fund a two-year demonstration grant
107.20 to be transferred to a nonprofit organization experienced in kinship advocacy and policy
107.21 that has:

107.22 (1) experience working with grandparents and relatives who are raising kinship
107.23 children;

107.24 (2) an established statewide outreach network;

107.25 (3) established kinship support groups;

107.26 (4) an intergenerational approach to programming; and

107.27 (5) a board of directors consisting of 50 percent grandparents and relatives raising
107.28 kinship children.

107.29 (b) The purpose of the grant is to provide support to grandparents or relatives raising
107.30 kinship children. One site must be in the metropolitan area, and the other in the Bemidji
107.31 region. One-stop services may include, but are not limited to, legal services, education,
107.32 information, family activities, support groups, mental health access, advocacy, mentors,
107.33 and information related to foster care licensing. Funds may also be used for a media
107.34 campaign to inform kinship families about available information and services, support
107.35 sites, and other program development.

Sec. 90. **MFIP PILOT PROGRAM; WORKFORCE U.**

Subdivision 1. Establishment. A pilot program is established in Stearns and Benton Counties to expand the Workforce U program administered by the Stearns-Benton Employment and Training Council.

Subd. 2. Evaluation. The Workforce U pilot program must be evaluated by a research and evaluation organization with experience evaluating welfare programs. The evaluation must include information on the total number of persons served, percentage of participants exiting the program, percentage of former participants reentering the program, average wages of program participants, and recommendations to the legislature for possible statewide implementation of the program. The evaluation must be presented to the legislature by February 15, 2011.

Subd. 3. Expiration. The Workforce U pilot program expires on June 30, 2011.

Sec. 91. **LEECH LAKE YOUTH TREATMENT CENTER PROPOSAL.**

(a) The commissioner of human services shall provide a planning grant to address the unmet need for local, effective, culturally relevant alcohol and drug treatment for American Indian youth, and develop a plan for a family-based youth treatment center in the Leech Lake area. The planning grant must be provided to a volunteer board consisting of at least four members appointed by the commissioner, to include at least the following:

(1) two members of the Leech Lake Tribal Council or their designees;

(2) one member appointed by the Cass County Social Services administrator; and

(3) one member appointed by the Cass Lake-Bena Public School superintendent.

(b) The plan must include:

(1) an interest, feasibility, and suitability of location study;

(2) defining scope of programs and services to be offered;

(3) defining site use limitations and restrictions, including physical and capacity;

(4) defining facilities required for programs and services offered;

(5) identifying partners, partnership roles, and partner resources;

(6) developing proposed operating and maintenance budgets;

(7) identifying funding sources;

(8) developing a long-term funding plan; and

(9) developing a formal steering committee, structure, and bylaws.

(c) The plan is due to the legislative committees having jurisdiction over chemical health issues no later than September 2008 in order to provide the 12 months necessary to complete the plan.

109.1 Sec. 92. **MINNESOTA FOOD SUPPORT PROGRAM SIMPLIFIED**
109.2 **APPLICATION.**

109.3 The Department of Human Services shall create a simplified application for the
109.4 Minnesota food support program for persons over the age of 60 and persons with
109.5 disabilities. The application must be no longer than three pages in length.

109.6 **EFFECTIVE DATE.** This section is effective January 1, 2008.

109.7 Sec. 93. **INSPECTION OF LEGAL UNLICENSED CHILD CARE PROVIDERS.**

109.8 The commissioner of human services, in consultation with the commissioners of
109.9 health and education and the counties, shall develop and present recommendations to
109.10 the legislature in January 2008 in order for each legally unlicensed child care provider
109.11 receiving child care assistance funds to receive a onetime home visit to receive information
109.12 on health and safety, and school readiness.

109.13 Sec. 94. **COMMISSIONER OF HUMAN SERVICES DUTIES; EARLY**
109.14 **CHILDHOOD AND SCHOOL-AGE PROFESSIONAL DEVELOPMENT**
109.15 **TRAINING.**

109.16 Subdivision 1. Development and implementation of an early childhood and
109.17 school-age professional development system. (a) The commissioner of human services,
109.18 in cooperation with the commissioners of education and health, shall develop and phase-in
109.19 the implementation of a professional development system for practitioners serving
109.20 children in early childhood and school-age programs. The system shall provide training
109.21 options and supports for practitioners to voluntarily choose, as they complete or exceed
109.22 existing licensing requirements.

109.23 The system must, at a minimum, include the following features:

109.24 (1) a continuum of training content based on the early childhood and school-age
109.25 care practitioner core competencies that translates knowledge into improved practice to
109.26 support children's school success;

109.27 (2) training strategies that provide direct feedback about practice to practitioners
109.28 through ongoing consultation, mentoring, or coaching with special emphasis on early
109.29 literacy and early mathematics;

109.30 (3) an approval process for trainers;

109.31 (4) a professional development registry for early childhood and school-age care
109.32 practitioners that will provide tracking and recognition of practitioner training/career
109.33 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.

(d) Beginning July 1, 2007, as appropriations permit, the commissioner shall phase-in the professional development system.

Subd. 2. **Two-hour early childhood training.** By January 15, 2008, the commissioner of human services, with input from the Minnesota Licensed Family Child Care Association and the Minnesota Professional Development Council, shall identify trainings that qualify for the two-hour early childhood development training requirement for new child care practitioners under Minnesota Statutes, section 245A.14, subdivision 9a, paragraphs (a) and (b). For licensed family child care, the commissioner shall also seek the input of labor unions that serve licensed family child care providers, if the union has been recognized by a county to serve licensed family child care providers.

Sec. 95. **SCHOOL READINESS SERVICE AGREEMENTS.**

Subdivision 1. **Overview.** (a) Effective July 1, 2007, funds must be made available to allow the commissioner to pay higher rates to up to 50 child care providers who are deemed by the commissioner to meet the requirements of a school readiness service agreement (SRSA) provider and perform services that support school readiness for children and economic stability for parents.

(b) A provider may be paid a rate above that currently allowed under Minnesota Statutes, section 119B.13, if:

(1) the provider has entered into an SRSA with the commissioner;

- 111.1 (2) a family using that provider receives child care assistance under any provision in
111.2 Minnesota Statutes, chapter 119B, except Minnesota Statutes, section 119B.035;
111.3 (3) the family using that provider meets the criteria in this section; and
111.4 (4) funding is available under this section.
- 111.5 Subd. 2. **Provider eligibility.** (a) To be considered for an SRSA, a provider shall
111.6 apply to the commissioner. To be eligible to apply for an SRSA, a provider shall:
111.7 (1) be eligible for child care assistance payments under Minnesota Statutes, chapter
111.8 119B;
111.9 (2) have at least 25 percent of the children enrolled with the provider subsidized
111.10 through the child care assistance program;
111.11 (3) provide full-time, full-year child care services; and
111.12 (4) serve at least one child who is subsidized through the child care assistance
111.13 program and who is expected to enter kindergarten within the following 30 months.
111.14 (b) The commissioner may waive the 25 percent requirement in paragraph (a), clause
111.15 (2), if necessary to achieve geographic distribution of SRSA providers and diversity of
111.16 types of care provided by SRSA providers.
111.17 (c) An eligible provider who would like to enter into an SRSA with the commissioner
111.18 shall submit an SRSA application. To determine whether to enter into an SRSA with a
111.19 provider, the commissioner shall evaluate the following factors:
111.20 (1) the qualifications of the provider and the provider's staff;
111.21 (2) the provider's staff-child ratios;
111.22 (3) the provider's curriculum;
111.23 (4) the provider's current or planned parent education activities;
111.24 (5) the provider's current or planned social service and employment linkages;
111.25 (6) the provider's child development assessment plan;
111.26 (7) the geographic distribution needed for SRSA providers;
111.27 (8) the inclusion of a variety of child care delivery models; and
111.28 (9) other related factors determined by the commissioner.
- 111.29 Subd. 3. **Family and child eligibility.** (a) A family eligible to choose an SRSA
111.30 provider for their children shall:
111.31 (1) be eligible to receive child care assistance under any provision in Minnesota
111.32 Statutes, chapter 119B, except Minnesota Statutes, section 119B.035;
111.33 (2) be in an authorized activity for an average of at least 35 hours per week when
111.34 initial eligibility is determined; and
111.35 (3) include a child who has not yet entered kindergarten.

112.1 (b) A family who is determined to be eligible to choose an SRSA provider remains
112.2 eligible to be paid at a higher rate through the SRSA provider when the following
112.3 conditions exist:

112.4 (1) the child attends child care with the SRSA provider a minimum of 25 hours per
112.5 week, on average;

112.6 (2) the family has a child who has not yet entered kindergarten; and

112.7 (3) the family maintains eligibility under Minnesota Statutes, chapter 119B, except
112.8 Minnesota Statutes, section 119B.035.

112.9 (c) For the 12 months after initial eligibility has been determined, a decrease in
112.10 the family's authorized activities to an average of less than 35 hours per week does not
112.11 result in ineligibility for the SRSA rate.

112.12 (d) A family that moves between counties but continues to use the same SRSA
112.13 provider shall continue to receive SRSA funding for the increased payments.

112.14 Subd. 4. **Requirements of providers.** An SRSA must include assessment,
112.15 evaluation, and reporting requirements that promote the goals of improved school
112.16 readiness and movement toward appropriate child development milestones. A provider
112.17 who enters into an SRSA shall comply with the assessment, evaluation, and reporting
112.18 requirements in the SRSA.

112.19 Subd. 5. **Relationship to current law.** (a) The following provisions in Minnesota
112.20 Statutes, chapter 119B, must be waived or modified for families receiving services under
112.21 this section.

112.22 (b) Notwithstanding Minnesota Statutes, section 119B.13, subdivisions 1 and 1a,
112.23 maximum weekly rates under this section are 125 percent of the existing maximum
112.24 weekly rate for like-care. Providers eligible for a differential rate under Minnesota
112.25 Statutes, section 119B.13, subdivision 3a, remain eligible for the differential above the
112.26 rate identified in this section. Only care for children who have not yet entered kindergarten
112.27 may be paid at the maximum rate under this section. The provider's charge for service
112.28 provided through an SRSA may not exceed the rate that the provider charges a private-pay
112.29 family for like-care arrangements.

112.30 (c) A family or child care provider may not be assessed an overpayment for care
112.31 provided through an SRSA unless:

112.32 (1) there was an error in the amount of care authorized for the family; or

112.33 (2) the family or provider did not timely report a change as required under the law.

112.34 (d) Care provided through an SRSA is authorized on a weekly basis.

112.35 (e) Funds appropriated under this section to serve families eligible under Minnesota
112.36 Statutes, section 119B.03, are not allocated through the basic sliding fee formula under

113.1 Minnesota Statutes, section 119B.03. Funds appropriated under this section are used to
113.2 offset increased costs when payments are made under SRSA's.

113.3 (f) Notwithstanding Minnesota Statutes, section 119B.09, subdivision 6, the
113.4 maximum amount of child care assistance that may be authorized for a child receiving
113.5 care through an SRSA in a two-week period is 160 hours per child.

113.6 Subd. 6. **Establishment of service agreements.** (a) The commissioner shall
113.7 approve SRSA's for up to 50 providers that represent diverse parts of the state and a
113.8 variety of child care delivery models. Entering into a service agreement does not guarantee
113.9 that a provider will receive payment at a higher rate for families receiving child care
113.10 assistance. A family eligible under this section shall choose a provider participating in an
113.11 SRSA in order for a higher rate to be paid. Payments through SRSA's are also limited by
113.12 the availability of SRSA funds.

113.13 (b) Nothing in this section shall be construed to limit parent choice as defined in
113.14 Minnesota Statutes, section 119B.09, subdivision 5.

113.15 (c) The commissioner may allow for startup time for some providers if failing to
113.16 do so would limit geographic diversity of SRSA providers or a variety of child care
113.17 delivery models.

113.18 Sec. 96. **FAMILY, FRIEND, AND NEIGHBOR GRANT PROGRAM.**

113.19 Subdivision 1. **Establishment.** A family, friend, and neighbor (FFN) grant program
113.20 is established to promote children's early literacy, healthy development, and school
113.21 readiness, and to foster community partnerships to promote children's school readiness.
113.22 The commissioner shall attempt to ensure that grants are made in all areas of the state. The
113.23 commissioner of human services shall make grants available to fund: community-based
113.24 organizations, nonprofit organizations, and Indian tribes working with FFN caregivers
113.25 under subdivision 2, paragraph (a); and community-based partnerships to implement early
113.26 literacy programs under subdivision 2, paragraph (b).

113.27 Subd. 2. **Program components.** (a)(1) Grants that the commissioner awards under
113.28 this section must be used by community-based organizations, nonprofit organizations, and
113.29 Indian tribes working with FFN caregivers in local communities, cultural communities,
113.30 and Indian tribes to:

113.31 (i) provide training, support, and resources to FFN caregivers in order to improve
113.32 and promote children's health, safety, nutrition, and school readiness;

113.33 (ii) connect FFN caregivers and children's families with appropriate community
113.34 resources that support the families' health, mental health, economic, and developmental
113.35 needs;

114.1 (iii) connect FFN caregivers and children's families to early childhood screening
114.2 programs and facilitate referrals where appropriate;

114.3 (iv) provide FFN caregivers and children's families with information about early
114.4 learning guidelines from the Departments of Human Services and Education;

114.5 (v) provide FFN caregivers and children's families with information about becoming
114.6 a licensed family child care provider; and

114.7 (vi) provide FFN caregivers and children's families with information about early
114.8 learning allowances and enrollment opportunities in high quality community-based
114.9 child-care and preschool programs.

114.10 (2) Grants that the commissioner awards under this paragraph also may be used for:

114.11 (i) health and safety and early learning kits for FFN caregivers;

114.12 (ii) play-and-learn groups with FFN caregivers;

114.13 (iii) culturally appropriate early childhood training for FFN caregivers;

114.14 (iv) transportation for FFN caregivers and children's families to school readiness and
114.15 other early childhood training activities;

114.16 (v) other activities that promote school readiness;

114.17 (vi) data collection and evaluation;

114.18 (vii) staff outreach and outreach activities;

114.19 (viii) translation needs; or

114.20 (ix) administrative costs that equal up to 12 percent of the recipient's grant award.

114.21 (b) Grants that the commissioner awards under this section also must be used to fund
114.22 partnerships among Minnesota public and regional library systems, community-based
114.23 organizations, nonprofit organizations, and Indian tribes to implement early literacy
114.24 programs in low-income communities, including tribal communities, to:

114.25 (1) purchase and equip early childhood read-mobiles that provide FFN caregivers
114.26 and children's families with books, training, and early literacy activities;

114.27 (2) provide FFN caregivers and children's families with translations of early
114.28 childhood books, training, and early literacy activities in native languages; or

114.29 (3) provide FFN caregivers and children's families with early literacy activities in
114.30 local libraries.

114.31 Subd. 3. **Grant awards.** Interested entities eligible to receive a grant under
114.32 this section may apply to the commissioner in the form and manner the commissioner
114.33 determines. The commissioner shall awards grants to eligible entities consistent with
114.34 the requirements of this section.

114.35 Subd. 4. **Evaluation.** The commissioner, in consultation with early childhood
114.36 care and education experts at the University of Minnesota, must evaluate the impact of

115.1 the grants under subdivision 2 on children's school readiness and submit a written report
115.2 to the human services and education finance and policy committees of the legislature by
115.3 February 15, 2010.

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

115.5 Sec. 97. **CHILD CARE PROVIDER STUDY.**

115.6 The commissioner of human services is directed to study the implications of
115.7 restricting the use of state subsidies in center-based child care to centers meeting state
115.8 quality standards under Minnesota Statutes, section 124D.175, paragraph (c), and to
115.9 publish the results no later than January 1, 2010. The study must include:

115.10 (1) the likelihood of there being sufficient child care providers meeting the standards;

115.11 (2) the cost to bring providers up to the standards and how this cost would be funded;

115.12 (3) how the standards and the ratings would be communicated to both parents and
115.13 the general public; and

115.14 (4) a determination whether a similar system could be implemented for
115.15 non-center-based care.

115.16 Sec. 98. **DIRECTION TO COMMISSIONER.**

115.17 (a) The commissioner of human services shall offer a request for proposals to
115.18 identify a research and evaluation firm with experience working with:

115.19 (1) homeless youth providers;

115.20 (2) data; and

115.21 (3) the topics of housing, homelessness, and a continuum of care for youth.

115.22 (b) The research and evaluation firm identified under paragraph (a) shall monitor and
115.23 evaluate the programs receiving funding under Minnesota Statutes, section 256K.45.

115.24 Sec. 99. **REVISOR'S INSTRUCTION.**

115.25 (a) The revisor shall renumber Minnesota Statutes, section 626.556, subdivision 3d,
115.26 as Minnesota Statutes, section 626.556, subdivision 3g.

115.27 (b) The revisor shall change references to Minnesota Statutes, section 260.851,
115.28 to section 260.853 and references to Minnesota Statutes, section 260.851, article 5, to
115.29 section 260.853, article 4, wherever those references appear in Minnesota Statutes and
115.30 Minnesota Rules.

115.31 Sec. 100. **REPEALER.**

- 116.1 (a) Minnesota Statutes 2006, sections 119B.08, subdivision 4; 256J.29; 256J.37,
116.2 subdivisions 3a and 3b; and 256J.626, subdivisions 7 and 9, are repealed.
116.3 (b) Laws 1997, chapter 8, section 1, is repealed.
116.4 (c) Minnesota Rules, part 9560.0102, subpart 2, item C, is repealed.

116.5 **ARTICLE 2**
116.6 **LICENSING**

116.7 Section 1. Minnesota Statutes 2006, section 245A.035, is amended to read:

116.8 **245A.035 ~~RELATIVE FOSTER CARE~~; UNLICENSED EMERGENCY**
116.9 **LICENSE RELATIVE PLACEMENT.**

116.10 Subdivision 1. ~~Grant of Emergency license placement.~~ Notwithstanding section
116.11 245A.03, subdivision 2a, or 245C.13, subdivision 2, a county agency may place a child
116.12 ~~for foster care~~ with a relative who is not licensed to provide foster care, provided the
116.13 requirements of ~~subdivision 2~~ this section are met. As used in this section, the term
116.14 "relative" has the meaning given it under section 260C.007, subdivision 27.

116.15 Subd. 2. **Cooperation with emergency licensing placement process.** (a) A county
116.16 agency that places a child with a relative who is not licensed to provide foster care must
116.17 ~~begin the process of securing an emergency license for the relative as soon as possible~~
116.18 ~~and must~~ conduct the initial inspection required by subdivision 3, clause (1), whenever
116.19 possible, prior to placing the child in the relative's home, but no later than three working
116.20 days after placing the child in the home. A child placed in the home of a relative who is
116.21 not licensed to provide foster care must be removed from that home if the relative fails
116.22 to cooperate with the county agency ~~in securing an emergency foster care license. The~~
116.23 ~~commissioner may issue an emergency foster care license to a relative with whom the~~
116.24 ~~county agency wishes to place or has placed a child for foster care, or to a relative with~~
116.25 ~~whom a child has been placed by court order.~~

116.26 (b) If a child is to be placed in the home of a relative not licensed to provide foster
116.27 care, either the placing agency or the county agency in the county in which the relative
116.28 lives shall conduct the emergency licensing placement process as required in this section.

116.29 Subd. 3. **Requirements for emergency license placement.** Before an emergency
116.30 license placement may be ~~issued~~ made, the following requirements must be met:

116.31 (1) the county agency must conduct an initial inspection of the premises where
116.32 ~~the foster care placement~~ is to be ~~provided~~ made to ensure the health and safety of any
116.33 child placed in the home. The county agency shall conduct the inspection using a form
116.34 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 shall receive 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 shall 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 must include reasons for the denial. Denial of an emergency license is not subject to appeal under chapter 14. The relative may request a review of the denial by submitting to the commissioner a written statement of the reasons an emergency license should be granted. The commissioner shall evaluate the request for review and determine whether to grant the emergency license. The commissioner's review shall be based on a review of the records submitted by the county agency and the relative. Within 15 working days of the receipt of the request for review, the commissioner shall notify the relative requesting review in written form whether the emergency license will be granted. The commissioner's review shall be based on a review of the records submitted by the county agency and the relative. A child shall not be placed or remain placed in the relative's home while the request for review is pending. Denial of an emergency license shall not preclude an individual from reapplying for an emergency license or from applying for a child foster care license. The decision of the commissioner is the final administrative agency action.~~

Sec. 2. Minnesota Statutes 2006, section 245A.10, subdivision 2, is amended to read:

Subd. 2. **County fees for background studies and licensing inspections.** (a) For purposes of family and group family child care licensing under this chapter, a county agency may charge a fee to an applicant or license holder to recover the actual cost of background studies, but in any case not to exceed \$100 annually. A county agency may also charge a license fee to an applicant or license holder to recover the actual cost of licensing inspections, but in any case not to exceed \$50 for a one-year license or \$100 for a two-year license.

119.1 (b) A county agency may charge a fee to a legal nonlicensed child care provider or
119.2 applicant for authorization to recover the actual cost of background studies completed
119.3 under section 119B.125, but in any case not to exceed \$100 annually.

119.4 (c) Counties may elect to reduce or waive the fees in paragraph (a) or (b):

119.5 (1) in cases of financial hardship;

119.6 (2) if the county has a shortage of providers in the county's area;

119.7 (3) for new providers; or

119.8 (4) for providers who have attained at least 16 hours of training before seeking
119.9 initial licensure.

119.10 (d) Counties may allow providers to pay the applicant fees in paragraph (a) or (b) on
119.11 an installment basis for up to one year. If the provider is receiving child care assistance
119.12 payments from the state, the provider may have the fees under paragraph (a) or (b)
119.13 deducted from the child care assistance payments for up to one year and the state shall
119.14 reimburse the county for the county fees collected in this manner.

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

119.16 Sec. 3. Minnesota Statutes 2006, section 245A.16, subdivision 1, is amended to read:

119.17 Subdivision 1. **Delegation of authority to agencies.** (a) County agencies and
119.18 private agencies that have been designated or licensed by the commissioner to perform
119.19 licensing functions and activities under section 245A.04 ~~and~~ background studies for adult
119.20 foster care, family adult day services, and until December 31, 2007, family child care,
119.21 under chapter 245C~~;~~₂ to recommend denial of applicants under section 245A.05~~;~~₂ to issue
119.22 correction orders, to issue variances, and recommend a conditional license under section
119.23 245A.06, or to recommend suspending or revoking a license or issuing a fine under section
119.24 245A.07, shall comply with rules and directives of the commissioner governing those
119.25 functions and with this section. The following variances are excluded from the delegation
119.26 of variance authority and may be issued only by the commissioner:

119.27 (1) dual licensure of family child care and child foster care, dual licensure of child
119.28 and adult foster care, and adult foster care and family child care;

119.29 (2) adult foster care maximum capacity;

119.30 (3) adult foster care minimum age requirement;

119.31 (4) child foster care maximum age requirement;

119.32 (5) variances regarding disqualified individuals except that county agencies may
119.33 issue variances under section 245C.30 regarding disqualified individuals when the county
119.34 is responsible for conducting a consolidated reconsideration according to sections 245C.25

and 245C.27, subdivision 2, clauses (a) and (b), of a county maltreatment determination and a disqualification based on serious or recurring maltreatment; and

(6) the required presence of a caregiver in the adult foster care residence during normal sleeping hours.

(b) County agencies must report:

~~(1) information about disqualification reconsiderations under sections 245C.25 and 245C.27, subdivision 2, clauses paragraphs (a) and (b), and variances granted under paragraph (a), clause (5), to the commissioner at least monthly in a format prescribed by the commissioner; and~~

~~(2) for relative child foster care applicants and license holders, the number of relatives, as defined in section 260C.007, subdivision 27, and household members of relatives who are disqualified under section 245C.14; the disqualifying characteristics under section 245C.15; the number of these individuals who requested reconsideration under section 245C.21; the number of set-asides under section 245C.22; and variances under section 245C.30 issued. This information shall be reported to the commissioner annually by January 15 of each year in a format prescribed by the commissioner.~~

(c) For family day care programs, the commissioner may authorize licensing reviews every two years after a licensee has had at least one annual review.

(d) For family adult day services programs, the commissioner may authorize licensing reviews every two years after a licensee has had at least one annual review.

(e) A license issued under this section may be issued for up to two years.

Sec. 4. Minnesota Statutes 2006, section 245A.16, subdivision 3, is amended to read:

Subd. 3. **Recommendations to the commissioner.** The county or private agency shall not make recommendations to the commissioner regarding licensure without first conducting an inspection, and for adult foster care, family adult day services, and until December 31, 2007, family child care, a background study of the applicant, ~~and evaluation pursuant to~~ under chapter 245C. The county or private agency must forward its recommendation to the commissioner regarding the appropriate licensing action within 20 working days of receipt of a completed application.

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

Sec. 5. Minnesota Statutes 2006, section 245C.02, is amended by adding a subdivision to read:

Subd. 14a. **Private agency.** "Private agency" has the meaning given in section 245A.02, subdivision 12.

121.1 Sec. 6. Minnesota Statutes 2006, section 245C.04, subdivision 1, is amended to read:

121.2 Subdivision 1. **Licensed programs.** (a) The commissioner shall conduct a
121.3 background study of an individual required to be studied under section 245C.03,
121.4 subdivision 1, at least upon application for initial license for all license types.

121.5 (b) The commissioner shall conduct a background study of an individual required
121.6 to be studied under section 245C.03, subdivision 1, at reapplication for a license for
121.7 family child care, ~~child foster care, and adult foster care,~~ family adult day services, and
121.8 until January 1, 2008, family child care.

121.9 (c) The commissioner is not required to conduct a study of an individual at the time
121.10 of reapplication for a license if the individual's background study was completed by the
121.11 commissioner of human services for an adult foster care license holder that is also:

121.12 (1) registered under chapter 144D; or

121.13 (2) licensed to provide home and community-based services to people with
121.14 disabilities at the foster care location and the license holder does not reside in the foster
121.15 care residence; and

121.16 (3) the following conditions are met:

121.17 (i) a study of the individual was conducted either at the time of initial licensure or
121.18 when the individual became affiliated with the license holder;

121.19 (ii) the individual has been continuously affiliated with the license holder since
121.20 the last study was conducted; and

121.21 (iii) the last study of the individual was conducted on or after October 1, 1995.

121.22 (d) From July 1, 2007, to June 30, 2009, the commissioner of human services
121.23 shall conduct a study of an individual required to be studied under section 245C.03, at
121.24 the time of reapplication for a child foster care license. The county or private agency
121.25 shall collect and forward to the commissioner the information required under section
121.26 245C.05, subdivisions 1, paragraphs (a) and (b), and 5, paragraphs (a) and (b). The
121.27 background study conducted by the commissioner of human services under this paragraph
121.28 must include a review of the information required under section 245C.08, subdivisions
121.29 1, paragraph (a), clauses (1) to (4), and 3.

121.30 (e) From January 1, 2008, to December 31, 2009, the commissioner shall conduct
121.31 a study of an individual required to be studied under section 245C.03, at the time of
121.32 reapplication for a family child care license. The county shall collect and forward to the
121.33 commissioner the information required under section 245C.05, subdivisions 1 and 5. The
121.34 background study conducted by the commissioner under this paragraph must include a
121.35 review of the information required under section 245C.08, subdivisions 1, paragraph
121.36 (a), and 3.

122.1 (f) The commissioner of human services shall conduct a background study of an
122.2 individual specified under section 245C.03, subdivision 1, paragraph (a), clauses (2)
122.3 to (6), who is newly affiliated with a child foster care license holder. The county or
122.4 private agency shall collect and forward to the commissioner the information required
122.5 under section 245C.05, subdivisions 1 and 5. The background study conducted by the
122.6 commissioner of human services under this paragraph must include a review of the
122.7 information required under section 245C.08, subdivisions 1, paragraph (a), and 3.

122.8 (g) Applicants for licensure, license holders, and other entities as provided in this
122.9 chapter must submit completed background study forms to the commissioner before
122.10 individuals specified in section 245C.03, subdivision 1, begin positions allowing direct
122.11 contact in any licensed program.

122.12 ~~(e)~~ (h) For purposes of this section, a physician licensed under chapter 147 is
122.13 considered to be continuously affiliated upon the license holder's receipt from the
122.14 commissioner of health or human services of the physician's background study results.

122.15 Sec. 7. Minnesota Statutes 2006, section 245C.05, subdivision 1, is amended to read:

122.16 Subdivision 1. **Individual studied.** (a) The individual who is the subject of the
122.17 background study must provide the applicant, license holder, or other entity under section
122.18 245C.04 with sufficient information to ensure an accurate study, including:

122.19 (1) the individual's first, middle, and last name and all other names by which the
122.20 individual has been known;

122.21 (2) home address, city, and state of residence;

122.22 (3) zip code;

122.23 (4) sex;

122.24 (5) date of birth; and

122.25 (6) Minnesota driver's license number or state identification number.

122.26 (b) Every subject of a background study conducted or initiated by counties or private
122.27 agencies under this chapter must also provide the home address, city, county, and state of
122.28 residence for the past five years.

122.29 (c) Every subject of a background study related to child foster care licensed through
122.30 a private agency shall also provide the commissioner a signed consent for the release of
122.31 any information received from national crime information databases to the private agency
122.32 that initiated the background study.

122.33 (d) The subject of a background study shall provide fingerprints as required in
122.34 subdivision 5, paragraph (c).

123.1 Sec. 8. Minnesota Statutes 2006, section 245C.05, is amended by adding a subdivision
123.2 to read:

123.3 Subd. 2a. **County or private agency.** For background studies related to child
123.4 foster care, and beginning January 1, 2008, for studies related to family child care, county
123.5 and private agencies must collect the information under subdivision 1 and forward it to
123.6 the commissioner.

123.7 Sec. 9. Minnesota Statutes 2006, section 245C.05, subdivision 4, is amended to read:

123.8 Subd. 4. **Electronic transmission.** For background studies conducted by the
123.9 Department of Human Services, the commissioner shall implement a system for the
123.10 electronic transmission of:

123.11 (1) background study information to the commissioner; ~~and~~

123.12 (2) background study results to the license holder; and

123.13 (3) background study results to county and private agencies for background studies
123.14 conducted by the commissioner for child foster care, and beginning January 1, 2008,
123.15 also for family child care.

123.16 **EFFECTIVE DATE.** This section is effective January 1, 2008.

123.17 Sec. 10. Minnesota Statutes 2006, section 245C.05, subdivision 5, is amended to read:

123.18 Subd. 5. **Fingerprints.** (a) Except as provided in paragraph (c), for any background
123.19 study completed under this chapter, when the commissioner has reasonable cause to
123.20 believe that further pertinent information may exist on the subject of the background
123.21 study, the subject shall provide the commissioner with a set of classifiable fingerprints
123.22 obtained from an authorized ~~law enforcement~~ agency.

123.23 (b) For purposes of requiring fingerprints, the commissioner has reasonable cause
123.24 when, but not limited to, the:

123.25 (1) information from the Bureau of Criminal Apprehension indicates that the subject
123.26 is a multistate offender;

123.27 (2) information from the Bureau of Criminal Apprehension indicates that multistate
123.28 offender status is undetermined; or

123.29 (3) commissioner has received a report from the subject or a third party indicating
123.30 that the subject has a criminal history in a jurisdiction other than Minnesota.

123.31 (c) Except as specified under section 245C.04, subdivision 1, paragraph (d), for
123.32 background studies conducted by the commissioner for child foster care, the subject of the
123.33 background study shall provide the commissioner with a set of classifiable fingerprints
123.34 obtained from an authorized agency.

124.1 Sec. 11. Minnesota Statutes 2006, section 245C.05, subdivision 7, is amended to read:

124.2 Subd. 7. **Probation officer and corrections agent.** (a) A probation officer or
124.3 corrections agent shall notify the commissioner of an individual's conviction if the
124.4 individual is:

124.5 (1) affiliated with a program or facility regulated by the Department of Human
124.6 Services or Department of Health, a facility serving children or youth licensed by the
124.7 Department of Corrections, or any type of home care agency or provider of personal care
124.8 assistance services; and

124.9 (2) convicted of a crime constituting a disqualification under section 245C.14.

124.10 (b) For the purpose of this subdivision, "conviction" has the meaning given it
124.11 in section 609.02, subdivision 5.

124.12 (c) The commissioner, in consultation with the commissioner of corrections, shall
124.13 develop forms and information necessary to implement this subdivision and shall provide
124.14 the forms and information to the commissioner of corrections for distribution to local
124.15 probation officers and corrections agents.

124.16 (d) The commissioner shall inform individuals subject to a background study that
124.17 criminal convictions for disqualifying crimes will be reported to the commissioner by the
124.18 corrections system.

124.19 (e) A probation officer, corrections agent, or corrections agency is not civilly or
124.20 criminally liable for disclosing or failing to disclose the information required by this
124.21 subdivision.

124.22 (f) Upon receipt of disqualifying information, the commissioner shall provide the
124.23 notice required under section 245C.17, as appropriate, to agencies on record as having
124.24 initiated a background study or making a request for documentation of the background
124.25 study status of the individual.

124.26 (g) This subdivision does not apply to family child care ~~and child foster care~~
124.27 programs until January 1, 2008.

124.28 Sec. 12. Minnesota Statutes 2006, section 245C.08, subdivision 1, is amended to read:

124.29 Subdivision 1. **Background studies conducted by commissioner of human**
124.30 **services.** (a) For a background study conducted by the commissioner, the commissioner
124.31 shall review:

124.32 (1) information related to names of substantiated perpetrators of maltreatment of
124.33 vulnerable adults that has been received by the commissioner as required under section
124.34 626.557, subdivision 9c, paragraph (i);

(2) the commissioner's records relating to the maltreatment of minors in licensed programs, and from ~~county agency~~ findings of maltreatment of minors as indicated through the social service information system;

(3) information from juvenile courts as required in subdivision 4 for individuals listed in section 245C.03, subdivision 1, clauses (2), (5), and (6); ~~and~~

(4) information from the Bureau of Criminal Apprehension;

(5) except as provided in clause (6), information from the national crime information system when the commissioner has reasonable cause as defined under section 245C.05, subdivision 5; and

(6) for a background study related to a child foster care application for licensure, the commissioner shall also review:

(i) information from the child abuse and neglect registry for any state in which the background study subject has resided in for the past five years; and

(ii) information from national crime information databases.

(b) Notwithstanding expungement by a court, the commissioner may consider information obtained under paragraph (a), clauses (3) and (4), unless the commissioner received notice of the petition for expungement and the court order for expungement is directed specifically to the commissioner.

Sec. 13. Minnesota Statutes 2006, section 245C.08, subdivision 2, is amended to read:

Subd. 2. **Background studies conducted by a county ~~or private~~ agency.** (a) For a background study conducted by a county ~~or private~~ agency for ~~child foster care~~, adult foster care, family adult day services, and until January 1, 2008, family child care homes services, the commissioner shall review:

(1) information from the county agency's record of substantiated maltreatment of adults and the maltreatment of minors;

(2) information from juvenile courts as required in subdivision 4 for individuals listed in section 245C.03, subdivision 1, clauses (2), (5), and (6);

(3) information from the Bureau of Criminal Apprehension; and

(4) arrest and investigative records maintained by the Bureau of Criminal Apprehension, county attorneys, county sheriffs, courts, county agencies, local police, the National Criminal Records Repository, and criminal records from other states.

(b) If the individual has resided in the county for less than five years, the study shall include the records specified under paragraph (a) for the previous county or counties of residence for the past five years.

126.1 (c) Notwithstanding expungement by a court, the county ~~or private~~ agency may
126.2 consider information obtained under paragraph (a), clauses (3) and (4), unless the
126.3 commissioner received notice of the petition for expungement and the court order for
126.4 expungement is directed specifically to the commissioner.

126.5 Sec. 14. Minnesota Statutes 2006, section 245C.10, is amended by adding a
126.6 subdivision to read:

126.7 Subd. 4. **Temporary personnel agencies, educational programs, and professional**
126.8 **services agencies.** The commissioner shall recover the cost of the background studies
126.9 initiated by temporary personnel agencies, educational programs, and professional
126.10 services agencies that initiate background studies under section 245C.03, subdivision 4,
126.11 through a fee of no more than \$20 per study charged to the agency. In fiscal years 2008
126.12 and 2009, the fees collected under this subdivision are appropriated to the commissioner
126.13 for the purpose of conducting background studies.

126.14 Sec. 15. Minnesota Statutes 2006, section 245C.11, subdivision 1, is amended to read:

126.15 Subdivision 1. **Adult foster care; criminal conviction data.** For individuals who
126.16 are required to have background studies under section 245C.03, subdivisions 1 and 2, and
126.17 who have been continuously affiliated with ~~a~~ an adult foster care provider that is licensed
126.18 in more than one county, criminal conviction data may be shared among those counties in
126.19 which the adult foster care programs are licensed. A county agency's receipt of criminal
126.20 conviction data from another county agency shall meet the criminal data background
126.21 study requirements of this chapter.

126.22 Sec. 16. Minnesota Statutes 2006, section 245C.11, subdivision 2, is amended to read:

126.23 Subd. 2. **Jointly licensed programs.** A county agency may accept a background
126.24 study completed by the commissioner under this chapter in place of the background study
126.25 required under section 245A.16, subdivision 3, in programs with joint licensure as home
126.26 and community-based services and adult foster care for people with developmental
126.27 disabilities when the license holder does not reside in the adult foster care residence and
126.28 the subject of the study has been continuously affiliated with the license holder since the
126.29 date of the commissioner's study.

126.30 Sec. 17. Minnesota Statutes 2006, section 245C.12, is amended to read:

126.31 **245C.12 BACKGROUND STUDY; TRIBAL ORGANIZATIONS.**

(a) For the purposes of background studies completed by tribal organizations performing licensing activities otherwise required of the commissioner under this chapter, after obtaining consent from the background study subject, tribal licensing agencies shall have access to criminal history data in the same manner as county licensing agencies and private licensing agencies under this chapter.

(b) Tribal organizations may contract with the commissioner to obtain background study data on individuals under tribal jurisdiction related to adoptions according to section 245C.34. Tribal organizations may also contract with the commissioner to obtain background study data on individuals under tribal jurisdiction related to child foster care according to section 245C.34.

Sec. 18. Minnesota Statutes 2006, section 245C.16, subdivision 1, is amended to read:

Subdivision 1. **Determining immediate risk of harm.** (a) If the commissioner determines that the individual studied has a disqualifying characteristic, the commissioner shall review the information immediately available and make a determination as to the subject's immediate risk of harm to persons served by the program where the individual studied will have direct contact.

(b) The commissioner shall consider all relevant information available, including the following factors in determining the immediate risk of harm:

- (1) the recency of the disqualifying characteristic;
- (2) the recency of discharge from probation for the crimes;
- (3) the number of disqualifying characteristics;
- (4) the intrusiveness or violence of the disqualifying characteristic;
- (5) the vulnerability of the victim involved in the disqualifying characteristic;
- (6) the similarity of the victim to the persons served by the program where the individual studied will have direct contact; and

(7) whether the individual has a disqualification from a previous background study that has not been set aside.

(c) This section does not apply when the subject of a background study is regulated by a health-related licensing board as defined in chapter 214, and the subject is determined to be responsible for substantiated maltreatment under section 626.556 or 626.557.

(d) This section does not apply to a background study related to an initial application for a child foster care license.

(e) If the commissioner has reason to believe, based on arrest information or an active maltreatment investigation, that an individual poses an imminent risk of harm to persons receiving services, the commissioner may order that the person be continuously

128.1 supervised or immediately removed pending the conclusion of the maltreatment
128.2 investigation or criminal proceedings.

128.3 Sec. 19. Minnesota Statutes 2006, section 245C.17, is amended by adding a
128.4 subdivision to read:

128.5 Subd. 5. **Notice to county or private agency.** For studies on individuals related
128.6 to a license to provide child foster care, and beginning January 1, 2008, for family child
128.7 care, the commissioner shall also provide a notice of the background study results to the
128.8 county or private agency that initiated the background study.

128.9 Sec. 20. Minnesota Statutes 2006, section 245C.21, is amended by adding a
128.10 subdivision to read:

128.11 Subd. 1a. **Submission of reconsideration request to county or private agency.**
128.12 (a) For disqualifications related to studies conducted by county agencies, and for
128.13 disqualifications related to studies conducted by the commissioner for child foster care, and
128.14 beginning January 1, 2008, for family child care, the individual shall submit the request
128.15 for reconsideration to the county or private agency that initiated the background study.
128.16 (b) A reconsideration request shall be submitted within the time frames specified in
128.17 subdivision 2.
128.18 (c) The county or private agency shall forward the individual's request for
128.19 reconsideration and provide the commissioner with a recommendation whether to set aside
128.20 the individual's disqualification.

128.21 Sec. 21. Minnesota Statutes 2006, section 245C.23, subdivision 2, is amended to read:

128.22 Subd. 2. **Commissioner's notice of disqualification that is not set aside.** (a) The
128.23 commissioner shall notify the license holder of the disqualification and order the license
128.24 holder to immediately remove the individual from any position allowing direct contact
128.25 with persons receiving services from the license holder if:

128.26 (1) the individual studied does not submit a timely request for reconsideration
128.27 under section 245C.21;

128.28 (2) the individual submits a timely request for reconsideration, but the commissioner
128.29 does not set aside the disqualification for that license holder under section 245C.22;

128.30 (3) an individual who has a right to request a hearing under sections 245C.27 and
128.31 256.045, or 245C.28 and chapter 14 for a disqualification that has not been set aside, does
128.32 not request a hearing within the specified time; or

129.1 (4) an individual submitted a timely request for a hearing under sections 245C.27
129.2 and 256.045, or 245C.28 and chapter 14, but the commissioner does not set aside the
129.3 disqualification under section 245A.08, subdivision 5, or 256.045.

129.4 (b) If the commissioner does not set aside the disqualification under section 245C.22,
129.5 and the license holder was previously ordered under section 245C.17 to immediately
129.6 remove the disqualified individual from direct contact with persons receiving services or
129.7 to ensure that the individual is under continuous, direct supervision when providing direct
129.8 contact services, the order remains in effect pending the outcome of a hearing under
129.9 sections 245C.27 and 256.045, or 245C.28 and chapter 14.

129.10 (c) For background studies related to child foster care, and beginning January
129.11 1, 2008, for family child care, the commissioner shall also notify the county or private
129.12 agency that initiated the study of the results of the reconsideration.

129.13 Sec. 22. Minnesota Statutes 2006, section 245C.24, subdivision 2, is amended to read:

129.14 Subd. 2. **Permanent bar to set aside a disqualification.** (a) Except as provided in
129.15 paragraph (b), the commissioner may not set aside the disqualification of any individual
129.16 disqualified pursuant to this chapter, in connection with a license to provide family child
129.17 care for children, foster care for children in the provider's home, or foster care or day care
129.18 services for adults in the provider's home regardless of how much time has passed, if the
129.19 individual was disqualified for a crime or conduct listed in section 245C.15, subdivision 1.

129.20 (b) For an individual in the chemical dependency field who was disqualified for a
129.21 crime or conduct listed under section 245C.15, subdivision 1, and whose disqualification
129.22 was set aside prior to July 1, 2005, the commissioner must consider granting a variance
129.23 pursuant to section 245C.30 for the license holder for a program dealing primarily with
129.24 adults. A request for reconsideration evaluated under this paragraph must include a
129.25 letter of recommendation from the license holder that was subject to the prior set-aside
129.26 decision addressing the individual's quality of care to children or vulnerable adults and the
129.27 circumstances of the individual's departure from that service.

129.28 Sec. 23. **[245C.33] ADOPTION BACKGROUND STUDY REQUIREMENTS.**

129.29 Subdivision 1. **Background studies conducted by commissioner.** Before
129.30 placement of a child for purposes of adoption, the commissioner shall conduct a
129.31 background study on individuals listed in section 259.41, subdivision 3, for county
129.32 agencies and private agencies licensed to place children for adoption.

130.1 Subd. 2. **Information and data provided to county or private agency.** The
130.2 subject of the background study shall provide the following information to the county
130.3 or private agency:

- 130.4 (1) the information specified in section 245C.05;
130.5 (2) a set of classifiable fingerprints obtained from an authorized agency; and
130.6 (3) for studies initiated by a private agency, a signed consent for the release of
130.7 information received from national crime information databases to the private agency.

130.8 Subd. 3. **Information and data provided to commissioner.** The county or private
130.9 agency shall forward the data collected under subdivision 2 to the commissioner.

130.10 Subd. 4. **Information commissioner reviews.** (a) The commissioner shall review
130.11 the following information regarding the background study subject:

- 130.12 (1) the information under section 245C.08, subdivisions 1, 3, and 4;
130.13 (2) information from the child abuse and neglect registry for any state in which the
130.14 subject has resided for the past five years; and
130.15 (3) information from national crime information databases.

130.16 (b) The commissioner shall provide any information collected under this subdivision
130.17 to the county or private agency that initiated the background study. The commissioner
130.18 shall indicate if the information collected shows that the subject of the background study
130.19 has a conviction listed in United States Code, title 42, section 671(a)(20)(A).

130.20 Sec. 24. **[245C.34] ADOPTION AND CHILD FOSTER CARE BACKGROUND**
130.21 **STUDIES; TRIBAL ORGANIZATIONS.**

130.22 Subdivision 1. **Background studies may be conducted by commissioner.** (a)
130.23 Tribal organizations may contract with the commissioner under section 245C.12 to obtain
130.24 background study data on individuals under tribal jurisdiction related to adoptions.

130.25 (b) Tribal organizations may contract with the commissioner under section 245C.12
130.26 to obtain background study data on individuals under tribal jurisdiction related to child
130.27 foster care.

130.28 (c) Background studies initiated by tribal organizations under paragraphs (a) and (b)
130.29 must be conducted as provided in subdivisions 2 and 3.

130.30 Subd. 2. **Information and data provided to tribal organization.** The background
130.31 study subject must provide the following information to the tribal organization:

- 130.32 (1) for background studies related to adoptions, the information under section
130.33 245C.05;
130.34 (2) for background studies related to child foster care, the information under section
130.35 245C.05;

131.1 (3) a set of classifiable fingerprints obtained from an authorized agency; and
131.2 (4) a signed consent for the release of information received from national crime
131.3 information databases to the tribal organization.

131.4 Subd. 3. **Information and data provided to commissioner.** The tribal organization
131.5 shall forward the data collected under subdivision 2 to the commissioner.

131.6 Subd. 4. **Information commissioner reviews.** (a) The commissioner shall review
131.7 the following information regarding the background study subject:

131.8 (1) the information under section 245C.08, subdivisions 1, 3, and 4;

131.9 (2) information from the child abuse and neglect registry for any state in which the
131.10 subject has resided for the past five years; and

131.11 (3) information from national crime information databases.

131.12 (b) The commissioner shall provide any information collected under this subdivision
131.13 to the tribal organization that initiated the background study. The commissioner shall
131.14 indicate if the information collected shows that the subject of the background study has a
131.15 conviction listed in United States Code, title 42, section 671(a)(20)(A).

131.16 Sec. 25. Minnesota Statutes 2006, section 259.20, subdivision 2, is amended to read:

131.17 Subd. 2. **Other applicable law.** (a) Portions of chapters 245A, 245C, 257, 260, and
131.18 317A may also affect the adoption of a particular child.

131.19 (b) Provisions of the Indian Child Welfare Act, United States Code, title 25, chapter
131.20 21, sections 1901-1923, may also apply in the adoption of an Indian child, and may
131.21 preempt specific provisions of this chapter.

131.22 (c) Consistent with section 245C.33 and Public Law 109-248, a completed
131.23 background study is required before the approval of any foster or adoptive placement in
131.24 a related or an unrelated home.

131.25 Sec. 26. Minnesota Statutes 2006, section 259.29, subdivision 1, is amended to read:

131.26 Subdivision 1. **Best interests of the child.** (a) The policy of the state of Minnesota
131.27 is to ensure that the best interests of the child are met by requiring individualized
131.28 determination of the needs of the child and of how the adoptive placement will serve the
131.29 needs of the child.

131.30 (b) Among the factors the agency shall consider in determining the needs of the child
131.31 are those specified under section 260C.193, subdivision 3, paragraph (b).

131.32 (c) Except for emergency placements provided for in section 245A.035, a completed
131.33 background study is required under section 245C.33 before the approval of an adoptive
131.34 placement in a home.

Sec. 27. Minnesota Statutes 2006, section 259.41, is amended to read:

259.41 ADOPTION STUDY.

Subdivision 1. **Study required before placement; certain relatives excepted.** (a)

An approved adoption study; completed background study, as required under section 245C.33; and written report must be completed before the child is placed in a prospective adoptive home under this chapter, except as allowed by section 259.47, subdivision 6. In an agency placement, the report must be filed with the court at the time the adoption petition is filed. In a direct adoptive placement, the report must be filed with the court in support of a motion for temporary preadoptive custody under section 259.47, subdivision 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;
- (2) provide all addresses at which the prospective adoptive parent and anyone in the household over the age of 13 has resided in the previous five years; and
- (3) disclose any names used previously other than the name used at the time of the study.

(b) When the requirements of paragraph (a) have been met, the agency shall immediately ~~begin~~ initiate a background ~~check~~, study under section 245C.33 to be completed by the commissioner on each person over the age of 13 living in the home; consisting, at a minimum, of the following. As required under section 245C.33 and Public Law 109-248, a completed background study is required before the approval of any foster or adoptive placement in a related or an unrelated home. The required background study must be completed as part of the home study.

~~(1) a check of criminal conviction data with the Bureau of Criminal Apprehension and local law enforcement authorities;~~

~~(2) a check for data on substantiated maltreatment of a child or vulnerable adult and domestic violence data with local law enforcement and social services agencies and district courts; and~~

~~(3) for those persons under the age of 25, a check of juvenile court records.~~

~~Notwithstanding the provisions of section 260B.171 or 260C.171, the Bureau of Criminal Apprehension, local law enforcement and social services agencies, district courts, and juvenile courts shall release the requested information to the agency completing the adoption study.~~

~~(c) When paragraph (b) requires checking the data or records of local law enforcement and social services agencies and district and juvenile courts, the agency shall check with the law enforcement and social services agencies and courts whose jurisdictions cover the addresses under paragraph (a), clause (2). In the event that the agency is unable to complete any of the record checks required by paragraph (b), the agency shall document the fact and the agency's efforts to obtain the information.~~

~~(d) For a study completed under this section, when the agency has reasonable cause to believe that further information may exist on the prospective adoptive parent or household member over the age of 13 that may relate to the health, safety, or welfare of the child, the prospective adoptive parent or household member over the age of 13 shall provide the agency with a set of classifiable fingerprints obtained from an authorized law enforcement agency and the agency may obtain criminal history data from the National Criminal Records Repository by submitting fingerprints to the Bureau of Criminal 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.~~

(c) A home study under paragraph (b) used to consider placement of any child on whose behalf Title IV-E adoption assistance payments are to be made must not be approved if a background study reveals a felony conviction at any time for:

(1) child abuse or neglect;

(2) spousal abuse;

(3) a crime against children, including child pornography; or

(4) a crime involving violence, including rape, sexual assault, or homicide, but not including other physical assault or battery.

(d) A home study under paragraph (b) used to consider placement of any child on whose behalf Title IV-E adoption assistance payments are to be made must not be approved if a background study reveals a felony conviction within the past five years for:

(1) physical assault or battery; or

(2) a drug-related offense.

Subd. 4. Updates to adoption study; period of validity. An agency may update an adoption study and report as needed, regardless of when the original study and report or most recent update was completed. An update must be in a format specified by the commissioner and must verify the continuing accuracy of the elements of the original report and document any changes to elements of the original report. An update to a study and report not originally completed under this section must ensure that the study and report, as updated, meet the requirements of this section. An adoption study is valid if the report has been completed or updated within the previous 12 months.

Sec. 28. Minnesota Statutes 2006, section 259.53, subdivision 2, is amended to read:

Subd. 2. Adoption agencies; postplacement assessment and report. (a) The agency to which the petition has been referred under subdivision 1 shall conduct a postplacement assessment and file a report with the court within 90 days of receipt of a copy of the adoption petition. The agency shall send a copy of the report to the commissioner at the time it files the report with the court. The assessment and report must evaluate the environment and antecedents of the child to be adopted, the home of

the petitioners, whether placement with the petitioners meets the needs of the child as described in section 259.57, subdivision 2. The report must include a recommendation to the court as to whether the petition should or should not be granted.

In making evaluations and recommendations, the postplacement assessment and report must, at a minimum, address the following:

(1) the level of adaptation by the prospective adoptive parents to parenting the child;
(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:

(i) the relative must be licensed for foster care; or

(ii) ~~the agency must conduct a background study~~ is required under section 259.53, subdivision 2; or

(iii) the agency or the commissioner has reasonable cause to believe the relative or household member over the age of 13 has a criminal history which would not make transfer of permanent legal and physical custody to the relative under section 260C.201, subdivision 11, in the child's best interest; and

(3) a parent, following an out-of-home placement, when the responsible social services agency has reasonable cause to believe that the parent has been convicted of a crime directly related to the parent's capacity to maintain the child's health, safety, or welfare or the parent is the subject of an open investigation of, or has been the subject of a substantiated allegation of, child or vulnerable-adult maltreatment within the past ten years.

"Reasonable cause" means that the agency has received information or a report from the subject or a third person that creates an articulable suspicion that the individual has a history that may pose a risk to the health, safety, or welfare of the child. The information or report must be specific to the potential subject of the background check and shall not be based on the race, religion, ethnic background, age, class, or lifestyle of the potential subject.

Subd. 2. **General procedures.** (a) When ~~conducting~~ initiating a background check under subdivision 1, the agency ~~may~~ shall require the individual being assessed to provide sufficient information to ensure an accurate assessment under this section, including:

(1) the individual's first, middle, and last name and all other names by which the individual has been known;

(2) home address, zip code, city, county, and state of residence for the past ~~ten~~ five years;

(3) sex;

(4) date of birth; and

(5) driver's license number or state identification number.

(b) When notified by the commissioner or the responsible social services agency that it is conducting an assessment under this section, the Bureau of Criminal Apprehension, commissioners of health and human services, law enforcement, and county agencies must provide the commissioner or the responsible social services agency or county attorney with the following information on the individual being assessed: criminal history data, reports about the maltreatment of adults substantiated under section 626.557, and reports 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. LICENSING MORATORIUM.

A program operated by a nonpublic school for children 33 months or older is exempt from the human services licensing requirements in Minnesota Statutes, chapter 245A, until July 1, 2009. Nothing in this section prohibits an already licensed nonpublic

141.1 school program from continuing its licensure or a nonpublic school program from seeking
141.2 licensure.

141.3 **EFFECTIVE DATE.** This moratorium is effective the day following final
141.4 enactment.

141.5 Sec. 33. **ANNUAL LICENSE REVIEW.**

141.6 The commissioner of human services shall work with counties to determine the cost
141.7 and propose an ongoing funding allocation from the general fund to cover the cost to
141.8 counties to implement an annual license review for licensed family child care providers.
141.9 The commissioner shall solicit input from counties to determine the outcome. The
141.10 commissioner shall report to the house and senate committees having jurisdiction over
141.11 early childhood programs by January 15, 2008, as to the costs and the funding allocation
141.12 recommended for future use.

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

141.14 Sec. 34. **EFFECTIVE DATE.**

141.15 Changes made to sections in this article related to family child care are effective
141.16 January 1, 2008.

141.17 **ARTICLE 3**
141.18 **HEALTH CARE**

141.19 Section 1. Minnesota Statutes 2006, section 256.482, subdivision 1, is amended to read:

141.20 Subdivision 1. **Establishment; members.** There is hereby established the Council
141.21 on Disability which shall consist of 21 members appointed by the governor. Members
141.22 shall be appointed from the general public and from organizations which provide services
141.23 for persons who have a disability. A majority of council members shall be persons with a
141.24 disability or parents or guardians of persons with a disability. There shall be at least
141.25 one member of the council appointed from each of the state development regions. The
141.26 commissioners of the Departments of Education, Human Services, Health, and Human
141.27 Rights and the directors of the Rehabilitation Services and State Services for the Blind in
141.28 the Department of Employment and Economic Development or their designees shall serve
141.29 as ex officio members of the council without vote. In addition, the council may appoint ex
141.30 officio members from other bureaus, divisions, or sections of state departments which are
141.31 directly concerned with the provision of services to persons with a disability.

142.1 Notwithstanding the provisions of section 15.059, each member of the council
142.2 appointed by the governor shall serve a three-year term and until a successor is appointed
142.3 and qualified. The compensation and removal of all members shall be as provided in
142.4 section 15.059. The council performs functions that are not purely advisory, therefore the
142.5 expiration dates provided in section 15.059 do not apply. The governor shall appoint a
142.6 chair of the council from among the members appointed from the general public or who
142.7 are persons with a disability or their parents or guardians. Vacancies shall be filled by the
142.8 authority for the remainder of the unexpired term.

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

142.10 Sec. 2. Minnesota Statutes 2006, section 256.482, subdivision 8, is amended to read:

142.11 ~~Subd. 8. **Sunset.** Notwithstanding section 15.059, subdivision 5, the Council on~~
142.12 ~~Disability shall not sunset until June 30, 2007.~~

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

142.14 Sec. 3. Minnesota Statutes 2006, section 256.969, subdivision 3a, is amended to read:

142.15 Subd. 3a. **Payments.** (a) Acute care hospital billings under the medical
142.16 assistance program must not be submitted until the recipient is discharged. However,
142.17 the commissioner shall establish monthly interim payments for inpatient hospitals that
142.18 have individual patient lengths of stay over 30 days regardless of diagnostic category.
142.19 Except as provided in section 256.9693, medical assistance reimbursement for treatment
142.20 of mental illness shall be reimbursed based on diagnostic classifications. Individual
142.21 hospital payments established under this section and sections 256.9685, 256.9686, and
142.22 256.9695, in addition to third party and recipient liability, for discharges occurring during
142.23 the rate year shall not exceed, in aggregate, the charges for the medical assistance covered
142.24 inpatient services paid for the same period of time to the hospital. This payment limitation
142.25 shall be calculated separately for medical assistance and general assistance medical
142.26 care services. The limitation on general assistance medical care shall be effective for
142.27 admissions occurring on or after July 1, 1991. Services that have rates established under
142.28 subdivision 11 or 12, must be limited separately from other services. After consulting with
142.29 the affected hospitals, the commissioner may consider related hospitals one entity and
142.30 may merge the payment rates while maintaining separate provider numbers. The operating
142.31 and property base rates per admission or per day shall be derived from the best Medicare
142.32 and claims data available when rates are established. The commissioner shall determine
142.33 the best Medicare and claims data, taking into consideration variables of recency of the

143.1 data, audit disposition, settlement status, and the ability to set rates in a timely manner.
143.2 The commissioner shall notify hospitals of payment rates by December 1 of the year
143.3 preceding the rate year. The rate setting data must reflect the admissions data used to
143.4 establish relative values. Base year changes from 1981 to the base year established for the
143.5 rate year beginning January 1, 1991, and for subsequent rate years, shall not be limited
143.6 to the limits ending June 30, 1987, on the maximum rate of increase under subdivision
143.7 1. The commissioner may adjust base year cost, relative value, and case mix index data
143.8 to exclude the costs of services that have been discontinued by the October 1 of the year
143.9 preceding the rate year or that are paid separately from inpatient services. Inpatient stays
143.10 that encompass portions of two or more rate years shall have payments established based
143.11 on payment rates in effect at the time of admission unless the date of admission preceded
143.12 the rate year in effect by six months or more. In this case, operating payment rates for
143.13 services rendered during the rate year in effect and established based on the date of
143.14 admission shall be adjusted to the rate year in effect by the hospital cost index.

143.15 (b) For fee-for-service admissions occurring on or after July 1, 2002, the total
143.16 payment, before third-party liability and spenddown, made to hospitals for inpatient
143.17 services is reduced by .5 percent from the current statutory rates.

143.18 (c) In addition to the reduction in paragraph (b), the total payment for fee-for-service
143.19 admissions occurring on or after July 1, 2003, made to hospitals for inpatient services
143.20 before third-party liability and spenddown, is reduced five percent from the current
143.21 statutory rates. Mental health services within diagnosis related groups 424 to 432, ~~and~~
143.22 facilities defined under subdivision 16, and, effective for admissions occurring on or after
143.23 July 1, 2007, a long-term hospital as designated by the Medicare program that is located in
143.24 a city of the first class as defined in section 410.01, are excluded from this paragraph.

143.25 (d) In addition to the reduction in paragraphs (b) and (c), the total payment for
143.26 fee-for-service admissions occurring on or after July 1, 2005, made to hospitals for
143.27 inpatient services before third-party liability and spenddown, is reduced 6.0 percent from
143.28 the current statutory rates. Mental health services within diagnosis related groups 424 to
143.29 432 ~~and,~~ facilities defined under subdivision 16, and, effective for admissions occurring
143.30 on or after July 1, 2007, a long-term hospital as designated by the Medicare program
143.31 that is located in a city of the first class as defined in section 410.01, are excluded from
143.32 this paragraph. Notwithstanding section 256.9686, subdivision 7, for purposes of this
143.33 paragraph, medical assistance does not include general assistance medical care. Payments
143.34 made to managed care plans shall be reduced for services provided on or after January
143.35 1, 2006, to reflect this reduction.

144.1 Sec. 4. Minnesota Statutes 2006, section 256.969, subdivision 9, is amended to read:

144.2 Subd. 9. **Disproportionate numbers of low-income patients served.** (a) For
144.3 admissions occurring on or after October 1, 1992, through December 31, 1992, the
144.4 medical assistance disproportionate population adjustment shall comply with federal law
144.5 and shall be paid to a hospital, excluding regional treatment centers and facilities of the
144.6 federal Indian Health Service, with a medical assistance inpatient utilization rate in excess
144.7 of the arithmetic mean. The adjustment must be determined as follows:

144.8 (1) for a hospital with a medical assistance inpatient utilization rate above the
144.9 arithmetic mean for all hospitals excluding regional treatment centers and facilities of the
144.10 federal Indian Health Service but less than or equal to one standard deviation above the
144.11 mean, the adjustment must be determined by multiplying the total of the operating and
144.12 property payment rates by the difference between the hospital's actual medical assistance
144.13 inpatient utilization rate and the arithmetic mean for all hospitals excluding regional
144.14 treatment centers and facilities of the federal Indian Health Service; and

144.15 (2) for a hospital with a medical assistance inpatient utilization rate above one
144.16 standard deviation above the mean, the adjustment must be determined by multiplying
144.17 the adjustment that would be determined under clause (1) for that hospital by 1.1. If
144.18 federal matching funds are not available for all adjustments under this subdivision, the
144.19 commissioner shall reduce payments on a pro rata basis so that all adjustments qualify for
144.20 federal match. The commissioner may establish a separate disproportionate population
144.21 operating payment rate adjustment under the general assistance medical care program.
144.22 For purposes of this subdivision medical assistance does not include general assistance
144.23 medical care. The commissioner shall report annually on the number of hospitals likely to
144.24 receive the adjustment authorized by this paragraph. The commissioner shall specifically
144.25 report on the adjustments received by public hospitals and public hospital corporations
144.26 located in cities of the first class.

144.27 (b) For admissions occurring on or after July 1, 1993, the medical assistance
144.28 disproportionate population adjustment shall comply with federal law and shall be paid to
144.29 a hospital, excluding regional treatment centers and facilities of the federal Indian Health
144.30 Service, with a medical assistance inpatient utilization rate in excess of the arithmetic
144.31 mean. The adjustment must be determined as follows:

144.32 (1) for a hospital with a medical assistance inpatient utilization rate above the
144.33 arithmetic mean for all hospitals excluding regional treatment centers and facilities of the
144.34 federal Indian Health Service but less than or equal to one standard deviation above the
144.35 mean, the adjustment must be determined by multiplying the total of the operating and
144.36 property payment rates by the difference between the hospital's actual medical assistance

inpatient utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service;

(2) for a hospital with a medical assistance inpatient utilization rate above one standard deviation above the mean, the adjustment must be determined by multiplying the adjustment that would be determined under clause (1) for that hospital by 1.1. The commissioner may establish a separate disproportionate population operating payment rate adjustment under the general assistance medical care program. For purposes of this subdivision, medical assistance does not include general assistance medical care. The commissioner shall report annually on the number of hospitals likely to receive the adjustment authorized by this paragraph. The commissioner shall specifically report on the adjustments received by public hospitals and public hospital corporations located in cities of the first class;

(3) for a hospital that had medical assistance fee-for-service payment volume during calendar year 1991 in excess of 13 percent of total medical assistance fee-for-service payment volume, a medical assistance disproportionate population adjustment shall be paid in addition to any other disproportionate payment due under this subdivision as follows: \$1,515,000 due on the 15th of each month after noon, beginning July 15, 1995. For a hospital that had medical assistance fee-for-service payment volume during calendar 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

146.1 ~~services made by the department and by prepaid health plans participating in general~~
146.2 ~~assistance medical care~~ effective July 1, 2007, payments under section 256B.199 shall be
146.3 considered Medicaid disproportionate share hospital payments, except as limited ~~below:~~
146.4 by clauses (1) to (5);

146.5 (1) only the portion of Minnesota's disproportionate share hospital allotment under
146.6 section 1923(f) of the Social Security Act that is not spent on the disproportionate
146.7 population adjustments in paragraph (b), clauses (1) and (2), may be used ~~for general~~
146.8 ~~assistance medical care expenditures;~~

146.9 (2) only those ~~general assistance medical care~~ expenditures made to hospitals that
146.10 qualify for disproportionate share payments under section 1923 of the Social Security Act
146.11 and the Medicaid state plan may be considered disproportionate share hospital payments;

146.12 (3) only those ~~general assistance medical care~~ expenditures made to an individual
146.13 hospital that would not cause the hospital to exceed its individual hospital limits under
146.14 section 1923 of the Social Security Act may be considered; ~~and~~

146.15 (4) ~~general assistance medical care~~ expenditures may be considered only to the
146.16 extent of Minnesota's aggregate allotment under section 1923 of the Social Security Act.

146.17 All hospitals and prepaid health plans participating in general assistance medical care
146.18 must provide any necessary expenditure, cost, and revenue information required by
146.19 the commissioner as necessary for purposes of obtaining federal Medicaid matching
146.20 funds ~~for general assistance medical care expenditures.~~ Medicaid disproportionate share
146.21 payments; and

146.22 (5) expenditures under general assistance medical care shall be used to the fullest
146.23 extent before payments under section 256B.199.

146.24 (g) Upon federal approval of the related state plan amendment, paragraph (f) is
146.25 effective retroactively from July 1, 2005, or the earliest effective date approved by the
146.26 Centers for Medicare and Medicaid Services.

146.27 Sec. 5. Minnesota Statutes 2006, section 256.969, is amended by adding a subdivision
146.28 to read:

146.29 Subd. 28. Long-term hospital payment adjustment. For admissions occurring on
146.30 or after July 1, 2009, the commissioner shall increase the medical assistance payments
146.31 to a long-term hospital with a medical assistance inpatient utilization rate of 17.95
146.32 percent of total patient days as of the base year in effect on July 1, 2005, by an amount
146.33 equal to 13 percent of the total of the operating and property payment rates. Payments
146.34 made to managed care plans shall not reflect this payment increase. For purposes of
146.35 this subdivision, medical assistance does not include general assistance medical care.

147.1 Payments to a hospital under this subdivision shall be reduced by the amount of any
147.2 payments made under subdivision 27.

147.3 Sec. 6. Minnesota Statutes 2006, section 256B.04, subdivision 14, is amended to read:

147.4 Subd. 14. **Competitive bidding.** (a) When determined to be effective, economical,
147.5 and feasible, the commissioner may utilize volume purchase through competitive bidding
147.6 and negotiation under the provisions of chapter 16C, to provide items under the medical
147.7 assistance program including but not limited to the following:

147.8 (1) eyeglasses;

147.9 (2) oxygen. The commissioner shall provide for oxygen needed in an emergency
147.10 situation on a short-term basis, until the vendor can obtain the necessary supply from
147.11 the contract dealer;

147.12 (3) hearing aids and supplies; and

147.13 (4) durable medical equipment, including but not limited to:

147.14 (i) hospital beds;

147.15 (ii) commodes;

147.16 (iii) glide-about chairs;

147.17 (iv) patient lift apparatus;

147.18 (v) wheelchairs and accessories;

147.19 (vi) oxygen administration equipment;

147.20 (vii) respiratory therapy equipment;

147.21 (viii) electronic diagnostic, therapeutic and life support systems;

147.22 (5) ~~special nonemergency transportation services~~ level of need determinations,
147.23 disbursement of public transportation passes and tokens, and volunteer and recipient
147.24 mileage and parking reimbursements; and

147.25 (6) drugs.

147.26 (b) Rate changes under this chapter and chapters 256D and 256L do not affect
147.27 contract payments under this subdivision unless specifically identified.

147.28 Sec. 7. Minnesota Statutes 2006, section 256B.04, is amended by adding a subdivision
147.29 to read:

147.30 Subd. 14a. **Level of need determination.** Nonemergency medical transportation
147.31 level of need determinations must be performed by a physician, a registered nurse working
147.32 under direct supervision of a physician, a physician's assistant, a nurse practitioner, a
147.33 licensed practical nurse, or a discharge planner. Nonemergency medical transportation
147.34 level of need determinations must not be performed more than semiannually on any

148.1 individual, unless the individual's circumstances have sufficiently changed so as to
148.2 require a new level of need determination. Individuals residing in licensed nursing
148.3 facilities and individuals requiring stretcher transportation are exempt from a level of need
148.4 determination and are eligible for special transportation services until the individual no
148.5 longer resides in a licensed nursing facility or no longer requires stretcher transportation.

148.6 Sec. 8. Minnesota Statutes 2006, section 256B.055, subdivision 14, is amended to read:

148.7 Subd. 14. **Persons detained by law.** (a) Medical assistance may be paid for an
148.8 inmate of a correctional facility who is conditionally released as authorized under section
148.9 241.26, 244.065, or 631.425, if the individual does not require the security of a public
148.10 detention facility and is housed in a halfway house or community correction center, or
148.11 under house arrest and monitored by electronic surveillance in a residence approved
148.12 by the commissioner of corrections, and if the individual meets the other eligibility
148.13 requirements of this chapter.

148.14 (b) An individual who is enrolled in medical assistance, and who is charged with a
148.15 crime and incarcerated in a local jail, workhouse, or juvenile correctional facility for less
148.16 than 12 months shall be suspended from eligibility at the time of incarceration until the
148.17 individual is released. Upon release, medical assistance eligibility is reinstated without
148.18 reapplication, if the individual is otherwise eligible.

148.19 (c) An individual, regardless of age, who is considered an inmate of a public
148.20 institution as defined in Code of Federal Regulations, title 42, section 435.1009, is not
148.21 eligible for medical assistance.

148.22 Sec. 9. Minnesota Statutes 2006, section 256B.056, is amended by adding a
148.23 subdivision to read:

148.24 Subd. 1d. **Treatment of certain monetary gifts.** The commissioner shall disregard
148.25 as income any portion of a monetary gift received by an applicant or enrollee that is
148.26 designated to purchase a prosthetic device not covered by insurance, other third-party
148.27 payers, or medical assistance.

148.28 Sec. 10. Minnesota Statutes 2006, section 256B.0625, subdivision 3f, is amended to
148.29 read:

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

149.1 Sec. 11. Minnesota Statutes 2006, section 256B.0625, is amended by adding a
149.2 subdivision to read:

149.3 Subd. 8d. **Chiropractic services.** Medical assistance covers the following
149.4 medically necessary chiropractic services: one initial or progress exam per year, manual
149.5 manipulation of the spine, and x-rays.

149.6 **EFFECTIVE DATE.** This section is effective July 1, 2007.

149.7 Sec. 12. Minnesota Statutes 2006, section 256B.0625, subdivision 13c, is amended to
149.8 read:

149.9 Subd. 13c. **Formulary committee.** The commissioner, after receiving
149.10 recommendations from professional medical associations and professional pharmacy
149.11 associations, and consumer groups shall designate a Formulary Committee to carry
149.12 out duties as described in subdivisions 13 to 13g. The Formulary Committee shall be
149.13 comprised of four licensed physicians actively engaged in the practice of medicine in
149.14 Minnesota one of whom must be actively engaged in the treatment of persons with mental
149.15 illness; at least three licensed pharmacists actively engaged in the practice of pharmacy
149.16 in Minnesota; and one consumer representative; the remainder to be made up of health
149.17 care professionals who are licensed in their field and have recognized knowledge in the
149.18 clinically appropriate prescribing, dispensing, and monitoring of covered outpatient drugs.
149.19 Members of the Formulary Committee shall not be employed by the Department of
149.20 Human Services, but the committee shall be staffed by an employee of the department
149.21 who shall serve as an ex officio, nonvoting member of the ~~board~~ committee. The
149.22 department's medical director shall also serve as an ex officio, nonvoting member for the
149.23 committee. Committee members shall serve three-year terms and may be reappointed
149.24 by the commissioner. The Formulary Committee shall meet at least quarterly. The
149.25 commissioner may require more frequent Formulary Committee meetings as needed. An
149.26 honorarium of \$100 per meeting and reimbursement for mileage shall be paid to each
149.27 committee member in attendance.

149.28 Sec. 13. Minnesota Statutes 2006, section 256B.0625, subdivision 13d, is amended to
149.29 read:

149.30 Subd. 13d. **Drug formulary.** (a) The commissioner shall establish a drug
149.31 formulary. Its establishment and publication shall not be subject to the requirements of the
149.32 Administrative Procedure Act, but the Formulary Committee shall review and comment
149.33 on the formulary contents.

149.34 (b) The formulary shall not include:

- 150.1 (1) drugs or products for which there is no federal funding;
150.2 (2) over-the-counter drugs, except as provided in subdivision 13;
150.3 (3) drugs used for weight loss, except that medically necessary lipase inhibitors may
150.4 be covered for a recipient with type II diabetes;
150.5 (4) drugs when used for the treatment of impotence or erectile dysfunction;
150.6 (5) drugs for which medical value has not been established; and
150.7 (6) drugs from manufacturers who have not signed a rebate agreement with the
150.8 Department of Health and Human Services pursuant to section 1927 of title XIX of the
150.9 Social Security Act.

150.10 (c) If a single-source drug used by at least two percent of the fee-for-service
150.11 medical assistance recipients is removed from the formulary due to the failure of the
150.12 manufacturer to sign a rebate agreement with the Department of Health and Human
150.13 Services, the commissioner shall notify prescribing practitioners within 30 days of
150.14 receiving notification from the Centers for Medicare and Medicaid Services (CMS) that a
150.15 rebate agreement was not signed.

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

150.17 Sec. 14. Minnesota Statutes 2006, section 256B.0625, is amended by adding a
150.18 subdivision to read:

150.19 Subd. 13i. **Medicare Part D.** Notwithstanding subdivision 13, paragraph (d), for
150.20 recipients who are enrolled in a Medicare Part D prescription drug plan or Medicare
150.21 Advantage special needs plan, medical assistance covers co-payments which the recipient
150.22 is responsible for under a Medicare Part D prescription drug plan or Medicare Advantage
150.23 special needs plan, once the recipient has paid \$12 per month in prescription drug
150.24 co-payments, and according to the requirements of the plan.

150.25 Sec. 15. Minnesota Statutes 2006, section 256B.0625, subdivision 17, is amended to
150.26 read:

150.27 Subd. 17. **Transportation costs.** (a) Medical assistance covers transportation costs
150.28 incurred solely for obtaining emergency medical care or transportation costs incurred
150.29 by eligible persons in obtaining emergency or nonemergency medical care when paid
150.30 directly to an ambulance company, common carrier, or other recognized providers of
150.31 transportation services.

150.32 (b) Medical assistance covers special transportation, as defined in Minnesota Rules,
150.33 part 9505.0315, subpart 1, item F, if the recipient has a physical or mental impairment that

151.1 would prohibit the recipient from safely accessing and using a bus, taxi, other commercial
151.2 transportation, or private automobile.

151.3 The commissioner may use an order by the recipient's attending physician to certify that
151.4 the recipient requires special transportation services. Special transportation includes
151.5 driver-assisted service to eligible individuals. Driver-assisted service includes passenger
151.6 pickup at and return to the individual's residence or place of business, assistance with
151.7 admittance of the individual to the medical facility, and assistance in passenger securement
151.8 or in securing of wheelchairs or stretchers in the vehicle. Special transportation providers
151.9 must obtain written documentation from the health care service provider who is serving
151.10 the recipient being transported, identifying the time that the recipient arrived. Special
151.11 transportation providers may not bill for separate base rates for the continuation of a trip
151.12 beyond the original destination. Special transportation providers must take recipients
151.13 to the nearest appropriate health care provider, using the ~~most direct~~ quickest route
151.14 available as determined by a commercially available mileage software program approved
151.15 by the commissioner. The maximum medical assistance reimbursement rates for special
151.16 transportation services are:

151.17 (1) \$17 for the base rate and ~~\$1.35~~ \$1.43 per mile for services to eligible persons
151.18 who need a wheelchair-accessible van;

151.19 (2) \$11.50 for the base rate and \$1.30 per mile for services to eligible persons who
151.20 do not need a wheelchair-accessible van; and

151.21 (3) \$60 for the base rate and \$2.40 per mile, and an attendant rate of \$9 per trip, for
151.22 services to eligible persons who need a stretcher-accessible vehicle.

151.23 Sec. 16. Minnesota Statutes 2006, section 256B.0625, subdivision 18a, is amended to
151.24 read:

151.25 Subd. 18a. **Access to medical services.** (a) Medical assistance reimbursement for
151.26 meals for persons traveling to receive medical care may not exceed \$5.50 for breakfast,
151.27 \$6.50 for lunch, or \$8 for dinner.

151.28 (b) Medical assistance reimbursement for lodging for persons traveling to receive
151.29 medical care may not exceed \$50 per day unless prior authorized by the local agency.

151.30 (c) Medical assistance direct mileage reimbursement to ~~the~~ an eligible person or ~~the~~
151.31 an eligible person's driver may not exceed 20 cents per mile friend, neighbor, or relative
151.32 that is providing direct transportation to a covered service shall be at 15 cents below the
151.33 current Internal Revenue Service mileage reimbursement for business purposes.

152.1 (d) Medical assistance covers oral language interpreter services when provided by
152.2 an enrolled health care provider during the course of providing a direct, person-to-person
152.3 covered health care service to an enrolled recipient with limited English proficiency.

152.4 Sec. 17. Minnesota Statutes 2006, section 256B.0625, is amended by adding a
152.5 subdivision to read:

152.6 Subd. 49. **Community health worker.** (a) Medical assistance covers the care
152.7 coordination and patient education services provided by a community health worker if
152.8 the community health worker has:

152.9 (1) received a certificate from the Minnesota State Colleges and Universities System
152.10 approved community health worker curriculum; or

152.11 (2) at least five years of supervised experience with an enrolled physician or
152.12 advanced practice registered nurse.

152.13 Community health workers eligible for payment under clause (2) must complete the
152.14 certification program by January 1, 2010, to continue to be eligible for payment.

152.15 (b) Community health workers must work under the supervision of a medical
152.16 assistance enrolled physician or advanced practice registered nurse.

152.17 Sec. 18. Minnesota Statutes 2006, section 256B.0644, is amended to read:

152.18 **256B.0644 REIMBURSEMENT UNDER OTHER STATE HEALTH CARE**
152.19 **PROGRAMS.**

152.20 (a) A vendor of medical care, as defined in section 256B.02, subdivision 7, and a
152.21 health maintenance organization, as defined in chapter 62D, must participate as a provider
152.22 or contractor in the medical assistance program, general assistance medical care program,
152.23 and MinnesotaCare as a condition of participating as a provider in health insurance plans
152.24 and programs or contractor for state employees established under section 43A.18, the
152.25 public employees insurance program under section 43A.316, for health insurance plans
152.26 offered to local statutory or home rule charter city, county, and school district employees,
152.27 the workers' compensation system under section 176.135, and insurance plans provided
152.28 through the Minnesota Comprehensive Health Association under sections 62E.01 to
152.29 62E.19. The limitations on insurance plans offered to local government employees shall
152.30 not be applicable in geographic areas where provider participation is limited by managed
152.31 care contracts with the Department of Human Services.

152.32 (b) For providers other than health maintenance organizations, participation in the
152.33 medical assistance program means that:

(1) the provider accepts new medical assistance, general assistance medical care, and MinnesotaCare patients ~~or~~;

(2) for providers other than dental service providers, at least 20 percent of the provider's patients are covered by medical assistance, general assistance medical care, and MinnesotaCare as their primary source of coverage, ~~or~~, or

(3) for dental service providers, at least ten percent of the provider's patients are covered by medical assistance, general assistance medical care, and MinnesotaCare as their primary source of coverage, or the provider accepts new medical assistance and MinnesotaCare patients who are children with special health care needs. For purposes of this section, "children with special health care needs" means children up to age 18 who: (i) require health and related services beyond that required by children generally; and (ii) have or are at risk for a chronic physical, developmental, behavioral, or emotional condition, including: bleeding and coagulation disorders; immunodeficiency disorders; cancer; endocrinopathy; developmental disabilities; epilepsy, cerebral palsy, and other neurological diseases; visual impairment or deafness; Down syndrome and other genetic disorders; autism; fetal alcohol syndrome; and other conditions designated by the commissioner after consultation with representatives of pediatric dental providers and consumers.

(c) Patients seen on a volunteer basis by the provider at a location other than the provider's usual place of practice may be considered in meeting ~~this~~ the participation requirement in this section. The commissioner shall establish participation requirements for health maintenance organizations. The commissioner shall provide lists of participating medical assistance providers on a quarterly basis to the commissioner of employee relations, the commissioner of labor and industry, and the commissioner of commerce. Each of the commissioners shall develop and implement procedures to exclude as participating providers in the program or programs under their jurisdiction those providers who do not participate in the medical assistance program. The commissioner of employee relations shall implement this section through contracts with participating health and dental carriers.

Sec. 19. **[256B.0751] CARE COORDINATION FOR CHILDREN WITH HIGH-COST MEDICAL CONDITIONS.**

Subdivision 1. Care coordination required. (a) The commissioner of human services shall contract with the U special kids program to provide care coordination, beginning October 1, 2007, for medical assistance enrollees who are children with high-cost medical conditions, and to perform the other duties specified in this section.

154.1 (b) For purposes of this section, "care coordination" means collaboration with
154.2 primary care physicians and specialists to manage care, development of medical
154.3 management plans for recurrent acute illnesses, oversight and coordination of all aspects
154.4 of care in partnership with families, organization of medical information into a summary
154.5 of critical information, coordination and appropriate sequencing of tests and multiple
154.6 appointments, information and assistance with accessing resources, and telephone triage
154.7 for acute illnesses or problems.

154.8 Subd. 2. **Referrals.** The commissioner shall develop a mechanism to refer
154.9 children to the U special kids program for care coordination. Beginning October 1, 2007,
154.10 and subject to the limits on total program enrollment specified in subdivision 3, the
154.11 commissioner shall refer to the U special kids program children who:

154.12 (1) incur medical expenses that exceed the qualifying level specified in subdivision 3;

154.13 (2) have medical conditions that involve four or more major systems; require
154.14 multiple specialists; require use of technology such as G-tube, trach, central line, or
154.15 oxygen; and require multiple medications;

154.16 (3) do not have a medical case manager for cancer, organ transplantation, epilepsy,
154.17 or bone marrow replacement; and

154.18 (4) voluntarily agree to participate in the program.

154.19 Subd. 3. **Qualifying level of medical expenses.** (a) For the period October 1, 2007,
154.20 through September 30, 2008, the commissioner shall refer children for care coordination
154.21 under this section if they incurred medical expenses of \$500,000 or more during the
154.22 fiscal year ending June 30, 2007.

154.23 (b) For the period October 1, 2008, through September 30, 2009, the commissioner
154.24 shall refer children for care coordination under this section if they incurred medical
154.25 expenses of \$400,000 or more during the fiscal year ending June 30, 2008.

154.26 (c) For the period October 1, 2009, through September 30, 2010, the commissioner
154.27 shall refer children for care coordination under this section if they incurred medical
154.28 expenses of \$300,000 or more during the fiscal year ending June 30, 2009.

154.29 (d) Beginning October 1, 2010, the commissioner shall refer children for care
154.30 coordination under this section if they incurred medical expenses of \$250,000 or more
154.31 during the previous fiscal year.

154.32 (e) The commissioner shall limit referrals to the extent necessary to ensure that
154.33 total enrollment in the U special kids program does not exceed 100 children for the
154.34 period October 1, 2007, through September 30, 2008, and does not exceed 150 children
154.35 beginning October 1, 2008.

155.1 Subd. 4. **Case management.** Beginning October 1, 2007, the U special kids
155.2 program shall coordinate all nonmedical case management services provided to children
155.3 who are required to receive care coordination under this section. The program may
155.4 require all nonmedical case managers, including, but not limited to, county case managers
155.5 and case managers for children served under a home and community-based waiver,
155.6 to submit care plans for approval, and to document client compliance with the care
155.7 plans. The U special kids program, beginning October 1, 2008, may employ or contract
155.8 with nonmedical case managers to provide all nonmedical case management services to
155.9 children required to receive care coordination under this section. The commissioner shall
155.10 reimburse the U special kids program for case management services through the medical
155.11 assistance program.

155.12 Subd. 5. **Statewide availability of care coordination.** The U special kids program
155.13 may contract with other entities to provide care coordination services as defined in
155.14 subdivision 1, in order to ensure the availability of these services in all regions of the state.

155.15 Subd. 6. **Advance practice nurse telephone triage system.** The U special kids
155.16 program shall establish and operate an advance practice nurse telephone triage system that
155.17 is available statewide, 24 hours a day, seven days per week. The system must provide
155.18 advance practice nurses with access to a Web-based information system to appropriately
155.19 triage medical problems, manage care, and reduce unnecessary hospitalizations.

155.20 Subd. 7. **Monitoring and evaluation.** The commissioner shall monitor program
155.21 outcomes and evaluate the extent to which referrals to the U special kids program have
155.22 improved the quality and coordination of care and provided financial savings to the
155.23 medical assistance program. The U special kids program shall submit to the commissioner,
155.24 in the form and manner specified by the commissioner, all data and information necessary
155.25 to monitor program outcomes and evaluate the program. The commissioner shall present a
155.26 preliminary evaluation to the legislature by January 15, 2008, and a final evaluation to the
155.27 legislature by January 15, 2010.

155.28 **EFFECTIVE DATE.** This section is effective October 1, 2007, or upon federal
155.29 approval, whichever is later.

155.30 Sec. 20. **[256B.0752] CARE COORDINATION FOR CHILDREN WITH**
155.31 **HIGH-COST MENTAL HEALTH CONDITIONS.**

155.32 Subdivision 1. **Care coordination required.** (a) The commissioner of human
155.33 services shall contract with the U special kids program to provide care coordination,
155.34 beginning October 1, 2007, for medical assistance enrollees who are children with

156.1 high-cost mental health conditions and behavioral problems, and to perform the other
156.2 duties specified in this section.

156.3 (b) For purposes of this section, "care coordination" means: collaboration with
156.4 primary care physicians and specialists to manage care; development of mental health
156.5 management plans for recurrent mental health issues; oversight and coordination of all
156.6 aspects of care in partnership with families; organization of medical, treatment, and
156.7 therapy information into a summary of critical information; coordination and appropriate
156.8 sequencing of evaluations and multiple appointments; information and assistance with
156.9 accessing resources; and telephone triage for behavior or other problems.

156.10 Subd. 2. **Referrals.** The commissioner shall develop a mechanism to refer children
156.11 to the program for care coordination. Beginning October 1, 2007, and subject to the limits
156.12 on total program enrollment specified in subdivision 3, the commissioner shall refer to
156.13 the U special kids program children who:

156.14 (1) incur mental health expenses that exceed the qualifying level specified in
156.15 subdivision 3;

156.16 (2) are currently receiving or at risk of needing inpatient mental health treatment,
156.17 foster home care, or both; and

156.18 (3) voluntarily agree to participate in the program.

156.19 Subd. 3. **Qualifying level of medical expenses.** (a) Beginning October 1, 2007, the
156.20 commissioner shall refer children for care coordination under this section if they incurred
156.21 medical and mental health expenses of \$250,000 or more in the previous fiscal year.

156.22 (b) The commissioner shall limit referrals to the extent necessary to ensure that total
156.23 enrollment in the U special kids program does not exceed 25 children for the period
156.24 October 1, 2007, through September 30, 2008; does not exceed 75 children for the
156.25 period October 1, 2008, through September 30, 2009; and does not exceed 125 children
156.26 beginning October 1, 2009.

156.27 Subd. 4. **Case management.** The U special kids program, beginning October 1,
156.28 2007, shall coordinate all nonmedical case management services provided to children who
156.29 are required to receive care coordination under this section. The program may require all
156.30 nonmedical case managers, including but not limited to county case managers and case
156.31 managers for children served under a home and community-based waiver, to submit care
156.32 plans for approval, and to document client compliance with the care plans. The U special
156.33 kids program, beginning October 1, 2008, may employ or contract with nonmedical case
156.34 managers to provide all nonmedical case management services to children required to
156.35 receive care coordination under this section. The commissioner shall reimburse the

157.1 U special kids program for case management services through the medical assistance
157.2 program.

157.3 Subd. 5. **Statewide availability of care coordination.** The program may contract
157.4 with other entities to provide care coordination services as defined in subdivision 1, in
157.5 order to ensure the availability of these services in all regions of the state.

157.6 Subd. 6. **Monitoring and evaluation.** The commissioner shall monitor program
157.7 outcomes and shall evaluate the extent to which referrals to the U special kids program
157.8 have improved the quality and coordination of care and provided financial savings to the
157.9 medical assistance program. The U special kids program shall submit to the commissioner,
157.10 in the form and manner specified by the commissioner, all data and information necessary
157.11 to monitor program outcomes and evaluate the program. The commissioner shall present a
157.12 preliminary evaluation to the legislature by January 15, 2008, and a final evaluation to the
157.13 legislature by January 15, 2010.

157.14 **EFFECTIVE DATE.** This section is effective October 1, 2007, or upon federal
157.15 approval, whichever is later. The commissioner shall notify the Office of the Revisor of
157.16 Statutes when federal approval is obtained.

157.17 Sec. 21. **[256B.194] FEDERAL PAYMENTS.**

157.18 Subdivision 1. **Payments at actual cost.** If the Centers for Medicare & Medicaid
157.19 Services (CMS) promulgates a final rule consistent with its stated intent in the proposed
157.20 rule published at 72 Federal Register, No. 11, January 18, 2007, regarding limiting
157.21 payments to units of government, and notwithstanding Minnesota Statutes or Minnesota
157.22 Rules to the contrary, for providers that are units of government, the commissioner may
157.23 limit medical assistance and MinnesotaCare payments to a provider's actual cost of
157.24 providing services, in accordance with the CMS final rule. If a final rule is promulgated,
157.25 the commissioner may also require medical assistance and MinnesotaCare providers to
157.26 provide any information necessary to determine Medicaid-related costs, and require the
157.27 cooperation of providers in any audit or review necessary to ensure payments are limited
157.28 to cost. This section does not apply to providers who are exempt from the provisions of
157.29 the CMS final rule.

157.30 Subd. 2. **Loss of federal financial participation.** For all transfers, certified
157.31 expenditures, and medical assistance payments listed below, if the commissioner
157.32 determines that federal financial participation is no longer available for the medical
157.33 assistance payments listed, then related obligations for the nonfederal share of payments
157.34 and the medical assistance payments shall terminate. The commissioner shall notify all
157.35 affected parties of the loss of federal financial participation, and the resulting payments

158.1 and obligations that are terminated. If the commissioner determines that federal financial
158.2 participation is no longer available for any medical assistance payments or contributions
158.3 to the nonfederal share of medical assistance payments that have already been made, the
158.4 commissioner may collect the medical assistance payments from providers and return
158.5 contributions of the nonfederal share to its source. The transfers, certified expenditures,
158.6 and medical assistance payments subject to this section are those specified in: sections
158.7 62J.692, subdivision 7, paragraphs (b) and (c); 256B.19, subdivisions 1c and 1d;
158.8 256B.195; 256B.431, subdivision 23; and 256B.69, subdivision 5c, paragraph (a), clauses
158.9 (2), (3), and (4); Laws 2002, chapter 220, article 17, section 2, subdivision 3; and Laws
158.10 2005, First Special Session chapter 4, article 9, section 2, subdivision 1.

158.11 Sec. 22. Minnesota Statutes 2006, section 256B.199, is amended to read:

158.12 **256B.199 PAYMENTS REPORTED BY GOVERNMENTAL ENTITIES.**

158.13 (a) ~~Hennepin County; and Hennepin County Medical Center, Ramsey County,~~
158.14 ~~Regions Hospital, the University of Minnesota, and Fairview-University Medical Center~~
158.15 shall report quarterly to the commissioner beginning June 1, 2007, payments made during
158.16 the second previous quarter that may qualify for reimbursement under federal law.

158.17 (b) Based on these reports, the commissioner shall apply for federal matching funds.
158.18 These funds are appropriated to the commissioner for ~~the payments under section 256.969,~~
158.19 ~~subdivision 27 to Hennepin County Medical Center.~~

158.20 (c) By May 1 of each year, beginning May 1, 2007, the commissioner shall inform
158.21 the nonstate entities listed in paragraph (a) of the amount of federal disproportionate share
158.22 hospital payment money expected to be available in the current federal fiscal year.

158.23 ~~(d) This section sunsets on June 30, 2009. The commissioner shall report to~~
158.24 ~~the legislature by December 15, 2008, with recommendations for maximizing federal~~
158.25 ~~disproportionate share hospital payments after June 30, 2009.~~

158.26 Sec. 23. Minnesota Statutes 2006, section 256B.75, is amended to read:

158.27 **256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.**

158.28 (a) For outpatient hospital facility fee payments for services rendered on or after
158.29 October 1, 1992, the commissioner of human services shall pay the lower of (1) submitted
158.30 charge, or (2) 32 percent above the rate in effect on June 30, 1992, except for those
158.31 services for which there is a federal maximum allowable payment. Effective for services
158.32 rendered on or after January 1, 2000, payment rates for nonsurgical outpatient hospital
158.33 facility fees and emergency room facility fees shall be increased by eight percent over the
158.34 rates in effect on December 31, 1999, except for those services for which there is a federal

159.1 maximum allowable payment. Services for which there is a federal maximum allowable
159.2 payment shall be paid at the lower of (1) submitted charge, or (2) the federal maximum
159.3 allowable payment. Total aggregate payment for outpatient hospital facility fee services
159.4 shall not exceed the Medicare upper limit. If it is determined that a provision of this
159.5 section conflicts with existing or future requirements of the United States government with
159.6 respect to federal financial participation in medical assistance, the federal requirements
159.7 prevail. The commissioner may, in the aggregate, prospectively reduce payment rates to
159.8 avoid reduced federal financial participation resulting from rates that are in excess of
159.9 the Medicare upper limitations.

159.10 (b) Notwithstanding paragraph (a), payment for outpatient, emergency, and
159.11 ambulatory surgery hospital facility fee services for critical access hospitals designated
159.12 under section 144.1483, clause (10), shall be paid on a cost-based payment system that
159.13 is based on the cost-finding methods and allowable costs of the Medicare program. All
159.14 hospital outpatient services provided by any hospital exclusively devoted to the care of
159.15 pediatric patients under age 21 that is located in a Minnesota metropolitan statistical area
159.16 must be paid for using the methodology established for critical access hospitals at a rate
159.17 equal to fee-for-service rates plus 46 percent, as limited by allowable costs.

159.18 (c) Effective for services provided on or after July 1, 2003, rates that are based
159.19 on the Medicare outpatient prospective payment system shall be replaced by a budget
159.20 neutral prospective payment system that is derived using medical assistance data. The
159.21 commissioner shall provide a proposal to the 2003 legislature to define and implement
159.22 this provision.

159.23 (d) For fee-for-service services provided on or after July 1, 2002, the total payment,
159.24 before third-party liability and spenddown, made to hospitals for outpatient hospital
159.25 facility services is reduced by .5 percent from the current statutory rate.

159.26 (e) In addition to the reduction in paragraph (d), the total payment for fee-for-service
159.27 services provided on or after July 1, 2003, made to hospitals for outpatient hospital
159.28 facility services before third-party liability and spenddown, is reduced five percent from
159.29 the current statutory rates. Facilities defined under section 256.969, subdivision 16, are
159.30 excluded from this paragraph.

159.31 **EFFECTIVE DATE.** This section is effective July 1, 2007, and applies to services
159.32 provided on or after that date.

159.33 Sec. 24. Minnesota Statutes 2006, section 256B.76, is amended to read:

159.34 **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

recipients, developing and implementing patient care criteria, upgrading or establishing new facilities, acquiring furnishings or equipment, recruiting new providers, or other development costs that will improve access to dental care in a region. In awarding grants, the commissioner shall give priority to applicants that plan to serve areas of the state in which the number of dental providers is not currently sufficient to meet the needs of recipients of public programs or uninsured individuals. The commissioner shall consider the following in awarding the grants:

- (i) potential to successfully increase access to an underserved population;
- (ii) the ability to raise matching funds;
- (iii) the long-term viability of the project to improve access beyond the period of initial funding;
- (iv) the efficiency in the use of the funding; and
- (v) the experience of the proposers in providing services to the target population.

The commissioner shall monitor the grants and may terminate a grant if the grantee does not increase dental access for public program recipients. The commissioner shall consider grants for the following:

- (i) implementation of new programs or continued expansion of current access programs that have demonstrated success in providing dental services in underserved areas;
- (ii) a pilot program for utilizing hygienists outside of a traditional dental office to provide dental hygiene services; and
- (iii) a program that organizes a network of volunteer dentists, establishes a system to refer eligible individuals to volunteer dentists, and through that network provides donated dental care services to public program recipients or uninsured individuals;

(5) beginning October 1, 1999, the payment for tooth sealants and fluoride treatments shall be the lower of (i) submitted charge, or (ii) 80 percent of median 1997 charges;

(6) the increases listed in clauses (3) and (5) shall be implemented January 1, 2000, for managed care; and

(7) effective for services provided on or after January 1, 2002, payment for diagnostic examinations and dental x-rays provided to children under age 21 shall be the lower of (i) the submitted charge, or (ii) 85 percent of median 1999 charges.

(c) Effective for dental services rendered on or after January 1, 2002, the commissioner may, ~~within the limits of available appropriation,~~ increase reimbursements to dentists and dental clinics deemed by the commissioner to be critical access dental providers. ~~Reimbursement to a critical access dental provider may be increased by not more than 50 percent above the reimbursement rate that would otherwise be paid to the~~

162.1 ~~provider. Payments to~~ For dental services rendered after June 30, 2007, the commissioner
162.2 shall increase reimbursement by 33 percent above the reimbursement rate that would
162.3 otherwise be paid to the provider. The commissioner shall pay the health plan companies
162.4 ~~shall be adjusted~~ in amounts sufficient to reflect increased reimbursements to critical
162.5 access dental providers as approved by the commissioner. In determining which dentists
162.6 and dental clinics shall be deemed critical access dental providers, the commissioner
162.7 shall review:

162.8 (1) the utilization rate in the service area in which the dentist or dental clinic operates
162.9 for dental services to patients covered by medical assistance, general assistance medical
162.10 care, or MinnesotaCare as their primary source of coverage;

162.11 (2) the level of services provided by the dentist or dental clinic to patients covered
162.12 by medical assistance, general assistance medical care, or MinnesotaCare as their primary
162.13 source of coverage; and

162.14 (3) whether the level of services provided by the dentist or dental clinic is critical to
162.15 maintaining adequate levels of patient access within the service area.

162.16 In the absence of a critical access dental provider in a service area, the commissioner may
162.17 designate a dentist or dental clinic as a critical access dental provider if the dentist or
162.18 dental clinic is willing to provide care to patients covered by medical assistance, general
162.19 assistance medical care, or MinnesotaCare at a level which significantly increases access
162.20 to dental care in the service area.

162.21 ~~The commissioner shall annually establish a reimbursement schedule for critical~~
162.22 ~~access dental providers and provider-specific limits on total reimbursement received~~
162.23 ~~under the reimbursement schedule, and shall notify each critical access dental provider~~
162.24 ~~of the schedule and limit.~~

162.25 (d) An entity that operates both a Medicare certified comprehensive outpatient
162.26 rehabilitation facility and a facility which was certified prior to January 1, 1993, that is
162.27 licensed under Minnesota Rules, parts 9570.2000 to 9570.3600, and for whom at least 33
162.28 percent of the clients receiving rehabilitation services in the most recent calendar year are
162.29 medical assistance recipients, shall be reimbursed by the commissioner for rehabilitation
162.30 services at rates that are 38 percent greater than the maximum reimbursement rate
162.31 allowed under paragraph (a), clause (2), when those services are (1) provided within the
162.32 comprehensive outpatient rehabilitation facility and (2) provided to residents of nursing
162.33 facilities owned by the entity.

162.34 (e) Effective for services rendered on or after January 1, 2007, the commissioner
162.35 shall make payments for physician and professional services based on the Medicare

163.1 relative value units (RVU's). This change shall be budget neutral and the cost of
163.2 implementing RVU's will be incorporated in the established conversion factor.

163.3 Sec. 25. Minnesota Statutes 2006, section 256D.03, subdivision 4, is amended to read:

163.4 Subd. 4. **General assistance medical care; services.** (a)(i) For a person who is
163.5 eligible under subdivision 3, paragraph (a), clause (2), item (i), general assistance medical
163.6 care covers, except as provided in paragraph (c):

163.7 (1) inpatient hospital services;

163.8 (2) outpatient hospital services;

163.9 (3) services provided by Medicare certified rehabilitation agencies;

163.10 (4) prescription drugs and other products recommended through the process
163.11 established in section 256B.0625, subdivision 13;

163.12 (5) equipment necessary to administer insulin and diagnostic supplies and equipment
163.13 for diabetics to monitor blood sugar level;

163.14 (6) eyeglasses and eye examinations provided by a physician or optometrist;

163.15 (7) hearing aids;

163.16 (8) prosthetic devices;

163.17 (9) laboratory and X-ray services;

163.18 (10) physician's services;

163.19 (11) medical transportation except special transportation;

163.20 (12) chiropractic services as covered under the medical assistance program;

163.21 (13) podiatric services;

163.22 (14) dental services as covered under the medical assistance program;

163.23 (15) outpatient services provided by a mental health center or clinic that is under
163.24 contract with the county board and is established under section 245.62;

163.25 (16) day treatment services for mental illness provided under contract with the
163.26 county board;

163.27 (17) prescribed medications for persons who have been diagnosed as mentally ill as
163.28 necessary to prevent more restrictive institutionalization;

163.29 (18) psychological services, medical supplies and equipment, and Medicare
163.30 premiums, coinsurance and deductible payments;

163.31 (19) medical equipment not specifically listed in this paragraph when the use of
163.32 the equipment will prevent the need for costlier services that are reimbursable under
163.33 this subdivision;

163.34 (20) services performed by a certified pediatric nurse practitioner, a certified family
163.35 nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological

164.1 nurse practitioner, a certified neonatal nurse practitioner, or a certified geriatric nurse
164.2 practitioner in independent practice, if (1) the service is otherwise covered under this
164.3 chapter as a physician service, (2) the service provided on an inpatient basis is not included
164.4 as part of the cost for inpatient services included in the operating payment rate, and (3) the
164.5 service is within the scope of practice of the nurse practitioner's license as a registered
164.6 nurse, as defined in section 148.171;

164.7 (21) services of a certified public health nurse or a registered nurse practicing in
164.8 a public health nursing clinic that is a department of, or that operates under the direct
164.9 authority of, a unit of government, if the service is within the scope of practice of the
164.10 public health nurse's license as a registered nurse, as defined in section 148.171;

164.11 (22) telemedicine consultations, to the extent they are covered under section
164.12 256B.0625, subdivision 3b; ~~and~~

164.13 (23) mental health telemedicine and psychiatric consultation as covered under
164.14 section 256B.0625, subdivisions 46 and 48;

164.15 (24) care coordination and patient education services provided by a community
164.16 health worker according to section 256B.0625, subdivision 49; and

164.17 (25) regardless of the number of employees that an enrolled health care provider
164.18 may have, sign language interpreter services when provided by an enrolled health care
164.19 provider during the course of providing a direct, person-to-person covered health care
164.20 service to an enrolled recipient who has a hearing loss and uses interpreting services.

164.21 (ii) Effective October 1, 2003, for a person who is eligible under subdivision 3,
164.22 paragraph (a), clause (2), item (ii), general assistance medical care coverage is limited
164.23 to inpatient hospital services, including physician services provided during the inpatient
164.24 hospital stay. A \$1,000 deductible is required for each inpatient hospitalization.

164.25 (b) Effective August 1, 2005, sex reassignment surgery is not covered under this
164.26 subdivision.

164.27 (c) In order to contain costs, the commissioner of human services shall select
164.28 vendors of medical care who can provide the most economical care consistent with high
164.29 medical standards and shall where possible contract with organizations on a prepaid
164.30 capitation basis to provide these services. The commissioner shall consider proposals by
164.31 counties and vendors for prepaid health plans, competitive bidding programs, block grants,
164.32 or other vendor payment mechanisms designed to provide services in an economical
164.33 manner or to control utilization, with safeguards to ensure that necessary services are
164.34 provided. Before implementing prepaid programs in counties with a county operated or
164.35 affiliated public teaching hospital or a hospital or clinic operated by the University of
164.36 Minnesota, the commissioner shall consider the risks the prepaid program creates for the

165.1 hospital and allow the county or hospital the opportunity to participate in the program in a
165.2 manner that reflects the risk of adverse selection and the nature of the patients served by
165.3 the hospital, provided the terms of participation in the program are competitive with the
165.4 terms of other participants considering the nature of the population served. Payment for
165.5 services provided pursuant to this subdivision shall be as provided to medical assistance
165.6 vendors of these services under sections 256B.02, subdivision 8, and 256B.0625. For
165.7 payments made during fiscal year 1990 and later years, the commissioner shall consult
165.8 with an independent actuary in establishing prepayment rates, but shall retain final control
165.9 over the rate methodology.

165.10 (d) Effective January 1, 2008, drug coverage under general assistance medical care
165.11 is limited to prescription drugs that:

165.12 (i) are covered under the medical assistance program as described in section
165.13 256B.0625, subdivisions 13 and 13d; and

165.14 (ii) are provided by manufacturers that have fully executed general assistance
165.15 medical care rebate agreements with the commissioner and comply with the agreements.

165.16 Prescription drug coverage under general assistance medical care must conform to
165.17 coverage under the medical assistance program according to section 256B.0625,
165.18 subdivisions 13 to 13g.

165.19 ~~(d)~~ (e) Recipients eligible under subdivision 3, paragraph (a), shall pay the following
165.20 co-payments for services provided on or after October 1, 2003:

165.21 (1) \$25 for eyeglasses;

165.22 (2) \$25 for nonemergency visits to a hospital-based emergency room;

165.23 (3) \$3 per brand-name drug prescription and \$1 per generic drug prescription,
165.24 subject to a \$12 per month maximum for prescription drug co-payments. No co-payments
165.25 shall apply to antipsychotic drugs when used for the treatment of mental illness; and

165.26 (4) 50 percent coinsurance on restorative dental services.

165.27 ~~(e)~~ (f) Co-payments shall be limited to one per day per provider for nonpreventive
165.28 visits, eyeglasses, and nonemergency visits to a hospital-based emergency room.

165.29 Recipients of general assistance medical care are responsible for all co-payments in this
165.30 subdivision. The general assistance medical care reimbursement to the provider shall be
165.31 reduced by the amount of the co-payment, except that reimbursement for prescription
165.32 drugs shall not be reduced once a recipient has reached the \$12 per month maximum for
165.33 prescription drug co-payments. The provider collects the co-payment from the recipient.
165.34 Providers may not deny services to recipients who are unable to pay the co-payment,
165.35 except as provided in paragraph (f).

166.1 ~~(f)~~ (g) If it is the routine business practice of a provider to refuse service to an
166.2 individual with uncollected debt, the provider may include uncollected co-payments
166.3 under this section. A provider must give advance notice to a recipient with uncollected
166.4 debt before services can be denied.

166.5 ~~(g)~~ (h) Any county may, from its own resources, provide medical payments for
166.6 which state payments are not made.

166.7 ~~(h)~~ (i) Chemical dependency services that are reimbursed under chapter 254B must
166.8 not be reimbursed under general assistance medical care.

166.9 ~~(i)~~ (j) The maximum payment for new vendors enrolled in the general assistance
166.10 medical care program after the base year shall be determined from the average usual and
166.11 customary charge of the same vendor type enrolled in the base year.

166.12 ~~(j)~~ (k) The conditions of payment for services under this subdivision are the same
166.13 as the conditions specified in rules adopted under chapter 256B governing the medical
166.14 assistance program, unless otherwise provided by statute or rule.

166.15 ~~(k)~~ (l) Inpatient and outpatient payments shall be reduced by five percent, effective
166.16 July 1, 2003. This reduction is in addition to the five percent reduction effective July 1,
166.17 2003, and incorporated by reference in paragraph (i).

166.18 ~~(l)~~ (m) Payments for all other health services except inpatient, outpatient, and
166.19 pharmacy services shall be reduced by five percent, effective July 1, 2003.

166.20 ~~(m)~~ (n) Payments to managed care plans shall be reduced by five percent for services
166.21 provided on or after October 1, 2003.

166.22 ~~(n)~~ (o) A hospital receiving a reduced payment as a result of this section may apply
166.23 the unpaid balance toward satisfaction of the hospital's bad debts.

166.24 ~~(o)~~ (p) Fee-for-service payments for nonpreventive visits shall be reduced by \$3
166.25 for services provided on or after January 1, 2006. For purposes of this subdivision, a
166.26 visit means an episode of service which is required because of a recipient's symptoms,
166.27 diagnosis, or established illness, and which is delivered in an ambulatory setting by
166.28 a physician or physician ancillary, chiropractor, podiatrist, advance practice nurse,
166.29 audiologist, optician, or optometrist.

166.30 ~~(p)~~ (q) Payments to managed care plans shall not be increased as a result of the
166.31 removal of the \$3 nonpreventive visit co-payment effective January 1, 2006.

166.32 Sec. 26. Minnesota Statutes 2006, section 256L.01, subdivision 4, is amended to read:

166.33 Subd. 4. **Gross individual or gross family income.** (a) "Gross individual or gross
166.34 family income" for nonfarm self-employed means income calculated for the six-month
166.35 period of eligibility using the net profit or loss reported on the applicant's federal income

167.1 tax form for the previous year and using the medical assistance families with children
167.2 methodology for determining allowable and nonallowable self-employment expenses and
167.3 countable income.

167.4 (b) "Gross individual or gross family income" for farm self-employed means income
167.5 calculated for the six-month period of eligibility using as the baseline the adjusted gross
167.6 income reported on the applicant's federal income tax form for the previous year ~~and~~
167.7 ~~adding back in reported depreciation amounts that apply to the business in which the~~
167.8 ~~family is currently engaged.~~

167.9 (c) "Gross individual or gross family income" means the total income for all family
167.10 members, calculated for the six-month period of eligibility.

167.11 **EFFECTIVE DATE.** This section is effective July 1, 2007, or upon federal
167.12 approval, whichever is later.

167.13 Sec. 27. Minnesota Statutes 2006, section 256L.03, subdivision 5, is amended to read:

167.14 Subd. 5. **Co-payments and coinsurance.** (a) Except as provided in paragraphs (b)
167.15 and (c), the MinnesotaCare benefit plan shall include the following co-payments and
167.16 coinsurance requirements for all enrollees:

167.17 (1) ten percent of the paid charges for inpatient hospital services for adult enrollees,
167.18 subject to an annual inpatient out-of-pocket maximum of \$1,000 per individual and
167.19 \$3,000 per family;

167.20 (2) \$3 per prescription for adult enrollees;

167.21 (3) \$25 for eyeglasses for adult enrollees;

167.22 (4) \$3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an
167.23 episode of service which is required because of a recipient's symptoms, diagnosis, or
167.24 established illness, and which is delivered in an ambulatory setting by a physician or
167.25 physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse,
167.26 audiologist, optician, or optometrist; and

167.27 (5) \$6 for nonemergency visits to a hospital-based emergency room.

167.28 (b) Paragraph (a), clause (1), does not apply to parents and relative caretakers of
167.29 children under the age of 21 in households with family income equal to or less than 175
167.30 percent of the federal poverty guidelines. Paragraph (a), clause (1), does not apply to
167.31 parents and relative caretakers of children under the age of 21 in households with family
167.32 income greater than 175 percent of the federal poverty guidelines for inpatient hospital
167.33 admissions occurring on or after January 1, 2001.

167.34 (c) Paragraph (a), ~~clauses (1) to (4), do~~ does not apply to pregnant women and
167.35 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. 28. 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. 29. 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. 30. 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. 31. **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. 32. **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;

170.1 (2) provide a history and description of managed care plan participation in the
170.2 prepaid medical assistance, prepaid general assistance medical care, and prepaid
170.3 Minnesota programs, and the provision by managed care plans of third-party administrator
170.4 services for county-based purchasing initiatives;
170.5 (3) provide relevant data, including limitations on data, data that was requested but
170.6 not received, and explanations for why requested data was not received;
170.7 (4) provide recommendations for further data collection and research;
170.8 (5) summarize successes and challenges of the two service delivery methods;
170.9 (6) provide recommendations for possible expansion of county-based purchasing
170.10 in rural and urban settings; and
170.11 (7) identify and describe features of county-based purchasing and managed care
170.12 plans serving medical assistance, general assistance medical care, and MinnesotaCare
170.13 enrollees, to provide a comparison of cost, quality, access, and community health
170.14 improvement that includes, but is not limited to:
170.15 (i) descriptions of how health care and social services are integrated and coordinated
170.16 for persons with complex care needs, including persons with high-risk pregnancies,
170.17 adolescents, persons who are disabled, persons who are elderly, and persons with chronic
170.18 health care and social needs;
170.19 (ii) use of monetary grants and surpluses to:
170.20 (A) increase provider reimbursement, including dental care reimbursement, in order
170.21 to improve health care access; and
170.22 (B) improve community health beyond the requirements of the public health care
170.23 programs, such as the funding of public education, research, and community initiatives to
170.24 enhance utilization of preventive services, social services, or mental health care;
170.25 (iii) administrative costs, including billing and collection of unpaid fees, co-pays or
170.26 other charges, and top five management salaries;
170.27 (iv) reporting requirements of contracts with the Department of Human Services;
170.28 (v) public access to all information about management and administration, including
170.29 but not limited to provider contracts and reimbursement, models of care management and
170.30 coordination, utilization review, contracts with consultants and other vendors, handling of
170.31 monetary grants and surpluses, and health outcomes data;
170.32 (vi) provider reimbursement by clinical practice area;
170.33 (vii) populations served, described by age, disability, income, race, language,
170.34 occupation, and other demographic characteristics;
170.35 (viii) utilization of community-based prevention interventions, including but not
170.36 limited to public health nursing visits to new parents, use of nurse-managed interventions

171.1 to reduce cardiac hospitalizations, and the use of medical homes for chronic disease
171.2 management;
171.3 (ix) utilization of cancer screening;
171.4 (x) utilization of interpreter services;
171.5 (xi) immunization rates for children age five and under;
171.6 (xii) hospitalization rates for conditions related to diabetes, asthma, or cardiac
171.7 illnesses;
171.8 (xiii) rates of rehospitalization within a month of hospital discharge;
171.9 (xiv) coordination with county agencies to increase enrollment;
171.10 (xv) number of new program enrollees and the rate of enrollment, including the
171.11 percentage of eligible persons who become enrollees;
171.12 (xvi) enrollee satisfaction with their care; and
171.13 (xvii) number of enrollees who do not receive care.
171.14 Managed care plans, county-based purchasing initiatives, health care providers,
171.15 counties, and the commissioner of human services shall, upon request, provide data to
171.16 the commissioner of health that is necessary to complete the study. The commissioner of
171.17 health shall submit the study to the legislature by December 31, 2007.

171.18 Sec. 33. **GRANT FOR TOLL-FREE HEALTH CARE ACCESS NUMBER.**

171.19 The commissioner of human services shall award a grant to the Neighborhood
171.20 Health Care Network to pay the costs of maintaining and staffing a toll-free telephone
171.21 number to provide callers with information on health coverage options, eligibility for
171.22 MinnesotaCare and other health care programs, and health care providers that offer free or
171.23 reduced-cost health care services.

171.24 Sec. 34. **IMPLEMENTATION OF PHARMACY DISPENSING FEE INCREASE.**

171.25 The commissioner of human services, after consulting with the Pharmacy Payment
171.26 Reform Advisory Committee established under Laws 2006, chapter 282, article 16, section
171.27 15, may proportionally increase or decrease the dispensing fee for multiple-source generic
171.28 drugs under Minnesota Statutes, section 256B.0625, subdivision 13e, paragraph (a), to
171.29 reflect the actual amount of reductions in program cost for ingredient reimbursement
171.30 savings obtained. The commissioner of human services shall seek federal matching funds
171.31 to further increase the dispensing fee to cover the cost of dispensing, up to a maximum
171.32 dispensing fee of \$12.92.

EFFECTIVE DATE. This section is effective upon implementation of changes to the federal upper reimbursement limit under title VI, chapter IV of the federal Deficit Reduction Act of 2005, United States Code, title 42, section 1396r-8(e)(5).

Sec. 35. **PHARMACY STUDIES.**

Subdivision 1. **Fiscal impact of deficit reduction act.** The commissioner of human services shall report to the legislature by January 1, 2008, on the fiscal impact of Deficit Reduction Act reforms on the Minnesota Medicaid pharmacy program, including but not limited to:

(1) overall cost reductions to the Minnesota Medicaid pharmacy program as a result of the Deficit Reduction Act of 2005;

(2) the impact of reforms on the federal upper limit on pharmacy reimbursement, and the amount that the dispensing fee for multiple-source generic drugs would have to be adjusted to offset any reductions resulting from federal upper limits implemented as a result of the Deficit Reduction Act of 2005;

(3) the cost of reduced federal rebates received from pharmaceutical manufacturers as a result of Deficit Reduction Act reforms, and strategies that could be employed in administering the Medicaid drug formulary to compensate for lost manufacturer rebates; and

(4) a detailed comparison of the federal upper limits and state maximum allowable cost (MAC) prices prior to and following implementation of the Deficit Reduction Act reforms.

Subd. 2. **Pharmacy payment reform advisory committee.** (a) The Pharmacy Payment Reform Advisory Committee established under Laws of Minnesota 2006, chapter 282, article 16, section 15, shall present findings and recommendations to the commissioner of human services on:

(1) whether pharmacy reimbursement for multiple-source generic prescriptions following implementation of Deficit Reduction Act reforms allows for payment sufficient to cover the actual pharmacy costs for acquiring the drug product and dispensing the prescription;

(2) the impact of the reforms on pharmacies with more than ten percent of annual prescription volume from Medicaid, and on pharmacies in rural areas or areas with a significant Medicaid population;

(3) the impact of changes in pharmacy reimbursement for multiple-source drugs on patient access to pharmacy services; and

173.1 (4) the impact of changes in pharmacy reimbursement for multiple-source drugs on
173.2 generic dispensing rates.

173.3 (b) The Pharmacy Payment Reform Advisory Committee shall also review the
173.4 current method of reimbursement for single-source drugs, and present recommendations
173.5 to the commissioner of human services on the creation of a transparent reimbursement
173.6 model for single-source drugs that would adequately reimburse pharmacies for drug
173.7 product costs and pharmacy dispensing services.

173.8 (c) The commissioner of human services shall present the advisory committee's
173.9 findings and recommendations on the topics specified in paragraphs (a) and (b) to the
173.10 legislature by January 1, 2008.

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

173.12 Sec. 36. **REPEALER.**

173.13 Minnesota Statutes 2006, section 256.969, subdivision 27, is repealed effective
173.14 July 1, 2007.

173.15	ARTICLE 4
173.16	CONTINUING CARE

173.17 Section 1. Minnesota Statutes 2006, section 144A.071, subdivision 4c, is amended to
173.18 read:

173.19 Subd. 4c. **Exceptions for replacement beds after June 30, 2003.** (a) The
173.20 commissioner of health, in coordination with the commissioner of human services, may
173.21 approve the renovation, replacement, upgrading, or relocation of a nursing home or
173.22 boarding care home, under the following conditions:

173.23 (1) to license and certify an 80-bed city-owned facility in Nicollet County to be
173.24 constructed on the site of a new city-owned hospital to replace an existing 85-bed facility
173.25 attached to a hospital that is also being replaced. The threshold allowed for this project
173.26 under section 144A.073 shall be the maximum amount available to pay the additional
173.27 medical assistance costs of the new facility;

173.28 (2) to license and certify 29 beds to be added to an existing 69-bed facility in St.
173.29 Louis County, provided that the 29 beds must be transferred from active or layaway status
173.30 at an existing facility in St. Louis County that had 235 beds on April 1, 2003.

173.31 The licensed capacity at the 235-bed facility must be reduced to 206 beds, but the payment
173.32 rate at that facility shall not be adjusted as a result of this transfer. The operating payment
173.33 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~~

(4) to license and certify up to 80 beds transferred from an existing state-owned nursing facility in Cass County to a new facility located on the grounds of the Ah-Gwah-Ching campus. The operating cost payment rates for the new facility shall be determined based on the interim and settle-up payment provisions of Minnesota Rules, part 9549.0057, and the reimbursement provisions of section 256B.431. The property payment rate for the first three years of operation shall be \$35 per day. For subsequent years, the property payment rate of \$35 per day shall be adjusted for inflation as provided in section 256B.434, subdivision 4, paragraph (c), as long as the facility has a contract under section 256B.434; and

(5) to license and certify 180 beds transferred from an existing facility in Minneapolis to a new facility in Robbinsdale; provided that the beds are transferred from a 219-bed facility under common ownership that shall be closed following the transfer. The operating payment rate of the new facility after completion of this project shall be adjusted upward by \$35 per day and the property payment rate shall be \$34.049 per day.

(b) Projects approved under this subdivision shall be treated in a manner equivalent to projects approved under subdivision 4a.

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

Sec. 2. Minnesota Statutes 2006, section 252.27, subdivision 2a, is amended to read:

Subd. 2a. **Contribution amount.** (a) The natural or adoptive parents of a minor child, including a child determined eligible for medical assistance without consideration of parental income, must contribute to the cost of services used by making monthly payments on a sliding scale based on income, unless the child is married or has been married, parental rights have been terminated, or the child's adoption is subsidized according to

section 259.67 or through title IV-E of the Social Security Act. The parental contribution is a partial or full payment for medical services provided for diagnostic, therapeutic, curing, treating, mitigating, rehabilitation, and maintenance and personal care services as defined in United States Code, title 26, section 213, needed by the child with a chronic illness or disability.

(b) For households with adjusted gross income equal to or greater than 100 percent of federal poverty guidelines, the parental contribution shall be computed by applying the following schedule of rates to the adjusted gross income of the natural or adoptive parents:

(1) if the adjusted gross income is equal to or greater than 100 percent of federal poverty guidelines and less than 175 percent of federal poverty guidelines, the parental 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.

(e) The contribution shall be explained in writing to the parents at the time eligibility for services is being determined. The contribution shall be made on a monthly basis effective with the first month in which the child receives services. Annually upon redetermination or at termination of eligibility, if the contribution exceeded the cost of services provided, the local agency or the state shall reimburse that excess amount to the parents, either by direct reimbursement if the parent is no longer required to pay a contribution, or by a reduction in or waiver of parental fees until the excess amount is exhausted.

(f) The monthly contribution amount must be reviewed at least every 12 months; when there is a change in household size; and when there is a loss of or gain in income from one month to another in excess of ten percent. The local agency shall mail a written notice 30 days in advance of the effective date of a change in the contribution amount. A decrease in the contribution amount is effective in the month that the parent verifies a reduction in income or change in household size.

(g) Parents of a minor child who do not live with each other shall each pay the contribution required under paragraph (a). An amount equal to the annual court-ordered child support payment actually paid on behalf of the child receiving services shall be deducted from the adjusted gross income of the parent making the payment prior to calculating the parental contribution under paragraph (b).

(h) The contribution under paragraph (b) shall be increased by an additional five percent if the local agency determines that insurance coverage is available but not obtained for the child. For purposes of this section, "available" means the insurance is a benefit of employment for a family member at an annual cost of no more than five percent of the family's annual income. For purposes of this section, "insurance" means health

and accident insurance coverage, enrollment in a nonprofit health service plan, health maintenance organization, self-insured plan, or preferred provider organization.

Parents who have more than one child receiving services shall not be required to pay more than the amount for the child with the highest expenditures. There shall be no resource contribution from the parents. The parent shall not be required to pay a contribution in excess of the cost of the services provided to the child, not counting payments made to school districts for education-related services. Notice of an increase in fee payment must be given at least 30 days before the increased fee is due.

(i) The contribution under paragraph (b) shall be reduced by \$300 per fiscal year if, in the 12 months prior to July 1:

(1) the parent applied for insurance for the child;

(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.

178.1 Items and services purchased with support grants must be those for which there
178.2 are no other public or private funds available to the family. Fees assessed to parents
178.3 for health or human services that are funded by federal, state, or county dollars are not
178.4 reimbursable through this program.

178.5 In approving or denying applications, the county shall consider the following factors:

- 178.6 (1) the extent and areas of the functional limitations of the disabled child;
178.7 (2) the degree of need in the home environment for additional support; and
178.8 (3) the potential effectiveness of the grant to maintain and support the person in
178.9 the family environment.

178.10 The maximum monthly grant amount shall be \$250 per eligible dependent, or
178.11 \$3,000 per eligible dependent per state fiscal year, within the limits of available funds and
178.12 as adjusted by any legislatively authorized cost of living adjustment. The county social
178.13 service agency may consider the dependent's supplemental security income in determining
178.14 the amount of the support grant.

178.15 Any adjustments to their monthly grant amount must be based on the needs of the
178.16 family and funding availability.

178.17 Sec. 4. Minnesota Statutes 2006, section 252.46, is amended by adding a subdivision
178.18 to read:

178.19 Subd. 22. **Provider rate increase; St. Louis County.** A day training and
178.20 habilitation provider in St. Louis County licensed to provide services to up to 80
178.21 individuals shall receive a per diem rate increase that does not exceed 95 percent of the
178.22 greater of 125 percent of the current statewide median or 125 percent of the regional
178.23 average per diem rate, whichever is higher.

178.24 Sec. 5. Minnesota Statutes 2006, section 256.01, is amended by adding a subdivision
178.25 to read:

178.26 Subd. 24. **Disability linkage line.** The commissioner shall establish the disability
178.27 linkage line, a statewide consumer information, referral, and assistance system for people
178.28 with disabilities and chronic illnesses that:

178.29 (1) provides information about state and federal eligibility requirements, benefits,
178.30 and service options;

178.31 (2) makes referrals to appropriate support entities;

178.32 (3) delivers information and assistance based on national and state standards;

178.33 (4) assists people to make well-informed decisions; and

178.34 (5) supports the timely resolution of service access and benefit issues.

Sec. 6. Minnesota Statutes 2006, section 256.476, subdivision 1, is amended to read:

Subdivision 1. **Purpose and goals.** The commissioner of human services shall establish a consumer support grant program for individuals with functional limitations and their families who wish to purchase and secure their own supports. ~~The commissioner and local agencies shall jointly develop an implementation plan which must include a way to resolve the issues related to county liability.~~ The program shall:

(1) make support grants available to individuals or families as an effective alternative to the ~~developmental disability~~ family support program, personal care attendant services, home health aide services, and private duty nursing services;

(2) provide consumers more control, flexibility, and responsibility over their services and supports;

(3) promote local program management and decision making; and

(4) encourage the use of informal and typical community supports.

Sec. 7. Minnesota Statutes 2006, section 256.476, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given them:

(a) "County board" means the county board of commissioners for the county of financial responsibility as defined in section 256G.02, subdivision 4, or its designated representative. When a human services board has been established under sections 402.01 to 402.10, it shall be considered the county board for the purposes of this section.

(b) "Family" means the person's birth parents, adoptive parents or stepparents, siblings or stepsiblings, children or stepchildren, grandparents, grandchildren, niece, nephew, aunt, uncle, or spouse. For the purposes of this section, a family member is at least 18 years of age.

(c) "Functional limitations" means the long-term inability to perform an activity or task in one or more areas of major life activity, including self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living. For the purpose of this section, the inability to perform an activity or task results from a mental, emotional, psychological, sensory, or physical disability, condition, or illness.

(d) "Informed choice" means a voluntary decision made by the person ~~or~~, the person's legal representative, or other authorized representative after becoming familiarized with the alternatives to:

(1) select a preferred alternative from a number of feasible alternatives;

(2) select an alternative which may be developed in the future; and

(3) refuse any or all alternatives.

(e) "Local agency" means the local agency authorized by the county board or, for counties not participating in the consumer grant program by July 1, 2002, the commissioner, to carry out the provisions of this section.

(f) "Person" or "persons" means a person or persons meeting the eligibility criteria in subdivision 3.

(g) "Authorized representative" means an individual designated by the person or their legal representative to act on their behalf. This individual may be a family member, guardian, representative payee, or other individual designated by the person or their legal representative, if any, to assist in purchasing and arranging for supports. For the purposes of this section, an authorized representative is at least 18 years of age.

(h) "Screening" means the screening of a person's service needs under sections 256B.0911 and 256B.092.

(i) "Supports" means services, care, aids, environmental modifications, or assistance purchased by the person ~~or the person's family~~, the person's legal representative, or other authorized representative. Examples of supports include respite care, assistance with daily living, and assistive technology. For the purpose of this section, notwithstanding the provisions of section 144A.43, supports purchased under the consumer support program are not considered home care services.

(j) "Program of origination" means the program the individual transferred from when approved for the consumer support grant program.

Sec. 8. Minnesota Statutes 2006, section 256.476, subdivision 3, is amended to read:

Subd. 3. **Eligibility to apply for grants.** (a) A person is eligible to apply for a consumer support grant if the person meets all of the following criteria:

(1) the person is eligible for and has been approved to receive services under medical assistance as determined under sections 256B.055 and 256B.056 or the person has been approved to receive a grant under the ~~developmental disability~~ family support program under section 252.32;

(2) the person is able to direct and purchase the person's own care and supports, or the person has a family member, legal representative, or other authorized representative who can purchase and arrange supports on the person's behalf;

(3) the person has functional limitations, requires ongoing supports to live in the community, and is at risk of or would continue institutionalization without such supports; and

181.1 (4) the person will live in a home. For the purpose of this section, "home" means the
181.2 person's own home or home of a person's family member. These homes are natural home
181.3 settings and are not licensed by the Department of Health or Human Services.

181.4 (b) Persons may not concurrently receive a consumer support grant if they are:

181.5 (1) receiving personal care attendant and home health aide services, or private duty
181.6 nursing under section 256B.0625; a ~~developmental disability~~ family support grant; or
181.7 alternative care services under section 256B.0913; or

181.8 (2) residing in an institutional or congregate care setting.

181.9 (c) A person or person's family receiving a consumer support grant shall not be
181.10 charged a fee or premium by a local agency for participating in the program.

181.11 (d) Individuals receiving home and community-based waivers under United States
181.12 Code, title 42, section 1396h(c), are not eligible for the consumer support grant, except
181.13 for individuals receiving consumer support grants before July 1, 2003, as long as other
181.14 eligibility criteria are met.

181.15 (e) The commissioner shall establish a budgeted appropriation each fiscal year
181.16 for the consumer support grant program. The number of individuals participating in
181.17 the program will be adjusted so the total amount allocated to counties does not exceed
181.18 the amount of the budgeted appropriation. The budgeted appropriation will be adjusted
181.19 annually to accommodate changes in demand for the consumer support grants.

181.20 Sec. 9. Minnesota Statutes 2006, section 256.476, subdivision 4, is amended to read:

181.21 Subd. 4. **Support grants; criteria and limitations.** (a) A county board may
181.22 choose to participate in the consumer support grant program. If a county has not chosen
181.23 to participate by July 1, 2002, the commissioner shall contract with another county or
181.24 other entity to provide access to residents of the nonparticipating county who choose
181.25 the consumer support grant option. The commissioner shall notify the county board
181.26 in a county that has declined to participate of the commissioner's intent to enter into
181.27 a contract with another county or other entity at least 30 days in advance of entering
181.28 into the contract. The local agency shall establish written procedures and criteria to
181.29 determine the amount and use of support grants. These procedures must include, at least,
181.30 the availability of respite care, assistance with daily living, and adaptive aids. The local
181.31 agency may establish monthly or annual maximum amounts for grants and procedures
181.32 where exceptional resources may be required to meet the health and safety needs of the
181.33 person on a time-limited basis, however, the total amount awarded to each individual may
181.34 not exceed the limits established in subdivision 11.

182.1 (b) Support grants to a person ~~or a person's family~~, a person's legal representative,
182.2 or other authorized representative will be provided through a monthly subsidy payment
182.3 and be in the form of cash, voucher, or direct county payment to vendor. Support grant
182.4 amounts must be determined by the local agency. Each service and item purchased with a
182.5 support grant must meet all of the following criteria:

182.6 (1) it must be over and above the normal cost of caring for the person if the person
182.7 did not have functional limitations;

182.8 (2) it must be directly attributable to the person's functional limitations;

182.9 (3) it must enable the person ~~or the person's family~~, a person's legal representative,
182.10 or other authorized representative to delay or prevent out-of-home placement of the
182.11 person; and

182.12 (4) it must be consistent with the needs identified in the service agreement, when
182.13 applicable.

182.14 (c) Items and services purchased with support grants must be those for which there
182.15 are no other public or private funds available to the person ~~or the person's family~~, a person's
182.16 legal representative, or other authorized representative. Fees assessed to the person or the
182.17 person's family for health and human services are not reimbursable through the grant.

182.18 (d) In approving or denying applications, the local agency shall consider the
182.19 following factors:

182.20 (1) the extent and areas of the person's functional limitations;

182.21 (2) the degree of need in the home environment for additional support; and

182.22 (3) the potential effectiveness of the grant to maintain and support the person in the
182.23 family environment or the person's own home.

182.24 (e) At the time of application to the program or screening for other services,
182.25 the person ~~or the person's family~~, a person's legal representative, or other authorized
182.26 representative shall be provided sufficient information to ensure an informed choice
182.27 of alternatives by the person, the person's legal representative, or other authorized
182.28 representative, if any, ~~or the person's family~~. The application shall be made to the local
182.29 agency and shall specify the needs of the person and family, the form and amount of
182.30 grant requested, the items and services to be reimbursed, and evidence of eligibility for
182.31 medical assistance.

182.32 (f) Upon approval of an application by the local agency and agreement on a support
182.33 plan for the person or person's family, the local agency shall make grants to the person or
182.34 the person's family. The grant shall be in an amount for the direct costs of the services or
182.35 supports outlined in the service agreement.

183.1 (g) Reimbursable costs shall not include costs for resources already available, such as
183.2 special education classes, day training and habilitation, case management, other services to
183.3 which the person is entitled, medical costs covered by insurance or other health programs,
183.4 or other resources usually available at no cost to the person or the person's family.

183.5 (h) The state of Minnesota, the county boards participating in the consumer
183.6 support grant program, or the agencies acting on behalf of the county boards in the
183.7 implementation and administration of the consumer support grant program shall not be
183.8 liable for damages, injuries, or liabilities sustained through the purchase of support by
183.9 the individual, the individual's family, or the authorized representative under this section
183.10 with funds received through the consumer support grant program. Liabilities include but
183.11 are not limited to: workers' compensation liability, the Federal Insurance Contributions
183.12 Act (FICA), or the Federal Unemployment Tax Act (FUTA). For purposes of this section,
183.13 participating county boards and agencies acting on behalf of county boards are exempt
183.14 from the provisions of section 268.04.

183.15 Sec. 10. Minnesota Statutes 2006, section 256.476, subdivision 5, is amended to read:

183.16 Subd. 5. **Reimbursement, allocations, and reporting.** (a) For the purpose of
183.17 transferring persons to the consumer support grant program from the ~~developmental~~
183.18 ~~disability~~ family support program and personal care assistant services, home health
183.19 aide services, or private duty nursing services, the amount of funds transferred by the
183.20 commissioner between the ~~developmental-disability~~ family support program account, the
183.21 medical assistance account, or the consumer support grant account shall be based on each
183.22 county's participation in transferring persons to the consumer support grant program
183.23 from those programs and services.

183.24 (b) At the beginning of each fiscal year, county allocations for consumer support
183.25 grants shall be based on:

183.26 (1) the number of persons to whom the county board expects to provide consumer
183.27 supports grants;

183.28 (2) their eligibility for current program and services;

183.29 (3) the amount of nonfederal dollars allowed under subdivision 11; and

183.30 (4) projected dates when persons will start receiving grants. County allocations shall
183.31 be adjusted periodically by the commissioner based on the actual transfer of persons or
183.32 service openings, and the nonfederal dollars associated with those persons or service
183.33 openings, to the consumer support grant program.

184.1 (c) The amount of funds transferred by the commissioner from the medical
184.2 assistance account for an individual may be changed if it is determined by the county or its
184.3 agent that the individual's need for support has changed.

184.4 (d) The authority to utilize funds transferred to the consumer support grant account
184.5 for the purposes of implementing and administering the consumer support grant program
184.6 will not be limited or constrained by the spending authority provided to the program
184.7 of origination.

184.8 (e) The commissioner may use up to five percent of each county's allocation, as
184.9 adjusted, for payments for administrative expenses, to be paid as a proportionate addition
184.10 to reported direct service expenditures.

184.11 (f) The county allocation for each individual or individual's family cannot exceed
184.12 the amount allowed under subdivision 11.

184.13 (g) The commissioner may recover, suspend, or withhold payments if the county
184.14 board, local agency, or grantee does not comply with the requirements of this section.

184.15 (h) Grant funds unexpended by consumers shall return to the state once a year. The
184.16 annual return of unexpended grant funds shall occur in the quarter following the end of
184.17 the state fiscal year.

184.18 Sec. 11. Minnesota Statutes 2006, section 256.476, subdivision 10, is amended to read:

184.19 Subd. 10. **Consumer responsibilities.** Persons receiving grants under this section
184.20 shall:

184.21 (1) spend the grant money in a manner consistent with their agreement with the
184.22 local agency;

184.23 (2) notify the local agency of any necessary changes in the grant or the items on
184.24 which it is spent;

184.25 (3) notify the local agency of any decision made by the person, ~~the~~ a person's legal
184.26 representative, ~~or the person's family~~ or other authorized representative that would change
184.27 their eligibility for consumer support grants;

184.28 (4) arrange and pay for supports; and

184.29 (5) inform the local agency of areas where they have experienced difficulty securing
184.30 or maintaining supports.

184.31 Sec. 12. Minnesota Statutes 2006, section 256.974, is amended to read:

184.32 **256.974 OFFICE OF OMBUDSMAN FOR ~~OLDER MINNESOTANS~~**
184.33 **LONG-TERM CARE; LOCAL PROGRAMS.**

185.1 The ombudsman for ~~older Minnesotans~~ long-term care serves in the classified service
185.2 under section 256.01, subdivision 7, in an office within the Minnesota Board on Aging that
185.3 incorporates the long-term care ombudsman program required by the Older Americans
185.4 Act, ~~Public Law 100-75~~ as amended, United States Code, title 42, section 3027(a)(12)
185.5 (9) and 3058g (a), and established within the Minnesota Board on Aging. The Minnesota
185.6 Board on Aging may make grants to and designate local programs for the provision of
185.7 ombudsman services to clients in county or multicounty areas. The local program may not
185.8 be an agency engaged in the provision of nursing home care, hospital care, or home care
185.9 services either directly or by contract, or have the responsibility for planning, coordinating,
185.10 funding, or administering nursing home care, hospital care, or home care services.

185.11 Sec. 13. Minnesota Statutes 2006, section 256.9741, subdivision 1, is amended to read:

185.12 Subdivision 1. **Long-term care facility.** "Long-term care facility" means a nursing
185.13 home licensed under sections 144A.02 to 144A.10 ~~or~~ a boarding care home licensed
185.14 under sections 144.50 to 144.56; or a licensed or registered residential setting which
185.15 provides or arranges for the provision of home care services.

185.16 Sec. 14. Minnesota Statutes 2006, section 256.9741, subdivision 3, is amended to read:

185.17 Subd. 3. **Client.** "Client" means an individual who requests, or on whose behalf a
185.18 request is made for, ombudsman services and is (a) a resident of a long-term care facility
185.19 or (b) a Medicare beneficiary who requests assistance relating to access, discharge, or
185.20 denial of inpatient or outpatient services, or (c) an individual reserving, receiving, or
185.21 requesting a home care service.

185.22 Sec. 15. Minnesota Statutes 2006, section 256.9742, subdivision 3, is amended to read:

185.23 Subd. 3. **Posting.** Every long-term care facility and acute care facility shall post in a
185.24 conspicuous place the address and telephone number of the office. A home care service
185.25 provider shall provide all recipients, including those in ~~elderly~~ housing with services
185.26 under chapter 144D, with the address and telephone number of the office. Counties shall
185.27 provide clients ~~receiving a consumer support grant or a service allowance~~ long-term care
185.28 consultation services under section 256B.0911 or home and community-based services
185.29 through a state or federally funded program with the name, address, and telephone number
185.30 of the office. The posting or notice is subject to approval by the ombudsman.

185.31 Sec. 16. Minnesota Statutes 2006, section 256.9742, subdivision 4, is amended to read:

Subd. 4. **Access to long-term care and acute care facilities and clients.** The ombudsman or designee may:

(1) enter any long-term care facility without notice at any time;

(2) enter any acute care facility without notice during normal business hours;

(3) enter any acute care facility without notice at any time to interview a patient or observe services being provided to the patient as part of an investigation of a matter that is within the scope of the ombudsman's authority, but only if the ombudsman's or designee's presence does not intrude upon the privacy of another patient or interfere with routine hospital services provided to any patient in the facility;

(4) communicate privately and without restriction with any client ~~in accordance with section 144.651~~, as long as the ombudsman has the client's consent for such communication;

(5) inspect records of a long-term care facility, home care service provider, or acute care facility that pertain to the care of the client according to ~~sections~~ section 144.335 ~~and 144.651~~; and

(6) with the consent of a client or client's legal guardian, the ombudsman or designated staff shall have access to review records pertaining to the care of the client according to ~~sections~~ section 144.335 ~~and 144.651~~. If a client cannot consent and has no legal guardian, access to the records is authorized by this section.

A person who denies access to the ombudsman or designee in violation of this subdivision or aids, abets, invites, compels, or coerces another to do so is guilty of a misdemeanor.

Sec. 17. Minnesota Statutes 2006, section 256.9742, subdivision 6, is amended to read:

Subd. 6. **Prohibition against discrimination or retaliation.** (a) No entity shall take discriminatory, disciplinary, or retaliatory action against an employee or volunteer, or a patient, resident, or guardian or family member of a patient, resident, or guardian for filing in good faith a complaint with or providing information to the ombudsman or designee including volunteers. A person who violates this subdivision or who aids, abets, invites, compels, or coerces another to do so is guilty of a misdemeanor.

(b) There shall be a rebuttable presumption that any adverse action, as defined below, within 90 days of report, is discriminatory, disciplinary, or retaliatory. For the purpose of this clause, the term "adverse action" refers to action taken by the entity involved in a report against the person making the report or the person with respect to whom the report was made because of the report, and includes, but is not limited to:

(1) discharge or transfer from a facility;

- 187.1 (2) termination of service;
- 187.2 (3) restriction or prohibition of access to the facility or its residents;
- 187.3 (4) discharge from or termination of employment;
- 187.4 (5) demotion or reduction in remuneration for services; and
- 187.5 (6) any restriction of rights set forth in section 144.651 ~~or~~, 144A.44, or 144A.751.

187.6 Sec. 18. Minnesota Statutes 2006, section 256.9744, subdivision 1, is amended to read:

187.7 Subdivision 1. **Classification.** Except as provided in this section, data maintained
187.8 by the office under sections 256.974 to 256.9744 are private data on individuals or
187.9 nonpublic data as defined in section 13.02, subdivision 9 or 12, and must be maintained
187.10 in accordance with the requirements of ~~Public Law 100-75~~ the Older Americans Act, as
187.11 amended, United States Code, title 42, section ~~3027(a)(12)(D)~~ 3058g(d).

187.12 Sec. 19. Minnesota Statutes 2006, section 256.975, subdivision 7, is amended to read:

187.13 Subd. 7. **Consumer information and assistance; senior linkage.** (a) The
187.14 Minnesota Board on Aging shall operate a statewide information and assistance service
187.15 to aid older Minnesotans and their families in making informed choices about long-term
187.16 care options and health care benefits. Language services to persons with limited English
187.17 language skills may be made available. The service, known as Senior LinkAge Line, must
187.18 be available during business hours through a statewide toll-free number and must also
187.19 be available through the Internet.

187.20 (b) The service must assist older adults, caregivers, and providers in accessing
187.21 information about choices in long-term care services that are purchased through private
187.22 providers or available through public options. The service must:

- 187.23 (1) develop a comprehensive database that includes detailed listings in both
- 187.24 consumer- and provider-oriented formats;
- 187.25 (2) make the database accessible on the Internet and through other telecommunication
- 187.26 and media-related tools;
- 187.27 (3) link callers to interactive long-term care screening tools and make these tools
- 187.28 available through the Internet by integrating the tools with the database;
- 187.29 (4) develop community education materials with a focus on planning for long-term
- 187.30 care and evaluating independent living, housing, and service options;
- 187.31 (5) conduct an outreach campaign to assist older adults and their caregivers in
- 187.32 finding information on the Internet and through other means of communication;
- 187.33 (6) implement a messaging system for overflow callers and respond to these callers
- 187.34 by the next business day;

(7) link callers with county human services and other providers to receive more in-depth assistance and consultation related to long-term care options; ~~and~~

(8) link callers with quality profiles for nursing facilities and other providers developed by the commissioner of health; and

(9) incorporate information about housing with services and consumer rights within the MinnesotaHelp.info network long-term care database to facilitate consumer comparison of services and costs among housing with services establishments and with other in-home services and to support financial self-sufficiency as long as possible. Housing with services establishments and their arranged home care providers shall provide information to the commissioner of human services that is consistent with information required by the commissioner of health under section 144G.06, the Uniform Consumer Information Guide. The commissioner of human services shall provide the data to the Minnesota Board on Aging for inclusion in the MinnesotaHelp.info network long-term care database.

(c) The Minnesota Board on Aging shall conduct an evaluation of the effectiveness of the statewide information and assistance, and submit this evaluation to the legislature by December 1, 2002. The evaluation must include an analysis of funding adequacy, gaps in service delivery, continuity in information between the service and identified linkages, and potential use of private funding to enhance the service.

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

Sec. 20. Minnesota Statutes 2006, section 256B.056, subdivision 1a, is amended to read:

Subd. 1a. **Income and assets generally.** Unless specifically required by state law or rule or federal law or regulation, the methodologies used in counting income and assets to determine eligibility for medical assistance for persons whose eligibility category is based on blindness, disability, or age of 65 or more years, the methodologies for the supplemental security income program shall be used, except as provided under subdivision 3, paragraph (f). Increases in benefits under title II of the Social Security Act shall not be counted as income for purposes of this subdivision until July 1 of each year. Effective upon federal approval, for children eligible under section 256B.055, subdivision 12, or for home and community-based waiver services whose eligibility for medical assistance is determined without regard to parental income, child support payments, including any payments made by an obligor in satisfaction of or in addition to a temporary or permanent order for child support, and Social Security payments are not counted as income. For families and children, which includes all other eligibility categories, the methodologies

189.1 under the state's AFDC plan in effect as of July 16, 1996, as required by the Personal
189.2 Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public
189.3 Law 104-193, shall be used, except that effective October 1, 2003, the earned income
189.4 disregards and deductions are limited to those in subdivision 1c. For these purposes, a
189.5 "methodology" does not include an asset or income standard, or accounting method,
189.6 or method of determining effective dates.

189.7 Sec. 21. Minnesota Statutes 2006, section 256B.056, subdivision 3, is amended to read:

189.8 Subd. 3. **Asset limitations for aged, blind, or disabled individuals ~~and families~~.**

189.9 To be eligible for medical assistance, a person whose eligibility is based on blindness,
189.10 disability, or age of 65 or more years must not individually own more than ~~\$3,000~~ \$6,000
189.11 in assets, or if a member of a household with two family members, husband and wife, or
189.12 parent and child, the household must not own more than ~~\$6,000~~ \$12,000 in assets, plus
189.13 ~~\$200~~ \$400 for each additional legal dependent. In addition to these maximum amounts,
189.14 an eligible individual or family may accrue interest on these amounts, but they must be
189.15 reduced to the maximum at the time of an eligibility redetermination. The accumulation
189.16 of the clothing and personal needs allowance according to section 256B.35 must also be
189.17 reduced to the maximum at the time of the eligibility redetermination. The value of assets
189.18 that are not considered in determining eligibility for medical assistance is the value of
189.19 those assets excluded under the supplemental security income program for aged, blind,
189.20 and disabled persons, with the following exceptions:

189.21 (a) Household goods and personal effects are not considered.

189.22 (b) Capital and operating assets of a trade or business that the local agency
189.23 determines are necessary to the person's ability to earn an income are not considered.

189.24 (c) Motor vehicles are excluded to the same extent excluded by the supplemental
189.25 security income program.

189.26 (d) Assets designated as burial expenses are excluded to the same extent excluded by
189.27 the supplemental security income program. Burial expenses funded by annuity contracts
189.28 or life insurance policies must irrevocably designate the individual's estate as contingent
189.29 beneficiary to the extent proceeds are not used for payment of selected burial expenses.

189.30 (e) Effective upon federal approval, for a person who no longer qualifies as an
189.31 employed person with a disability due to loss of earnings, assets allowed while eligible
189.32 for medical assistance under section 256B.057, subdivision 9, are not considered for 12
189.33 months, beginning with the first month of ineligibility as an employed person with a
189.34 disability, to the extent that the person's total assets remain within the allowed limits of
189.35 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.

(b) The excess income standard for a person whose eligibility is based on blindness, disability, or age of 65 or more years is 70 percent of the federal poverty guidelines for the family size. Effective July 1, 2002, the excess income standard for this paragraph shall equal 75 percent of the federal poverty guidelines. Effective July 1, 2007, the excess income standard for this paragraph shall equal 85 percent of the federal poverty guidelines. The excess income standard for this paragraph shall be increased by five percentage points on July 1 of each of the next three years, so that the excess income standard shall equal 100 percent of the federal poverty guidelines effective July 1, 2010.

EFFECTIVE DATE. This section is effective July 1, 2007.

Sec. 23. Minnesota Statutes 2006, section 256B.059, subdivision 5, is amended to read:

Subd. 5. **Asset availability.** (a) At the time of initial determination of eligibility for medical assistance benefits following the first continuous period of institutionalization on or after October 1, 1989, assets considered available to the institutionalized spouse shall be the total value of all assets in which either spouse has an ownership interest, reduced by the following amount for the community spouse:

191.1 (1) prior to July 1, 1994, the greater of:
191.2 (i) \$14,148;
191.3 (ii) the lesser of the spousal share or \$70,740; or
191.4 (iii) the amount required by court order to be paid to the community spouse;
191.5 (2) for persons whose date of initial determination of eligibility for medical
191.6 assistance following their first continuous period of institutionalization occurs on or after
191.7 July 1, 1994, the greater of:

191.8 (i) \$20,000;
191.9 (ii) the lesser of the spousal share or \$70,740; or
191.10 (iii) the amount required by court order to be paid to the community spouse.

191.11 The value of assets transferred for the sole benefit of the community spouse under section
191.12 256B.0595, subdivision 4, in combination with other assets available to the community
191.13 spouse under this section, cannot exceed the limit for the community spouse asset
191.14 allowance determined under subdivision 3 or 4. Assets that exceed this allowance shall be
191.15 considered available to the institutionalized spouse, as provided by federal law, whether or
191.16 not converted to income. If the community spouse asset allowance has been increased
191.17 under subdivision 4, then the assets considered available to the institutionalized spouse
191.18 under this subdivision shall be further reduced by the value of additional amounts allowed
191.19 under subdivision 4.

191.20 (b) An institutionalized spouse may be found eligible for medical assistance even
191.21 though assets in excess of the allowable amount are found to be available under paragraph
191.22 (a) if the assets are owned jointly or individually by the community spouse, and the
191.23 institutionalized spouse cannot use those assets to pay for the cost of care without the
191.24 consent of the community spouse, and if: (i) the institutionalized spouse assigns to the
191.25 commissioner the right to support from the community spouse under section 256B.14,
191.26 subdivision 3; (ii) the institutionalized spouse lacks the ability to execute an assignment
191.27 due to a physical or mental impairment; or (iii) the denial of eligibility would cause an
191.28 imminent threat to the institutionalized spouse's health and well-being.

191.29 (c) After the month in which the institutionalized spouse is determined eligible for
191.30 medical assistance, during the continuous period of institutionalization, no assets of the
191.31 community spouse are considered available to the institutionalized spouse, unless the
191.32 institutionalized spouse has been found eligible under paragraph (b).

191.33 (d) Assets determined to be available to the institutionalized spouse under this
191.34 section must be used for the health care or personal needs of the institutionalized spouse.

191.35 (e) For purposes of this section, assets do not include assets excluded under the
191.36 supplemental security income program.

192.1 Sec. 24. Minnesota Statutes 2006, section 256B.0621, subdivision 11, is amended to
192.2 read:

192.3 Subd. 11. **Data use agreement; Notice of relocation assistance.** The commissioner
192.4 shall ~~execute a data use agreement with the Centers for Medicare and Medicaid Services~~
192.5 ~~to obtain the long-term care minimum data set data to assist residents of nursing facilities~~
192.6 ~~who have~~ establish a process with the Centers for Independent Living that allows a person
192.7 residing in a Minnesota nursing facility to receive needed information, consultation, and
192.8 assistance from one of the centers about the available community support options that may
192.9 enable the person to relocate to the community, if the person: (1) is under the age of 65,
192.10 (2) has indicated a desire to live in the community. The commissioner shall in turn enter
192.11 into agreements with the Centers for Independent Living to provide information about
192.12 assistance for persons who want to move to the community. The commissioner shall work
192.13 with the Centers for Independent Living on both the content of the information to be
192.14 provided and privacy protections for the individual residents, and (3) has signed a release
192.15 of information authorized by the person or the person's appointed legal representative.
192.16 The process established under this subdivision shall be coordinated with the long-term
192.17 care consultation service activities established in section 256B.0911.

192.18 Sec. 25. Minnesota Statutes 2006, section 256B.0625, subdivision 18a, is amended to
192.19 read:

192.20 Subd. 18a. **Access to medical services.** (a) Medical assistance reimbursement for
192.21 meals for persons traveling to receive medical care may not exceed \$5.50 for breakfast,
192.22 \$6.50 for lunch, or \$8 for dinner.

192.23 (b) Medical assistance reimbursement for lodging for persons traveling to receive
192.24 medical care may not exceed \$50 per day unless prior authorized by the local agency.

192.25 (c) Medical assistance direct mileage reimbursement to the eligible person or the
192.26 eligible person's driver may not exceed 20 cents per mile.

192.27 (d) Regardless of the number of employees that an enrolled health care provider
192.28 may have, medical assistance covers sign and oral language interpreter services when
192.29 provided by an enrolled health care provider during the course of providing a direct,
192.30 person-to-person covered health care service to an enrolled recipient with limited English
192.31 proficiency or who has a hearing loss and uses interpreting services.

192.32 Sec. 26. Minnesota Statutes 2006, section 256B.0625, is amended by adding a
192.33 subdivision to read:

193.1 Subd. 49. **Self-directed supports option.** Upon federal approval, medical
193.2 assistance covers the self-directed supports option as defined under section 256B.0657 and
193.3 section 6087 of the Federal Deficit Reduction Act of 2005, Public Law 109-171.

193.4 **EFFECTIVE DATE.** This section is effective upon federal approval of the state
193.5 Medicaid plan amendment. The commissioner of human services shall inform the Office
193.6 of the Revisor of Statutes when approval is obtained.

193.7 Sec. 27. **[256B.0657] SELF-DIRECTED SUPPORTS OPTION.**

193.8 Subdivision 1. **Definition.** "Self-directed supports option" means personal
193.9 assistance, supports, items, and related services purchased under an approved budget
193.10 plan and budget by a recipient.

193.11 Subd. 2. **Eligibility.** (a) The self-directed supports option is available to a person
193.12 who:

193.13 (1) is a recipient of medical assistance as determined under sections 256B.055,
193.14 256B.056, and 256B.057, subdivision 9;

193.15 (2) is eligible for personal care assistant services under section 256B.0655;

193.16 (3) lives in the person's own apartment or home, which is not owned, operated, or
193.17 controlled by a provider of services not related by blood or marriage;

193.18 (4) has the ability to hire, fire, supervise, establish staff compensation for, and
193.19 manage the individuals providing services, and to choose and obtain items, related
193.20 services, and supports as described in the participant's plan. If the recipient is not able to
193.21 carry out these functions but has a legal guardian or parent to carry them out, the guardian
193.22 or parent may fulfill these functions on behalf of the recipient; and

193.23 (5) has not been excluded or disenrolled by the commissioner.

193.24 (b) The commissioner may disenroll or exclude recipients, including guardians and
193.25 parents, under the following circumstances:

193.26 (1) recipients who have been restricted by the Primary Care Utilization Review
193.27 Committee may be excluded for a specified time period; and

193.28 (2) recipients who exit the self-directed supports option during the recipient's
193.29 service plan year shall not access the self-directed supports option for the remainder
193.30 of that service plan year.

193.31 Subd. 3. **Eligibility for other services.** Selection of the self-directed supports
193.32 option by a recipient shall not restrict access to other medically necessary care and
193.33 services furnished under the state plan medical assistance benefit, including home care
193.34 targeted case management, except that a person receiving home and community-based

194.1 waiver services, a family support grant or a consumer support grant is not eligible for
194.2 funding under the self-directed supports option.

194.3 Subd. 4. **Assessment requirements.** (a) The self-directed supports option
194.4 assessment must meet the following requirements:

194.5 (1) it shall be conducted by the county public health nurse or a certified public
194.6 health nurse under contract with the county;

194.7 (2) it shall be conducted face-to-face in the recipient's home initially, and at least
194.8 annually thereafter; when there is a significant change in the recipient's condition; and
194.9 when there is a change in the need for personal care assistant services. A recipient who is
194.10 residing in a facility may be assessed for the self-directed support option for the purpose
194.11 of returning to the community using this option; and

194.12 (3) it shall be completed using the format established by the commissioner.

194.13 (b) The results of the assessment and recommendations shall be communicated to
194.14 the commissioner and the recipient by the county public health nurse or certified public
194.15 health nurse under contract with the county.

194.16 Subd. 5. **Self-directed supports option plan requirements.** (a) The plan for the
194.17 self-directed supports option must meet the following requirements:

194.18 (1) the plan must be completed using a person-centered process that:

194.19 (i) builds upon the recipient's capacity to engage in activities that promote
194.20 community life;

194.21 (ii) respects the recipient's preferences, choices, and abilities;

194.22 (iii) involves families, friends, and professionals in the planning or delivery of
194.23 services or supports as desired or required by the recipient; and

194.24 (iv) addresses the need for personal care assistant services identified in the recipient's
194.25 self-directed supports option assessment;

194.26 (2) the plan shall be developed by the recipient or by the guardian of an adult
194.27 recipient or by a parent or guardian of a minor child, with the assistance of an enrolled
194.28 medical assistance home care targeted case manager provider who meets the requirements
194.29 established for using a person-centered planning process and shall be reviewed at least
194.30 annually upon reassessment or when there is a significant change in the recipient's
194.31 condition; and

194.32 (3) the plan must include the total budget amount available divided into monthly
194.33 amounts that cover the number of months of personal care assistant services authorization
194.34 included in the budget. The amount used each month may vary, but additional funds shall
194.35 not be provided above the annual personal care assistant services authorized amount
194.36 unless a change in condition is documented.

195.1 (b) The commissioner shall:

195.2 (1) establish the format and criteria for the plan as well as the requirements for
195.3 providers who assist with plan development;

195.4 (2) review the assessment and plan and, within 30 days after receiving the
195.5 assessment and plan, make a decision on approval of the plan;

195.6 (3) notify the recipient, parent, or guardian of approval or denial of the plan and
195.7 provide notice of the right to appeal under section 256.045; and

195.8 (4) provide a copy of the plan to the fiscal support entity selected by the recipient.

195.9 Subd. 6. **Services covered.** (a) Services covered under the self-directed supports
195.10 option include:

195.11 (1) personal care assistant services under section 256B.0655; and

195.12 (2) items, related services, and supports, including assistive technology, that increase
195.13 independence or substitute for human assistance to the extent expenditures would
195.14 otherwise be used for human assistance.

195.15 (b) Items, supports, and related services purchased under this option shall not be
195.16 considered home care services for the purposes of section 144A.43.

195.17 Subd. 7. **Noncovered services.** Services or supports that are not eligible for
195.18 payment under the self-directed supports option include:

195.19 (1) services, goods, or supports that do not benefit the recipient;

195.20 (2) any fees incurred by the recipient, such as Minnesota health care program fees
195.21 and co-pays, legal fees, or costs related to advocate agencies;

195.22 (3) insurance, except for insurance costs related to employee coverage or fiscal
195.23 support entity payments;

195.24 (4) room and board and personal items that are not related to the disability, except
195.25 that medically prescribed specialized diet items may be covered if they reduce the need for
195.26 human assistance;

195.27 (5) home modifications that add square footage;

195.28 (6) home modifications for a residence other than the primary residence of the
195.29 recipient, or in the event of a minor with parents not living together, the primary residences
195.30 of the parents;

195.31 (7) expenses for travel, lodging, or meals related to training the recipient, the parent
195.32 or guardian of an adult recipient, or the parent or guardian of a minor child, or paid or
195.33 unpaid caregivers that exceed \$500 in a 12-month period;

195.34 (8) experimental treatment;

(9) any service or item covered by other medical assistance state plan services, including prescription and over-the-counter medications, compounds, and solutions and related fees, including premiums and co-payments;

(10) membership dues or costs, except when the service is necessary and appropriate to treat a physical condition or to improve or maintain the recipient's physical condition.

The condition must be identified in the recipient's plan of care and monitored by a Minnesota health care program enrolled physician;

(11) vacation expenses other than the cost of direct services;

(12) vehicle maintenance or modifications not related to the disability;

(13) tickets and related costs to attend sporting or other recreational events; and

(14) costs related to Internet access, except when necessary for operation of assistive technology, to increase independence, or to substitute for human assistance.

Subd. 8. **Self-directed budget requirements.** The budget for the provision of the self-directed service option shall be equal to the greater of either:

(1) the annual amount of personal care assistant services under section 256B.0655 that the recipient has used in the most recent 12-month period; or

(2) the amount determined using the consumer support grant methodology under section 256.476, subdivision 11, except that the budget amount shall include the federal and nonfederal share of the average service costs.

Subd. 9. **Quality assurance and risk management.** (a) The commissioner shall establish quality assurance and risk management measures for use in developing and implementing self-directed plans and budgets that (1) recognize the roles and responsibilities involved in obtaining services in a self-directed manner, and (2) assure the appropriateness of such plans and budgets based upon a recipient's resources and capabilities. These measures must include (i) background studies, and (ii) backup and emergency plans, including disaster planning.

(b) The commissioner shall provide ongoing technical assistance and resource and educational materials for families and recipients selecting the self-directed option.

(c) Performance assessments measures, such as of a recipient's satisfaction with the services and supports, and ongoing monitoring of health and well-being shall be identified in consultation with the stakeholder group.

Subd. 10. **Fiscal support entity.** (a) Each recipient shall choose a fiscal support entity provider certified by the commissioner to make payments for services, items, supports, and administrative costs related to managing a self-directed service plan authorized for payment in the approved plan and budget. Recipients shall also choose

197.1 the payroll, agency with choice, or the fiscal conduit model of financial and service
197.2 management.

197.3 (b) The fiscal support entity:

197.4 (1) may not limit or restrict the recipient's choice of service or support providers,
197.5 including use of the payroll, agency with choice, or fiscal conduit model of financial
197.6 and service management;

197.7 (2) must have a written agreement with the recipient or the recipient's representative
197.8 that identifies the duties and responsibilities to be performed and the specific related
197.9 charges;

197.10 (3) must provide the recipient and the home care targeted case manager with a
197.11 monthly written summary of the self-directed supports option services that were billed,
197.12 including charges from the fiscal support entity;

197.13 (4) must be knowledgeable of and comply with Internal Revenue Service
197.14 requirements necessary to process employer and employee deductions, provide appropriate
197.15 and timely submission of employer tax liabilities, and maintain documentation to support
197.16 medical assistance claims;

197.17 (5) must have current and adequate liability insurance and bonding and sufficient
197.18 cash flow and have on staff or under contract a certified public accountant or an individual
197.19 with a baccalaureate degree in accounting; and

197.20 (6) must maintain records to track all self-directed supports option services
197.21 expenditures, including time records of persons paid to provide supports and receipts for
197.22 any goods purchased. The records must be maintained for a minimum of five years from
197.23 the claim date and be available for audit or review upon request. Claims submitted by
197.24 the fiscal support entity must correspond with services, amounts, and time periods as
197.25 authorized in the recipient's self-directed supports option plan.

197.26 (c) The commissioner shall have authority to:

197.27 (1) set or negotiate rates with fiscal support entities;

197.28 (2) limit the number of fiscal support entities;

197.29 (3) identify a process to certify and recertify fiscal support entities and assure fiscal
197.30 support entities are available to recipients throughout the state; and

197.31 (4) establish a uniform format and protocol to be used by eligible fiscal support
197.32 entities.

197.33 Subd. 11. **Stakeholder consultation.** The commissioner shall consult with a
197.34 statewide consumer-directed services stakeholder group, including representatives of
197.35 all types of consumer-directed service users, advocacy organizations, counties, and

198.1 consumer-directed service providers. The commissioner shall seek recommendations
198.2 from this stakeholder group in developing:
198.3 (1) the self-directed plan format;
198.4 (2) requirements and guidelines for the person-centered plan assessment and
198.5 planning process;
198.6 (3) implementation of the option and the quality assurance and risk management
198.7 techniques; and
198.8 (4) standards and requirements, including rates for the personal support plan
198.9 development provider and the fiscal support entity; policies; training; and implementation.
198.10 The stakeholder group shall provide recommendations on the repeal of the personal care
198.11 assistant choice option, transition issues, and whether the consumer support grant program
198.12 under section 256.476 should be modified. The stakeholder group shall meet at least
198.13 three times each year to provide advice on policy, implementation, and other aspects of
198.14 consumer and self-directed services.

198.15 **EFFECTIVE DATE.** Subdivisions 1 to 10 are effective upon federal approval of
198.16 the state Medicaid plan amendment. The commissioner of human services shall inform
198.17 the Office of the Revisor of Statutes when federal approval is obtained. Subdivision 11
198.18 is effective July 1, 2007.

198.19 Sec. 28. Minnesota Statutes 2006, section 256B.0911, subdivision 3a, is amended to
198.20 read:

198.21 Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment,
198.22 services planning, or other assistance intended to support community-based living,
198.23 including persons who need assessment in order to determine waiver or alternative care
198.24 program eligibility, must be visited by a long-term care consultation team within ten
198.25 working days after the date on which an assessment was requested or recommended.

198.26 Assessments must be conducted according to paragraphs (b) to ~~(g)~~ (i).

198.27 (b) The county may utilize a team of either the social worker or public health nurse,
198.28 or both, to conduct the assessment in a face-to-face interview. The consultation team
198.29 members must confer regarding the most appropriate care for each individual screened or
198.30 assessed.

198.31 (c) The long-term care consultation team must assess the health and social needs of
198.32 the person, using an assessment form provided by the commissioner.

198.33 (d) The team must conduct the assessment in a face-to-face interview with the
198.34 person being assessed and the person's legal representative, if applicable.

199.1 (e) The team must provide the person, or the person's legal representative, with
199.2 written recommendations for facility- or community-based services. The team must
199.3 document that the most cost-effective alternatives available were offered to the individual.
199.4 For purposes of this requirement, "cost-effective alternatives" means community services
199.5 and living arrangements that cost the same as or less than nursing facility care.

199.6 (f) If the person chooses to use community-based services, the team must provide
199.7 the person or the person's legal representative with a written community support plan,
199.8 regardless of whether the individual is eligible for Minnesota health care programs.
199.9 The person may request assistance in developing a community support plan without
199.10 participating in a complete assessment.

199.11 (g) The person has the right to make the final decision between nursing facility
199.12 placement and community placement after the screening team's recommendation, except
199.13 as provided in subdivision 4a, paragraph (c).

199.14 (h) The team must give the person receiving assessment or support planning, or
199.15 the person's legal representative, materials, and forms supplied by the commissioner
199.16 containing the following information:

199.17 (1) the need for and purpose of preadmission screening and assessment if the person
199.18 selects nursing facility placement;

199.19 (2) the role of the long-term care consultation assessment and support planning in
199.20 waiver and alternative care program eligibility determination;

199.21 ~~(2)~~ (3) information about Minnesota health care programs;

199.22 ~~(3)~~ (4) the person's freedom to accept or reject the recommendations of the team;

199.23 ~~(4)~~ (5) the person's right to confidentiality under the Minnesota Government Data
199.24 Practices Act, chapter 13; and

199.25 (6) the long-term care consultant's decision regarding the person's need for nursing
199.26 facility level of care;

199.27 ~~(5)~~ (7) the person's right to appeal the decision regarding the need for nursing facility
199.28 level of care or the county's final decisions regarding public programs eligibility according
199.29 to section 256.045, subdivision 3.

199.30 (i) Face-to-face assessment completed as part of eligibility determination for
199.31 the alternative care, elderly waiver, community alternatives for disabled individuals,
199.32 community alternative care, and traumatic brain injury waiver programs under sections
199.33 256B.0915, 256B.0917, and 256B.49 is valid to establish service eligibility for no more
199.34 than 60 calendar days after the date of assessment. The effective eligibility start date
199.35 for these programs can never be prior to the date of assessment. If an assessment was
199.36 completed more than 60 days before the effective waiver or alternative care program

200.1 eligibility start date, assessment and support plan information must be updated in a
200.2 face-to-face visit and documented in the department's Medicaid Management Information
200.3 System (MMIS). The effective date of program eligibility in this case cannot be prior to
200.4 the date the updated assessment is completed.

200.5 Sec. 29. Minnesota Statutes 2006, section 256B.0911, subdivision 3b, is amended to
200.6 read:

200.7 Subd. 3b. **Transition assistance.** (a) A long-term care consultation team shall
200.8 provide assistance to persons residing in a nursing facility, hospital, regional treatment
200.9 center, or intermediate care facility for persons with developmental disabilities who
200.10 request or are referred for assistance. Transition assistance must include assessment,
200.11 community support plan development, referrals to Minnesota health care programs,
200.12 and referrals to programs that provide assistance with housing. Transition assistance
200.13 must also include information about the Centers for Independent Living and about other
200.14 organizations that can provide assistance with relocation efforts, and information about
200.15 contacting these organizations to obtain their assistance and support.

200.16 (b) The county shall develop transition processes with institutional social workers
200.17 and discharge planners to ensure that:

200.18 (1) persons admitted to facilities receive information about transition assistance
200.19 that is available;

200.20 (2) the assessment is completed for persons within ten working days of the date of
200.21 request or recommendation for assessment; and

200.22 (3) there is a plan for transition and follow-up for the individual's return to the
200.23 community. The plan must require notification of other local agencies when a person
200.24 who may require assistance is screened by one county for admission to a facility located
200.25 in another county.

200.26 (c) If a person who is eligible for a Minnesota health care program is admitted to a
200.27 nursing facility, the nursing facility must include a consultation team member or the case
200.28 manager in the discharge planning process.

200.29 Sec. 30. Minnesota Statutes 2006, section 256B.0911, is amended by adding a
200.30 subdivision to read:

200.31 Subd. 3c. **Transition to housing with services.** (a) Transitional consultation shall
200.32 be offered to all prospective residents 65 years of age or older regardless of income, assets,
200.33 or funding sources before housing with services establishments offering or providing
200.34 assisted living execute a lease or contract with the prospective resident. The purpose of

201.1 transitional long-term care consultation is to support persons with current or anticipated
201.2 long-term care needs in making informed choices among options that include the most
201.3 cost-effective and least restrictive settings, and to delay spenddown to eligibility for
201.4 publicly funded programs by connecting people to alternative services in their homes
201.5 before transition to housing with services.

201.6 (b) Transitional consultation services are provided as determined by the
201.7 commissioner of human services in partnership with county long-term care consultation
201.8 units, and the Area Agencies on Aging, and are a combination of telephone-based
201.9 and in-person assistance provided under models developed by the commissioner. The
201.10 consultation is to be performed in a manner which provides objective and complete
201.11 information. Transitional consultation must be provided within five working days of the
201.12 request of the prospective resident as follows:

201.13 (1) the consultation must be provided by a qualified professional as determined by
201.14 the commissioner;

201.15 (2) the consultation must include a review of the prospective resident's reasons for
201.16 considering assisted living, the prospective resident's personal goals, a discussion of the
201.17 prospective resident's immediate and projected long-term care needs, and alternative
201.18 community services or assisted living settings that may meet the prospective resident's
201.19 needs; and

201.20 (3) the prospective resident will be informed of the availability of long-term care
201.21 consultation services described in subdivision 3a that are available at no charge to the
201.22 prospective resident to assist the prospective resident in assessment and planning to
201.23 meet the prospective resident's long-term care needs. Regardless of the consultation,
201.24 prospective residents maintain the right to choose housing with services or assisted living,
201.25 if that is their choice.

201.26 **EFFECTIVE DATE.** This section is effective October 1, 2008.

201.27 Sec. 31. Minnesota Statutes 2006, section 256B.0911, subdivision 4b, is amended to
201.28 read:

201.29 Subd. 4b. **Exemptions and emergency admissions.** (a) Exemptions from the
201.30 federal screening requirements outlined in subdivision 4a, paragraphs (b) and (c), are
201.31 limited to:

201.32 (1) a person who, having entered an acute care facility from a certified nursing
201.33 facility, is returning to a certified nursing facility;

201.34 (2) a person transferring from one certified nursing facility in Minnesota to another
201.35 certified nursing facility in Minnesota; and

202.1 (3) a person, 21 years of age or older, who satisfies the following criteria, as specified
202.2 in Code of Federal Regulations, title 42, section 483.106(b)(2):

202.3 (i) the person is admitted to a nursing facility directly from a hospital after receiving
202.4 acute inpatient care at the hospital;

202.5 (ii) the person requires nursing facility services for the same condition for which
202.6 care was provided in the hospital; and

202.7 (iii) the attending physician has certified before the nursing facility admission that
202.8 the person is likely to receive less than 30 days of nursing facility services.

202.9 (b) Persons who are exempt from preadmission screening for purposes of level of
202.10 care determination include:

202.11 (1) persons described in paragraph (a);

202.12 (2) an individual who has a contractual right to have nursing facility care paid for
202.13 indefinitely by the veterans' administration;

202.14 (3) an individual enrolled in a demonstration project under section 256B.69,
202.15 subdivision 8, at the time of application to a nursing facility; and

202.16 (4) an individual currently being served under the alternative care program or under
202.17 a home and community-based services waiver authorized under section 1915(c) of the
202.18 federal Social Security Act; ~~and,~~

202.19 ~~(5) individuals admitted to a certified nursing facility for a short-term stay, which~~
202.20 ~~is expected to be 14 days or less in duration based upon a physician's certification, and~~
202.21 ~~who have been assessed and approved for nursing facility admission within the previous~~
202.22 ~~six months. This exemption applies only if the consultation team member determines at~~
202.23 ~~the time of the initial assessment of the six-month period that it is appropriate to use the~~
202.24 ~~nursing facility for short-term stays and that there is an adequate plan of care for return to~~
202.25 ~~the home or community-based setting. If a stay exceeds 14 days, the individual must be~~
202.26 ~~referred no later than the first county working day following the 14th resident day for a~~
202.27 ~~screening, which must be completed within five working days of the referral. The payment~~
202.28 ~~limitations in subdivision 7 apply to an individual found at screening to not meet the level~~
202.29 ~~of care criteria for admission to a certified nursing facility.~~

202.30 (c) Persons admitted to a Medicaid-certified nursing facility from the community
202.31 on an emergency basis as described in paragraph (d) or from an acute care facility on a
202.32 nonworking day must be screened the first working day after admission.

202.33 (d) Emergency admission to a nursing facility prior to screening is permitted when
202.34 all of the following conditions are met:

202.35 (1) a person is admitted from the community to a certified nursing or certified
202.36 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. 32. 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;

(2) the person needs an immediate face-to-face screening interview to determine the need for nursing facility level of care and complete activities required under subdivision 4a; or

(3) the person may be exempt from screening requirements as outlined in subdivision 4b, but will need transitional assistance after admission or in-person follow-along after a return home.

(b) Persons admitted on a nonemergency basis to a Medicaid-certified nursing facility must be screened prior to admission.

~~(e) The long-term care consultation team shall recommend a case mix classification for persons admitted to a certified nursing facility when sufficient information is received to make that classification. The nursing facility is authorized to conduct all case mix assessments for persons who have been screened prior to admission for whom the county did not recommend a case mix classification. The nursing facility is authorized to conduct all case mix assessments for persons admitted to the facility prior to a preadmission screening. The county retains the responsibility of distributing appropriate case mix forms to the nursing facility.~~

~~(d)~~ (c) The county screening or intake activity must include processes to identify persons who may require transition assistance as described in subdivision 3b.

Sec. 33. Minnesota Statutes 2006, section 256B.0911, subdivision 6, is amended to read:

Subd. 6. **Payment for long-term care consultation services.** (a) The total payment for each county must be paid monthly by certified nursing facilities in the county. The monthly amount to be paid by each nursing facility for each fiscal year must be determined by dividing the county's annual allocation for long-term care consultation services by 12 to determine the monthly payment and allocating the monthly payment to each nursing facility based on the number of licensed beds in the nursing facility. Payments to counties in which there is no certified nursing facility must be made by increasing the payment rate of the two facilities located nearest to the county seat.

(b) The commissioner shall include the total annual payment determined under paragraph (a) for each nursing facility reimbursed under section 256B.431 or 256B.434 according to section 256B.431, subdivision 2b, paragraph (g), ~~or 256B.435.~~

(c) In the event of the layaway, delicensure and decertification, or removal from layaway of 25 percent or more of the beds in a facility, the commissioner may adjust the per diem payment amount in paragraph (b) and may adjust the monthly payment 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. 34. 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. 35. 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 level of care criteria for nursing facility placement or, if indicated, has not had a level II OBRA evaluation as required under the federal Omnibus Budget Reconciliation Act of 1987 completed unless an admission for a recipient with mental illness is approved by the local mental health authority or an admission for a recipient with developmental disability is approved by the state developmental disability authority.

(b) The nursing facility must not bill a person who is not a medical assistance recipient for resident days that preceded the date of completion of screening activities as

required under subdivisions 4a, 4b, and 4c. The nursing facility must include unreimbursed resident days in the nursing facility resident day totals reported to the commissioner.

~~(e) The commissioner shall make a request to the Centers for Medicare and Medicaid Services for a waiver allowing team approval of Medicaid payments for certified nursing facility care. An individual has a choice and makes the final decision between nursing facility placement and community placement after the screening team's recommendation, except as provided in subdivision 4a, paragraph (c).~~

Sec. 36. Minnesota Statutes 2006, section 256B.0913, subdivision 4, is amended to read:

Subd. 4. **Eligibility for funding for services for nonmedical assistance recipients.**

(a) Funding for services under the alternative care program is available to persons who meet the following criteria:

(1) the person has been determined by a community assessment under section 256B.0911 to be a person who would require the level of care provided in a nursing facility, but for the provision of services under the alternative care program;

(2) the person is age 65 or older;

(3) the person would be eligible for medical assistance within 135 days of admission to a nursing facility;

(4) the person is not ineligible for the payment of long-term care services by the medical assistance program due to an asset transfer penalty under section 256B.0595 or equity interest in the home exceeding \$500,000 as stated in section 256B.056;

(5) the person needs long-term care services that are not funded through other state or federal funding;

(6) the monthly cost of the alternative care services funded by the program for this person does not exceed 75 percent of the monthly limit described under section 256B.0915, subdivision 3a. This monthly limit does not prohibit the alternative care client from payment for additional services, but in no case may the cost of additional services purchased under this section exceed the difference between the client's monthly service limit defined under section 256B.0915, subdivision 3, and the alternative care program monthly service limit defined in this paragraph. If ~~medical~~ care-related supplies and equipment or environmental modifications and adaptations are or will be purchased for an alternative care services recipient, the costs may be prorated on a monthly basis for up to 12 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's other alternative care services exceeds the monthly limit established in this paragraph, the annual cost of the alternative care services shall be determined. In this

207.1 event, the annual cost of alternative care services shall not exceed 12 times the monthly
207.2 limit described in this paragraph; and

207.3 (7) the person is making timely payments of the assessed monthly fee.

207.4 A person is ineligible if payment of the fee is over 60 days past due, unless the person
207.5 agrees to:

207.6 (i) the appointment of a representative payee;

207.7 (ii) automatic payment from a financial account;

207.8 (iii) the establishment of greater family involvement in the financial management of
207.9 payments; or

207.10 (iv) another method acceptable to the ~~county~~ lead agency to ensure prompt fee
207.11 payments.

207.12 The ~~county shall~~ lead agency may extend the client's eligibility as necessary while
207.13 making arrangements to facilitate payment of past-due amounts and future premium
207.14 payments. Following disenrollment due to nonpayment of a monthly fee, eligibility shall
207.15 not be reinstated for a period of 30 days.

207.16 (b) Alternative care funding under this subdivision is not available for a person
207.17 who is a medical assistance recipient or who would be eligible for medical assistance
207.18 without a spenddown or waiver obligation. A person whose initial application for medical
207.19 assistance and the elderly waiver program is being processed may be served under the
207.20 alternative care program for a period up to 60 days. If the individual is found to be eligible
207.21 for medical assistance, medical assistance must be billed for services payable under the
207.22 federally approved elderly waiver plan and delivered from the date the individual was
207.23 found eligible for the federally approved elderly waiver plan. Notwithstanding this
207.24 provision, alternative care funds may not be used to pay for any service the cost of which:
207.25 (i) is payable by medical assistance; (ii) is used by a recipient to meet a waiver obligation;
207.26 or (iii) is used to pay a medical assistance income spenddown for a person who is eligible
207.27 to participate in the federally approved elderly waiver program under the special income
207.28 standard provision.

207.29 (c) Alternative care funding is not available for a person who resides in a licensed
207.30 nursing home, certified boarding care home, hospital, or intermediate care facility, except
207.31 for case management services which are provided in support of the discharge planning
207.32 process for a nursing home resident or certified boarding care home resident to assist with
207.33 a relocation process to a community-based setting.

207.34 (d) Alternative care funding is not available for a person whose income is greater
207.35 than the maintenance needs allowance under section 256B.0915, subdivision 1d, but equal
207.36 to or less than 120 percent of the federal poverty guideline effective July 1 in the fiscal

208.1 year for which alternative care eligibility is determined, who would be eligible for the
208.2 elderly waiver with a waiver obligation.

208.3 Sec. 37. Minnesota Statutes 2006, section 256B.0913, subdivision 5, is amended to
208.4 read:

208.5 Subd. 5. **Services covered under alternative care.** Alternative care funding may
208.6 be used for payment of costs of:

- 208.7 (1) adult day care;
- 208.8 (2) home health aide;
- 208.9 (3) homemaker services;
- 208.10 (4) personal care;
- 208.11 (5) case management;
- 208.12 (6) respite care;
- 208.13 (7) care-related supplies and equipment;
- 208.14 (8) meals delivered to the home;
- 208.15 (9) nonmedical transportation;
- 208.16 (10) nursing services;
- 208.17 (11) chore services;
- 208.18 (12) companion services;
- 208.19 (13) nutrition services;
- 208.20 (14) training for direct informal caregivers;
- 208.21 (15) telehome care to provide services in their own homes in conjunction with
208.22 in-home visits;
- 208.23 (16) ~~discretionary services, for which counties may make payment from their~~
208.24 ~~alternative care program allocation or services not otherwise defined in this section~~
208.25 ~~or section 256B.0625, following approval by the commissioner~~ consumer-directed
208.26 community services under the alternative care programs which are available statewide and
208.27 limited to the average monthly expenditures representative of all alternative care program
208.28 participants for the same case mix resident class assigned in the most recent fiscal year for
208.29 which complete expenditure data is available;
- 208.30 (17) environmental modifications and adaptations; and
- 208.31 (18) ~~direct cash payments for which counties may make payment from their~~
208.32 ~~alternative care program allocation to clients for the purpose of purchasing services,~~
208.33 ~~following approval by the commissioner, and subject to the provisions of subdivision 5h,~~
208.34 ~~until approval and implementation of consumer-directed services through the federally~~
208.35 ~~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. 38. 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

210.1 meets the criteria and is also the responsible party under an individual service plan that
210.2 ensures the client's health and safety and supervision of the personal care services by a
210.3 qualified professional as defined in section 256B.0625, subdivision 19c. Relative hardship
210.4 is established by the ~~county~~ lead agency when the client's care causes a relative caregiver
210.5 to do any of the following: resign from a paying job, reduce work hours resulting in lost
210.6 wages, obtain a leave of absence resulting in lost wages, incur substantial client-related
210.7 expenses, provide services to address authorized, unstaffed direct care time, or meet
210.8 special needs of the client unmet in the formal service plan.

210.9 Sec. 39. Minnesota Statutes 2006, section 256B.0913, subdivision 8, is amended to
210.10 read:

210.11 Subd. 8. **Requirements for individual care plan.** (a) The case manager shall
210.12 implement the plan of care for each alternative care client and ensure that a client's
210.13 service needs and eligibility are reassessed at least every 12 months. The plan shall
210.14 include any services prescribed by the individual's attending physician as necessary to
210.15 allow the individual to remain in a community setting. In developing the individual's care
210.16 plan, the case manager should include the use of volunteers from families and neighbors,
210.17 religious organizations, social clubs, and civic and service organizations to support the
210.18 formal home care services. The ~~county~~ lead agency shall be held harmless for damages or
210.19 injuries sustained through the use of volunteers under this subdivision including workers'
210.20 compensation liability. The ~~county of service~~ case manager shall provide documentation
210.21 in each individual's plan of care and, if requested, to the commissioner that the most
210.22 cost-effective alternatives available have been offered to the individual and that the
210.23 individual was free to choose among available qualified providers, both public and private,
210.24 including qualified case management or service coordination providers other than those
210.25 employed by any county; however, the county or tribe maintains responsibility for prior
210.26 authorizing services in accordance with statutory and administrative requirements. The
210.27 case manager must give the individual a ten-day written notice of any denial, termination,
210.28 or reduction of alternative care services.

210.29 (b) The county of service or tribe must provide access to and arrange for case
210.30 management services, including assuring implementation of the plan. "County of service"
210.31 has the meaning given it in Minnesota Rules, part 9505.0015, subpart 11. The county of
210.32 service must notify the county of financial responsibility of the approved care plan and
210.33 the amount of encumbered funds.

211.1 Sec. 40. Minnesota Statutes 2006, section 256B.0913, subdivision 9, is amended to
211.2 read:

211.3 Subd. 9. **Contracting provisions for providers.** Alternative care funds paid to
211.4 service providers are subject to audit by the commissioner for fiscal and utilization control.

211.5 The lead agency must select providers for contracts or agreements using the
211.6 following criteria and other criteria established by the county lead agency:

211.7 (1) the need for the particular services offered by the provider;

211.8 (2) the population to be served, including the number of clients, the length of time
211.9 services will be provided, and the medical condition of clients;

211.10 (3) the geographic area to be served;

211.11 (4) quality assurance methods, including appropriate licensure, certification, or
211.12 standards, and supervision of employees when needed;

211.13 (5) rates for each service and unit of service exclusive of county lead agency
211.14 administrative costs;

211.15 (6) evaluation of services previously delivered by the provider; and

211.16 (7) contract or agreement conditions, including billing requirements, cancellation,
211.17 and indemnification.

211.18 The county lead agency must evaluate its own agency services under the criteria
211.19 established for other providers.

211.20 Sec. 41. Minnesota Statutes 2006, section 256B.0913, subdivision 10, is amended to
211.21 read:

211.22 Subd. 10. **Allocation formula.** (a) ~~The alternative care appropriation for fiscal~~
211.23 ~~years 1992 and beyond shall cover only alternative care eligible clients.~~ By July 1st of
211.24 each year, the commissioner shall allocate to county agencies the state funds available for
211.25 alternative care for persons eligible under subdivision 2.

211.26 (b) The adjusted base for each county lead agency is the county's lead agency's
211.27 current fiscal year base allocation plus any targeted funds approved during the current
211.28 fiscal year. Calculations for paragraphs (c) and (d) are to be made as follows: for each
211.29 county lead agency, the determination of alternative care program expenditures shall be
211.30 based on payments for services rendered from April 1 through March 31 in the base year,
211.31 to the extent that claims have been submitted and paid by June 1 of that year.

211.32 (c) If the alternative care program expenditures as defined in paragraph (b) are 95
211.33 percent or more of the county's lead agency's adjusted base allocation, the allocation for
211.34 the next fiscal year is 100 percent of the adjusted base, plus inflation to the extent that
211.35 inflation is included in the state budget.

212.1 (d) If the alternative care program expenditures as defined in paragraph (b) are less
212.2 than 95 percent of the ~~county's~~ lead agency's adjusted base allocation, the allocation
212.3 for the next fiscal year is the adjusted base allocation less the amount of unspent funds
212.4 below the 95 percent level.

212.5 (e) If the annual legislative appropriation for the alternative care program is
212.6 inadequate to fund the combined ~~county~~ lead agency allocations for a biennium, the
212.7 commissioner shall distribute to each ~~county~~ lead agency the entire annual appropriation
212.8 as that ~~county's~~ lead agency's percentage of the computed base as calculated in paragraphs
212.9 (c) and (d).

212.10 (f) On agreement between the commissioner and the lead agency, the commissioner
212.11 may have discretion to reallocate alternative care base allocations distributed to lead
212.12 agencies in which the base amount exceeds program expenditures.

212.13 Sec. 42. Minnesota Statutes 2006, section 256B.0913, subdivision 11, is amended to
212.14 read:

212.15 Subd. 11. **Targeted funding.** (a) The purpose of targeted funding is to make
212.16 additional money available to ~~counties~~ lead agencies with the greatest need. Targeted
212.17 funds are not intended to be distributed equitably among all ~~counties~~ lead agencies, but
212.18 rather, allocated to those with long-term care strategies that meet state goals.

212.19 (b) The funds available for targeted funding shall be the total appropriation for each
212.20 fiscal year minus ~~county~~ lead agency allocations determined under subdivision 10 as
212.21 adjusted for any inflation increases provided in appropriations for the biennium.

212.22 (c) The commissioner shall allocate targeted funds to ~~counties~~ lead agencies that
212.23 demonstrate to the satisfaction of the commissioner that they have developed feasible
212.24 plans to increase alternative care spending. In making targeted funding allocations, the
212.25 commissioner shall use the following priorities:

212.26 (1) ~~counties~~ lead agencies that received a lower allocation in fiscal year 1991 than in
212.27 fiscal year 1990. Counties remain in this priority until they have been restored to their
212.28 fiscal year 1990 level plus inflation;

212.29 (2) ~~counties~~ lead agencies that sustain a base allocation reduction for failure to spend
212.30 95 percent of the allocation if they demonstrate that the base reduction should be restored;

212.31 (3) ~~counties~~ lead agencies that propose projects to divert community residents from
212.32 nursing home placement or convert nursing home residents to community living; and

212.33 (4) ~~counties~~ lead agencies that can otherwise justify program growth by
212.34 demonstrating the existence of waiting lists, demographically justified needs, or other
212.35 unmet needs.

213.1 (d) ~~Counties~~ Lead agencies that would receive targeted funds according to
213.2 paragraph (c) must demonstrate to the commissioner's satisfaction that the funds
213.3 would be appropriately spent by showing how the funds would be used to further the
213.4 state's alternative care goals as described in subdivision 1, and that the county has the
213.5 administrative and service delivery capability to use them.

213.6 (e) The commissioner shall ~~request applications~~ make applications available for
213.7 targeted funds by November 1 of each year. The ~~counties~~ lead agencies selected for
213.8 targeted funds shall be notified of the amount of their additional funding. Targeted funds
213.9 allocated to a ~~county~~ lead agency in one year shall be treated as part of the ~~county's~~ lead
213.10 agency's base allocation for that year in determining allocations for subsequent years. No
213.11 reallocations between ~~counties~~ lead agencies shall be made.

213.12 Sec. 43. Minnesota Statutes 2006, section 256B.0913, subdivision 12, is amended to
213.13 read:

213.14 Subd. 12. **Client fees.** (a) A fee is required for all alternative care eligible clients
213.15 to help pay for the cost of participating in the program. The amount of the fee for the
213.16 alternative care client shall be determined as follows:

213.17 (1) when the alternative care client's income less recurring and predictable medical
213.18 expenses is less than 100 percent of the federal poverty guideline effective on July 1 of
213.19 the state fiscal year in which the fee is being computed, and total assets are less than
213.20 \$10,000, the fee is zero;

213.21 (2) when the alternative care client's income less recurring and predictable medical
213.22 expenses is equal to or greater than 100 percent but less than 150 percent of the federal
213.23 poverty guideline effective on July 1 of the state fiscal year in which the fee is being
213.24 computed, and total assets are less than \$10,000, the fee is five percent of the cost of
213.25 alternative care services;

213.26 (3) when the alternative care client's income less recurring and predictable medical
213.27 expenses is equal to or greater than 150 percent but less than 200 percent of the federal
213.28 poverty guidelines effective on July 1 of the state fiscal year in which the fee is being
213.29 computed and assets are less than \$10,000, the fee is 15 percent of the cost of alternative
213.30 care services;

213.31 (4) when the alternative care client's income less recurring and predictable medical
213.32 expenses is equal to or greater than 200 percent of the federal poverty guidelines effective
213.33 on July 1 of the state fiscal year in which the fee is being computed and assets are less than
213.34 \$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 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.

215.1 If a ~~county~~ lead agency does not adhere to these reporting requirements, the commissioner
215.2 may terminate the billing, collecting, and remitting portions of the pilot project and require
215.3 the ~~county~~ lead agency involved to operate under the procedures set forth in this paragraph.

215.4 Sec. 44. Minnesota Statutes 2006, section 256B.0913, subdivision 13, is amended to
215.5 read:

215.6 Subd. 13. **~~County~~ Lead agency biennial plan.** The ~~county~~ lead agency biennial
215.7 plan for long-term care consultation services under section 256B.0911, the alternative
215.8 care program under this section, and waivers for the elderly under section 256B.0915,
215.9 shall be submitted by the lead agency as the home and community-based services quality
215.10 assurance plan on a form provided by the commissioner.

215.11 Sec. 45. Minnesota Statutes 2006, section 256B.0913, subdivision 14, is amended to
215.12 read:

215.13 Subd. 14. **Provider requirements, payment, and rate adjustments.** (a) Unless
215.14 otherwise specified in statute, providers must be enrolled as Minnesota health care
215.15 program providers and abide by the requirements for provider participation according to
215.16 Minnesota Rules, part 9505.0195.

215.17 (b) Payment for provided alternative care services as approved by the client's
215.18 case manager shall occur through the invoice processing procedures of the department's
215.19 Medicaid Management Information System (MMIS). To receive payment, the ~~county~~ lead
215.20 agency or vendor must submit invoices within 12 months following the date of service.
215.21 The ~~county~~ lead agency and its vendors under contract shall not be reimbursed for services
215.22 which exceed the county allocation.

215.23 (c) The ~~county~~ lead agency shall negotiate individual rates with vendors and may
215.24 authorize service payment for actual costs up to the county's current approved rate.
215.25 Notwithstanding any other rule or statutory provision to the contrary, the commissioner
215.26 shall not be authorized to increase rates by an annual inflation factor, unless so authorized
215.27 by the legislature. To improve access to community services and eliminate payment
215.28 disparities between the alternative care program and the elderly waiver program, the
215.29 commissioner shall establish statewide maximum service rate limits and eliminate
215.30 county-specific service rate limits.

215.31 (1) Effective July 1, 2001, for service rate limits, except those in subdivision 5,
215.32 paragraphs (d) and (i), the rate limit for each service shall be the greater of the alternative
215.33 care statewide maximum rate or the elderly waiver statewide maximum rate.

216.1 (2) ~~Counties~~ Lead agencies may negotiate individual service rates with vendors for
216.2 actual costs up to the statewide maximum service rate limit.

216.3 Sec. 46. Minnesota Statutes 2006, section 256B.0915, is amended to read:

216.4 **256B.0915 MEDICAID WAIVER FOR ELDERLY SERVICES.**

216.5 Subdivision 1. **Authority.** The commissioner is authorized to apply for a home
216.6 and community-based services waiver for the elderly, authorized under section 1915(c)
216.7 of the Social Security Act, in order to obtain federal financial participation to expand
216.8 the availability of services for persons who are eligible for medical assistance. The
216.9 commissioner may apply for additional waivers or pursue other federal financial
216.10 participation which is advantageous to the state for funding home care services for the
216.11 frail elderly who are eligible for medical assistance. The provision of waived services
216.12 to elderly and disabled medical assistance recipients must comply with the criteria for
216.13 service definitions and provider standards approved in the waiver.

216.14 Subd. 1a. **Elderly waiver case management services.** (a) Elderly case management
216.15 services under the home and community-based services waiver for elderly individuals are
216.16 available from providers meeting qualification requirements and the standards specified
216.17 in subdivision 1b. Eligible recipients may choose any qualified provider of elderly case
216.18 management services.

216.19 Case management services assist individuals who receive waiver services in gaining
216.20 access to needed waiver and other state plan services, as well as needed medical, social,
216.21 educational, and other services regardless of the funding source for the services to which
216.22 access is gained.

216.23 A case aide shall provide assistance to the case manager in carrying out
216.24 administrative activities of the case management function. The case aide may not assume
216.25 responsibilities that require professional judgment including assessments, reassessments,
216.26 and care plan development. The case manager is responsible for providing oversight of
216.27 the case aide.

216.28 Case managers shall be responsible for ongoing monitoring of the provision of
216.29 services included in the individual's plan of care. Case managers shall initiate and oversee
216.30 the process of assessment and reassessment of the individual's care and review plan of
216.31 care at intervals specified in the federally approved waiver plan.

216.32 (b) The county of service or tribe must provide access to and arrange for case
216.33 management services. County of service has the meaning given it in Minnesota Rules,
216.34 part 9505.0015, subpart 11.

217.1 Subd. 1b. **Provider qualifications and standards.** The commissioner must
217.2 enroll qualified providers of elderly case management services under the home
217.3 and community-based waiver for the elderly under section 1915(c) of the Social
217.4 Security Act. The enrollment process shall ensure the provider's ability to meet the
217.5 qualification requirements and standards in this subdivision and other federal and state
217.6 requirements of this service. An elderly case management provider is an enrolled medical
217.7 assistance provider who is determined by the commissioner to have all of the following
217.8 characteristics:

217.9 (1) the demonstrated capacity and experience to provide the components of
217.10 case management to coordinate and link community resources needed by the eligible
217.11 population;

217.12 (2) administrative capacity and experience in serving the target population for
217.13 whom it will provide services and in ensuring quality of services under state and federal
217.14 requirements;

217.15 (3) a financial management system that provides accurate documentation of services
217.16 and costs under state and federal requirements;

217.17 (4) the capacity to document and maintain individual case records under state and
217.18 federal requirements; and

217.19 (5) the ~~county~~ lead agency may allow a case manager employed by the ~~county~~ lead
217.20 agency to delegate certain aspects of the case management activity to another individual
217.21 employed by the ~~county~~ lead agency provided there is oversight of the individual by
217.22 the case manager. The case manager may not delegate those aspects which require
217.23 professional judgment including assessments, reassessments, and care plan development.
217.24 Lead agencies include counties, health plans, and federally recognized tribes who
217.25 authorize services under this section.

217.26 ~~Subd. 1c. Case management activities under the state plan. The commissioner~~
217.27 ~~shall seek an amendment to the home and community-based services waiver for the~~
217.28 ~~elderly to implement the provisions of subdivisions 1a and 1b. If the commissioner~~
217.29 ~~is unable to secure the approval of the secretary of health and human services for the~~
217.30 ~~requested waiver amendment by December 31, 1993, the commissioner shall amend~~
217.31 ~~the medical assistance state plan to provide that case management provided under the~~
217.32 ~~home and community-based services waiver for the elderly is performed by counties~~
217.33 ~~as an administrative function for the proper and effective administration of the state~~
217.34 ~~medical assistance plan. The state shall reimburse counties for the nonfederal share of~~
217.35 ~~costs for case management performed as an administrative function under the home and~~
217.36 ~~community-based services waiver for the elderly.~~

218.1 Subd. 1d. **Posteligibility treatment of income and resources for elderly waiver.**

218.2 Notwithstanding the provisions of section 256B.056, the commissioner shall make the
218.3 following amendment to the medical assistance elderly waiver program effective July 1,
218.4 1999, or upon federal approval, whichever is later.

218.5 A recipient's maintenance needs will be an amount equal to the Minnesota
218.6 supplemental aid equivalent rate as defined in section 256I.03, subdivision 5, plus the
218.7 medical assistance personal needs allowance as defined in section 256B.35, subdivision
218.8 1, paragraph (a), when applying posteligibility treatment of income rules to the gross
218.9 income of elderly waiver recipients, except for individuals whose income is in excess of
218.10 the special income standard according to Code of Federal Regulations, title 42, section
218.11 435.236. Recipient maintenance needs shall be adjusted under this provision each July 1.

218.12 Subd. 2. **Spousal impoverishment policies.** The commissioner shall ~~seek to amend~~
218.13 ~~the federal waiver and the medical assistance state plan to allow~~ apply:

218.14 (1) the spousal impoverishment criteria as authorized under United States Code, title
218.15 42, section 1396r-5, and as implemented in sections 256B.0575, 256B.058, and 256B.059;
218.16 ~~except that the amendment shall seek to add to;~~

218.17 (2) the personal needs allowance permitted in section 256B.0575; and

218.18 (3) an amount equivalent to the group residential housing rate as set by section
218.19 256I.03, subdivision 5, and according to the approved federal waiver and medical
218.20 assistance state plan.

218.21 Subd. 3. **Limits of cases.** The number of medical assistance waiver recipients that
218.22 a ~~county~~ lead agency may serve must be allocated according to the number of medical
218.23 assistance waiver cases open on July 1 of each fiscal year. Additional recipients may be
218.24 served with the approval of the commissioner.

218.25 Subd. 3a. **Elderly waiver cost limits.** (a) The monthly limit for the cost of waived
218.26 services to an individual elderly waiver client shall be the weighted average monthly
218.27 nursing facility rate of the case mix resident class to which the elderly waiver client would
218.28 be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, less the recipient's
218.29 maintenance needs allowance as described in subdivision 1d, paragraph (a), until the first
218.30 day of the state fiscal year in which the resident assessment system as described in section
218.31 256B.437 for nursing home rate determination is implemented. Effective on the first day
218.32 of the state fiscal year in which the resident assessment system as described in section
218.33 256B.437 for nursing home rate determination is implemented and the first day of each
218.34 subsequent state fiscal year, the monthly limit for the cost of waived services to an
218.35 individual elderly waiver client shall be the rate of the case mix resident class to which the
218.36 waiver client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059,

in effect on the last day of the previous state fiscal year, adjusted by the greater of any legislatively adopted home and community-based services percentage rate increase or the average statewide percentage increase in nursing facility payment rates.

(b) If extended medical supplies and equipment or environmental modifications are or will be purchased for an elderly waiver client, the costs may be prorated for up to 12 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's waived services exceeds the monthly limit established in paragraph (a), the annual cost of all waived services shall be determined. In this event, the annual cost of all waived services shall not exceed 12 times the monthly limit of waived services as described in paragraph (a).

Subd. 3b. **Cost limits for elderly waiver applicants who reside in a nursing facility.** (a) For a person who is a nursing facility resident at the time of requesting a determination of eligibility for elderly waived services, a monthly conversion limit for the cost of elderly waived services may be requested. The monthly conversion limit for the cost of elderly waiver services shall be the resident class assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, for that resident in the nursing facility where the resident currently resides until 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, the monthly conversion limit for the cost of elderly waiver services shall be the per diem nursing facility rate as determined by the resident assessment system as described in section 256B.437 for that resident in the nursing facility where the resident currently resides multiplied by 365 and divided by 12, less the recipient's maintenance needs allowance as described in subdivision 1d. The initially approved conversion rate may be adjusted by the greater of any subsequent legislatively adopted home and community-based services percentage rate increase or the average statewide percentage increase in nursing facility payment rates. The limit under this subdivision only applies to persons discharged from a nursing facility after a minimum 30-day stay and found eligible for waived services on or after July 1, 1997. For conversions from the nursing home to the elderly waiver with consumer directed community support services, the conversion rate limit is equal to the nursing facility rate reduced by a percentage equal to the percentage difference between the consumer directed services budget limit that would be assigned according to the federally approved waiver plan and the corresponding community case mix cap, but not to exceed 50 percent.

220.1 (b) The following costs must be included in determining the total monthly costs
220.2 for the waiver client:

220.3 (1) cost of all waived services, including extended medical supplies and equipment
220.4 and environmental modifications and adaptations; and

220.5 (2) cost of skilled nursing, home health aide, and personal care services reimbursable
220.6 by medical assistance.

220.7 Subd. 3c. **Service approval and contracting provisions.** (a) Medical assistance
220.8 funding for skilled nursing services, private duty nursing, home health aide, and personal
220.9 care services for waiver recipients must be approved by the case manager and included in
220.10 the individual care plan.

220.11 (b) A ~~county~~ lead agency is not required to contract with a provider of supplies and
220.12 equipment if the monthly cost of the supplies and equipment is less than \$250.

220.13 Subd. 3d. **Adult foster care rate.** The adult foster care rate shall be considered
220.14 a difficulty of care payment and shall not include room and board. The adult foster
220.15 care service rate shall be negotiated between the ~~county~~ lead agency and the foster care
220.16 provider. The elderly waiver payment for the foster care service in combination with
220.17 the payment for all other elderly waiver services, including case management, must not
220.18 exceed the limit specified in subdivision 3a, paragraph (a).

220.19 Subd. 3e. ~~Assisted living~~ **Customized living service rate.** (a) Payment for ~~assisted~~
220.20 ~~living service~~ customize living services shall be a monthly rate negotiated and authorized
220.21 by the ~~county agency based on an individualized service plan for each resident and may~~
220.22 ~~not cover direct rent or food costs.~~ lead agency within the parameters established by
220.23 the commissioner. The payment agreement must delineate the services that have been
220.24 customized for each recipient and specify the amount of each service to be provided. The
220.25 lead agency shall ensure that there is a documented need for all services authorized.
220.26 Customized living services must not include rent or raw food costs. The negotiated
220.27 payment rate must be based on services to be provided. Negotiated rates must not exceed
220.28 payment rates for comparable elderly waiver or medical assistance services and must
220.29 reflect economies of scale.

220.30 (b) The individualized monthly negotiated payment for ~~assisted living~~ customized
220.31 living services as described in section 256B.0913, subdivisions 5d to 5f, and residential
220.32 care services as described in section 256B.0913, subdivision 5e, shall not exceed the
220.33 nonfederal share, in effect on July 1 of the state fiscal year for which the rate limit
220.34 is being calculated, of the greater of either the statewide or any of the geographic
220.35 groups' weighted average monthly nursing facility rate of the case mix resident class
220.36 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 Medicaid expenditures shall be forecasted with the medical assistance budget, and shall be consistent with the approved waiver.

Subd. 3g. **Service rate limits; state assumption of costs.** (a) To improve access to community services and eliminate payment disparities between the alternative care program and the elderly waiver, the commissioner shall establish statewide maximum service rate limits and eliminate ~~county-specific~~ lead agency-specific service rate limits.

(b) Effective July 1, 2001, for service rate limits, except those described or defined in subdivisions 3d and 3e, the rate limit for each service shall be the greater of the alternative care statewide maximum rate or the elderly waiver statewide maximum rate.

(c) ~~Counties~~ Lead agencies may negotiate individual service rates with vendors for actual costs up to the statewide maximum service rate limit.

Subd. 3h. **Service rate limits; 24-hour customized living services.** The payment rates for 24-hour customized living services is a monthly rate negotiated and authorized by the lead agency within the parameters established by the commissioner of human services. The payment agreement must delineate the services that have been customized for each recipient and specify the amount of each service to be provided. The lead agency shall ensure that there is a documented need for all services authorized. The lead agency shall not authorize 24-hour customized living services unless there is a documented need for 24-hour supervision. For purposes of this section, "24-hour supervision" means that the recipient requires assistance due to needs related to one or more of the following:

(1) intermittent assistance with toileting or transferring;

(2) cognitive or behavioral issues;

(3) a medical condition that requires clinical monitoring; or

(4) other conditions or needs as defined by the commissioner of human services.

The lead agency shall ensure that the frequency and mode of supervision of the recipient and the qualifications of staff providing supervision are described and meet the needs of the recipient. Customized living services must not include rent or raw food costs. The negotiated payment rate for 24-hour customized living services must be based on services to be provided. Negotiated rates must not exceed payment rates for comparable elderly waiver or medical assistance services and must reflect economies of scale. The individually negotiated 24-hour customized living payments, in combination with the payment for other elderly waiver services, including case management, must not exceed the recipient's community budget cap specified in subdivision 3a.

Subd. 4. Termination notice. The case manager must give the individual a ten-day written notice of any denial, reduction, or termination of waived services.

Subd. 5. Assessments and reassessments for waiver clients. Each client shall receive an initial assessment of strengths, informal supports, and need for services in accordance with section 256B.0911, subdivisions 3, 3a, and 3b. A reassessment of a client served under the elderly waiver must be conducted at least every 12 months and at other times when the case manager determines that there has been significant change in the client's functioning. This may include instances where the client is discharged from the hospital.

Subd. 6. **Implementation of care plan.** Each elderly waiver client shall be provided a copy of a written care plan that meets the requirements outlined in section 256B.0913, subdivision 8. The care plan must be implemented by the county ~~administering waived services~~ of service when it is different than the county of financial responsibility. The county of service administering waived services must notify the county of financial responsibility of the approved care plan.

Subd. 7. **Prepaid elderly waiver services.** An individual for whom a prepaid health plan is liable for nursing home services or elderly waiver services according to section 256B.69, subdivision 6a, is not eligible to also receive county-administered elderly waiver services ~~under this section~~.

Subd. 8. **Services and supports.** (a) Services and supports shall meet the requirements set out in United States Code, title 42, section 1396n.

(b) Services and supports shall promote consumer choice and be arranged and provided consistent with individualized, written care plans.

(c) The state of Minnesota, county, managed care organization, or tribal government under contract to administer the elderly waiver shall not be liable for damages, injuries, or liabilities sustained through the purchase of direct supports or goods by the person, the person's family, or the authorized representatives with funds received through consumer-directed community support services under the federally approved waiver plan. Liabilities include, but are not limited to, workers' compensation liability, the Federal Insurance Contributions Act (FICA), or the Federal Unemployment Tax Act (FUTA).

Subd. 9. **Tribal management of elderly waiver.** Notwithstanding contrary provisions of this section, or those in other state laws or rules, the commissioner may develop a model for tribal management of the elderly waiver program and implement this model through a contract between the state and any of the state's federally recognized tribal governments. The model shall include the provision of tribal waiver case management, assessment for personal care assistance, and administrative requirements otherwise carried out by ~~counties~~ lead agencies but shall not include tribal financial eligibility determination for medical assistance.

EFFECTIVE DATE. Subdivision 3h is effective the day following final enactment.

Sec. 47. Minnesota Statutes 2006, section 256B.0917, subdivision 8, is amended to read:

Subd. 8. **Living-at-home/block nurse program grant.** (a) The organization awarded the contract under subdivision 7, shall develop and administer a grant program to establish or expand up to ~~33~~ 51 community-based organizations that will implement

224.1 living-at-home/block nurse programs that are designed to enable senior citizens to live as
224.2 independently as possible in their homes and in their communities. At least one-half of
224.3 the programs must be in counties outside the seven-county metropolitan area. Nonprofit
224.4 organizations and units of local government are eligible to apply for grants to establish
224.5 the community organizations that will implement living-at-home/block nurse programs.
224.6 In awarding grants, the organization awarded the contract under subdivision 7 shall give
224.7 preference to nonprofit organizations and units of local government from communities
224.8 that:

- 224.9 (1) have high nursing home occupancy rates;
- 224.10 (2) have a shortage of health care professionals;
- 224.11 (3) are located in counties adjacent to, or are located in, counties with existing
224.12 living-at-home/block nurse programs; and
- 224.13 (4) meet other criteria established by LAH/BN, Inc., in consultation with the
224.14 commissioner.

224.15 (b) Grant applicants must also meet the following criteria:

- 224.16 (1) the local community demonstrates a readiness to establish a community model
224.17 of care, including the formation of a board of directors, advisory committee, or similar
224.18 group, of which at least two-thirds is comprised of community citizens interested in
224.19 community-based care for older persons;

- 224.20 (2) the program has sponsorship by a credible, representative organization within
224.21 the community;

- 224.22 (3) the program has defined specific geographic boundaries and defined its
224.23 organization, staffing and coordination/delivery of services;

- 224.24 (4) the program demonstrates a team approach to coordination and care, ensuring
224.25 that the older adult participants, their families, the formal and informal providers are all
224.26 part of the effort to plan and provide services; and

- 224.27 (5) the program provides assurances that all community resources and funding will
224.28 be coordinated and that other funding sources will be maximized, including a person's
224.29 own resources.

224.30 (c) Grant applicants must provide a minimum of five percent of total estimated
224.31 development costs from local community funding. Grants shall be awarded for four-year
224.32 periods, and the base amount shall not exceed ~~\$80,000~~ \$100,000 per applicant for the grant
224.33 period. The organization under contract may increase the grant amount for applicants from
224.34 communities that have socioeconomic characteristics that indicate a higher level of need
224.35 for assistance. Subject to the availability of funding, grants and grant renewals awarded or
224.36 entered into on or after July 1, 1997, shall be renewed by LAH/BN, Inc. every four years,

225.1 unless LAH/BN, Inc. determines that the grant recipient has not satisfactorily operated the
225.2 living-at-home/block nurse program in compliance with the requirements of paragraphs
225.3 (b) and (d). Grants provided to living-at-home/block nurse programs under this paragraph
225.4 may be used for both program development and the delivery of services.

225.5 (d) Each living-at-home/block nurse program shall be designed by representatives of
225.6 the communities being served to ensure that the program addresses the specific needs of
225.7 the community residents. The programs must be designed to:

225.8 (1) incorporate the basic community, organizational, and service delivery principles
225.9 of the living-at-home/block nurse program model;

225.10 (2) provide senior citizens with registered nurse directed assessment, provision and
225.11 coordination of health and personal care services on a sliding fee basis as an alternative
225.12 to expensive nursing home care;

225.13 (3) provide information, support services, homemaking services, counseling, and
225.14 training for the client and family caregivers;

225.15 (4) encourage the development and use of respite care, caregiver support, and
225.16 in-home support programs, such as adult foster care and in-home adult day care;

225.17 (5) encourage neighborhood residents and local organizations to collaborate in
225.18 meeting the needs of senior citizens in their communities;

225.19 (6) recruit, train, and direct the use of volunteers to provide informal services and
225.20 other appropriate support to senior citizens and their caregivers; and

225.21 (7) provide coordination and management of formal and informal services to senior
225.22 citizens and their families using less expensive alternatives.

225.23 Sec. 48. Minnesota Statutes 2006, section 256B.0919, subdivision 3, is amended to
225.24 read:

225.25 Subd. 3. **County certification of persons providing adult foster care to related**
225.26 **persons.** A person exempt from licensure under section 245A.03, subdivision 2, who
225.27 provides adult foster care to a related individual age 65 and older, and who meets the
225.28 requirements in Minnesota Rules, parts 9555.5105 to 9555.6265, may be certified by the
225.29 county to provide adult foster care. A person certified by the county to provide adult foster
225.30 care may be reimbursed for services provided and eligible for funding under ~~sections~~
225.31 ~~256B.0913 and section~~ 256B.0915, if the relative would suffer a financial hardship as
225.32 a result of providing care. For purposes of this subdivision, financial hardship refers
225.33 to a situation in which a relative incurs a substantial reduction in income as a result of
225.34 resigning from a full-time job or taking a leave of absence without pay from a full-time
225.35 job to care for the client.

226.1 Sec. 49. Minnesota Statutes 2006, section 256B.095, is amended to read:

226.2 **256B.095 QUALITY ASSURANCE SYSTEM ESTABLISHED.**

226.3 (a) Effective July 1, 1998, a quality assurance system for persons with developmental
226.4 disabilities, which includes an alternative quality assurance licensing system for programs,
226.5 is established in Dodge, Fillmore, Freeborn, Goodhue, Houston, Mower, Olmsted, Rice,
226.6 Steele, Wabasha, and Winona Counties for the purpose of improving the quality of
226.7 services provided to persons with developmental disabilities. A county, at its option, may
226.8 choose to have all programs for persons with developmental disabilities located within
226.9 the county licensed under chapter 245A using standards determined under the alternative
226.10 quality assurance licensing system or may continue regulation of these programs under
226.11 the licensing system operated by the commissioner. The project expires on June 30,
226.12 ~~2009~~ 2014.

226.13 (b) Effective July 1, 2003, a county not listed in paragraph (a) may apply to
226.14 participate in the quality assurance system established under paragraph (a). The
226.15 commission established under section 256B.0951 may, at its option, allow additional
226.16 counties to participate in the system.

226.17 (c) Effective July 1, 2003, any county or group of counties not listed in paragraph (a)
226.18 may establish a quality assurance system under this section. A new system established
226.19 under this section shall have the same rights and duties as the system established
226.20 under paragraph (a). A new system shall be governed by a commission under section
226.21 256B.0951. The commissioner shall appoint the initial commission members based
226.22 on recommendations from advocates, families, service providers, and counties in the
226.23 geographic area included in the new system. Counties that choose to participate in a
226.24 new system shall have the duties assigned under section 256B.0952. The new system
226.25 shall establish a quality assurance process under section 256B.0953. The provisions of
226.26 section 256B.0954 shall apply to a new system established under this paragraph. The
226.27 commissioner shall delegate authority to a new system established under this paragraph
226.28 according to section 256B.0955.

226.29 (d) Effective July 1, 2007, the quality assurance system may be expanded to include
226.30 programs for persons with disabilities and older adults.

226.31 Sec. 50. Minnesota Statutes 2006, section 256B.0951, subdivision 1, is amended to
226.32 read:

226.33 Subdivision 1. **Membership.** The Quality Assurance Commission is established.
226.34 The commission consists of at least 14 but not more than 21 members as follows: at
226.35 least three but not more than five members representing advocacy organizations; at

227.1 least three but not more than five members representing consumers, families, and their
227.2 legal representatives; at least three but not more than five members representing service
227.3 providers; at least three but not more than five members representing counties; and the
227.4 commissioner of human services or the commissioner's designee. The first commission
227.5 shall establish membership guidelines for the transition and recruitment of membership for
227.6 the commission's ongoing existence. Members of the commission who do not receive a
227.7 salary or wages from an employer for time spent on commission duties may receive a per
227.8 diem payment when performing commission duties and functions. All members may be
227.9 reimbursed for expenses related to commission activities. Notwithstanding the provisions
227.10 of section 15.059, subdivision 5, the commission expires on June 30, ~~2009~~ 2014.

227.11 Sec. 51. **[256B.096] QUALITY MANAGEMENT; ASSURANCE; AND**
227.12 **IMPROVEMENT SYSTEM FOR MINNESOTANS RECEIVING DISABILITY**
227.13 **SERVICES.**

227.14 Subdivision 1. **Scope.** In order to improve the quality of services provided to
227.15 Minnesotans with disabilities and to meet the requirements of the federally approved home
227.16 and community-based waivers under section 1915c of the Social Security Act, a statewide
227.17 quality assurance and improvement system for Minnesotans receiving disability services
227.18 shall be developed. The disability services included are the home and community-based
227.19 services waiver programs for persons with developmental disabilities under section
227.20 256B.092, subdivision 4, and persons with disabilities under section 256B.49.

227.21 Subd. 2. **Stakeholder advisory group.** The commissioner shall consult with a
227.22 stakeholder advisory group on the development and implementation of the state quality
227.23 management, assurance, and improvement system, including representatives from:
227.24 disability service recipients, disability service providers, disability advocacy groups,
227.25 county human service agencies, and state agency staff from the Departments of Human
227.26 Services and Health and ombudsman for mental health and developmental disabilities on
227.27 the development of a statewide quality assurance and improvement system.

227.28 Subd. 3. **Annual survey of service recipients.** The commissioner, in consultation
227.29 with the stakeholder advisory group, shall develop and conduct an annual independent
227.30 random statewide survey of between five and ten percent of service recipients to determine
227.31 the effectiveness and quality of disability services. The survey shall be consistent with
227.32 the system performance expectations of the Centers for Medicare and Medicaid Services
227.33 quality management requirements and framework. The survey shall analyze whether
227.34 desired outcomes have been achieved for persons with different demographic, diagnostic,
227.35 health, and functional needs and receiving different types of services, in different settings,

228.1 with different costs. The survey shall be field tested during 2008 and implemented by
228.2 February 1, 2009. Annual statewide and regional reports of the results shall be published
228.3 for use by regions, counties, and providers to plan and measure the impact of quality
228.4 improvement activities.

228.5 Subd. 4. **Improvements for incident reporting, investigation, analysis, and**
228.6 **follow-up.** In consultation with the stakeholder advisory group, the commissioner shall
228.7 identify the information, data sources, and technology needed to improve the system
228.8 of incident reporting, including:

228.9 (1) reports made under the Maltreatment of Minors and Vulnerable Adults Acts; and
228.10 (2) investigation, analysis, and follow-up for disability services.

228.11 The commissioner must ensure that the federal home and community-based waiver
228.12 requirements are met and that incidents that may have jeopardized safety; health; or
228.13 violated service-related assurances, civil and human rights, and other protections designed
228.14 to prevent abuse, neglect, and exploitation are reviewed, investigated, and acted upon
228.15 in a timely manner.

228.16 Subd. 5. **Biennial report.** The commissioner shall provide a biennial report to the
228.17 chairs of the legislative committees with jurisdiction over health and human services
228.18 policy and funding beginning January 15, 2009, on the development and activities of the
228.19 quality management, assurance, and improvement system designed to meet the federal
228.20 requirements under the home and community-based services waiver programs for persons
228.21 with disabilities. By January 15, 2008, the commissioner shall provide a preliminary
228.22 report on the priorities for meeting the federal requirements, progress on the annual
228.23 survey, recommendations for improvements in the incident reporting system, and a plan
228.24 for incorporating the quality assurance efforts under section 256B.095 and other regional
228.25 efforts into the statewide system.

228.26 Sec. 52. Minnesota Statutes 2006, section 256B.431, subdivision 1, is amended to read:

228.27 Subdivision 1. **In general.** The commissioner shall determine prospective
228.28 payment rates for resident care costs. For rates established on or after July 1, 1985, the
228.29 commissioner shall develop procedures for determining operating cost payment rates that
228.30 take into account the mix of resident needs, geographic location, and other factors as
228.31 determined by the commissioner. The commissioner shall consider whether the fact that a
228.32 facility is attached to a hospital or has an average length of stay of 180 days or less should
228.33 be taken into account in determining rates. The commissioner shall consider the use of the
228.34 standard metropolitan statistical areas when developing groups by geographic location.
228.35 The commissioner shall provide notice to each nursing facility on or before ~~May 1~~ August

229.1 15 of the rates effective for the following rate year except that if legislation is pending on
229.2 ~~May 1~~ August 15 that may affect rates for nursing facilities, the commissioner shall set the
229.3 rates after the legislation is enacted and provide notice to each facility as soon as possible.

229.4 Compensation for top management personnel shall continue to be categorized as a
229.5 general and administrative cost and is subject to any limits imposed on that cost category.

229.6 Sec. 53. Minnesota Statutes 2006, section 256B.431, subdivision 2e, is amended to
229.7 read:

229.8 Subd. 2e. **Contracts for services for ventilator-dependent persons.** (a)

229.9 The commissioner may negotiate with a nursing facility eligible to receive medical
229.10 assistance payments to provide services to a ventilator-dependent person identified by the
229.11 commissioner according to criteria developed by the commissioner, including:

229.12 (1) nursing facility care has been recommended for the person by a preadmission
229.13 screening team;

229.14 (2) the person has been hospitalized and no longer requires inpatient acute care
229.15 hospital services; and

229.16 (3) the commissioner has determined that necessary services for the person cannot
229.17 be provided under existing nursing facility rates.

229.18 The commissioner may negotiate an adjustment to the operating cost payment
229.19 rate for a nursing facility with a resident who is ventilator-dependent, for that resident.
229.20 The negotiated adjustment must reflect only the actual additional cost of meeting the
229.21 specialized care needs of a ventilator-dependent person identified by the commissioner
229.22 for whom necessary services cannot be provided under existing nursing facility rates and
229.23 which are not otherwise covered under Minnesota Rules, parts 9549.0010 to 9549.0080 or
229.24 9505.0170 to 9505.0475. For persons who are initially admitted to a nursing facility before
229.25 July 1, 2001, and have their payment rate under this subdivision negotiated after July 1,
229.26 2001, the negotiated payment rate must not exceed 200 percent of the highest multiple
229.27 bedroom payment rate for the facility, as initially established by the commissioner for the
229.28 rate year for case mix classification K; or, upon implementation of the RUG's-based case
229.29 mix system, 200 percent of the highest RUG's rate. For persons initially admitted to a
229.30 nursing facility on or after July 1, 2001, the negotiated payment rate must not exceed 300
229.31 percent of the facility's multiple bedroom payment rate for case mix classification K; or,
229.32 upon implementation of the RUG's-based case mix system, 300 percent of the highest
229.33 RUG's rate. The negotiated adjustment shall not affect the payment rate charged to private
229.34 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. 54. 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 computed in accordance with Minnesota Rules, part 9549.0060, subpart 8. If an operating lease provides that the lessee's rent is adjusted to recognize improvements made by the lessor and related debt, the costs for capital improvements and related debt shall be allowed in the computation of the lessee's building capital allowance, provided that reimbursement for these costs under an operating lease shall not exceed the rate otherwise paid.

Sec. 55. Minnesota Statutes 2006, section 256B.431, subdivision 17e, is amended to read:

Subd. 17e. **Replacement-costs-new per bed limit effective July 1, 2001.**

Notwithstanding Minnesota Rules, part 9549.0060, subpart 11, item C, subitem (2), for a total replacement, as defined in ~~paragraph (f)~~ subdivision 17d, authorized under section 144A.071 or 144A.073 after July 1, 1999, or any building project that is a relocation, renovation, upgrading, or conversion completed on or after July 1, 2001, the replacement-costs-new per bed limit shall be \$74,280 per licensed bed in multiple-bed rooms, \$92,850 per licensed bed in semiprivate rooms with a fixed partition separating the resident beds, and \$111,420 per licensed bed in single rooms. Minnesota Rules, part 9549.0060, subpart 11, item C, subitem (2), does not apply. These amounts must be adjusted annually as specified in subdivision 3f, paragraph (a), beginning January 1, 2000.

Sec. 56. Minnesota Statutes 2006, section 256B.434, subdivision 4, is amended to read:

Subd. 4. **Alternate rates for nursing facilities.** (a) For nursing facilities which have their payment rates determined under this section rather than section 256B.431, the commissioner shall establish a rate under this subdivision. The nursing facility must enter into a written contract with the commissioner.

(b) A nursing facility's case mix payment rate for the first rate year of a facility's contract under this section is the payment rate the facility would have received under section 256B.431.

(c) A nursing facility's case mix payment rates for the second and subsequent years of a facility's contract under this section are the previous rate year's contract payment rates plus an inflation adjustment and, for facilities reimbursed under this section or section 256B.431, an adjustment to include the cost of any increase in Health Department licensing fees for the facility taking effect on or after July 1, 2001. The index for the inflation adjustment must be based on the change in the Consumer Price Index-all items (United States City average) (CPI-U) forecasted by the commissioner of finance's national economic consultant, as forecasted in the fourth quarter of the calendar year preceding the rate year. The inflation adjustment must be based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined. For the rate years beginning on July 1, 1999, July 1, 2000, July 1, 2001, July 1, 2002, July 1, 2003, July 1, 2004, July 1, 2005, July 1, 2006, July 1, 2007, and July 1, 2008, this paragraph shall apply only to the property-related payment rate, except that adjustments to include the cost of any increase in Health Department licensing fees taking effect on or after July 1, 2001, shall be provided. Beginning in 2005, adjustment to the property payment rate under this section and section 256B.431 shall be effective on October 1. In determining the amount of the property-related payment rate adjustment

under this paragraph, the commissioner shall determine the proportion of the facility's rates that are property-related based on the facility's most recent cost report.

(d) The commissioner shall develop additional incentive-based payments of up to five percent above a facility's operating payment rate for achieving outcomes specified in a contract. The commissioner may solicit contract amendments and implement those which, on a competitive basis, best meet the state's policy objectives. The commissioner shall limit the amount of any incentive payment and the number of contract amendments under this paragraph to operate the incentive payments within funds appropriated for this purpose. The contract amendments may specify various levels of payment for various levels of performance. Incentive payments to facilities under this paragraph may be in the form of time-limited rate adjustments or onetime supplemental payments. In establishing the specified outcomes and related criteria, the commissioner shall consider the following state policy objectives:

(1) successful diversion or discharge of residents to the residents' prior home or other community-based alternatives;

(2) adoption of new technology to improve quality or efficiency;

(3) improved quality as measured in the Nursing Home Report Card;

(4) reduced acute care costs; and

(5) any additional outcomes proposed by a nursing facility that the commissioner finds desirable.

(e) Notwithstanding the threshold in section 256B.431, subdivision 16, facilities that take action to come into compliance with existing or pending requirements of the life safety code provisions or other federal regulations governing sprinkler systems shall receive reimbursement for the costs associated with compliance if all of the following conditions are met:

(1) the expenses associated with compliance occurred on or after January 1, 2005, 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

234.1 commissioner by June 30, 2007, on a form provided by the commissioner the actual
234.2 costs of a completed project or the estimated costs, based on a project bid, of a planned
234.3 project. The commissioner shall calculate a rate adjustment equal to the allowable
234.4 costs of the project divided by the resident days reported for the report year ending
234.5 September 30, 2006. If the costs from all projects exceed the appropriation for this
234.6 purpose, the commissioner shall allocate the funds appropriated on a pro rata basis to the
234.7 qualifying facilities by reducing the rate adjustment determined for each facility by an
234.8 equal percentage. If the rate adjustments under this subdivision are reduced to fit the
234.9 appropriation, facilities may include the portion of the costs that are not reimbursed by
234.10 the rate adjustment as part of a project that meets the requirements of subdivision 4f.
234.11 If the commissioner determines that there are any unexpended funds for the purposes
234.12 of this paragraph, the commissioner may allocate the remainder of the funds to the
234.13 qualifying facilities on a pro rata basis for other physical plant changes required by the
234.14 nursing facility in order to meet the most recent life safety code compliance standards.
234.15 Facilities that used estimated costs when requesting the rate adjustment shall report to
234.16 the commissioner by January 31, 2009, on the use of these funds on a form provided by
234.17 the commissioner. If the nursing facility fails to provide the report, the commissioner
234.18 shall recoup the funds appropriated to the facility for this purpose. If the facility reports
234.19 expenditures allowable under this subdivision that are less than the amount received in the
234.20 facility's annualized rate adjustment, the commissioner shall recoup the difference.

234.21 Sec. 57. Minnesota Statutes 2006, section 256B.434, is amended by adding a
234.22 subdivision to read:

234.23 Subd. 4i. **Nursing facility rate increase effective October 1, 2007; Hennepin**
234.24 **County.** For the rate year beginning October 1, 2007, the commissioner shall provide to
234.25 a nursing facility in Hennepin County licensed for 268 beds as of February 1, 2007, an
234.26 increase in the property payment rate of \$6.52 per resident per day. The increase under
234.27 this subdivision must be added following the determination under this chapter of the
234.28 payment rate for the rate year beginning October 1, 2007, and must be included in the
234.29 facility's total payment rate for purposes of determining future rates under this section or
234.30 any other section.

234.31 Sec. 58. Minnesota Statutes 2006, section 256B.434, is amended by adding a
234.32 subdivision to read:

234.33 Subd. 4j. **Rate increase for facilities in Chisago County.** Effective October
234.34 1, 2007, operating payment rates of all nursing facilities in Chisago County that are

235.1 reimbursed under this section or section 256B.441 shall be increased to be equal, for
235.2 a RUG's rate with a weight of 1.00, to the geographic group III median rate for the
235.3 same RUG's weight. The percentage of the operating payment rate for each facility to
235.4 be case-mix adjusted shall be equal to the percentage that is case-mix adjusted in that
235.5 facility's September 30, 2007, operating payment rate. This subdivision applies only if it
235.6 results in a rate increase. Increases provided by this subdivision shall be added to the rate
235.7 determined under any new reimbursement system established under section 256B.441.

235.8 Sec. 59. Minnesota Statutes 2006, section 256B.434, is amended by adding a
235.9 subdivision to read:

235.10 Subd. 4k. **Nursing facility rate increase effective January 1, 2008; Hennepin**
235.11 **County.** Effective January 1, 2008, a nursing facility in Hennepin County licensed for
235.12 137 beds as of February 1, 2007, shall receive an increase of \$2.81 in each case mix
235.13 payment rate to offset property tax payments due as a result of the facility's conversion
235.14 from nonprofit to for-profit status. The increase under this subdivision must be added
235.15 following the determination under this chapter of the payment rate for the rate year
235.16 beginning October 1, 2007, and must be included in the facility's total payment rate for the
235.17 purposes of determining future rates under this section or any other section.

235.18 Sec. 60. Minnesota Statutes 2006, section 256B.434, is amended by adding a
235.19 subdivision to read:

235.20 Subd. 4l. **Property rate adjustment; Kanabec County.** The commissioner
235.21 shall allow a property rate adjustment for a facility located in Kanabec County that
235.22 was approved for a moratorium exception project in 2001, but experienced a delay and
235.23 additional costs associated with the project, and completed the project in 2005. The
235.24 property payment rate for the rate years beginning October 1, 2007, and ending September
235.25 30, 2009, must be \$22.73 per resident day. For subsequent years, the property rate of
235.26 \$22.73 per resident day shall be adjusted as provided in subdivision 4, paragraph (c), as
235.27 long as the facility has a contract under this section.

235.28 Sec. 61. Minnesota Statutes 2006, section 256B.434, is amended by adding a
235.29 subdivision to read:

235.30 Subd. 4m. **Rate increase for facilities in Rice County.** Effective July 1, 2007,
235.31 operating payment rates of nursing facilities in Rice County located within two miles
235.32 of Scott County or Dakota County that are reimbursed under this section or section
235.33 256B.441 must be increased to be equal, for a RUG's rate with a weight of 1.00, to the

236.1 geographic group III median rate for the same RUG's weight. The percentage of the
236.2 operating payment rate for each facility to be case-mix adjusted must be equal to the
236.3 percentage that is case-mix adjusted in that facility's June 30, 2006, operating payment
236.4 rate. This subdivision applies only if it results in a rate increase.

236.5 Sec. 62. Minnesota Statutes 2006, section 256B.434, is amended by adding a
236.6 subdivision to read:

236.7 Subd. 4n. **Facility rate increase.** For the rate year beginning October 1, 2007, a
236.8 nursing facility in Faribault County licensed for 50 beds as of April 19, 2006, shall receive
236.9 a rate increase of \$2.64 in each case mix payment rate to offset property tax payments
236.10 due as a result of the facility's conversion from nonprofit to for-profit status. The increase
236.11 under this subdivision shall be added to the payment rates in effect for the facility on
236.12 September 30, 2007, and shall be included in the facility's total payment rates for the
236.13 purposes of determining future rates under this section or any other section.

236.14 Sec. 63. Minnesota Statutes 2006, section 256B.434, is amended by adding a
236.15 subdivision to read:

236.16 Subd. 19. **Nursing facility rate increases beginning October 1, 2007, and**
236.17 **October 1, 2008.** (a) For the rate year beginning October 1, 2007, the commissioner
236.18 shall make available to each nursing facility reimbursed under this section operating
236.19 payment rate adjustments equal to three percent of the operating payment rates in effect
236.20 on September 30, 2007. For the rate year beginning October 1, 2008, the commissioner
236.21 shall make available to each nursing facility reimbursed under this section operating
236.22 payment rate adjustments equal to three percent of the operating payment rates in effect
236.23 on September 30, 2008.

236.24 (b) Seventy-five percent of the money resulting from the rate adjustments under
236.25 paragraph (a) must be used for increases in compensation-related costs of eligible
236.26 employees.

236.27 (c) For purposes of this subdivision, eligible employees includes all persons directly
236.28 employed by the nursing facility on or after the effective date of the rate adjustments,
236.29 except:

236.30 (1) persons employed in the central office of a corporation that has an ownership
236.31 interest in the nursing facility or exercises control over the nursing facility; and

236.32 (2) persons paid by the nursing facility under a management contract.

236.33 (d) The commissioner shall allow as compensation-related costs all costs for:

236.34 (1) wages and salaries;

237.1 (2) FICA taxes, Medicare taxes, state and federal unemployment taxes, and workers'
237.2 compensation;

237.3 (3) the employer's share of health and dental insurance, life insurance, disability
237.4 insurance, long-term care insurance, uniform allowance, and pensions; and

237.5 (4) other benefits provided, subject to the approval of the commissioner.

237.6 (e) The portion of the rate adjustments under paragraph (a) that is not subject to the
237.7 requirements in paragraph (b) shall be provided to nursing facilities effective October
237.8 1 of each year.

237.9 (f) Nursing facilities may apply for the portion of the rate adjustments under
237.10 paragraph (a) that is subject to the requirements in paragraph (b). The application
237.11 must be submitted to the commissioner within six months of the effective date of the
237.12 rate adjustments, and the nursing facility must provide additional information required
237.13 by the commissioner within nine months of the effective date of the rate adjustments.

237.14 The commissioner must respond to all applications within three weeks of receipt.

237.15 The commissioner may waive the deadlines in this paragraph under extraordinary
237.16 circumstances, to be determined at the sole discretion of the commissioner. The
237.17 application must contain:

237.18 (1) an estimate of the amounts of money that must be used as specified in paragraph
237.19 (b);

237.20 (2) a detailed distribution plan specifying the allowable compensation-related
237.21 increases the nursing facility will implement to use the funds available in clause (1);

237.22 (3) a description of how the nursing facility will notify eligible employees of
237.23 the contents of the approved application, which must provide for giving each eligible
237.24 employee a copy of the approved application, excluding the information required in clause
237.25 (1), or posting a copy of the approved application, excluding the information required in
237.26 clause (1), for a period of at least six weeks in an area of the nursing facility to which all
237.27 eligible employees have access; and

237.28 (4) instructions for employees who believe they have not received the
237.29 compensation-related increases specified in clause (2), as approved by the commissioner,
237.30 and which must include a mailing address, e-mail address, and the telephone number
237.31 that may be used by the employee to contact the commissioner or the commissioner's
237.32 representative.

237.33 (g) The commissioner shall ensure that cost increases in distribution plans under
237.34 paragraph (f), clause (2), that may be included in approved applications, comply with
237.35 requirements in clauses (1) to (4):

238.1 (1) costs to be incurred during the applicable rate year resulting from wage and
238.2 salary increases implemented prior to the first day of the nursing facility's payroll period
238.3 that includes October 1 of each year shall be allowed if they were not used in a prior
238.4 year's application;

238.5 (2) a portion of the costs resulting from tenure-related wage or salary increases may
238.6 be considered to be allowable compensation-related increases, in accordance with existing
238.7 formulas that the commissioner shall provide;

238.8 (3) the annualized amount of increases in costs for the employer's share of health
238.9 and dental insurance, life insurance, disability insurance, and workers' compensation shall
238.10 be allowable compensation-related increases if they are effective on or after April 1 of
238.11 the year in which the rate adjustments are effective and prior to April 1 of the following
238.12 year; and

238.13 (4) for nursing facilities in which employees are represented by an exclusive
238.14 bargaining representative, an agreement negotiated and agreed to by the employer and
238.15 the exclusive bargaining representative constitutes the plan. The commissioner shall not
238.16 review and shall not require changes to the portions of the plan covered by collective
238.17 bargaining agreements. A negotiated agreement may constitute the plan only if the
238.18 agreement is finalized after the date of enactment of all increases for the rate year and
238.19 signed by both parties prior to submission to the commissioner.

238.20 (h) The commissioner shall review applications received under paragraph (f) and
238.21 shall provide the portion of the rate adjustments under paragraph (b) if the requirements of
238.22 this subdivision have been met. The rate adjustments shall be effective October 1 of each
238.23 year. Notwithstanding paragraph (a), if the approved application distributes less money
238.24 than is available, the amount of the rate adjustment shall be reduced so that the amount of
238.25 money made available is equal to the amount to be distributed.

238.26 Sec. 64. Minnesota Statutes 2006, section 256B.434, is amended by adding a
238.27 subdivision to read:

238.28 Subd. 20. **Payment of Public Employees Retirement Association costs.** Nursing
238.29 facilities that participate in the Public Employees Retirement Association (PERA) shall
238.30 have the component of their payment rate associated with the costs of PERA determined
238.31 for each rate year. Effective for rate years beginning on and after October 1, 2007, the
238.32 commissioner shall determine the portion of the payment rate in effect on September 30
238.33 each year and shall subtract that amount from the payment rate to be effective on the
238.34 following October 1. The portion that shall be deemed to be included in the September 30,
238.35 2007, rate that is associated with PERA costs shall be the allowed costs in the facility's

239.1 base for determining rates under this section, divided by the resident days reported for that
239.2 year. The commissioner shall add to the payment rate to be effective on October 1 each
239.3 year an amount equal to the reported costs associated with PERA, for the year ended on
239.4 the most recent September 30 for which data is available, divided by total resident days
239.5 for that year, as reported by the facility and audited under section 256B.441.

239.6 Sec. 65. Minnesota Statutes 2006, section 256B.437, is amended by adding a
239.7 subdivision to read:

239.8 Subd. 11. **Big Stone County rate adjustment.** Notwithstanding the time period
239.9 specified in subdivision 3, the commissioner shall approve a planned closure rate
239.10 adjustment in Big Stone County for an eight-bed facility in Clinton for reassignment to a
239.11 50-bed facility in Graceville. The adjustment shall be calculated according to subdivisions
239.12 3 and 6.

239.13 Sec. 66. Minnesota Statutes 2006, section 256B.438, subdivision 3, is amended to read:

239.14 Subd. 3. **Case mix indices.** (a) The commissioner of human services shall assign a
239.15 case mix index to each resident class based on the Centers for Medicare and Medicaid
239.16 Services staff time measurement study and adjusted for Minnesota-specific wage indices.
239.17 The case mix indices assigned to each resident class shall be published in the Minnesota
239.18 State Register at least 120 days prior to the implementation of the 34 group, RUG-III
239.19 resident classification system.

239.20 (b) An index maximization approach shall be used to classify residents.

239.21 ~~(c) After implementation of the revised case mix system, the commissioner of~~
239.22 ~~human services may annually rebase case mix indices and base rates using more current~~
239.23 ~~data on average wage rates and staff time measurement studies. This rebasing shall be~~
239.24 ~~calculated under subdivision 7, paragraph (b). The commissioner shall publish in the~~
239.25 ~~Minnesota State Register adjusted case mix indices at least 45 days prior to the effective~~
239.26 ~~date of the adjusted case mix indices.~~

239.27 Sec. 67. Minnesota Statutes 2006, section 256B.439, subdivision 1, is amended to read:

239.28 Subdivision 1. **Development and implementation of quality profiles.** (a) The
239.29 commissioner of human services, in cooperation with the commissioner of health, shall
239.30 develop and implement a quality profile system for nursing facilities and, beginning not
239.31 later than July 1, 2004, other providers of long-term care services, except when the quality
239.32 profile system would duplicate requirements under section 256B.5011, 256B.5012, or
239.33 256B.5013. Beginning July 1, 2008, the commissioners shall include quality profiles of

240.1 nursing homes that are not medical assistance certified in the Minnesota Nursing Home
240.2 Report Card. The nonmedical assistance certified nursing homes may provide to the
240.3 commissioners information necessary to conduct consumer satisfaction surveys and to
240.4 determine other quality measures. The system must be developed and implemented to the
240.5 extent possible without the collection of significant amounts of new data. To the extent
240.6 possible, the system must incorporate or be coordinated with information on quality
240.7 maintained by area agencies on aging, long-term care trade associations, and other entities.
240.8 The system must be designed to provide information on quality to:

240.9 (1) consumers and their families to facilitate informed choices of service providers;
240.10 (2) providers to enable them to measure the results of their quality improvement
240.11 efforts and compare quality achievements with other service providers; and
240.12 (3) public and private purchasers of long-term care services to enable them to
240.13 purchase high-quality care.

240.14 (b) The system must be developed in consultation with the long-term care task force,
240.15 area agencies on aging, and representatives of consumers, providers, and labor unions.
240.16 Within the limits of available appropriations, the commissioners may employ consultants
240.17 to assist with this project.

240.18 Sec. 68. Minnesota Statutes 2006, section 256B.441, subdivision 1, is amended to read:

240.19 Subdivision 1. ~~Rate determination~~ Rebasing of nursing facility operating cost
240.20 payment rates. (a) ~~The commissioner shall establish a value-based nursing facility~~
240.21 ~~reimbursement system which will provide facility-specific, prospective rates for nursing~~
240.22 ~~facilities participating in the medical assistance program. The rates shall be determined~~
240.23 ~~using an annual statistical and cost report filed by each nursing facility. The total payment~~
240.24 ~~rate shall be composed of four rate components: direct care services, support services,~~
240.25 ~~external fixed, and property-related rate components. The payment rate shall be derived~~
240.26 ~~from statistical measures of actual costs incurred in facility operation of nursing facilities.~~
240.27 ~~From this cost basis, the components of the total payment rate shall be adjusted for quality~~
240.28 ~~of services provided, recognition of staffing levels, geographic variation in labor costs, and~~
240.29 ~~resident acuity.~~ The commissioner shall rebase nursing facility operating cost payment
240.30 rates to align payments to facilities with the cost of providing care. The rebased operating
240.31 cost payment rates shall be calculated using the statistical and cost report filed by each
240.32 nursing facility for the report period ending one year prior to the rate year.

240.33 (b) ~~Rates shall be rebased annually.~~ The new operating cost payment rates based on
240.34 this section shall take effect beginning with the rate year beginning October 1, 2009, and
240.35 shall be phased in over two rate years through October 1, 2010.

241.1 (c) Operating cost payment rates shall be rebased on October 1, 2011, and every
241.2 two years after that date.

241.3 (d) Operating cost payment rates for rate years in which rebasing does not occur
241.4 shall be increased by the Global Insight SNF Market Basket inflation factor from the
241.5 midpoint of the previous rate year to the midpoint of the next rate year.

241.6 (e) Each cost reporting year shall begin on October 1 and end on the following
241.7 September 30. Beginning in 2006, a statistical and cost report shall be filed by each
241.8 nursing facility by January 15. Notice of rates shall be distributed by August 15 and the
241.9 rates shall go into effect on October 1 for one year.

241.10 ~~(c) The commissioner shall begin to phase in the new reimbursement system~~
241.11 ~~beginning October 1, 2007. Full phase-in shall be completed by October 1, 2011.~~

241.12 Sec. 69. Minnesota Statutes 2006, section 256B.441, subdivision 2, is amended to read:

241.13 Subd. 2. **Definitions.** For purposes of this section, the terms in subdivisions 3 to
241.14 ~~42~~ 42a have the meanings given unless otherwise provided for in this section.

241.15 Sec. 70. Minnesota Statutes 2006, section 256B.441, subdivision 5, is amended to read:

241.16 Subd. 5. **Administrative costs.** "Administrative costs" means the direct costs for
241.17 administering the overall activities of the nursing home. These costs include salaries and
241.18 wages of the administrator, assistant administrator, business office employees, security
241.19 guards, and associated fringe benefits and payroll taxes, fees, contracts, or purchases
241.20 related to business office functions, licenses, and permits except as provided in the
241.21 external fixed costs category, employee recognition, travel including meals and lodging,
241.22 training, voice and data communication or transmission, office supplies, liability insurance
241.23 and other forms of insurance not designated to other areas, personnel recruitment, legal
241.24 services, accounting services, management or business consultants, data processing,
241.25 information technology, Web site, central or home office costs, business meetings and
241.26 seminars, postage, fees for professional organizations, subscriptions, security services,
241.27 advertising, board of director's fees, working capital interest expense, and bad debts and
241.28 bad debt collection fees.

241.29 Sec. 71. Minnesota Statutes 2006, section 256B.441, subdivision 6, is amended to read:

241.30 Subd. 6. **Allowed costs.** "Allowed costs" means the amounts reported by the facility
241.31 which are necessary for the operation of the facility and the care of residents and which
241.32 are reviewed by the department for accuracy, ~~reasonableness,~~ and compliance with this

242.1 section and generally accepted accounting principles. All references to costs in this section
242.2 shall be assumed to refer to allowed costs.

242.3 Sec. 72. Minnesota Statutes 2006, section 256B.441, subdivision 10, is amended to
242.4 read:

242.5 Subd. 10. **Dietary costs.** "Dietary costs" means the costs for the salaries and wages
242.6 of the dietary supervisor, dietitians, chefs, cooks, dishwashers, and other employees
242.7 assigned to the kitchen and dining room, and associated fringe benefits and payroll
242.8 taxes. Dietary costs also includes the salaries or fees of dietary consultants, ~~direct costs~~
242.9 ~~of raw food (both normal and special diet food);~~ dietary supplies, and food preparation
242.10 and serving. ~~Also included are special dietary supplements used for tube feeding or oral~~
242.11 ~~feeding, such as elemental high nitrogen diet, even if written as a prescription item by a~~
242.12 ~~physician.~~

242.13 Sec. 73. Minnesota Statutes 2006, section 256B.441, subdivision 11, is amended to
242.14 read:

242.15 Subd. 11. **Direct care costs category.** ~~"Direct care costs category"~~ "Direct care
242.16 costs" means costs for ~~nursing services, activities, and social services~~ the wages of nursing
242.17 administration, staff education, direct care registered nurses, licensed practical nurses,
242.18 certified nursing assistants, trained medication aides, and associated fringe benefits and
242.19 payroll taxes; services from a supplemental nursing services agency; supplies that are
242.20 stocked at nursing stations or on the floor and distributed or used individually, including,
242.21 but not limited to: alcohol, applicators, cotton balls, incontinence pads, disposable ice
242.22 bags, dressings, bandages, water pitchers, tongue depressors, disposable gloves, enemas,
242.23 enema equipment, soap, medication cups, diapers, plastic waste bags, sanitary products,
242.24 thermometers, hypodermic needles and syringes, clinical reagents or similar diagnostic
242.25 agents, drugs that are not paid for on a separate fee schedule by the medical assistance
242.26 program or any other payer, and technology related to the provision of nursing care to
242.27 residents, such as electronic charting systems.

242.28 Sec. 74. Minnesota Statutes 2006, section 256B.441, subdivision 13, is amended to
242.29 read:

242.30 Subd. 13. **External fixed costs category.** ~~"External fixed costs category"~~ "External
242.31 fixed costs" means costs related to the nursing home surcharge under section 256.9657,
242.32 subdivision 1; licensure fees under section 144.122; long-term care consultation fees
242.33 under section 256B.0911, subdivision 6; family advisory council fee under section

243.1 144A.33; scholarships under section 256B.431, subdivision 36; planned closure rate
243.2 adjustments under section 256B.436 or 256B.437; or single bed room incentives under
243.3 section 256B.431, subdivision 42; property taxes and property insurance; and PERA.

243.4 Sec. 75. Minnesota Statutes 2006, section 256B.441, subdivision 14, is amended to
243.5 read:

243.6 Subd. 14. **Facility average case mix index.** "Facility average case mix index" or
243.7 "CMI" means a numerical value score that describes the relative resource use for all
243.8 residents within the groups under the resource utilization group (RUG-III) classification
243.9 system prescribed by the commissioner based on an assessment of each resident. The
243.10 facility average CMI shall be computed as the standardized days divided by total days for
243.11 all residents in the facility. The RUG's weights used in this section shall be as follows
243.12 for each RUG's class: SE3 1.605; SE2 1.247; SE1 1.081; RAD 1.509; RAC 1.259; RAB
243.13 1.109; RAA 0.957; SSC 1.453; SSB 1.254; SSA 1.047; CC2 1.292; CC1 1.200; CB2
243.14 1.086; CB1 1.017; CA2 0.908; CA1 0.834; IB2 0.877; IB1 0.817; IA2 0.720; IA1 0.676;
243.15 BB2 0.956; BB1 0.885; BA2 0.716; BA1 0.673; PE2 1.199; PE1 1.104; PD2 1.023;
243.16 PD1 0.948; PC2 0.926; PC1 0.860; PB2 0.786; PB1 0.734; PA2 0.691; PA1 0.651; BC1
243.17 0.651; and DDF 1.000

243.18 Sec. 76. Minnesota Statutes 2006, section 256B.441, is amended by adding a
243.19 subdivision to read:

243.20 Subd. 14a. **Facility type groups.** Facilities shall be classified into two groups,
243.21 called "facility type groups," which shall consist of:

243.22 (1) C&NC/R80: facilities that are hospital-attached, or are licensed under Minnesota
243.23 Rules, parts 9570.2000 to 9570.3400; and

243.24 (2) freestanding: all other facilities.

243.25 Sec. 77. Minnesota Statutes 2006, section 256B.441, subdivision 17, is amended to
243.26 read:

243.27 Subd. 17. **Fringe benefit costs.** "Fringe benefit costs" means the costs for group
243.28 life, health, dental, workers' compensation, and other employee insurances and pension,
243.29 profit-sharing, and retirement plans for which the employer pays all or a portion of the
243.30 costs ~~and that are available to at least all employees who work at least 20 hours per week.~~

243.31 Sec. 78. Minnesota Statutes 2006, section 256B.441, subdivision 20, is amended to
243.32 read:

244.1 Subd. 20. **Housekeeping costs.** "Housekeeping costs" means the costs for the
244.2 salaries and wages of the housekeeping supervisor, housekeepers, and other cleaning
244.3 employees and associated fringe benefits and payroll taxes. It also includes the cost of
244.4 housekeeping supplies, including, but not limited to, cleaning and lavatory supplies and
244.5 contract services.

244.6 Sec. 79. Minnesota Statutes 2006, section 256B.441, subdivision 24, is amended to
244.7 read:

244.8 Subd. 24. **Maintenance and plant operations costs.** "Maintenance and plant
244.9 operations costs" means the costs for the salaries and wages of the maintenance supervisor,
244.10 engineers, heating-plant employees, and other maintenance employees and associated
244.11 fringe benefits and payroll taxes. It also includes direct costs for maintenance and
244.12 operation of the building and grounds, including, but not limited to, fuel, electricity,
244.13 medical waste and garbage removal, water, sewer, supplies, tools, and repairs.

244.14 Sec. 80. Minnesota Statutes 2006, section 256B.441, is amended by adding a
244.15 subdivision to read:

244.16 Subd. 28a. **Other direct care costs.** "Other direct care costs" means the costs
244.17 for the salaries and wages and associated fringe benefits and payroll taxes of mental
244.18 health workers, religious personnel, and other direct care employees not specified in
244.19 the definition of direct care costs.

244.20 Sec. 81. Minnesota Statutes 2006, section 256B.441, subdivision 30, is amended to
244.21 read:

244.22 Subd. 30. **Peer groups.** Facilities shall be classified into three groups, ~~called "peer~~
244.23 ~~groups," which~~ by county. The groups shall consist of:

244.24 (1) ~~C&NC/Short Stay/R80 - facilities that have three or more admissions per bed~~
244.25 ~~per year, are hospital-attached, or are licensed under Minnesota Rules, parts 9570.2000~~
244.26 ~~to 9570.3600~~ group one: facilities in Anoka, Benton, Carlton, Carver, Chisago, Dakota,
244.27 Dodge, Goodhue, Hennepin, Isanti, Mille Lacs, Morrison, Olmsted, Ramsey, Rice, Scott,
244.28 Sherburne, St. Louis, Stearns, Steele, Wabasha, Washington, Winona, or Wright County;
244.29 (2) ~~boarding care homes - facilities that have more than 50 percent of their beds~~
244.30 ~~licensed as boarding care homes~~ group two: facilities in Aitkin, Beltrami, Blue Earth,
244.31 Brown, Cass, Clay, Cook, Crow Wing, Faribault, Fillmore, Freeborn, Houston, Hubbard,
244.32 Itasca, Kanabec, Koochiching, Lake, Lake of the Woods, Le Sueur, Martin, McLeod,

245.1 Meeker, Mower, Nicollet, Norman, Pine, Roseau, Sibley, Todd, Wadena, Waseca,
245.2 Watsonwan, or Wilkin County; and
245.3 (3) ~~standard - all other facilities~~ group three: facilities in all other counties.

245.4 Sec. 82. Minnesota Statutes 2006, section 256B.441, subdivision 31, is amended to
245.5 read:

245.6 Subd. 31. **Prior rate-setting method system operating cost payment rate.** ~~"Prior~~
245.7 ~~rate-setting method"~~ "Prior system operating cost payment rate" means the operating cost
245.8 payment rate determination process in effect prior to October 1, 2006 on September 30,
245.9 2009, under Minnesota Rules and Minnesota Statutes, not including planned closure rate
245.10 adjustments under section 256B.436 or 256B.437, or single bed room incentives under
245.11 section 256B.431, subdivision 42.

245.12 Sec. 83. Minnesota Statutes 2006, section 256B.441, is amended by adding a
245.13 subdivision to read:

245.14 Subd. 33a. **Raw food costs.** "Raw food costs" means the cost of food provided to
245.15 nursing facility residents. Also included are special dietary supplements used for tube
245.16 feeding or oral feeding, such as elemental high nitrogen diet.

245.17 Sec. 84. Minnesota Statutes 2006, section 256B.441, subdivision 34, is amended to
245.18 read:

245.19 Subd. 34. **Related organization.** "Related organization" means a person that
245.20 furnishes goods or services to a nursing facility and that is a close relative of a nursing
245.21 facility, an affiliate of a nursing facility, a close relative of an affiliate of a nursing facility,
245.22 or an affiliate of a close relative of an affiliate of a nursing facility. As used in this
245.23 subdivision, paragraphs (a) to (d) apply:

245.24 (a) "Affiliate" means a person that directly, or indirectly through one or more
245.25 intermediaries, controls or is controlled by, or is under common control with another
245.26 person.

245.27 (b) "Person" means an individual, a corporation, a partnership, an association, a
245.28 trust, an unincorporated organization, or a government or political subdivision.

245.29 (c) "Close relative of an affiliate of a nursing facility" means an individual whose
245.30 relationship by blood, marriage, or adoption to an individual who is an affiliate of a
245.31 nursing facility is no more remote than first cousin.

245.32 (d) "Control" including the terms "controlling," "controlled by," and "under common
245.33 control with" means the possession, direct or indirect, of the power to direct or cause the

246.1 direction of the management, operations, or policies of a person, whether through the
246.2 ownership of voting securities, by contract, or otherwise, ~~or to influence in any manner~~
246.3 ~~other than through an arms length, legal transaction.~~

246.4 Sec. 85. Minnesota Statutes 2006, section 256B.441, subdivision 38, is amended to
246.5 read:

246.6 Subd. 38. **Social services costs.** "Social services costs" means the costs for the
246.7 salaries and wages of the supervisor and other social work employees, associated fringe
246.8 benefits and payroll taxes, supplies, services, and consultants. This category includes the
246.9 cost of those employees who manage and process admission to the nursing facility.

246.10 Sec. 86. Minnesota Statutes 2006, section 256B.441, is amended by adding a
246.11 subdivision to read:

246.12 Subd. 42a. **Therapy costs.** "Therapy costs" means any costs related to medical
246.13 assistance therapy services provided to residents that are not billed separately from the
246.14 daily operating rate.

246.15 Sec. 87. Minnesota Statutes 2006, section 256B.441, is amended by adding a
246.16 subdivision to read:

246.17 Subd. 48. **Calculation of operating per diems.** The direct care per diem for
246.18 each facility shall be the facility's direct care costs divided by its standardized days.
246.19 The other care-related per diem shall be the sum of the facility's activities costs, other
246.20 direct care costs, raw food costs, therapy costs, and social services costs, divided by the
246.21 facility's resident days. The other operating per diem shall be the sum of the facility's
246.22 administrative costs, dietary costs, housekeeping costs, laundry costs, and maintenance
246.23 and plant operations costs divided by the facility's resident days.

246.24 Sec. 88. Minnesota Statutes 2006, section 256B.441, is amended by adding a
246.25 subdivision to read:

246.26 Subd. 49. **Determination of total care-related per diem.** The total care-related
246.27 per diem for each facility shall be the sum of the direct care per diem and the other
246.28 care-related per diem.

246.29 Sec. 89. Minnesota Statutes 2006, section 256B.441, is amended by adding a
246.30 subdivision to read:

Subd. 50. **Determination of total care-related limit.** The limit on the total care-related per diem shall be determined for each peer group and facility type group combination. A facility's total care-related per diems shall be limited to 120 percent of the median for the facility's peer and facility type group. The facility-specific direct care costs used in making this comparison and in the calculation of the median shall be based on a RUG's weight of 1.00. A facility that is above that limit shall have its total care-related per diem reduced to the limit. If a reduction of the total care-related per diem is necessary because of this limit, the reduction shall be made proportionally to both the direct care per diem and the other care-related per diem.

Sec. 90. Minnesota Statutes 2006, section 256B.441, is amended by adding a subdivision to read:

Subd. 51. **Determination of other operating limit.** The limit on the other operating per diem shall be determined for each peer group. A facility's other operating per diem shall be limited to 105 percent of the median for its peer group. A facility that is above that limit shall have its other operating per diem reduced to the limit.

Sec. 91. Minnesota Statutes 2006, section 256B.441, is amended by adding a subdivision to read:

Subd. 52. **Determination of efficiency incentive.** Each facility shall be eligible for an efficiency incentive based on its other operating per diem. A facility with an other operating per diem that exceeds the limit in subdivision 51 shall receive no efficiency incentive. All other facilities shall receive an incentive calculated as 50 percent times the difference between the facility's other operating per diem and its other operating per diem limit, up to a maximum incentive of \$3.

Sec. 92. Minnesota Statutes 2006, section 256B.441, is amended by adding a subdivision to read:

Subd. 53. **Calculation of payment rate for external fixed costs.** The commissioner shall calculate a payment rate for external fixed costs.

(a) For a facility licensed as a nursing home, the portion related to section 256.9657 shall be equal to \$8.86. For a facility licensed as both a nursing home and a boarding care home, the portion related to section 256.9657 shall be equal to \$8.86 multiplied by the result of its number of nursing home beds divided by its total number of licensed beds.

(b) The portion related to the licensure fee under section 144.122, paragraph (d), shall be the amount of the fee divided by actual resident days.

248.1 (c) The portion related to scholarships shall be determined under section 256B.431,
248.2 subdivision 36.

248.3 (d) The portion related to long-term care consultation shall be determined according
248.4 to section 256B.0911, subdivision 6.

248.5 (e) The portion related to development and education of resident and family advisory
248.6 councils under section 144A.33 shall be \$5 divided by 365.

248.7 (f) The portion related to planned closure rate adjustments shall be as determined
248.8 under sections 256B.436 and 256B.437, subdivision 6.

248.9 (g) The portions related to property insurance, real estate taxes, special assessments,
248.10 and payments made in lieu of real estate taxes directly identified or allocated to the nursing
248.11 facility shall be the actual amounts divided by actual resident days.

248.12 (h) The portion related to the Public Employees Retirement Association shall be
248.13 actual costs divided by resident days.

248.14 (i) The single bed room incentives shall be as determined under section 256B.431,
248.15 subdivision 42.

248.16 (j) The payment rate for external fixed costs shall be the sum of the amounts in
248.17 paragraphs (a) to (i).

248.18 Sec. 93. Minnesota Statutes 2006, section 256B.441, is amended by adding a
248.19 subdivision to read:

248.20 Subd. 54. **Adjustment of per diem for inflation.** The total care-related per diem
248.21 and other operating per diem calculated under this section shall be adjusted for inflation to
248.22 adjust for the delay between the reporting year and the rate year. The total care-related
248.23 payment rate and other operating payment rate shall be calculated as the per diem
248.24 increased by the Global Insight Consumer Price Index urban inflation factor for the period
248.25 from the midpoint of the reporting year to the midpoint of the rate year.

248.26 Sec. 94. Minnesota Statutes 2006, section 256B.441, is amended by adding a
248.27 subdivision to read:

248.28 Subd. 55. **Determination of total payment rates.** In rate years when rates are
248.29 rebased, the total payment rate for a RUG's weight of 1.00 shall be the sum of the total
248.30 care-related payment rate, other operating payment rate, efficiency incentive, external
248.31 fixed cost rate, and the property rate determined under section 256B.434. To determine
248.32 a total payment rate for each RUG's level, the total care-related payment rate shall be
248.33 divided into the direct care payment rate and the other care-related payment rate, and the

249.1 direct care payment rate multiplied by the RUG's weight for each RUG's level using the
249.2 weights in subdivision 14.

249.3 Sec. 95. Minnesota Statutes 2006, section 256B.441, is amended by adding a
249.4 subdivision to read:

249.5 Subd. 56. **Rate increase; phase-in of rebased operating payment rates.** (a)
249.6 Effective October 1, 2009, operating payment rates of all nursing facilities shall be
249.7 increased to be equal, for a RUG's rate with a weight of 1.00, to the median rate for the
249.8 same RUG's weight of all nursing facilities in subdivision 31, paragraph 1. The percentage
249.9 of the operating payment rate for each facility to be case-mix adjusted shall be equal to
249.10 the percentage that is case-mix adjusted in that facility's September 30, 2009, operating
249.11 payment rate. This paragraph shall apply only if it results in a rate increase.

249.12 (b) For the rate years beginning October 1, 2009, and October 1, 2010, the operating
249.13 cost payment rate calculated under this section shall be phased in by blending them
249.14 with the operating cost payment rate determined under section 256B.434. For the rate
249.15 year beginning October 1, 2009, the operating cost payment rate for each facility shall
249.16 be 42 percent of the operating cost payment rate from this section, and 58 percent of the
249.17 operating cost payment rate from section 256B.434. For the rate year beginning October 1,
249.18 2010, the operating cost payment rate for each facility shall be the operating cost payment
249.19 rate determined under this section. The blending of operating cost payment rates under
249.20 this subdivision shall be performed separately for each RUG's class.

249.21 (c) All funds received under this subdivision that are in excess of operating cost
249.22 payment rates that a facility would have received under section 256B.434 shall be subject
249.23 to the requirements in section 256B.434, subdivision 19, paragraphs (b) to (h).

249.24 Sec. 96. Minnesota Statutes 2006, section 256B.441, is amended by adding a
249.25 subdivision to read:

249.26 Subd. 57. **Adjustment for inflation during phase-in of rebased operating cost**
249.27 **payment rates.** During the phase-in of operating cost payment rates under subdivision
249.28 56, both the operating costs per diem under this section and the operating cost payment
249.29 rate under section 256B.434 shall be adjusted for inflation. The adjustment for each year
249.30 for the operating cost per diems shall be the Global Insight Consumer Price Index urban
249.31 inflation factor from the midpoint of the reporting year to the midpoint of the current rate
249.32 year. The adjustment for each year for the operating cost payment rate under section
249.33 256B.434 shall be the Global Insight Consumer Price Index urban inflation factor from the
249.34 midpoint of the October 1, 2007, rate year to the midpoint of the current rate year.

250.1 Sec. 97. Minnesota Statutes 2006, section 256B.441, is amended by adding a
250.2 subdivision to read:

250.3 Subd. 58. **Hold harmless.** For the rate years beginning October 1, 2009, October 1,
250.4 2010, and October 1, 2011, no nursing facility shall receive an operating cost payment
250.5 rate less than its operating cost payment rate under section 256B.434. The comparison
250.6 of operating cost payment rates under this section shall be made for each of the RUG's
250.7 classes separately, and the operating cost payment rates under section 256B.434 used
250.8 under this section shall not include the inflation increases described in subdivision 57.

250.9 Sec. 98. Minnesota Statutes 2006, section 256B.441, is amended by adding a
250.10 subdivision to read:

250.11 Subd. 59. **Appeals.** Nursing facilities may appeal, as defined under section 256B.50,
250.12 the determination of a payment rate established under this chapter.

250.13 Sec. 99. Minnesota Statutes 2006, section 256B.49, subdivision 11, is amended to read:

250.14 Subd. 11. **Authority.** (a) The commissioner is authorized to apply for home and
250.15 community-based service waivers, as authorized under section 1915(c) of the Social
250.16 Security Act to serve persons under the age of 65 who are determined to require the level
250.17 of care provided in a nursing home and persons who require the level of care provided in a
250.18 hospital. The commissioner shall apply for the home and community-based waivers in
250.19 order to:

250.20 (i) promote the support of persons with disabilities in the most integrated settings;

250.21 (ii) expand the availability of services for persons who are eligible for medical
250.22 assistance;

250.23 (iii) promote cost-effective options to institutional care; and

250.24 (iv) obtain federal financial participation.

250.25 (b) The provision of waived services to medical assistance recipients with
250.26 disabilities shall comply with the requirements outlined in the federally approved
250.27 applications for home and community-based services and subsequent amendments,
250.28 including provision of services according to a service plan designed to meet the needs of
250.29 the individual. For purposes of this section, the approved home and community-based
250.30 application is considered the necessary federal requirement.

250.31 (c) The commissioner shall provide interested persons serving on agency advisory
250.32 committees ~~and~~ task forces, the Centers for Independent Living, and others upon who
250.33 request, with to be on a list to receive, notice of, and an opportunity to comment on,
250.34 at least 30 days before any effective dates, (1) any substantive changes to the state's

251.1 disability services program manual, or (2) changes or amendments to the federally
251.2 approved applications for home and community-based waivers, prior to their submission
251.3 to the federal Centers for Medicare and Medicaid Services.

251.4 (d) The commissioner shall seek approval, as authorized under section 1915(c) of
251.5 the Social Security Act, to allow medical assistance eligibility under this section for
251.6 children under age 21 without deeming of parental income or assets.

251.7 (e) The commissioner shall seek approval, as authorized under section 1915(c) of
251.8 the Social Act, to allow medical assistance eligibility under this section for individuals
251.9 under age 65 without deeming the spouse's income or assets.

251.10 Sec. 100. Minnesota Statutes 2006, section 256B.49, is amended by adding a
251.11 subdivision to read:

251.12 Subd. 16a. **Medical assistance reimbursement.** (a) The commissioner shall
251.13 seek federal approval for medical assistance reimbursement of independent living skills
251.14 services, foster care waiver service, supported employment, prevocational service,
251.15 structured day service, and adult day care under the home and community-based waiver
251.16 for persons with a traumatic brain injury, the community alternatives for disabled
251.17 individuals waivers, and the community alternative care waivers.

251.18 (b) Medical reimbursement shall be made only when the provider demonstrates
251.19 evidence of its capacity to meet basic health, safety, and protection standards through
251.20 one of the methods in paragraphs (c) to (e).

251.21 (c) The provider is licensed to provide services under chapter 245B and agrees to
251.22 apply these standards to services funded through the traumatic brain injury, community
251.23 alternatives for disabled, or community alternative care home and community-based
251.24 waivers.

251.25 (d) The local agency contracting for the services certifies on a form provided by the
251.26 commissioner that the provider has the capacity to meet the individual needs as identified
251.27 in each person's individual service plan. When certifying that the service provider meets
251.28 the necessary provider qualifications, the local agency shall verify that the provider has
251.29 policies and procedures governing the following:

251.30 (1) protection of the consumer's rights and privacy;

251.31 (2) risk assessment and planning;

251.32 (3) record keeping and reporting of incidents and emergencies with documentation
251.33 of corrective action if needed;

251.34 (4) service outcomes, regular reviews of progress, and periodic reports;

251.35 (5) complaint and grievance procedures;

- 252.1 (6) service termination or suspension;
- 252.2 (7) necessary training and supervision of direct care staff that includes:
- 252.3 (i) documentation in personnel files of 20 hours of orientation training in providing
- 252.4 training related to service provision;
- 252.5 (ii) training in recognizing the symptoms and effects of certain disabilities, health
- 252.6 conditions, and positive behavioral supports and interventions; and
- 252.7 (iii) a minimum of five hours of related training annually; and
- 252.8 (8) when applicable, the local agency shall verify that the provider has policies and
- 252.9 procedures in place governing the following:
- 252.10 (i) safe medication administration;
- 252.11 (ii) proper handling of consumer funds; and
- 252.12 (iii) behavioral interventions that are in compliance with prohibitions and standards
- 252.13 developed by the commissioner to meet federal requirements regarding the use of
- 252.14 restraints and restrictive interventions.
- 252.15 (e) For foster care waiver services or independent living skills services, the local
- 252.16 agency contracting for the services certifies on a form provided by the commissioner that
- 252.17 the provider meets the following:
- 252.18 (1) the provider of foster care waiver services is licensed to provide adult foster
- 252.19 care under Minnesota Rules, parts 9555.5105 to 9555.6265, or child foster care under
- 252.20 Minnesota Rules, parts 2960.3000 to 2960.3230;
- 252.21 (2) the provider of independent living skills services also provides licensed foster
- 252.22 care services and agrees to apply the foster care standards under Minnesota Rules, parts
- 252.23 9555.5105; 9555.5705, subpart 2; 9555.6167; 9555.6185; 9555.6195; 9555.6225, subpart
- 252.24 8; 9555.6245; 9555.6255; and 9555.6265, or parts 2960.3010; 2960.3080, subparts 10
- 252.25 and 11; 2960.3210; 2960.3220, subparts 5 to 7; and 2960.3230, for the provision of those
- 252.26 services; and
- 252.27 (3) the provider has policies and procedures applying to the provision of foster
- 252.28 care waiver services or independent living skills services that govern (i) behavioral
- 252.29 interventions that are in compliance with prohibitions and standards developed by the
- 252.30 commissioner to meet federal requirements regarding the use of restraints and restrictive
- 252.31 interventions and (ii) documentation of service needs and outcomes, regular reviews
- 252.32 of progress, and periodic reports.
- 252.33 (f) The local agency shall review each provider's continued compliance with
- 252.34 the basic health, safety, and protection standards on a regular basis. For the review
- 252.35 of paragraph (e), the local agency shall coordinate the review with the county review
- 252.36 of foster care licensure.

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

253.2 Sec. 101. Minnesota Statutes 2006, section 256B.5012, is amended by adding a
253.3 subdivision to read:

253.4 Subd. 7. **ICF/MR rate increases October 1, 2007, and October 1, 2008.** (a) For
253.5 the rate periods beginning October 1, 2007, and October 1, 2008, the commissioner shall
253.6 make available to each facility reimbursed under this section an adjustment to the total
253.7 operating payment rate of three percent.

253.8 (b) Seventy-five percent of the money resulting from the rate adjustment under
253.9 paragraph (a) must be used to increase wages and benefits and pay associated costs for
253.10 employees, except for administrative and central office employees. Seventy-five percent
253.11 of the money received by a facility as a result of the rate adjustment provided in paragraph
253.12 (a) must be used only for wage, benefit, and staff increases implemented on or after
253.13 the effective date of the rate increase each year, and must not be used for increases
253.14 implemented prior to that date. The wage adjustment eligible employees may receive may
253.15 vary based on merit, seniority, or other factors determined by the provider.

253.16 (c) For each facility, the commissioner shall make available an adjustment, based
253.17 on occupied beds, using the percentage specified in paragraph (a) multiplied by the total
253.18 payment rate, including variable rate but excluding the property-related payment rate, in
253.19 effect on the preceding day. The total payment rate must include the adjustment provided
253.20 in section 256B.501, subdivision 12.

253.21 (d) A facility whose payment rates are governed by closure agreements, receivership
253.22 agreements, or Minnesota Rules, part 9553.0075, is not eligible for an adjustment
253.23 otherwise granted under this subdivision.

253.24 (e) A facility may apply for the portion of the payment rate adjustment provided
253.25 under paragraph (a) for employee wages and benefits and associated costs. The application
253.26 must be made to the commissioner and contain a plan by which the facility will distribute
253.27 the funds according to paragraph (b). For facilities in which the employees are represented
253.28 by an exclusive bargaining representative, an agreement negotiated and agreed to by
253.29 the employer and the exclusive bargaining representative constitutes the plan. The
253.30 commissioner shall not review, and shall not require changes, to the portion or portions
253.31 of the plan covered by collective bargaining agreements. A negotiated agreement may
253.32 constitute the plan only if the agreement is finalized after the date of enactment of all rate
253.33 increases for the rate year. The commissioner shall review the plan to ensure that the
253.34 payment rate adjustment per diem is used as provided in this subdivision. To be eligible, a
253.35 facility must submit its plan by March 31, 2008, and December 31, 2008, respectively.

254.1 If a facility's plan is effective for its employees after the first day of the applicable rate
254.2 period that the funds are available, the payment rate adjustment per diem is effective
254.3 the same date as its plan.

254.4 (f) A copy of the approved distribution plan must be made available to all employees
254.5 by giving each employee a copy or by posting it in an area of the facility to which all
254.6 employees have access. If an employee does not receive the wage and benefit adjustment
254.7 described in the facility's approved plan and is unable to resolve the problem with the
254.8 facility's management or through the employee's union representative, the employee
254.9 may contact the commissioner at an address or telephone number provided by the
254.10 commissioner and included in the approved plan.

254.11 Sec. 102. Minnesota Statutes 2006, section 256B.69, subdivision 23, is amended to
254.12 read:

254.13 Subd. 23. **Alternative services; elderly and disabled persons.** (a) The
254.14 commissioner may implement demonstration projects to create alternative integrated
254.15 delivery systems for acute and long-term care services to elderly persons and persons
254.16 with disabilities as defined in section 256B.77, subdivision 7a, that provide increased
254.17 coordination, improve access to quality services, and mitigate future cost increases.
254.18 The commissioner may seek federal authority to combine Medicare and Medicaid
254.19 capitation payments for the purpose of such demonstrations and may contract with
254.20 Medicare-approved special needs plans to provide Medicaid services. Medicare funds and
254.21 services shall be administered according to the terms and conditions of the federal contract
254.22 and demonstration provisions. For the purpose of administering medical assistance funds,
254.23 demonstrations under this subdivision are subject to subdivisions 1 to 22. The provisions
254.24 of Minnesota Rules, parts 9500.1450 to 9500.1464, apply to these demonstrations,
254.25 with the exceptions of parts 9500.1452, subpart 2, item B; and 9500.1457, subpart 1,
254.26 items B and C, which do not apply to persons enrolling in demonstrations under this
254.27 section. An initial open enrollment period may be provided. Persons who disenroll from
254.28 demonstrations under this subdivision remain subject to Minnesota Rules, parts 9500.1450
254.29 to 9500.1464. When a person is enrolled in a health plan under these demonstrations and
254.30 the health plan's participation is subsequently terminated for any reason, the person shall
254.31 be provided an opportunity to select a new health plan and shall have the right to change
254.32 health plans within the first 60 days of enrollment in the second health plan. Persons
254.33 required to participate in health plans under this section who fail to make a choice of
254.34 health plan shall not be randomly assigned to health plans under these demonstrations.
254.35 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.

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

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

(f) The commissioner shall seek federal approval to expand the Minnesota disability health options (MnDHO) program established under this subdivision in stages, first to regional population centers outside the seven-county metro area and then to all areas of the state. ~~Until January 1, 2008~~ July 1, 2009, expansion for MnDHO projects that include home and community-based services is limited to the two projects and service areas in effect on March 1, 2006. Enrollment in integrated MnDHO programs that include home and community-based services shall remain voluntary. Costs for home and community-based services included under MnDHO must not exceed costs that would have been incurred under the fee-for-service program. In developing program specifications for expansion of integrated programs, the commissioner shall involve and consult the state-level stakeholder group established in subdivision 28, paragraph (d), including consultation on whether and how to include home and community-based waiver programs. Plans for further expansion of MnDHO projects shall be presented to the chairs

257.1 of the house and senate committees with jurisdiction over health and human services
257.2 policy and finance by February 1, 2007.

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

257.7 Sec. 103. Minnesota Statutes 2006, section 256B.69, subdivision 28, is amended to
257.8 read:

257.9 Subd. 28. **Medicare special needs plans; medical assistance basic health care.**

257.10 (a) The commissioner may contract with qualified Medicare-approved special needs
257.11 plans to provide medical assistance basic health care services to persons with disabilities,
257.12 including those with developmental disabilities. Basic health care services include:

257.13 (1) those services covered by the medical assistance state plan except for ICF/MR
257.14 services, home and community-based waiver services, case management for persons with
257.15 developmental disabilities under section 256B.0625, subdivision 20a, and personal care
257.16 and certain home care services defined by the commissioner in consultation with the
257.17 stakeholder group established under paragraph (d); and

257.18 (2) basic health care services may also include risk for up to 100 days of nursing
257.19 facility services for persons who reside in a noninstitutional setting and home health
257.20 services related to rehabilitation as defined by the commissioner after consultation with
257.21 the stakeholder group.

257.22 The commissioner may exclude other medical assistance services from the basic
257.23 health care benefit set. Enrollees in these plans can access any excluded services on the
257.24 same basis as other medical assistance recipients who have not enrolled.

257.25 Unless a person is otherwise required to enroll in managed care, enrollment in these
257.26 plans for Medicaid services must be voluntary. For purposes of this subdivision, automatic
257.27 enrollment with an option to opt out is not voluntary enrollment.

257.28 (b) Beginning January 1, 2007, the commissioner may contract with qualified
257.29 Medicare special needs plans to provide basic health care services under medical
257.30 assistance to persons who are dually eligible for both Medicare and Medicaid and those
257.31 Social Security beneficiaries eligible for Medicaid but in the waiting period for Medicare.
257.32 The commissioner shall consult with the stakeholder group under paragraph ~~(d)~~ (e) in
257.33 developing program specifications for these services. The commissioner shall report to
257.34 the chairs of the house and senate committees with jurisdiction over health and human
257.35 services policy and finance by February 1, 2007, on implementation of these programs and

the need for increased funding for the ombudsman for managed care and other consumer assistance and protections needed due to enrollment in managed care of persons with disabilities. Payment for Medicaid services provided under this subdivision for the months of May and June will be made no earlier than July 1 of the same calendar year.

(c) Beginning January 1, 2008, the commissioner may expand contracting under this subdivision to all persons with disabilities not otherwise required to enroll in managed care.

(d) By February 1, 2009, the commissioner shall report to the chairs of the house and senate committees with jurisdiction over health and human services policy and finance on the initial results of implementation of contracts with qualified Medicare special needs plans to provide basic health care services under medical assistance to persons who are dually eligible for both Medicare and Medicaid. This report shall include an overall assessment of the impact on quality of care including actual costs and benefits.

(e) The commissioner shall establish a state-level stakeholder group to provide advice on managed care programs for persons with disabilities, including both MnDHO and contracts with special needs plans that provide basic health care services as described in paragraphs (a) and (b). The stakeholder group shall include representatives of the counties and labor organizations representing county social service workers, members, consumer advocates, and providers, and provide advice on program expansions under this subdivision and subdivision 23, including:

(1) implementation efforts;

(2) consumer protections; ~~and~~

(3) program specifications such as quality assurance measures, data collection and reporting, and evaluation of costs, quality, and results; and

(4) county safety net protections for persons with disabilities.

~~(e)~~ (f) Each plan under contract to provide medical assistance basic health care services shall establish a local or regional stakeholder group, including representatives of the counties covered by the plan and labor organizations representing county social service workers, members, consumer advocates, and current providers, for advice on issues that arise in the local or regional area.

Sec. 104. **[256C.261] SERVICES FOR DEAF-BLIND PERSONS.**

(a) The commissioner of human services shall combine the existing biennial base level funding for deaf-blind services into a single grant program. At least 35 percent of the total funding is awarded for services and other supports to deaf-blind children

259.1 and their families and at least 25 percent is awarded for services and other supports to
259.2 deaf-blind adults.

259.3 The commissioner shall award grants for the purposes of:

259.4 (1) providing services and supports to individuals who are deaf-blind; and

259.5 (2) developing and providing training to counties and the network of senior citizen
259.6 service providers. The purpose of the training grants is to teach counties how to use
259.7 existing programs that capture federal financial participation to meet the needs of eligible
259.8 deaf-blind persons and to build capacity of senior service programs to meet the needs of
259.9 seniors with a dual sensory hearing and vision loss.

259.10 (b) The commissioner may make grants:

259.11 (1) for services and training provided by organizations; and

259.12 (2) to develop and administer consumer-directed services.

259.13 (c) Any entity that is able to satisfy the grant criteria is eligible to receive a grant
259.14 under paragraph (a).

259.15 (d) Deaf-blind service providers are not required to, but may, provide intervenor
259.16 services as part of the service package provided with grant funds under this section.

259.17 Sec. 105. Minnesota Statutes 2006, section 256D.44, subdivision 2, is amended to read:

259.18 Subd. 2. **Standard of assistance for persons eligible for medical assistance**
259.19 **waivers or at risk of placement in a group residential housing facility.** The state
259.20 standard of assistance for a person (1) who is eligible for a medical assistance home
259.21 and community-based services waiver or a person, (2) who has been determined by the
259.22 local agency to meet the plan requirements for placement in a group residential housing
259.23 facility under section 256I.04, subdivision 1a, or (3) who is eligible for a shelter needy
259.24 payment under subdivision 5, paragraph (f), is the standard established in subdivision 3,
259.25 paragraph (a) or (b).

259.26 Sec. 106. Minnesota Statutes 2006, section 256D.44, subdivision 5, is amended to read:

259.27 Subd. 5. **Special needs.** In addition to the state standards of assistance established in
259.28 subdivisions 1 to 4, payments are allowed for the following special needs of recipients of
259.29 Minnesota supplemental aid who are not residents of a nursing home, a regional treatment
259.30 center, or a group residential housing facility.

259.31 (a) The county agency shall pay a monthly allowance for medically prescribed
259.32 diets if the cost of those additional dietary needs cannot be met through some other
259.33 maintenance benefit. The need for special diets or dietary items must be prescribed by
259.34 a licensed physician. Costs for special diets shall be determined as percentages of the

260.1 allotment for a one-person household under the thrifty food plan as defined by the United
260.2 States Department of Agriculture. The types of diets and the percentages of the thrifty
260.3 food plan that are covered are as follows:

- 260.4 (1) high protein diet, at least 80 grams daily, 25 percent of thrifty food plan;
- 260.5 (2) controlled protein diet, 40 to 60 grams and requires special products, 100 percent
260.6 of thrifty food plan;
- 260.7 (3) controlled protein diet, less than 40 grams and requires special products, 125
260.8 percent of thrifty food plan;
- 260.9 (4) low cholesterol diet, 25 percent of thrifty food plan;
- 260.10 (5) high residue diet, 20 percent of thrifty food plan;
- 260.11 (6) pregnancy and lactation diet, 35 percent of thrifty food plan;
- 260.12 (7) gluten-free diet, 25 percent of thrifty food plan;
- 260.13 (8) lactose-free diet, 25 percent of thrifty food plan;
- 260.14 (9) antidumping diet, 15 percent of thrifty food plan;
- 260.15 (10) hypoglycemic diet, 15 percent of thrifty food plan; or
- 260.16 (11) ketogenic diet, 25 percent of thrifty food plan.

260.17 (b) Payment for nonrecurring special needs must be allowed for necessary home
260.18 repairs or necessary repairs or replacement of household furniture and appliances using
260.19 the payment standard of the AFDC program in effect on July 16, 1996, for these expenses,
260.20 as long as other funding sources are not available.

260.21 (c) A fee for guardian or conservator service is allowed at a reasonable rate
260.22 negotiated by the county or approved by the court. This rate shall not exceed five percent
260.23 of the assistance unit's gross monthly income up to a maximum of \$100 per month. If the
260.24 guardian or conservator is a member of the county agency staff, no fee is allowed.

260.25 (d) The county agency shall continue to pay a monthly allowance of \$68 for
260.26 restaurant meals for a person who was receiving a restaurant meal allowance on June 1,
260.27 1990, and who eats two or more meals in a restaurant daily. The allowance must continue
260.28 until the person has not received Minnesota supplemental aid for one full calendar month
260.29 or until the person's living arrangement changes and the person no longer meets the criteria
260.30 for the restaurant meal allowance, whichever occurs first.

260.31 (e) A fee of ten percent of the recipient's gross income or \$25, whichever is less,
260.32 is allowed for representative payee services provided by an agency that meets the
260.33 requirements under SSI regulations to charge a fee for representative payee services. This
260.34 special need is available to all recipients of Minnesota supplemental aid regardless of
260.35 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. 107. 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 developmental disabilities at regional treatment centers; (2) to ensure compliance with the federal Omnibus Budget Reconciliation Act alternative disposition plan requirements for inappropriately placed persons with developmental disabilities or mental illness;

262.1 (3) up to 80 beds in a single, specialized facility located in Hennepin County that will
262.2 provide housing for chronic inebriates who are repetitive users of detoxification centers
262.3 and are refused placement in emergency shelters because of their state of intoxication,
262.4 and planning for the specialized facility must have been initiated before July 1, 1991, in
262.5 anticipation of receiving a grant from the Housing Finance Agency under section 462A.05,
262.6 subdivision 20a, paragraph (b); (4) notwithstanding the provisions of subdivision 2a, for
262.7 up to 190 supportive housing units in Anoka, Dakota, Hennepin, or Ramsey County
262.8 for homeless adults with a mental illness, a history of substance abuse, or human
262.9 immunodeficiency virus or acquired immunodeficiency syndrome. For purposes of this
262.10 section, "homeless adult" means a person who is living on the street or in a shelter or
262.11 discharged from a regional treatment center, community hospital, or residential treatment
262.12 program and has no appropriate housing available and lacks the resources and support
262.13 necessary to access appropriate housing. At least 70 percent of the supportive housing
262.14 units must serve homeless adults with mental illness, substance abuse problems, or human
262.15 immunodeficiency virus or acquired immunodeficiency syndrome who are about to be
262.16 or, within the previous six months, has been discharged from a regional treatment center,
262.17 or a state-contracted psychiatric bed in a community hospital, or a residential mental
262.18 health or chemical dependency treatment program. If a person meets the requirements of
262.19 subdivision 1, paragraph (a), and receives a federal or state housing subsidy, the group
262.20 residential housing rate for that person is limited to the supplementary rate under section
262.21 256I.05, subdivision 1a, and is determined by subtracting the amount of the person's
262.22 countable income that exceeds the MSA equivalent rate from the group residential housing
262.23 supplementary rate. A resident in a demonstration project site who no longer participates
262.24 in the demonstration program shall retain eligibility for a group residential housing
262.25 payment in an amount determined under section 256I.06, subdivision 8, using the MSA
262.26 equivalent rate. Service funding under section 256I.05, subdivision 1a, will end June 30,
262.27 1997, if federal matching funds are available and the services can be provided through a
262.28 managed care entity. If federal matching funds are not available, then service funding will
262.29 continue under section 256I.05, subdivision 1a; ~~or (6) (5)~~ for group residential housing
262.30 beds in settings meeting the requirements of subdivision 2a, clauses (1) and (3), which
262.31 are used exclusively for recipients receiving home and community-based waiver services
262.32 under sections 256B.0915, 256B.092, subdivision 5, 256B.093, and 256B.49, and who
262.33 resided in a nursing facility for the six months immediately prior to the month of entry
262.34 into the group residential housing setting. The group residential housing rate for these
262.35 beds must be set so that the monthly group residential housing payment for an individual
262.36 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. 108. 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 county agency shall negotiate a supplementary rate in addition to the rate specified in subdivision 1, not to exceed \$737.87 per month, including any legislatively authorized inflationary adjustments, for a group residential housing provider that:

264.1 (1) is located in Ramsey County and has had a group residential housing contract
264.2 with the county since 1982 and has been licensed as a board and lodge facility with special
264.3 services since 1979; and

264.4 (2) serves recovering and chemically dependent males, providing 24-hour-a-day
264.5 supervision.

264.6 Sec. 109. Minnesota Statutes 2006, section 256I.05, is amended by adding a
264.7 subdivision to read:

264.8 Subd. 1i. **Supplementary rate for certain facilities; Hennepin County.**

264.9 Notwithstanding the provisions of subdivisions 1a and 1c, a county agency shall negotiate
264.10 a supplementary rate in addition to the rate specified in subdivision 1, not to exceed \$700
264.11 per month, including any legislatively authorized inflationary adjustments, for a facility
264.12 located in Hennepin County with a capacity of up to 48 beds that has been licensed since
264.13 1978 as a board and lodging facility and that until August 1, 2007, operated as a licensed
264.14 chemical dependency treatment program.

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

264.16 Sec. 110. Minnesota Statutes 2006, section 256I.05, is amended by adding a
264.17 subdivision to read:

264.18 Subd. 1j. **Supplementary rate for certain facilities; St. Louis County.** (a)

264.19 Notwithstanding the provisions of subdivisions 1a and 1c, beginning July 1, 2007, a
264.20 county agency shall negotiate a supplementary rate in addition to the rate specified in
264.21 subdivision 1, not to exceed \$700 per month, including any legislatively authorized
264.22 inflationary adjustments, for a 60-bed facility in St. Louis County which opened in
264.23 January 2006 that will serve chemically dependent persons operated by a group residential
264.24 housing provider that currently operates a 304-bed facility in Minneapolis.

264.25 (b) The supplementary rate in paragraph (a) applies to the 48 beds which do not
264.26 already receive a supplementary rate.

264.27 Sec. 111. Minnesota Statutes 2006, section 256I.05, is amended by adding a
264.28 subdivision to read:

264.29 Subd. 1k. **Supplementary rate for certain facilities; Crow Wing County.**

264.30 Notwithstanding the provisions of subdivisions 1a and 1c, beginning July 1, 2007, a
264.31 county agency shall negotiate a supplementary rate in addition to the rate specified in
264.32 subdivision 1, not to exceed \$700 per month, including any legislatively authorized
264.33 inflationary adjustments, for a new 65-bed facility in Crow Wing County that will serve

265.1 chemically dependent persons operated by a group residential housing provider that
265.2 currently operates a 304-bed facility in Minneapolis and a 44-bed facility in Duluth which
265.3 opened in January of 2006.

265.4 Sec. 112. Minnesota Statutes 2006, section 256I.05, is amended by adding a
265.5 subdivision to read:

265.6 Subd. 11. **Supplementary rate for certain facilities; Stearns County.**
265.7 Notwithstanding the provisions of this section, beginning July 1, 2007, a county agency
265.8 shall negotiate a supplementary service rate in addition to the rate specified in subdivision
265.9 1, not to exceed \$700 per month, including any legislatively authorized inflationary
265.10 adjustments, for a group residential housing provider located in Stearns County that
265.11 operates a 40-bed facility, that received financing through the Minnesota Housing Finance
265.12 Agency Ending Long-Term Homelessness Initiative and serves chemically dependent
265.13 clientele, providing 24-hour-a-day supervision.

265.14 Sec. 113. Minnesota Statutes 2006, section 256I.05, is amended by adding a
265.15 subdivision to read:

265.16 Subd. 1m. **Supplementary rate for certain facilities; St. Louis County.**
265.17 Notwithstanding the provisions of this section, beginning July 1, 2007, a county agency
265.18 shall negotiate a supplementary service rate in addition to the rate specified in subdivision
265.19 1, not to exceed \$700 per month, including any legislatively authorized inflationary
265.20 adjustments, for a group residential housing provider located in St. Louis County that
265.21 operates a 30-bed facility, that received financing through the Minnesota Housing Finance
265.22 Agency Ending Long-Term Homelessness Initiative and serves chemically dependent
265.23 clientele, providing 24-hour-a-day supervision.

265.24 Sec. 114. Minnesota Statutes 2006, section 256I.05, is amended by adding a
265.25 subdivision to read:

265.26 Subd. 1n. **Supplemental rate for certain facilities; Hennepin and Ramsey**
265.27 **Counties.** Notwithstanding the provisions of this section, beginning July 1, 2007, a county
265.28 agency shall negotiate a supplemental service rate in addition to the rate specified in
265.29 subdivision 1, not to exceed \$715.78 per month, including any legislatively authorized
265.30 inflationary adjustments, for a group residential housing provider that operates two
265.31 ten-bed facilities, one located in Hennepin County and one located in Ramsey County,
265.32 which provide community support and serve the mental health needs of individuals who
265.33 have chronically lived unsheltered, providing 24-hour-a-day supervision.

266.1 Sec. 115. Laws 2000, chapter 340, section 19, is amended to read:

266.2 Sec. 19. **ALTERNATIVE CARE PILOT PROJECTS.**

266.3 (a) Expenditures for housing with services and adult foster care shall be excluded
266.4 when determining average monthly expenditures per client for alternative care pilot
266.5 projects authorized in Laws 1993, First Special Session chapter 1, article 5, section 133.

266.6 (b) Alternative care pilot projects shall not expire on June 30, 2001, but shall
266.7 continue until June 30, ~~2005~~ 2007.

266.8 **EFFECTIVE DATE.** This section is effective retroactively from June 29, 2005, for
266.9 activities related to discontinuing pilot projects under this section.

266.10 Sec. 116. Laws 2006, chapter 282, article 20, section 37, is amended to read:

266.11 Sec. 37. **REPAYMENT DELAY.**

266.12 A county that overspent its allowed amounts in calendar year 2004 or 2005 under
266.13 the waived services program for persons with developmental disabilities shall not be
266.14 required to pay back the amount of overspending ~~until May 31, 2007~~.

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

266.16 Sec. 117. **LICENSURE; SERVICES FOR YOUTH WITH DISABILITIES.**

266.17 (a) Notwithstanding the requirements of Minnesota Statutes, chapter 245A, upon the
266.18 recommendation of a county agency, the commissioner of human services shall grant a
266.19 license with any necessary variances to a nonresidential program for youth which provides
266.20 services to youth with disabilities under age 21 during nonschool hours established
266.21 to ensure health and safety, prevent out-of-home placement, and increase community
266.22 inclusion of youth with disabilities. The nonresidential youth program is subject to the
266.23 conditions of any variances granted and with consumer rights under Minnesota Statutes,
266.24 section 245B.04, consumer protection standards under Minnesota Statutes, section
266.25 245B.05, service standards under Minnesota Statutes, section 245B.06, management
266.26 standards under Minnesota Statutes, section 245B.07, and fire marshal inspections under
266.27 Minnesota Statutes, section 245A.151, until the commissioner develops other licensure
266.28 requirements for this type of program.

266.29 (b) By February 1, 2008, the commissioner shall recommend amendments to
266.30 licensure requirements in Minnesota Statutes, chapter 245A, to allow licensure of
266.31 appropriate services for school-age youth with disabilities under age 21 who need
266.32 supervision and services to develop skills necessary to maintain personal safety and
266.33 increase their independence, productivity, and participation in their communities during

267.1 nonschool hours. As part of developing the recommendations, the commissioner shall
267.2 survey county agencies to determine how the needs of youth with disabilities under age 21
267.3 who require supervision and support services are being met and the funding sources used.
267.4 The recommendations must be provided to the house and senate chairs of the committees
267.5 with jurisdiction over licensing of programs for youth with disabilities.

267.6 Sec. 118. **INDEPENDENT LIVING.**

267.7 An individual who has lived in one of the facilities under Minnesota Statutes,
267.8 section 256I.05, subdivision 1n, who is being transitioned to independent living as
267.9 part of the program plan continues to be eligible for group residential housing and the
267.10 supplemental service rate negotiated with the county under Minnesota Statutes, section
267.11 256I.05, subdivision 1n.

267.12 Sec. 119. **ASSISTIVE TECHNOLOGY RECOMMENDATIONS.**

267.13 Subdivision 1. **Review.** (a) During the biennium ending June 30, 2009, the Council
267.14 on Disability shall facilitate a statewide review of the assistive technology needs of people
267.15 with disabling conditions, and seniors. The council shall identify community-based
267.16 service providers, state agencies, and other entities involved in providing assistive
267.17 technology supports.

267.18 (b) The council shall provide oversight and direction to the Minnesota Regions
267.19 Assistive Technology Collaborative during the biennium ending June 30, 2009.

267.20 Subd. 2. **Recommendations.** The council shall present to the chairs of the house
267.21 and senate committees having jurisdiction over human services, by January 1, 2009,
267.22 recommendations, including proposed legislation creating a statewide comprehensive plan
267.23 to meet the assistive technology needs of people with disabling conditions and seniors.
267.24 The statewide plan must include steps to coordinate and streamline assistive technology
267.25 services.

267.26 Sec. 120. **COMMUNITY SERVICES PROVIDER RATE INCREASES.**

267.27 (a) The commissioner of human services shall increase allocations, reimbursement
267.28 rates, or rate limits, as applicable, by three percent for the rate period beginning October 1,
267.29 2007, and the rate period beginning October 1, 2008, effective for services rendered on
267.30 or after those dates.

267.31 (b) The three percent annual rate increase described in this section must be provided
267.32 to:

- 268.1 (1) home and community-based waived services for persons with developmental
268.2 disabilities or related conditions under Minnesota Statutes, section 256B.501;
- 268.3 (2) home and community-based waived services for the elderly under Minnesota
268.4 Statutes, section 256B.0915;
- 268.5 (3) waived services under community alternatives for disabled individuals under
268.6 Minnesota Statutes, section 256B.49;
- 268.7 (4) community alternative care waived services under Minnesota Statutes, section
268.8 256B.49;
- 268.9 (5) traumatic brain injury waived services under Minnesota Statutes, section
268.10 256B.49;
- 268.11 (6) nursing services and home health services under Minnesota Statutes, section
268.12 256B.0625, subdivision 6a;
- 268.13 (7) personal care services and nursing supervision of personal care services under
268.14 Minnesota Statutes, section 256B.0625, subdivision 19a;
- 268.15 (8) private duty nursing services under Minnesota Statutes, section 256B.0625,
268.16 subdivision 7;
- 268.17 (9) day training and habilitation services for adults with developmental disabilities
268.18 or related conditions under Minnesota Statutes, sections 252.40 to 252.46, including the
268.19 additional cost of rate adjustments on day training and habilitation service, provided as a
268.20 social service under Minnesota Statutes, section 256M.60;
- 268.21 (10) alternative care services under Minnesota Statutes, section 256B.0913;
- 268.22 (11) adult residential program grants under Minnesota Statutes, section 245.73;
- 268.23 (12) adult and children's mental health grants under Minnesota Rules, parts
268.24 9535.1700 to 9535.1760;
- 268.25 (13) the group residential housing supplementary service rate under Minnesota
268.26 Statutes, section 256I.05, subdivision 1a;
- 268.27 (14) adult mental health integrated fund grants under Minnesota Statutes, section
268.28 245.4661;
- 268.29 (15) semi-independent living services (SILS) under Minnesota Statutes, section
268.30 252.275, including SILS funding under county social services grants formerly funded
268.31 under Minnesota Statutes, chapter 256I;
- 268.32 (16) community support services for deaf and hard-of-hearing adults with mental
268.33 illness who use or wish to use sign language as their primary means of communication
268.34 under Minnesota Statutes, section 256.01, subdivision 2;
- 268.35 (17) living skills training programs for persons with intractable epilepsy who need
268.36 assistance in the transition to independent living under Laws 1988, chapter 689;

- 269.1 (18) physical therapy services under Minnesota Statutes, sections 256B.0625,
269.2 subdivision 8, and 256D.03, subdivision 4;
- 269.3 (19) occupational therapy services under Minnesota Statutes, sections 256B.0625,
269.4 subdivision 8a, and 256D.03, subdivision 4;
- 269.5 (20) speech-language therapy services under Minnesota Statutes, section 256D.03,
269.6 subdivision 4, and Minnesota Rules, part 9505.0390;
- 269.7 (21) respiratory therapy services under Minnesota Statutes, section 256D.03,
269.8 subdivision 4, and Minnesota Rules, part 9505.0295;
- 269.9 (22) aging grants under Minnesota Statutes, sections 256.975 to 256.977, 256B.0917,
269.10 and 256B.0928;
- 269.11 (23) deaf and hard-of-hearing grants under Minnesota Statutes, sections 256C.233;
269.12 256C.25; Laws 1985, chapter 9, article 1; and Laws 1997, First Special Session chapter
269.13 5, section 20;
- 269.14 (24) children's therapeutic services and supports under Minnesota Statutes, section
269.15 256B.0943;
- 269.16 (25) tier I chemical health services under Minnesota Statutes, chapter 254B;
- 269.17 (26) consumer support grants under Minnesota Statutes, section 256.476;
- 269.18 (27) family support grants under Minnesota Statutes, section 252.32;
- 269.19 (28) case management services to persons with HIV or AIDS under Minnesota
269.20 Statutes, section 256.01, subdivision 19; and
- 269.21 (29) adult rehabilitative mental health services under Minnesota Statutes, section
269.22 256B.0623.
- 269.23 (c) Providers that receive a rate increase under this section shall use 75 percent of
269.24 the additional revenue to increase wages and benefits and pay associated costs for all
269.25 employees, except for management fees, the administrator, and central office staff.
- 269.26 (d) For public employees, the increase for wages and benefits for certain staff is
269.27 available and pay rates must be increased only to the extent that they comply with laws
269.28 governing public employees' collective bargaining. Money received by a provider for pay
269.29 increases under this section may be used only for increases implemented on or after the
269.30 first day of the rate period in which the increase is available and must not be used for
269.31 increases implemented prior to that date.
- 269.32 (e) A copy of the provider's plan for complying with paragraph (c) must be made
269.33 available to all employees by giving each employee a copy or by posting a copy in an area
269.34 of the provider's operation to which all employees have access. If an employee does not
269.35 receive the adjustment, if any, described in the plan and is unable to resolve the problem
269.36 with the provider, the employee may contact the employee's union representative. If the

270.1 employee is not covered by a collective bargaining agreement, the employee may contact
270.2 the commissioner at a telephone number provided by the commissioner and included in
270.3 the provider's plan.

270.4 (f) The commissioner and each county agency shall take steps necessary to
270.5 implement the increases required by this section on the dates specified, and the increases
270.6 must be effective on the dates specified, regardless of the client's service authorization date
270.7 and notwithstanding the terms of any provider contract, service agreement, or schedule
270.8 that limits when a county may increase payment rates.

270.9 Sec. 121. **DENTAL ACCESS FOR PERSONS WITH DISABILITIES.**

270.10 The commissioner of human services shall study access to dental services for
270.11 persons with disabilities, and shall present recommendations for improving access to
270.12 dental services to the legislature by January 15, 2008. The study must examine physical
270.13 and geographic access, the willingness of dentists to serve persons with disabilities
270.14 enrolled in state health care programs, reimbursement rates for dental service providers,
270.15 and other factors identified by the commissioner.

270.16 Sec. 122. **COMMISSIONER REQUIRED TO SEEK FEDERAL APPROVAL.**

270.17 By October 1, 2007, the commissioner shall seek federal approval to allow persons
270.18 who have been eligible for medical assistance for employed persons with disabilities
270.19 (MA-EPD) under Minnesota Statutes, section 256B.057, subdivision 9, for each of the 24
270.20 consecutive months prior to becoming age 65 to continue using the MA-EPD eligibility
270.21 rules as long as they qualify.

270.22 Sec. 123. **RECOMMENDATIONS FOR PAYMENT OF NURSING FACILITIES.**

270.23 The commissioner of human services shall provide recommendations to the
270.24 legislature by February 15, 2008, on changes to the nursing facility payment system
270.25 for specialized care, setting property payment rates and proper treatment of bed closure
270.26 incentives.

270.27 Sec. 124. **RATE ADJUSTMENTS FOR FINANCIALLY STRESSED**
270.28 **FACILITIES.**

270.29 The commissioner of human services may negotiate operations payment rate
270.30 adjustments with nursing facilities in danger of financial failure. The commissioner
270.31 shall publish a request for proposals by September 30, 2007. Facilities may apply to

271.1 the commissioner to negotiate for funding under this provision based on submittal of
271.2 the following information:
271.3 (1) financial statements demonstrating financial losses and low net worth;
271.4 (2) statement of support from county agency;
271.5 (3) demonstrated potential for access problems for services if the facility closed; and
271.6 (4) cost per bed required to preserve the nursing facilities ability to operate until
271.7 October 1, 2009.

271.8 Sec. 125. **MINNESOTA RULES.**

271.9 The Department of Administration shall publish adopted rules in the State Register
271.10 making the terminology changes specified in section 126 in Minnesota Rules. Upon
271.11 publication in the State Register, the terminology changes for Minnesota Rules are
271.12 adopted without further administrative action.

271.13 Sec. 126. **REVISOR'S INSTRUCTION.**

271.14 The revisor of statutes shall change the terms in column A to the terms in column B
271.15 wherever they appear in Minnesota Statutes:

271.16	<u>Column A</u>	<u>Column B</u>
271.17	<u>"Office of Ombudsman</u>	<u>"Office of Ombudsman</u>
271.18	<u>for Older Minnesotans"</u>	<u>for Long-Term Care"</u>
271.19	<u>and "Office of the</u>	
271.20	<u>Ombudsman for Older</u>	
271.21	<u>Minnesotans"</u>	
271.22	<u>"ombudsman for older</u>	<u>"ombudsman for</u>
271.23	<u>Minnesotans"</u>	<u>long-term care"</u>

271.24 Sec. 127. **REPEALER.**

271.25 Minnesota Statutes 2006, sections 252.21; 252.22; 252.23; 252.24; 252.25; 252.261;
271.26 252.275, subdivision 5; 256.9743; 256B.0913, subdivisions 5b, 5c, 5d, 5e, 5f, 5g, and 5h;
271.27 and 256B.441, subdivisions 12, 16, 21, 26, 28, 42, and 45, are repealed.

271.28 **ARTICLE 5**
271.29 **MENTAL HEALTH**

271.30 Section 1. Minnesota Statutes 2006, section 245.462, subdivision 20, is amended to
271.31 read:

271.32 Subd. 20. **Mental illness.** (a) "Mental illness" means an organic disorder of the
271.33 brain or a clinically significant disorder of thought, mood, perception, orientation,
271.34 memory, or behavior that is listed in the clinical manual of the International Classification

272.1 of Diseases (ICD-9-CM), current edition, code range 290.0 to 302.99 or 306.0 to 316.0
272.2 or the corresponding code in the American Psychiatric Association's Diagnostic and
272.3 Statistical Manual of Mental Disorders (DSM-MD), current edition, Axes I, II, or III, and
272.4 that seriously limits a person's capacity to function in primary aspects of daily living such
272.5 as personal relations, living arrangements, work, and recreation.

272.6 (b) An "adult with acute mental illness" means an adult who has a mental illness that
272.7 is serious enough to require prompt intervention.

272.8 (c) For purposes of case management and community support services, a "person
272.9 with serious and persistent mental illness" means an adult who has a mental illness and
272.10 meets at least one of the following criteria:

272.11 (1) the adult has undergone two or more episodes of inpatient care for a mental
272.12 illness within the preceding 24 months;

272.13 (2) the adult has experienced a continuous psychiatric hospitalization or residential
272.14 treatment exceeding six months' duration within the preceding 12 months;

272.15 (3) the adult has been treated by a crisis team two or more times within the preceding
272.16 24 months;

272.17 (4) the adult:

272.18 (i) has a diagnosis of schizophrenia, bipolar disorder, major depression, or borderline
272.19 personality disorder;

272.20 (ii) indicates a significant impairment in functioning; and

272.21 (iii) has a written opinion from a mental health professional, in the last three years,
272.22 stating that the adult is reasonably likely to have future episodes requiring inpatient or
272.23 residential treatment, of a frequency described in clause (1) or (2), unless ongoing case
272.24 management or community support services are provided;

272.25 ~~(4)~~ (5) the adult has, in the last three years, been committed by a court as a person
272.26 who is mentally ill under chapter 253B, or the adult's commitment has been stayed or
272.27 continued; or

272.28 ~~(5)~~ (6) the adult (i) was eligible under clauses (1) to ~~(4)~~ (5), but the specified time
272.29 period has expired or the adult was eligible as a child under section 245.4871, subdivision
272.30 6; and (ii) has a written opinion from a mental health professional, in the last three years,
272.31 stating that the adult is reasonably likely to have future episodes requiring inpatient or
272.32 residential treatment, of a frequency described in clause (1) or (2), unless ongoing case
272.33 management or community support services are provided.

272.34 Sec. 2. Minnesota Statutes 2006, section 245.465, is amended by adding a subdivision
272.35 to read:

273.1 Subd. 3. **Responsibility not duplicated.** For individuals who have health care
273.2 coverage, the county board is not responsible for providing mental health services which
273.3 are within the limits of the individual's health care coverage.

273.4 Sec. 3. Minnesota Statutes 2006, section 245.4874, is amended to read:

273.5 **245.4874 DUTIES OF COUNTY BOARD.**

273.6 Subdivision 1. **Duties of the county board.** (a) The county board must:

273.7 (1) develop a system of affordable and locally available children's mental health
273.8 services according to sections 245.487 to 245.4887;

273.9 (2) establish a mechanism providing for interagency coordination as specified in
273.10 section 245.4875, subdivision 6;

273.11 (3) consider the assessment of unmet needs in the county as reported by the local
273.12 children's mental health advisory council under section 245.4875, subdivision 5, paragraph
273.13 (b), clause (3). The county shall provide, upon request of the local children's mental health
273.14 advisory council, readily available data to assist in the determination of unmet needs;

273.15 (4) assure that parents and providers in the county receive information about how to
273.16 gain access to services provided according to sections 245.487 to 245.4887;

273.17 (5) coordinate the delivery of children's mental health services with services
273.18 provided by social services, education, corrections, health, and vocational agencies to
273.19 improve the availability of mental health services to children and the cost-effectiveness of
273.20 their delivery;

273.21 (6) assure that mental health services delivered according to sections 245.487
273.22 to 245.4887 are delivered expeditiously and are appropriate to the child's diagnostic
273.23 assessment and individual treatment plan;

273.24 (7) provide the community with information about predictors and symptoms of
273.25 emotional disturbances and how to access children's mental health services according to
273.26 sections 245.4877 and 245.4878;

273.27 (8) provide for case management services to each child with severe emotional
273.28 disturbance according to sections 245.486; 245.4871, subdivisions 3 and 4; and 245.4881,
273.29 subdivisions 1, 3, and 5;

273.30 (9) provide for screening of each child under section 245.4885 upon admission
273.31 to a residential treatment facility, acute care hospital inpatient treatment, or informal
273.32 admission to a regional treatment center;

273.33 (10) prudently administer grants and purchase-of-service contracts that the county
273.34 board determines are necessary to fulfill its responsibilities under sections 245.487 to
273.35 245.4887;

274.1 (11) assure that mental health professionals, mental health practitioners, and case
274.2 managers employed by or under contract to the county to provide mental health services
274.3 are qualified under section 245.4871;

274.4 (12) assure that children's mental health services are coordinated with adult mental
274.5 health services specified in sections 245.461 to 245.486 so that a continuum of mental
274.6 health services is available to serve persons with mental illness, regardless of the person's
274.7 age;

274.8 (13) assure that culturally informed mental health consultants are used as necessary
274.9 to assist the county board in assessing and providing appropriate treatment for children of
274.10 cultural or racial minority heritage; and

274.11 (14) consistent with section 245.486, arrange for or provide a children's mental
274.12 health screening to a child receiving child protective services or a child in out-of-home
274.13 placement, a child for whom parental rights have been terminated, a child found to be
274.14 delinquent, and a child found to have committed a juvenile petty offense for the third or
274.15 subsequent time, unless a screening has been performed within the previous 180 days, or
274.16 the child is currently under the care of a mental health professional. The court or county
274.17 agency must notify a parent or guardian whose parental rights have not been terminated of
274.18 the potential mental health screening and the option to prevent the screening by notifying
274.19 the court or county agency in writing. The screening shall be conducted with a screening
274.20 instrument approved by the commissioner of human services according to criteria that
274.21 are updated and issued annually to ensure that approved screening instruments are valid
274.22 and useful for child welfare and juvenile justice populations, and shall be conducted
274.23 by a mental health practitioner as defined in section 245.4871, subdivision 26, or a
274.24 probation officer or local social services agency staff person who is trained in the use of
274.25 the screening instrument. Training in the use of the instrument shall include training in the
274.26 administration of the instrument, the interpretation of its validity given the child's current
274.27 circumstances, the state and federal data practices laws and confidentiality standards, the
274.28 parental consent requirement, and providing respect for families and cultural values.
274.29 If the screen indicates a need for assessment, the child's family, or if the family lacks
274.30 mental health insurance, the local social services agency, in consultation with the child's
274.31 family, shall have conducted a diagnostic assessment, including a functional assessment,
274.32 as defined in section 245.4871. The administration of the screening shall safeguard the
274.33 privacy of children receiving the screening and their families and shall comply with the
274.34 Minnesota Government Data Practices Act, chapter 13, and the federal Health Insurance
274.35 Portability and Accountability Act of 1996, Public Law 104-191. Screening results shall be
274.36 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 detained, committed, or placed on an involuntary basis under the civil law of a bordering state may be confined or treated in Minnesota pursuant to a contract under this section. A peace or health officer who is acting under the authority of the sending state may transport an individual to a receiving agency that provides services pursuant to a contract under this section and may transport the individual back to the sending state under the laws of the sending state. Court orders valid under the law of the sending state are granted recognition and reciprocity in the receiving state for individuals covered by a contract under this section to the extent that the court orders relate to confinement for treatment or care of mental illness or chemical dependency. Such treatment or care may address other conditions that may be co-occurring with the mental illness or chemical dependency. These court orders are not subject to legal challenge in the courts of the receiving state. Individuals who are detained, committed, or placed under the law of a sending state and who are transferred to a receiving state under this section continue to be in the legal custody of the authority responsible for them under the law of the sending state. Except in emergencies, those individuals may not be transferred, removed, or furloughed from a receiving agency without the specific approval of the authority responsible for them under the law of the sending state.

(b) While in the receiving state pursuant to a contract under this section, an individual shall be subject to the sending state's laws and rules relating to length of confinement, reexaminations, and extensions of confinement. No individual may be sent to another state pursuant to a contract under this section until the receiving state has enacted a law recognizing the validity and applicability of this section.

(c) If an individual receiving services pursuant to a contract under this section leaves the receiving agency without permission and the individual is subject to involuntary confinement under the law of the sending state, the receiving agency shall use all reasonable means to return the individual to the receiving agency. The receiving agency shall immediately report the absence to the sending agency. The receiving state has the primary responsibility for, and the authority to direct, the return of these individuals within its borders and is liable for the cost of the action to the extent that it would be liable for costs of its own resident.

(d) Responsibility for payment for the cost of care remains with the sending agency.

(e) This subdivision also applies to county contracts under subdivision 2 which include emergency care and treatment provided to a county resident in a bordering state.

(f) If a Minnesota resident is admitted to a facility in a bordering state under this chapter, a physician, licensed psychologist who has a doctoral degree in psychology, or an advance practice registered nurse certified in mental health, who is licensed in the bordering state, may act as an examiner under sections 253B.07, 253B.08, 253B.092, 253B.12, and 253B.17 subject to the same requirements and limitations in section 253B.02, subdivision 7.

Sec. 5. Minnesota Statutes 2006, section 245.98, subdivision 2, is amended to read:

Subd. 2. **Program.** The commissioner of human services shall establish a program for the treatment of compulsive gamblers. The commissioner may contract with an entity with expertise regarding the treatment of compulsive gambling to operate the program. The program may include the establishment of a statewide toll-free number, resource library, public education programs; regional in-service training programs and conferences for health care professionals, educators, treatment providers, employee assistance programs, and criminal justice representatives; and the establishment of certification standards for programs and service providers. The commissioner may enter into agreements with other entities and may employ or contract with consultants to facilitate the provision of these services or the training of individuals to qualify them to provide these services. The program may also include inpatient and outpatient treatment and rehabilitation services ~~and~~ for residents in a temporary or permanent residential setting for mental health or chemical dependency, and individuals in jails or correctional facilities. The program may also include research studies. The research studies must include baseline and prevalence studies for adolescents and adults to identify those at the highest risk. The program must be approved by the commissioner before it is established.

Sec. 6. Minnesota Statutes 2006, section 245.98, subdivision 5, is amended to read:

Subd. 5. **Standards.** The commissioner shall create standards for treatment and provider qualifications for the treatment component of the compulsive gambling program. The commissioner, in coordination with the commissioner of corrections, shall create standards for the assessment and treatment of compulsive gamblers in programs operated by the commissioner of corrections.

Sec. 7. **[245A.175] MENTAL HEALTH TRAINING REQUIREMENT.**

Prior to placement of a child in a foster care home, the child foster care provider, if required to be licensed, must complete two hours of training that addresses the causes, symptoms, and key warning signs of mental health disorders; cultural considerations; and effective approaches for dealing with a child's behaviors. At least one hour of the annual 12-hour training requirement for foster parents must be on children's mental health issues and treatment. Training curriculum shall be approved by the commissioner of human services.

Sec. 8. Minnesota Statutes 2006, section 246.54, subdivision 1, is amended to read:

Subdivision 1. **County portion for cost of care.** Except for chemical dependency services provided under sections 254B.01 to 254B.09, the client's county shall pay to the state of Minnesota a portion of the cost of care provided in a regional treatment center or a state nursing facility to a client legally settled in that county. A county's payment shall be made from the county's own sources of revenue and payments shall be ~~paid as follows: payments to the state from the county shall equal 20 percent~~ a percentage of the cost of care, as determined by the commissioner, for each day, or the portion thereof, that the client spends at a regional treatment center or a state nursing facility: according to the following schedule for each admission:

(1) for the first 30 days: 20 percent until January 1, 2008, ten percent from January 1, 2008, to June 30, 2009, and zero percent thereafter;

(2) 20 percent for days 31 to 60; and

(3) for any days over 60: 20 percent until January 1, 2008, 30 percent from January 1, 2008, to June 30, 2009, 40 percent from July 1, 2009, to June 30, 2010, and 50 percent thereafter.

If payments received by the state under sections 246.50 to 246.53 exceed ~~80 percent~~ the noncounty portion of the cost of care, the county shall be responsible for paying the state only the remaining amount. The county shall not be entitled to reimbursement from the client, the client's estate, or from the client's relatives, except as provided in section

278.1 246.53. ~~No such payments shall be made for any client who was last committed prior to~~
278.2 ~~July 1, 1947.~~

278.3 Sec. 9. Minnesota Statutes 2006, section 256B.0625, subdivision 20, is amended to
278.4 read:

278.5 Subd. 20. **Mental health case management.** (a) To the extent authorized by rule
278.6 of the state agency, medical assistance covers case management services to persons with
278.7 serious and persistent mental illness and children with severe emotional disturbance.
278.8 Services provided under this section must meet the relevant standards in sections 245.461
278.9 to 245.4887, the Comprehensive Adult and Children's Mental Health Acts, Minnesota
278.10 Rules, parts 9520.0900 to 9520.0926, and 9505.0322, excluding subpart 10.

278.11 (b) Entities meeting program standards set out in rules governing family community
278.12 support services as defined in section 245.4871, subdivision 17, are eligible for medical
278.13 assistance reimbursement for case management services for children with severe
278.14 emotional disturbance when these services meet the program standards in Minnesota
278.15 Rules, parts 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

278.16 (c) Medical assistance and MinnesotaCare payment for mental health case
278.17 management shall be made on a monthly basis. In order to receive payment for an eligible
278.18 child, the provider must document at least a face-to-face contact with the child, the child's
278.19 parents, or the child's legal representative. To receive payment for an eligible adult, the
278.20 provider must document:

278.21 (1) at least a face-to-face contact with the adult or the adult's legal representative; or

278.22 (2) at least a telephone contact with the adult or the adult's legal representative and
278.23 document a face-to-face contact with the adult or the adult's legal representative within
278.24 the preceding two months.

278.25 (d) Payment for mental health case management provided by county or state staff
278.26 shall be based on the monthly rate methodology under section 256B.094, subdivision 6,
278.27 paragraph (b), with separate rates calculated for child welfare and mental health, and
278.28 within mental health, separate rates for children and adults.

278.29 (e) Payment for mental health case management provided by Indian health services
278.30 or by agencies operated by Indian tribes may be made according to this section or other
278.31 relevant federally approved rate setting methodology.

278.32 (f) Payment for mental health case management provided by vendors who contract
278.33 with a county or Indian tribe shall be based on a monthly rate negotiated by the host county
278.34 or tribe. The negotiated rate must not exceed the rate charged by the vendor for the same
278.35 service to other payers. If the service is provided by a team of contracted vendors, the

279.1 county or tribe may negotiate a team rate with a vendor who is a member of the team. The
279.2 team shall determine how to distribute the rate among its members. No reimbursement
279.3 received by contracted vendors shall be returned to the county or tribe, except to reimburse
279.4 the county or tribe for advance funding provided by the county or tribe to the vendor.

279.5 (g) If the service is provided by a team which includes contracted vendors, tribal
279.6 staff, and county or state staff, the costs for county or state staff participation in the team
279.7 shall be included in the rate for county-provided services. In this case, the contracted
279.8 vendor, the tribal agency, and the county may each receive separate payment for services
279.9 provided by each entity in the same month. In order to prevent duplication of services,
279.10 each entity must document, in the recipient's file, the need for team case management and
279.11 a description of the roles of the team members.

279.12 (h) The commissioner shall calculate the nonfederal share of actual medical
279.13 assistance and general assistance medical care payments for each county, based on the
279.14 higher of calendar year 1995 or 1996, by service date, project that amount forward to 1999,
279.15 and transfer one-half of the result from medical assistance and general assistance medical
279.16 care to each county's mental health grants under section 256E.12 for calendar year 1999.
279.17 The annualized minimum amount added to each county's mental health grant shall be
279.18 \$3,000 per year for children and \$5,000 per year for adults. The commissioner may reduce
279.19 the statewide growth factor in order to fund these minimums. The annualized total amount
279.20 transferred shall become part of the base for future mental health grants for each county.

279.21 (i) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs
279.22 for mental health case management shall be provided by the recipient's county of
279.23 responsibility, as defined in sections 256G.01 to 256G.12, from sources other than federal
279.24 funds or funds used to match other federal funds. If the service is provided by a tribal
279.25 agency, the nonfederal share, if any, shall be provided by the recipient's tribe. When this
279.26 service is paid by the state without a federal share through fee-for-service, 50 percent of
279.27 the cost shall be provided by the recipient's county of responsibility.

279.28 (j) Notwithstanding any administrative rule to the contrary, prepaid medical
279.29 assistance, general assistance medical care, and MinnesotaCare include mental health case
279.30 management. When the service is provided through prepaid capitation, the nonfederal
279.31 share is paid by the state and the county pays no share.

279.32 ~~(j)~~ (k) The commissioner may suspend, reduce, or terminate the reimbursement to a
279.33 provider that does not meet the reporting or other requirements of this section. The county
279.34 of responsibility, as defined in sections 256G.01 to 256G.12, or, if applicable, the tribal
279.35 agency, is responsible for any federal disallowances. The county or tribe may share this
279.36 responsibility with its contracted vendors.

280.1 ~~(k)~~ (l) The commissioner shall set aside a portion of the federal funds earned for
280.2 county expenditures under this section to repay the special revenue maximization account
280.3 under section 256.01, subdivision 2, clause (15). The repayment is limited to:

280.4 (1) the costs of developing and implementing this section; and

280.5 (2) programming the information systems.

280.6 ~~(h)~~ (m) Payments to counties and tribal agencies for case management expenditures
280.7 under this section shall only be made from federal earnings from services provided
280.8 under this section. When this service is paid by the state without a federal share through
280.9 fee-for-service, 50 percent of the cost shall be provided by the state. Payments to
280.10 county-contracted vendors shall include ~~both~~ the federal earnings, the state share, and the
280.11 county share.

280.12 ~~(m)~~ (n) Notwithstanding section 256B.041, county payments for the cost of mental
280.13 health case management services provided by county or state staff shall not be made
280.14 to the commissioner of finance. For the purposes of mental health case management
280.15 services provided by county or state staff under this section, the centralized disbursement
280.16 of payments to counties under section 256B.041 consists only of federal earnings from
280.17 services provided under this section.

280.18 ~~(n)~~ (o) Case management services under this subdivision do not include therapy,
280.19 treatment, legal, or outreach services.

280.20 ~~(o)~~ (p) If the recipient is a resident of a nursing facility, intermediate care facility,
280.21 or hospital, and the recipient's institutional care is paid by medical assistance, payment
280.22 for case management services under this subdivision is limited to the last 180 days of
280.23 the recipient's residency in that facility and may not exceed more than six months in a
280.24 calendar year.

280.25 ~~(p)~~ (q) Payment for case management services under this subdivision shall not
280.26 duplicate payments made under other program authorities for the same purpose.

280.27 ~~(q)~~ (r) By July 1, 2000, the commissioner shall evaluate the effectiveness of the
280.28 changes required by this section, including changes in number of persons receiving
280.29 mental health case management, changes in hours of service per person, and changes in
280.30 caseload size.

280.31 ~~(r)~~ (s) For each calendar year beginning with the calendar year 2001, the annualized
280.32 amount of state funds for each county determined under paragraph (h) shall be adjusted by
280.33 the county's percentage change in the average number of clients per month who received
280.34 case management under this section during the fiscal year that ended six months prior to
280.35 the calendar year in question, in comparison to the prior fiscal year.

281.1 ~~(s)~~ (t) For counties receiving the minimum allocation of \$3,000 or \$5,000 described
281.2 in paragraph (h), the adjustment in paragraph (s) shall be determined so that the county
281.3 receives the higher of the following amounts:

281.4 (1) a continuation of the minimum allocation in paragraph (h); or

281.5 (2) an amount based on that county's average number of clients per month who
281.6 received case management under this section during the fiscal year that ended six months
281.7 prior to the calendar year in question, times the average statewide grant per person per
281.8 month for counties not receiving the minimum allocation.

281.9 ~~(t)~~ (u) The adjustments in paragraphs (s) and (t) shall be calculated separately for
281.10 children and adults.

281.11 **EFFECTIVE DATE.** This section is effective January 1, 2009, except the
281.12 amendment to paragraph (i) is effective January 1, 2008.

281.13 Sec. 10. Minnesota Statutes 2006, section 256B.0625, subdivision 47, is amended to
281.14 read:

281.15 Subd. 47. **Treatment foster care services.** Effective July 1, ~~2006~~ 2009, and subject
281.16 to federal approval, medical assistance covers treatment foster care services according to
281.17 section 256B.0946.

281.18 Sec. 11. Minnesota Statutes 2006, section 256B.0945, subdivision 4, is amended to
281.19 read:

281.20 Subd. 4. **Payment rates.** (a) Notwithstanding sections 256B.19 and 256B.041,
281.21 payments to counties for residential services provided by a residential facility shall only
281.22 be made of federal earnings for services provided under this section, and the nonfederal
281.23 share of costs for services provided under this section shall be paid by the county from
281.24 sources other than federal funds or funds used to match other federal funds. Payment to
281.25 counties for services provided according to this section shall be a proportion of the per
281.26 day contract rate that relates to rehabilitative mental health services and shall not include
281.27 payment for costs or services that are billed to the IV-E program as room and board.

281.28 (b) Per diem rates paid to providers under this section by prepaid plans shall be the
281.29 proportion of the per-day contract rate that relates to rehabilitative mental health services
281.30 and shall not include payment for group foster care costs or services that are billed to the
281.31 county of financial responsibility.

281.32 (c) The commissioner shall set aside a portion not to exceed five percent of the
281.33 federal funds earned for county expenditures under this section to cover the state costs of

282.1 administering this section. Any unexpended funds from the set-aside shall be distributed
282.2 to the counties in proportion to their earnings under this section.

282.3 **EFFECTIVE DATE.** This section is effective January 1, 2009.

282.4 Sec. 12. Minnesota Statutes 2006, section 256B.69, subdivision 5g, is amended to read:

282.5 Subd. 5g. **Payment for covered services.** For services rendered on or after January
282.6 1, 2003, the total payment made to managed care plans for providing covered services
282.7 under the medical assistance and general assistance medical care programs is reduced by
282.8 .5 percent from their current statutory rates. This provision excludes payments for nursing
282.9 home services, home and community-based waivers, ~~and~~ payments to demonstration
282.10 projects for persons with disabilities, and mental health services added as covered benefits
282.11 after December 31, 2007.

282.12 Sec. 13. Minnesota Statutes 2006, section 256B.69, subdivision 5h, is amended to read:

282.13 Subd. 5h. **Payment reduction.** In addition to the reduction in subdivision 5g,
282.14 the total payment made to managed care plans under the medical assistance program is
282.15 reduced 1.0 percent for services provided on or after October 1, 2003, and an additional
282.16 1.0 percent for services provided on or after January 1, 2004. This provision excludes
282.17 payments for nursing home services, home and community-based waivers, ~~and~~ payments
282.18 to demonstration projects for persons with disabilities, and mental health services added as
282.19 covered benefits after December 1, 2007.

282.20 Sec. 14. Minnesota Statutes 2006, section 256B.763, is amended to read:

282.21 **256B.763 CRITICAL ACCESS MENTAL HEALTH RATE INCREASE.**

282.22 (a) For services defined in paragraph (b) and rendered on or after July 1, 2007,
282.23 payment rates shall be increased by 23.7 percent over the rates in effect on January 1,
282.24 2006, for:

282.25 (1) psychiatrists and advanced practice registered nurses with a psychiatric specialty;
282.26 (2) community mental health centers under section 256B.0625, subdivision 5; and
282.27 (3) mental health clinics and centers certified under Minnesota Rules, parts
282.28 9520.0750 to 9520.0870, or hospital outpatient psychiatric departments that are designated
282.29 as essential community providers under section 62Q.19.

282.30 (b) This increase applies to group skills training when provided as a component of
282.31 children's therapeutic services and support, psychotherapy, medication management,
282.32 evaluation and management, diagnostic assessment, explanation of findings, psychological

283.1 testing, neuropsychological services, direction of behavioral aides, and inpatient
283.2 consultation.

283.3 (c) This increase does not apply to rates that are governed by section 256B.0625,
283.4 subdivision 30, or 256B.761, paragraph (b), other cost-based rates, rates that are
283.5 negotiated with the county, rates that are established by the federal government, or rates
283.6 that increased between January 1, 2004, and January 1, 2005.

283.7 (d) The commissioner shall adjust rates paid to prepaid health plans under contract
283.8 with the commissioner to reflect the rate increases provided in paragraph (a). The prepaid
283.9 health plan must pass this rate increase to the providers identified in ~~paragraph (a)~~
283.10 paragraphs (a), (e), and (f). The prepaid plan must pass this rate increase to the providers
283.11 identified in paragraphs (a), (e), and (f).

283.12 (e) For MinnesotaCare only, payment rates shall be increased by 23.7 percent over
283.13 the rates in effect on December 31, 2007, for:

283.14 (1) medication education services provided on or after January 1, 2008, by adult
283.15 rehabilitative mental health services providers certified under section 256B.0623; and

283.16 (2) mental health behavioral aide services provided on or after January 1, 2008, by
283.17 children's therapeutic services and support providers certified under section 256B.0943.

283.18 (f) For services defined in paragraph (b) and rendered on or after January 1, 2008, by
283.19 children's therapeutic services and support providers certified under section 256B.0943
283.20 and not already included in paragraph (a), payment rates for MinnesotaCare shall be
283.21 increased by 23.7 percent over the rates in effect on December 31, 2007.

283.22 Sec. 15. Minnesota Statutes 2006, section 256L.03, subdivision 1, is amended to read:

283.23 Subdivision 1. **Covered health services.** For individuals under section 256L.04,
283.24 subdivision 7, with income no greater than 75 percent of the federal poverty guidelines
283.25 or for families with children under section 256L.04, subdivision 1, all subdivisions of
283.26 this section apply. "Covered health services" means the health services reimbursed
283.27 under chapter 256B, with the exception of inpatient hospital services, special education
283.28 services, private duty nursing services, adult dental care services other than services
283.29 covered under section 256B.0625, subdivision 9, orthodontic services, nonemergency
283.30 medical transportation services, personal care assistant and case management services,
283.31 nursing home or intermediate care facilities services, inpatient mental health services,
283.32 and chemical dependency services. ~~Outpatient mental health services covered under the~~
283.33 ~~MinnesotaCare program are limited to diagnostic assessments, psychological testing,~~
283.34 ~~explanation of findings, mental health telemedicine, psychiatric consultation, medication~~

284.1 ~~management by a physician, day treatment, partial hospitalization, and individual, family,~~
284.2 ~~and group psychotherapy.~~

284.3 "Covered health services" also includes intensive mental health outpatient treatment
284.4 for dialectical behavioral therapy for adults.

284.5 No public funds shall be used for coverage of abortion under MinnesotaCare
284.6 except where the life of the female would be endangered or substantial and irreversible
284.7 impairment of a major bodily function would result if the fetus were carried to term; or
284.8 where the pregnancy is the result of rape or incest.

284.9 Covered health services shall be expanded as provided in this section.

284.10 **EFFECTIVE DATE.** This section is effective January 1, 2008, except coverage for
284.11 mental health case management is effective January 1, 2009.

284.12 Sec. 16. Minnesota Statutes 2006, section 256L.03, subdivision 5, is amended to read:

284.13 Subd. 5. **Co-payments and coinsurance.** (a) Except as provided in paragraphs (b)
284.14 and (c), the MinnesotaCare benefit plan shall include the following co-payments and
284.15 coinsurance requirements for all enrollees:

284.16 (1) ten percent of the paid charges for inpatient hospital services for adult enrollees,
284.17 subject to an annual inpatient out-of-pocket maximum of \$1,000 per individual and
284.18 \$3,000 per family;

284.19 (2) \$3 per prescription for adult enrollees;

284.20 (3) \$25 for eyeglasses for adult enrollees;

284.21 (4) \$3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an
284.22 episode of service which is required because of a recipient's symptoms, diagnosis, or
284.23 established illness, and which is delivered in an ambulatory setting by a physician or
284.24 physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse,
284.25 audiologist, optician, or optometrist; and

284.26 (5) \$6 for nonemergency visits to a hospital-based emergency room.

284.27 (b) Paragraph (a), clause (1), does not apply to parents and relative caretakers of
284.28 children under the age of 21 in households with family income equal to or less than 175
284.29 percent of the federal poverty guidelines. Paragraph (a), clause (1), does not apply to
284.30 parents and relative caretakers of children under the age of 21 in households with family
284.31 income greater than 175 percent of the federal poverty guidelines for inpatient hospital
284.32 admissions occurring on or after January 1, 2001.

284.33 (c) Paragraph (a), clauses (1) to (4), do not apply to pregnant women and children
284.34 under the age of 21.

284.35 (d) Paragraph (a), clause (4), does not apply to mental health services.

285.1 (e) Adult enrollees with family gross income that exceeds 175 percent of the
285.2 federal poverty guidelines and who are not pregnant shall be financially responsible for
285.3 the coinsurance amount, if applicable, and amounts which exceed the \$10,000 inpatient
285.4 hospital benefit limit.

285.5 ~~(e)~~ (f) When a MinnesotaCare enrollee becomes a member of a prepaid health plan,
285.6 or changes from one prepaid health plan to another during a calendar year, any charges
285.7 submitted towards the \$10,000 annual inpatient benefit limit, and any out-of-pocket
285.8 expenses incurred by the enrollee for inpatient services, that were submitted or incurred
285.9 prior to enrollment, or prior to the change in health plans, shall be disregarded.

285.10 Sec. 17. Minnesota Statutes 2006, section 256L.035, is amended to read:

285.11 **256L.035 LIMITED BENEFITS COVERAGE FOR CERTAIN SINGLE**
285.12 **ADULTS AND HOUSEHOLDS WITHOUT CHILDREN.**

285.13 (a) "Covered health services" for individuals under section 256L.04, subdivision
285.14 7, with income above 75 percent, but not exceeding 175 percent, of the federal poverty
285.15 guideline means:

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

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

285.19 (3) physician services not provided during an inpatient stay; outpatient hospital
285.20 services; freestanding ambulatory surgical center services; chiropractic services; lab and
285.21 diagnostic services; diabetic supplies and equipment; mental health services as covered
285.22 under chapter 256B; and prescription drugs; subject to the following co-payments:

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

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

285.25 (iii) \$5 co-pay per nonpreventive visit; except this co-pay does not apply to mental
285.26 health services or community mental health services.

285.27 The services covered under this section may be provided by a physician, physician
285.28 ancillary, chiropractor, psychologist, ~~or~~ licensed independent clinical social worker, or
285.29 other mental health providers covered under chapter 256B if the services are within the
285.30 scope of practice of that health care professional.

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

285.34 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 program is reduced 1.0 percent. This provision excludes payments for mental health services added as covered benefits after December 31, 2007.

Sec. 19. Minnesota Statutes 2006, section 609.115, subdivision 9, is amended to read:

Subd. 9. **Compulsive gambling assessment required.** (a) If a person is convicted of theft under section 609.52, embezzlement of public funds under section 609.54, or forgery under section 609.625, 609.63, or 609.631, the probation officer shall determine in the report prepared under subdivision 1 whether or not compulsive gambling contributed to the commission of the offense. If so, the report shall contain the results of a compulsive gambling assessment conducted in accordance with this subdivision. The probation officer shall make an appointment for the offender to undergo the assessment if so indicated.

(b) The compulsive gambling assessment report must include a recommended level of treatment for the offender if the assessor concludes that the offender is in need of compulsive gambling treatment. The assessment must be conducted by an assessor qualified under section 245.98, subdivision 2a, to perform these assessments or to provide compulsive gambling treatment. An assessor providing a compulsive gambling assessment may not have any direct or shared financial interest or referral relationship resulting in shared financial gain with a treatment provider. If an independent assessor is not available, the probation officer may use the services of an assessor with a financial

interest or referral relationship as authorized under rules adopted by the commissioner of human services under section 245.98, subdivision 2a.

(c) The commissioner of human services shall reimburse the assessor for the costs associated with a compulsive gambling assessment at a rate established by the commissioner up to a maximum of \$100 for each assessment. To the extent practicable, the commissioner shall standardize reimbursement rates for assessments. The commissioner shall reimburse these costs after receiving written verification from the probation officer that the assessment was performed and found acceptable.

Sec. 20. **REPORT.**

The commissioner shall make a report to the legislature by January 15, 2008, regarding the transfer of funds to counties for state registered nurses employed in community mental health pilot projects as part of the assertive community treatment teams under Minnesota Statutes, section 245.4661. The report shall address the impact of the nursing shortage on replacing these positions, continuity of patient care if these positions cannot be filled, and ways to maintain state registered nurses in these positions until the nurse retires or leaves employment. No funds for state registered nurse positions may be transferred before the report date.

Sec. 21. **CASE MANAGEMENT; BEST PRACTICES.**

The commissioner of human services, in consultation with consumers, families, counties, and other interested stakeholders, will develop recommendations for changes in the adult mental health act related to case management, consistent with evidence-based and best practices.

Sec. 22. **REGIONAL CHILDREN'S MENTAL HEALTH INITIATIVE.**

Subdivision 1. Pilot project authorized; purpose. A two-year Regional Children's Mental Health Initiative pilot project is established to improve children's mental health service coordination, communication, and processes in Blue Earth, Brown, Faribault, Freeborn, Le Sueur, Martin, Nicollet, Rice, Sibley, Waseca, and Watonwan Counties. The purpose of the Regional Children's Mental Health Initiative will be to plan and develop new programs and services related to children's mental health in south central Minnesota.

Subd. 2. Goals. To accomplish its purpose, the Regional Children's Mental Health Initiative shall have the following goals:

(1) work to streamline delivery and regional access to services;

(2) share strategies and resources for the management of out-of-home placements;

288.1 (3) establish standard protocols and operating procedures for functions that are
288.2 performed across all counties;

288.3 (4) share information to improve resource allocation and service delivery across
288.4 counties;

288.5 (5) evaluate outcomes of various treatment alternatives;

288.6 (6) create a network for and provide support to service delivery groups;

288.7 (7) establish a regional process to match children in need of out-of-home placement
288.8 with foster homes that can meet their needs; and

288.9 (8) recruit and retain foster homes.

288.10 Subd. 3. **Director's Council.** The Director's Council shall govern the operations of
288.11 the Regional Children's Mental Health Initiative. Members of the Director's Council shall
288.12 represent each of the 11 counties participating in the pilot project.

288.13 Subd. 4. **Regional Children's Mental Health Initiative Team.** The members
288.14 of the Regional Children's Mental Health Initiative Team shall conduct planning and
288.15 development of new and modified children's mental health programs and services in the
288.16 region. Members of the team shall reflect the cultural, demographic, and geographic
288.17 diversity of the region and shall be composed of representatives from each of the
288.18 following:

288.19 (1) the medical community;

288.20 (2) human services;

288.21 (3) corrections;

288.22 (4) education;

288.23 (5) mental health providers and vendors;

288.24 (6) advocacy organizations;

288.25 (7) parents; and

288.26 (8) children and youth.

288.27 Subd. 5. **Authority.** The regional children's mental health initiative shall have the
288.28 authority to develop and implement the following programs:

288.29 (1) Flexible funding payments. This program will make funds available to respond to
288.30 the unique and unpredictable needs of children with mental health issues such as the need
288.31 for prescription drugs, transportation, clothing, and assessments not otherwise available.

288.32 (2) Transition to self-sufficiency. This program will help youths between the ages of
288.33 14 and 21 establish professional relationships, find jobs, build financial foundations, and
288.34 learn to fulfill their roles as productive citizens.

288.35 (3) Crisis response. This program will establish public and private partnerships
288.36 to offer a range of options to meet the needs of children in crisis. Methods to meet

these needs may include accessible local services, holistic assessments, urgent care and stabilization services, and telehealth for specialized diagnosis and therapeutic sessions.

(4) Integrated services for complex conditions. This program will design, develop, and implement packages of integrated services to meet the needs of children with specific complex conditions.

Subd. 6. **Evaluation and report.** The regional children's mental health initiative shall develop a method for evaluating the effectiveness of this pilot project focusing on identifiable goals and outcomes. An interim report on the pilot project's effectiveness shall be submitted to the house and senate finance committees having jurisdiction over mental health, the commissioner of human services, and the Minnesota Association of County Social Service Administrators no later than December 31, 2008. A final report is due no later than December 31, 2009.

Sec. 23. **TRAUMA-FOCUSED EVIDENCE-BASED PRACTICES TO CHILDREN.**

Organizations that are certified to provide children's therapeutic services and supports under Minnesota Statutes, section 256B.0943, are eligible to apply for a grant. Grants are to be used to provide trauma-focused evidence-based practices to children who are living in a battered women's shelter, homeless shelter, transitional housing, or supported housing. Children served must have been exposed to or witnessed domestic violence, have been exposed to or witnessed community violence, or be a refugee. Priority shall be given to organizations that demonstrate collaboration with battered women's shelters, homeless shelters, or providers of transitional housing or supported housing. The commissioner shall specify which constitutes evidence-based practice. Organizations shall use all available funding streams.

Sec. 24. **DUAL DIAGNOSIS; DEMONSTRATION PROJECT.**

(a) The commissioner of human services shall fund demonstration projects for high risk adults with serious mental illness and co-occurring substance abuse problems. The projects must include, but not be limited to, the following:

(1) housing services, including rent or housing subsidies, housing with clinical staff, or housing support;

(2) assertive outreach services; and

(3) intensive direct therapeutic, rehabilitative, and care management services oriented to harm reduction.

290.1 (b) The commissioner shall work with providers to ensure proper licensure or
290.2 certification to meet medical assistance or third-party payor reimbursement requirements.

290.3 Sec. 25. **MINNESOTA FAMILY INVESTMENT PROGRAM AND CHILDREN'S**
290.4 **MENTAL HEALTH PILOT PROJECT.**

290.5 Subdivision 1. **Pilot project authorized.** The commissioner of human services
290.6 shall fund a three-year pilot project to measure the effect of children's identified mental
290.7 health needs, including social and emotional needs, on Minnesota family investment
290.8 program (MFIP) participants' ability to obtain and retain employment. The project shall
290.9 also measure the effect on work activity of MFIP participants' needs to address their
290.10 children's identified mental health needs.

290.11 Subd. 2. **Provider and agency proposals.** (a) Interested MFIP providers and
290.12 agencies shall:

290.13 (1) submit proposals defining how they will identify participants whose children
290.14 have mental health needs that hinder the employment process;

290.15 (2) connect families with appropriate developmental, social, and emotional
290.16 screenings and services; and

290.17 (3) incorporate those services into the participant's employment plan.

290.18 Each proposal under this paragraph must include an evaluation component.

290.19 (b) Interested MFIP providers and agencies shall develop a protocol to inform MFIP
290.20 participants of the following:

290.21 (1) the availability of developmental, social, and emotional screening tools for
290.22 children and youth;

290.23 (2) the purpose of the screenings;

290.24 (3) how the information will be used to assist the participants in identifying and
290.25 addressing potential barriers to employment; and

290.26 (4) that their employment plan may be modified based on the screening results.

290.27 Subd. 3. **Program components.** (a) MFIP providers shall obtain the participant's
290.28 written consent for participation in the pilot project, including consent for developmental,
290.29 social, and emotional screening.

290.30 (b) MFIP providers shall coordinate with county social service agencies and health
290.31 plans to assist recipients in arranging referrals indicated by the screening results.

290.32 (c) Tools used for developmental, social, and emotional screenings shall be approved
290.33 by the commissioner of human services.

290.34 Subd. 4. **Program evaluation.** The commissioner of human services shall conduct
290.35 an evaluation of the pilot project to determine:

- 291.1 (1) the number of participants who took part in the screening;
291.2 (2) the number of children who were screened and what screening tools were used;
291.3 (3) the number of children who were identified in the screening who needed referral
291.4 or follow-up services;
291.5 (4) the number of children who received services, what agency provided the services,
291.6 and what type of services were provided;
291.7 (5) the number of employment plans that were adjusted to include the activities
291.8 recommended in the screenings;
291.9 (6) the changes in work participation rates;
291.10 (7) the changes in earned income;
291.11 (8) the changes in sanction rates; and
291.12 (9) the participants' report of program effectiveness.
291.13 Subd. 5. **Work activity.** Participant involvement in screenings and subsequent
291.14 referral and follow-up services shall count as work activity under Minnesota Statutes,
291.15 section 256J.49, subdivision 13.

291.16 Sec. 26. **SOCIAL AND ECONOMIC COSTS OF GAMBLING.**

291.17 Subdivision 1. **Report.** The commissioner of human services, in consultation with
291.18 the state affiliate of the National Council on Problem Gambling, stakeholders, and licensed
291.19 vendors, shall prepare a report that provides a process and funding mechanism to study the
291.20 issues in subdivisions 2 and 3. The commissioner, in consultation with the state affiliate
291.21 of the National Council on Problem Gambling, stakeholders, and licensed vendors, shall
291.22 include in the report potential financial commitments made by stakeholders and others in
291.23 order to fund the study. The report is due to the legislative committees having jurisdiction
291.24 over compulsive gambling issues by December 1, 2007.

291.25 Subd. 2. **Issues to be addressed.** The study must address:

- 291.26 (1) state, local, and tribal government policies and practices in Minnesota to legalize
291.27 or prohibit gambling;
291.28 (2) the relationship between gambling and crime in Minnesota, including: (i) the
291.29 relationship between gambling and overall crime rates; (ii) the relationship between
291.30 gambling and crimes rates for specific crimes, such as forgery, domestic abuse, child
291.31 neglect and abuse, alcohol and drug offenses, and youth crime; and (iii) enforcement
291.32 and regulation practices that are intended to address the relationship between gambling
291.33 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.~~

293.1 ~~(e)~~ (b) "Health care service" means:

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

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

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

293.10 ~~(f)~~ (c) "Major spending commitment" means an expenditure in excess of \$1,000,000
293.11 for:

293.12 (1) acquisition of a unit of medical equipment;

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

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

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

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

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

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

293.26 (1) an extracorporeal shock wave lithotripter;

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

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

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

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

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

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

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

294.3 (3) megavoltage radiation therapy;

294.4 (4) open heart surgery;

294.5 (5) neonatal intensive care services; and

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

294.9 (f) "Specialty care" includes but is not limited to cardiac, neurology, orthopedic,
294.10 obstetrics, mental health, chemical dependency, and emergency services.

294.11 Sec. 2. Minnesota Statutes 2006, section 62J.17, subdivision 4a, is amended to read:

294.12 Subd. 4a. **Expenditure reporting.** ~~(a) A provider making a major spending~~
294.13 ~~commitment after April 1, 1992, shall submit notification of the expenditure to the~~
294.14 ~~commissioner and provide the commissioner with any relevant background information.~~

294.15 ~~(b) Notification must include a report, submitted within 60 days after the date of the~~
294.16 ~~major spending commitment, using terms conforming to the definitions in section 62J.03~~
294.17 ~~and this section. Each report is subject to retrospective review and must contain:~~

294.18 ~~(1) a detailed description of the major spending commitment, including the specific~~
294.19 ~~dollar amount of each expenditure, and its purpose;~~

294.20 ~~(2) the date of the major spending commitment;~~

294.21 ~~(3) a statement of the expected impact that the major spending commitment will~~
294.22 ~~have on charges by the provider to patients and third party payers;~~

294.23 ~~(4) a statement of the expected impact on the clinical effectiveness or quality of care~~
294.24 ~~received by the patients that the provider expects to serve;~~

294.25 ~~(5) a statement of the extent to which equivalent services or technology are already~~
294.26 ~~available to the provider's actual and potential patient population;~~

294.27 ~~(6) a statement of the distance from which the nearest equivalent services or~~
294.28 ~~technology are already available to the provider's actual and potential population;~~

294.29 ~~(7) a statement describing the pursuit of any lawful collaborative arrangements; and~~

294.30 ~~(8) a statement of assurance that the provider will not use, purchase, or perform~~
294.31 ~~health care technologies and procedures that are not clinically effective and cost-effective,~~
294.32 ~~unless the technology is used for experimental or research purposes to determine whether~~
294.33 ~~a technology or procedure is clinically effective and cost-effective.~~

294.34 ~~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;

(b) the cost of land acquisition, construction of new facilities, and renovation of existing facilities;

(c) the cost of purchased or leased medical equipment, by type of equipment;

(d) expenditures by type for specialty care and new specialized services;

(e) information on the amount and types of added capacity for diagnostic imaging services, outpatient surgical services, and new specialized services; and

(f) information on investments in electronic medical records systems.

For hospitals and outpatient surgical centers, this information shall be included in reports to the commissioner that are required under section 144.698. For diagnostic imaging centers, this information shall be included in reports to the commissioner that are required under section 144.565. For physician clinics, this information shall be included in reports to the commissioner that are required under section 62J.41. For all other health care providers that are subject to this reporting requirement, reports must be submitted to the commissioner by March 1 each year for the preceding calendar year.

Sec. 3. Minnesota Statutes 2006, section 62J.17, subdivision 7, is amended to read:

Subd. 7. **Exceptions.** ~~(a) The retrospective review process as described in subdivision 5a and the prospective review and approval process as described in subdivision 6a reporting requirement in subdivision 4a do~~ does not apply to:

~~(1) a major spending commitment to replace existing equipment with comparable equipment used for direct patient care, upgrades of equipment beyond the current model, or comparable model must be reported;~~

~~(2)~~ (1) a major spending commitment made by a research and teaching institution for purposes of conducting medical education, medical research supported or sponsored by a medical school, or by a federal or foundation grant or clinical trials;

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

~~(4)~~ (2) a major spending commitment for building maintenance including heating, water, electricity, and other maintenance-related expenditures; and

~~(5)~~ (3) a major spending commitment for activities, not directly related to the delivery of patient care services, including food service, laundry, housekeeping, and 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

297.1 plan corporations, commercial insurers, health maintenance organizations, and individual
297.2 patients;
297.3 (7) revenue from research activities;
297.4 (8) revenue from educational activities;
297.5 (9) revenue from out-of-pocket payments by patients;
297.6 (10) revenue from donations; ~~and~~
297.7 (11) a report on health care capital expenditures during the previous year, as required
297.8 by section 62J.17; and
297.9 ~~(11)~~ (12) any other data required by the commissioner, including data in
297.10 unaggregated form, for the purposes of developing spending estimates, setting spending
297.11 limits, monitoring actual spending, and monitoring costs.
297.12 The commissioner may, by rule, modify the data submission categories listed above if the
297.13 commissioner determines that this will reduce the reporting burden on providers without
297.14 having a significant negative effect on necessary data collection efforts.

297.15 Sec. 5. Minnesota Statutes 2006, section 62J.52, subdivision 1, is amended to read:

297.16 Subdivision 1. **Uniform billing form CMS 1450.** (a) On and after January 1,
297.17 1996, all institutional inpatient hospital services, ancillary services, institutionally owned
297.18 or operated outpatient services rendered by providers in Minnesota, and institutional
297.19 or noninstitutional home health services that are not being billed using an equivalent
297.20 electronic billing format, must be billed using the uniform billing form CMS 1450, except
297.21 as provided in subdivision 5.

297.22 (b) The instructions and definitions for the use of the uniform billing form CMS
297.23 1450 shall be in accordance with the uniform billing form manual specified by the
297.24 commissioner. In promulgating these instructions, the commissioner may utilize the
297.25 manual developed by the National Uniform Billing Committee, as adopted and finalized
297.26 by the Minnesota Uniform Billing Committee.

297.27 (c) Services to be billed using the uniform billing form CMS 1450 include:
297.28 institutional inpatient hospital services and distinct units in the hospital such as psychiatric
297.29 unit services, physical therapy unit services, swing bed (SNF) services, inpatient state
297.30 psychiatric hospital services, inpatient skilled nursing facility services, home health
297.31 services (Medicare part A), and hospice services; ancillary services, where benefits are
297.32 exhausted or patient has no Medicare part A, from hospitals, state psychiatric hospitals,
297.33 skilled nursing facilities, and home health (Medicare part B); institutional owned or
297.34 operated outpatient services such as waived services, hospital outpatient services,
297.35 including ambulatory surgical center services, hospital referred laboratory services,

298.1 hospital-based ambulance services, and other hospital outpatient services, skilled nursing
298.2 facilities, home health, freestanding renal dialysis centers, comprehensive outpatient
298.3 rehabilitation facilities (CORF), outpatient rehabilitation facilities (ORF), rural health
298.4 clinics, and community mental health centers; home health services such as home health
298.5 intravenous therapy providers, waived services, personal care attendants, and hospice;
298.6 and any other health care provider certified by the Medicare program to use this form.

298.7 (d) On and after January 1, 1996, a mother and newborn child must be billed
298.8 separately, and must not be combined on one claim form.

298.9 (e) Services provided by Medicare Critical Access Hospitals electing Method
298.10 II billing will be allowed an exception to this provision to allow the inclusion of the
298.11 professional fees on the CMS 1450.

298.12 Sec. 6. Minnesota Statutes 2006, section 62J.52, subdivision 2, is amended to read:

298.13 Subd. 2. **Uniform billing form CMS 1500.** (a) On and after January 1, 1996, all
298.14 noninstitutional health care services rendered by providers in Minnesota except dental
298.15 or pharmacy providers, that are not currently being billed using an equivalent electronic
298.16 billing format, must be billed using the health insurance claim form CMS 1500, except as
298.17 provided in subdivision 5.

298.18 (b) The instructions and definitions for the use of the uniform billing form CMS
298.19 1500 shall be in accordance with the manual developed by the Administrative Uniformity
298.20 Committee entitled standards for the use of the CMS 1500 form, dated February 1994,
298.21 as further defined by the commissioner.

298.22 (c) Services to be billed using the uniform billing form CMS 1500 include physician
298.23 services and supplies, durable medical equipment, noninstitutional ambulance services,
298.24 independent ancillary services including occupational therapy, physical therapy, speech
298.25 therapy and audiology, home infusion therapy, podiatry services, optometry services,
298.26 mental health licensed professional services, substance abuse licensed professional
298.27 services, nursing practitioner professional services, certified registered nurse anesthetists,
298.28 chiropractors, physician assistants, laboratories, medical suppliers, and other health care
298.29 providers such as day activity centers and freestanding ambulatory surgical centers.

298.30 (d) Services provided by Medicare Critical Access Hospitals electing Method
298.31 II billing will be allowed an exception to this provision to allow the inclusion of the
298.32 professional fees on the CMS 1450.

298.33 Sec. 7. Minnesota Statutes 2006, section 62J.60, subdivision 2, is amended to read:

Subd. 2. **General characteristics.** (a) The Minnesota uniform health care identification card must be a preprinted card constructed of plastic, paper, or any other medium that conforms with ANSI and ISO 7810 physical characteristics standards. The card dimensions must also conform to ANSI and ISO 7810 physical characteristics standard. The use of a signature panel is optional. The uniform prescription drug information contained on the card must conform with the format adopted by the NCPDP and, except as provided in subdivision 3, paragraph (a), clause (2), must include all of the fields required to submit a claim in conformance with the most recent pharmacy identification card implementation guide produced by the NCPDP. All information required to submit a prescription drug claim, exclusive of information provided on a prescription that is required by law, must be included on the card in a clear, readable, and understandable manner. If a health benefit plan requires a conditional or situational field, as defined by the NCPDP, the conditional or situational field must conform to the most recent pharmacy information card implementation guide produced by the NCPDP.

(b) The Minnesota uniform health care identification card must have an essential information window on the front side with the following data elements: card issuer name, electronic transaction routing information, card issuer identification number, cardholder (insured) identification number, and cardholder (insured) identification name. No optional data may be interspersed between these data elements.

(c) Standardized labels are required next to human readable data elements and must come before the human data elements.

Sec. 8. Minnesota Statutes 2006, section 62J.60, subdivision 3, is amended to read:

Subd. 3. **Human readable data elements.** (a) The following are the minimum human readable data elements that must be present on the front side of the Minnesota uniform health care identification card:

(1) card issuer name or logo, which is the name or logo that identifies the card issuer. The card issuer name or logo may be located at the top of the card. No standard label is required for this data element;

(2) complete electronic transaction routing information including, at a minimum, the international identification number. The standardized label of this data element is "RxBIN." Processor control numbers and group numbers are required if needed to electronically process a prescription drug claim. The standardized label for the process control numbers data element is "RxPCN" and the standardized label for the group numbers data element is "RxGrp," except that if the group number data element is a universal element to be used by all health care providers, the standardized label may be

300.1 "Grp." To conserve vertical space on the card, the international identification number and
300.2 the processor control number may be printed on the same line;

300.3 (3) cardholder (insured) identification number, which is the unique identification
300.4 number of the individual card holder established and defined under this section. The
300.5 standardized label for the data element is "ID";

300.6 (4) cardholder (insured) identification name, which is the name of the individual
300.7 card holder. The identification name must be formatted as follows: first name, space,
300.8 optional middle initial, space, last name, optional space and name suffix. The standardized
300.9 label for this data element is "Name";

300.10 (5) care type, which is the description of the group purchaser's plan product under
300.11 which the beneficiary is covered. The description shall include the health plan company
300.12 name and the plan or product name. The standardized label for this data element is
300.13 "Care Type";

300.14 (6) service type, which is the description of coverage provided such as hospital,
300.15 dental, vision, prescription, or mental health. The standard label for this data element
300.16 is "Svc Type"; and

300.17 (7) provider/clinic name, which is the name of the primary care clinic the card
300.18 holder is assigned to by the health plan company. The standard label for this field is
300.19 "PCP." This information is mandatory only if the health plan company assigns a specific
300.20 primary care provider to the card holder.

300.21 (b) The following human readable data elements shall be present on the back side
300.22 of the Minnesota uniform health care identification card. These elements must be left
300.23 justified, and no optional data elements may be interspersed between them:

300.24 (1) claims submission names and addresses, which are the names and addresses of
300.25 the entity or entities to which claims should be submitted. If different destinations are
300.26 required for different types of claims, this must be labeled;

300.27 (2) telephone numbers and names that pharmacies and other health care providers
300.28 may call for assistance. These telephone numbers and names are required on the back
300.29 side of the card only if one of the contacts listed in clause (3) cannot provide pharmacies
300.30 or other providers with assistance or with the telephone numbers and names of contacts
300.31 for assistance; and

300.32 (3) telephone numbers and names; which are the telephone numbers and names of the
300.33 following contacts with a standardized label describing the service function as applicable:

300.34 (i) eligibility and benefit information;

300.35 (ii) utilization review;

300.36 (iii) precertification; or

301.1 (iv) customer services.

301.2 (c) The following human readable data elements are mandatory on the back
301.3 side of the Minnesota uniform health care identification card for health maintenance
301.4 organizations:

301.5 (1) emergency care authorization telephone number or instruction on how to receive
301.6 authorization for emergency care. There is no standard label required for this information;
301.7 and

301.8 (2) one of the following:

301.9 (i) telephone number to call to appeal to or file a complaint with the commissioner of
301.10 health; or

301.11 (ii) for persons enrolled under section 256B.69, 256D.03, or 256L.12, the telephone
301.12 number to call to file a complaint with the ombudsperson designated by the commissioner
301.13 of human services under section 256B.69 and the address to appeal to the commissioner of
301.14 human services. There is no standard label required for this information.

301.15 (d) All human readable data elements not required under paragraphs (a) to (c) are
301.16 optional and may be used at the issuer's discretion.

301.17 Sec. 9. Minnesota Statutes 2006, section 62Q.80, is amended by adding a subdivision
301.18 to read:

301.19 Subd. 1a. **Demonstration project.** The commissioner of health shall award a
301.20 demonstration project grant to a community-based health care initiative to develop and
301.21 operate a community-based health care coverage program to operate within Carlton,
301.22 Cook, Lake, and St. Louis Counties. The demonstration project shall extend for five years
301.23 and must comply with all the requirements of this section.

301.24 Sec. 10. Minnesota Statutes 2006, section 62Q.80, subdivision 3, is amended to read:

301.25 Subd. 3. **Approval.** (a) Prior to the operation of a community-based health care
301.26 coverage program, a community-based health initiative shall submit to the commissioner
301.27 of health for approval the community-based health care coverage program developed by
301.28 the initiative. ~~The commissioner shall only approve a program that has been awarded~~
301.29 ~~a community access program grant from the United States Department of Health and~~
301.30 ~~Human Services.~~ The commissioner shall ensure that the program meets the federal grant
301.31 requirements and any requirements described in this section and is actuarially sound based
301.32 on a review of appropriate records and methods utilized by the community-based health
301.33 initiative in establishing premium rates for the community-based health care coverage
301.34 program.

(b) Prior to approval, the commissioner shall also ensure that:

(1) the benefits offered comply with subdivision 8 and that there are adequate numbers of health care providers participating in the community-based health network to deliver the benefits offered under the program;

(2) the activities of the program are limited to activities that are exempt under this section or otherwise from regulation by the commissioner of commerce;

(3) the complaint resolution process meets the requirements of subdivision 10; and

(4) the data privacy policies and procedures comply with state and federal law.

Sec. 11. 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. 12. 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;

(4) the number of employers and employees who have been denied access to the program and the basis for the denial;

(5) specific analysis on enrollees who have aggregate medical claims totaling over \$5,000 per year, including data on the enrollee's main diagnosis and whether all the medical claims were covered by the program;

(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).

304.1 (b) **Group purchaser.** "Group purchaser" has the meaning given in section 62J.03,
304.2 subdivision 6.

304.3 (c) **Health record.** "Health record" means any information, whether oral or recorded
304.4 in any form or medium, that relates to the past, present, or future physical or mental health
304.5 or condition of a patient; the provision of health care to a patient; or the past, present, or
304.6 future payment for the provision of health care to a patient.

304.7 (d) **Identifying information.** "Identifying information" means the patient's name,
304.8 address, date of birth, gender, parent's or guardian's name regardless of the age of the
304.9 patient, and other nonclinical data which can be used to uniquely identify a patient.

304.10 (e) **Individually identifiable form.** "Individually identifiable form" means a form in
304.11 which the patient is or can be identified as the subject of the health records.

304.12 (f) **Medical emergency.** "Medical emergency" means medically necessary care
304.13 which is immediately needed to preserve life, prevent serious impairment to bodily
304.14 functions, organs, or parts, or prevent placing the physical or mental health of the patient
304.15 in serious jeopardy.

304.16 (g) **Patient.** "Patient" means a natural person who has received health care services
304.17 from a provider for treatment or examination of a medical, psychiatric, or mental
304.18 condition, the surviving spouse and parents of a deceased patient, or a person the patient
304.19 appoints in writing as a representative, including a health care agent acting according to
304.20 chapter 145C, unless the authority of the agent has been limited by the principal in the
304.21 principal's health care directive. Except for minors who have received health care services
304.22 under sections 144.341 to 144.347, in the case of a minor, patient includes a parent or
304.23 guardian, or a person acting as a parent or guardian in the absence of a parent or guardian.

304.24 (h) **Provider.** "Provider" means:

304.25 (1) any person who furnishes health care services and is regulated to furnish the
304.26 services under chapter 147, 147A, 147B, 147C, 147D, 148, 148B, 148C, 148D, 150A,
304.27 151, 153, or 153A;

304.28 (2) a home care provider licensed under section 144A.46;

304.29 (3) a health care facility licensed under this chapter or chapter 144A;

304.30 (4) a physician assistant registered under chapter 147A; and

304.31 (5) an unlicensed mental health practitioner regulated under sections 148B.60 to
304.32 148B.71.

304.33 (i) **Record locator service.** "Record locator service" means an electronic index of
304.34 patient identifying information that directs providers in a health information exchange to
304.35 the location of patient health records held by providers and group purchasers.

305.1 (j) **Related health care entity.** "Related health care entity" means an affiliate of
305.2 the provider releasing the health records.

305.3 Sec. 15. **[144.292] PATIENT RIGHTS.**

305.4 Subdivision 1. **Scope.** Patients have the rights specified in this section regarding the
305.5 treatment the patient receives and the patient's health record.

305.6 Subd. 2. **Patient access.** Upon request, a provider shall supply to a patient complete
305.7 and current information possessed by that provider concerning any diagnosis, treatment,
305.8 and prognosis of the patient in terms and language the patient can reasonably be expected
305.9 to understand.

305.10 Subd. 3. **Additional patient rights.** A patient's right specified in this section and
305.11 sections 144.293 to 144.298 are in addition to the rights specified in sections 144.651 and
305.12 144.652 and any other provision of law relating to the access of a patient to the patient's
305.13 health records.

305.14 Subd. 4. **Notice of rights; information on release.** A provider shall provide to
305.15 patients, in a clear and conspicuous manner, a written notice concerning practices and
305.16 rights with respect to access to health records. The notice must include an explanation of:

305.17 (1) disclosures of health records that may be made without the written consent of the
305.18 patient, including the type of records and to whom the records may be disclosed; and

305.19 (2) the right of the patient to have access to and obtain copies of the patient's health
305.20 records and other information about the patient that is maintained by the provider.

305.21 The notice requirements of this subdivision are satisfied if the notice is included with
305.22 the notice and copy of the patient and resident bill of rights under section 144.652 or if it
305.23 is displayed prominently in the provider's place of business. The commissioner of health
305.24 shall develop the notice required in this subdivision and publish it in the State Register.

305.25 Subd. 5. **Copies of health records to patients.** Except as provided in section
305.26 144.296, upon a patient's written request, a provider, at a reasonable cost to the patient,
305.27 shall promptly furnish to the patient:

305.28 (1) copies of the patient's health record, including but not limited to laboratory
305.29 reports, x-rays, prescriptions, and other technical information used in assessing the
305.30 patient's health conditions; or

305.31 (2) the pertinent portion of the record relating to a condition specified by the patient.

305.32 With the consent of the patient, the provider may instead furnish only a summary
305.33 of the record. The provider may exclude from the health record written speculations
305.34 about the patient's health condition, except that all information necessary for the patient's
305.35 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.

307.1 Subd. 2. **Patient consent to release of records.** A provider, or a person who
307.2 receives health records from a provider, may not release a patient's health records to a
307.3 person without:

307.4 (1) a signed and dated consent from the patient or the patient's legally authorized
307.5 representative authorizing the release;

307.6 (2) specific authorization in law; or

307.7 (3) a representation from a provider that the provider holds a consent from the
307.8 patient.

307.9 Subd. 3. **Release from one provider to another.** A patient's health record,
307.10 including, but not limited to, laboratory reports, x-rays, prescriptions, and other technical
307.11 information used in assessing the patient's condition, or the pertinent portion of the record
307.12 relating to a specific condition, or a summary of the record, shall promptly be furnished to
307.13 another provider upon the written request of the patient. The written request shall specify
307.14 the name of the provider to whom the health record is to be furnished. The provider who
307.15 furnishes the health record or summary may retain a copy of the materials furnished. The
307.16 patient shall be responsible for the reasonable costs of furnishing the information.

307.17 Subd. 4. **Duration of consent.** Except as provided in this section, a consent is
307.18 valid for one year or for a lesser period specified in the consent or for a different period
307.19 provided by law.

307.20 Subd. 5. **Exceptions to consent requirement.** This section does not prohibit the
307.21 release of health records:

307.22 (1) for a medical emergency when the provider is unable to obtain the patient's
307.23 consent due to the patient's condition or the nature of the medical emergency;

307.24 (2) to other providers within related health care entities when necessary for the
307.25 current treatment of the patient; or

307.26 (3) to a health care facility licensed by this chapter, chapter 144A, or to the same
307.27 types of health care facilities licensed by this chapter and chapter 144A that are licensed
307.28 in another state when a patient:

307.29 (i) is returning to the health care facility and unable to provide consent; or

307.30 (ii) who resides in the health care facility, has services provided by an outside
307.31 resource under Code of Federal Regulations, title 42, section 483.75(h), and is unable
307.32 to provide consent.

307.33 Subd. 6. **Consent does not expire.** Notwithstanding subdivision 4, if a patient
307.34 explicitly gives informed consent to the release of health records for the purposes and
307.35 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.

Subd. 8. **Record locator service.** (a) A provider or group purchaser may send patient identifying information and information about the location of the patient's health records to a record locator service without consent from the patient. Except in the case of a medical emergency, a provider participating in a health information exchange using a record locator service cannot access patient identifying information and information about the location of the patient's health records until the patient has provided consent. The Minnesota Department of Health may not access the record locator service or receive data from the record locator service. Only a provider may access patient identifying information in a record locator service. The consent does not expire and may be revoked by the patient at any time by providing written notice of the revocation to the provider.

(b) A health information exchange maintaining a record locator service or an entity maintaining a record locator service for a health information exchange must maintain an audit log of providers accessing information in a record locator service that minimally contains information on:

(1) the identity of the provider accessing the information;

(2) the identity of the patient whose information was accessed by the provider; and

(3) the date the information was accessed.

(c) No group purchaser may in any way require a provider to participate in any record locator service as a condition of payment or participation.

(d) A record locator service must provide a mechanism for patients to opt out of including their identifying information and information about the location of their health records in a record locator service. At a minimum, any consent form that permits a

provider to access a record locator service must include a check-box option that allows a patient to completely opt out of the record locator service which shall be clearly displayed to the patient. A provider participating in a health information exchange with a record locator service who receives a patient's request to completely opt out of the record locator service or to not have a specific provider contact in the record locator service shall be responsible for removing the patient's information from the record locator service.

Subd. 9. **Documentation of release.** (a) In cases where a provider releases health records without patient consent as authorized by law, the release must be documented in the patient's health record. In the case of a release under section 144.294, subdivision 2, the documentation must include the date and circumstances under which the release was made, the person or agency to whom the release was made, and the records that were released.

(b) When a health record is released using a representation from a provider that holds a consent from the patient, the releasing provider shall document:

(1) the provider requesting the health records;

(2) the identity of the patient;

(3) the health records requested; and

(4) the date the health records were requested.

Sec. 17. **[144.294] RECORDS RELATING TO MENTAL HEALTH.**

Subdivision 1. **Provider inquiry.** Upon the written request of a spouse, parent, child, or sibling of a patient being evaluated for or diagnosed with mental illness, a provider shall inquire of a patient whether the patient wishes to authorize a specific individual to receive information regarding the patient's current and proposed course of treatment. If the patient so authorizes, the provider shall communicate to the designated individual the patient's current and proposed course of treatment. Section 144.293, subdivisions 2 and 4, apply to consents given under this subdivision.

Subd. 2. **Disclosure to law enforcement agency.** Notwithstanding section 144.293, subdivisions 2 and 4, a provider must disclose health records relating to a patient's mental health to a law enforcement agency if the law enforcement agency provides the name of the patient and communicates that the:

(1) patient is currently involved in an emergency interaction with the law enforcement agency; and

(2) disclosure of the records is necessary to protect the health or safety of the patient or of another person.

The scope of disclosure under this subdivision is limited to the minimum necessary for law enforcement to respond to the emergency. A law enforcement agency that obtains

health records under this subdivision shall maintain a record of the requestor, the provider of the information, and the patient's name. Health records obtained by a law enforcement agency under this subdivision are private data on individuals as defined in section 13.02, subdivision 12, and must not be used by law enforcement for any other purpose.

Subd. 3. **Records release for family and caretaker; mental health care.** (a) Notwithstanding section 144.293, a provider providing mental health care and treatment may disclose health record information described in paragraph (b) about a patient to a family member of the patient or other person who requests the information if:

(1) the request for information is in writing;

(2) the family member or other person lives with, provides care for, or is directly involved in monitoring the treatment of the patient;

(3) the involvement under clause (2) is verified by the patient's mental health care provider, the patient's attending physician, or a person other than the person requesting the 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.

311.1 Subdivision 1. **Methods of release.** (a) Notwithstanding section 144.293,
311.2 subdivisions 2 and 4, health records may be released to an external researcher solely for
311.3 purposes of medical or scientific research only as follows:

311.4 (1) health records generated before January 1, 1997, may be released if the patient
311.5 has not objected or does not elect to object after that date;

311.6 (2) for health records generated on or after January 1, 1997, the provider must:

311.7 (i) disclose in writing to patients currently being treated by the provider that health
311.8 records, regardless of when generated, may be released and that the patient may object, in
311.9 which case the records will not be released; and

311.10 (ii) use reasonable efforts to obtain the patient's written general authorization that
311.11 describes the release of records in item (i), which does not expire but may be revoked or
311.12 limited in writing at any time by the patient or the patient's authorized representative;

311.13 (3) the provider must advise the patient of the rights specified in clause (4); and

311.14 (4) the provider must, at the request of the patient, provide information on how the
311.15 patient may contact an external researcher to whom the health record was released and
311.16 the date it was released.

311.17 (b) Authorization may be established if an authorization is mailed at least two
311.18 times to the patient's last known address with a postage prepaid return envelope and a
311.19 conspicuous notice that the patient's medical records may be released if the patient does
311.20 not object, and at least 60 days have expired since the second notice was sent.

311.21 Subd. 2. **Duties of researcher.** In making a release for research purposes, the
311.22 provider shall make a reasonable effort to determine that:

311.23 (1) the use or disclosure does not violate any limitations under which the record
311.24 was collected;

311.25 (2) the use or disclosure in individually identifiable form is necessary to accomplish
311.26 the research or statistical purpose for which the use or disclosure is to be made;

311.27 (3) the recipient has established and maintains adequate safeguards to protect the
311.28 records from unauthorized disclosure, including a procedure for removal or destruction of
311.29 information that identifies the patient; and

311.30 (4) further use or release of the records in individually identifiable form to a person
311.31 other than the patient without the patient's consent is prohibited.

311.32 Sec. 19. **[144.296] COPIES OF VIDEOTAPES.**

311.33 A provider may not release a copy of a videotape of a child victim or alleged victim
311.34 of physical or sexual abuse without a court order under section 13.03, subdivision 6, or

312.1 as provided in section 611A.90. This section does not limit the right of a patient to view
312.2 the videotape.

312.3 Sec. 20. **[144.297] INDEPENDENT MEDICAL EXAMINATION.**

312.4 This section applies to the subject and provider of an independent medical
312.5 examination requested by or paid for by a third party. Notwithstanding section 144.293, a
312.6 provider may release health records created as part of an independent medical examination
312.7 to the third party who requested or paid for the examination.

312.8 Sec. 21. **[144.298] PENALTIES.**

312.9 Subdivision 1. **Licensing action.** A violation of sections 144.291 to 144.298 may
312.10 be grounds for disciplinary action against a provider by the appropriate licensing board
312.11 or agency.

312.12 Subd. 2. **Allocation of liability.** In adjudicating a dispute involving the disclosure
312.13 of patient health records, a court shall use the criteria in this subdivision in determining
312.14 how liability will be allocated.

312.15 (a) When requesting health records using consent, a person warrants that the consent:

312.16 (1) contains no information known to the person to be false; and

312.17 (2) accurately states the patient's desire to have health records disclosed or that there
312.18 is specific authorization in law.

312.19 (b) When requesting health records using consent or the representation authorized in
312.20 section 144.293, subdivision 2, a provider warrants that the request:

312.21 (1) contains no information known to the provider to be false;

312.22 (2) accurately states the patient's desire to have health records disclosed or that
312.23 there is specific authorization in law; and

312.24 (3) does not exceed any limits imposed by the patient in the consent.

312.25 (c) When disclosing health records, a person releasing health records warrants that
312.26 the person:

312.27 (1) has complied with the requirements of this section regarding disclosure of
312.28 health records;

312.29 (2) knows of no information related to the request that is false; and

312.30 (3) has complied with the limits set by the patient in the consent or as described
312.31 in the representation of consent.

312.32 (d) A court of this state presumes that:

312.33 (1) a request made by a person that complies with the provisions of this section is
312.34 valid and represents the wishes of the patient;

313.1 (2) the information listed in a consent or representation of consent is accurate;

313.2 (3) the recipient of a consent or representation of consent has no knowledge or
313.3 notice that the person making the request breached a duty to the patient or does not
313.4 rightfully have a consent;

313.5 (4) the signature on the consent or representation of consent is not forged;

313.6 (5) the consent or representation of consent was not obtained under false pretenses;
313.7 and

313.8 (6) the consent or representation of consent was not altered without the patient's
313.9 permission.

313.10 (e) No person or provider may disclaim or contractually limit the application of this
313.11 section, or obtain indemnity for its effects, if the disclaimer, limitation, or indemnity
313.12 restricts liability for misrepresentation against persons reasonably relying on the consent,
313.13 representation of consent, or disclosure.

313.14 (f) A court of this state shall give effect to liability allocations between the parties
313.15 provided by contract that does not allocate liability to the detriment of the patient and the
313.16 allocation is consistent with the requirements of sections 144.291 to 144.298.

313.17 (g) A patient is eligible to receive compensatory damages plus costs and reasonable
313.18 attorney fees if there is a negligent or intentional violation of sections 144.293 to 144.295.

313.19 Subd. 3. **Liability for a record locator service.** A patient is eligible to receive
313.20 compensatory damages plus costs and reasonable attorney fees if a health information
313.21 exchange maintaining a record locator service, or an entity maintaining a record locator
313.22 service for a health information exchange, negligently or intentionally violates the
313.23 provisions of section 144.293, subdivision 8.

313.24 Sec. 22. Minnesota Statutes 2006, section 144.3345, is amended to read:

313.25 **144.3345 INTERCONNECTED ELECTRONIC HEALTH RECORD**
313.26 **GRANTS.**

313.27 Subdivision 1. **Definitions.** The following definitions are used for the purposes
313.28 of this section.

313.29 (a) "Eligible community e-health collaborative" means an existing or newly
313.30 established collaborative to support the adoption and use of interoperable electronic
313.31 health records. A collaborative must consist of at least ~~three~~ two or more eligible health
313.32 care entities in at least two of the categories listed in paragraph (b) and have a focus on
313.33 interconnecting the members of the collaborative for secure and interoperable exchange of
313.34 health care information.

313.35 (b) "Eligible health care entity" means one of the following:

- 314.1 (1) community clinics, as defined under section 145.9268;
- 314.2 (2) hospitals eligible for rural hospital capital improvement grants, as defined
- 314.3 in section 144.148;
- 314.4 (3) physician clinics located in a community with a population of less than 50,000
- 314.5 according to United States Census Bureau statistics and outside the seven-county
- 314.6 metropolitan area;
- 314.7 (4) nursing facilities licensed under sections 144A.01 to 144A.27;
- 314.8 (5) community health boards or boards of health as established under chapter 145A;
- 314.9 (6) nonprofit entities with a purpose to provide health information exchange
- 314.10 coordination governed by a representative, multi-stakeholder board of directors; and
- 314.11 (7) other providers of health or health care services approved by the commissioner
- 314.12 for which interoperable electronic health record capability would improve quality of
- 314.13 care, patient safety, or community health.
- 314.14 Subd. 2. **Grants authorized.** The commissioner of health shall award grants to:
- 314.15 (a) eligible community e-health collaborative projects to improve the implementation
- 314.16 and use of interoperable electronic health records including but not limited to the
- 314.17 following projects:
- 314.18 (1) collaborative efforts to host and support fully functional interoperable electronic
- 314.19 health records in multiple care settings;
- 314.20 (2) electronic medication history and electronic patient ~~registration~~ medical history
- 314.21 information;
- 314.22 (3) electronic personal health records for persons with chronic diseases and for
- 314.23 prevention services;
- 314.24 (4) rural and underserved community models for electronic prescribing; ~~and~~
- 314.25 (5) ~~enabling~~ modernize local public health information systems to rapidly and
- 314.26 electronically exchange information needed to participate in community e-health
- 314.27 collaboratives or for public health emergency preparedness and response; and
- 314.28 (6) implement regional or community-based health information exchange
- 314.29 organizations;
- 314.30 (b) community clinics, as defined under section 145.9268, to implement and use
- 314.31 interoperable electronic health records, including but not limited to the following projects:
- 314.32 (1) efforts to plan for and implement fully functional, standards-based interoperable
- 314.33 electronic health records; and
- 314.34 (2) purchases and implementation of computer hardware, software, and technology
- 314.35 to fully implement interoperable electronic health records;

(c) regional or community-based health information exchange organizations to connect and facilitate the exchange of health information between eligible health care entities, including but not limited to the development, testing, and implementation of:

(1) data exchange standards, including data, vocabulary, and messaging standards, for the exchange of health information, provided that such standards are consistent with state and national standards;

(2) security standards necessary to ensure the confidentiality and integrity of health records;

(3) computer interfaces and mechanisms for standardizing health information exchanged between eligible health care entities;

(4) a record locator service for identifying the location of patient health records; or

(5) interfaces and mechanisms for implementing patient consent requirements; and

(d) community health boards and boards of health as established under chapter 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

317.1 and expenditure reports to evaluate the grant program from the eligible community
317.2 collaboratives receiving grants.

317.3 Sec. 23. Minnesota Statutes 2006, section 144.565, is amended to read:

317.4 **144.565 DIAGNOSTIC IMAGING FACILITIES.**

317.5 Subdivision 1. **Utilization and services data; economic and financial interests.**

317.6 The commissioner shall require diagnostic imaging facilities and providers of diagnostic
317.7 imaging services in Minnesota to annually report by March 1 each year for the preceding
317.8 fiscal year to the commissioner, in the form and manner specified by the commissioner:

317.9 (1) utilization data for each health plan company and each public program,
317.10 including workers' compensation, ~~as follows:~~ of diagnostic imaging services as defined
317.11 in subdivision 4, paragraph (b);

317.12 ~~(i) the number of computerized tomography (CT) procedures performed;~~
317.13 ~~(ii) the number of magnetic resonance imaging (MRI) procedures performed; and~~
317.14 ~~(iii) the number of positron emission tomography (PET) procedures performed; and~~

317.15 (2) the names of all physicians with any financial or economic interest and all other
317.16 individuals with a ten percent or greater financial or economic interest in the facility;

317.17 (3) the location where procedures were performed;

317.18 (4) the number of units of each type of fixed, portable, and mobile scanner used at
317.19 each location;

317.20 (5) the average number of hours per month each mobile scanner was operated at
317.21 each location;

317.22 (6) the number of hours per month each scanner was leased, if applicable;

317.23 (7) the total number of diagnostic imaging procedures billed for by the provider at
317.24 each location, by type of diagnostic imaging service as defined in subdivision 4, paragraph
317.25 (b); and

317.26 (8) a report on major health care capital expenditures during the previous year, as
317.27 required by section 62J.17.

317.28 Subd. 2. **Commissioner's right to inspect records.** If the report is not filed or
317.29 the commissioner of health has reason to believe the report is incomplete or false, the
317.30 commissioner shall have the right to inspect diagnostic imaging facility books, audits,
317.31 and records.

317.32 Subd. 3. **Separate reports.** ~~For a diagnostic imaging facility that is not attached~~
317.33 ~~or not contiguous to a hospital or a hospital affiliate, the commissioner shall require~~
317.34 ~~the information in subdivision 1 be reported separately for each detached diagnostic~~
317.35 ~~imaging facility as part of the report required under section 144.702. If any entity owns~~

more than one diagnostic imaging facility, that entity must report by individual facility. Reports must include only services that were billed by the provider of diagnostic imaging services submitting the report. If a diagnostic imaging facility leases capacity, technical services, or professional services to one or more other providers of diagnostic imaging services, each provider must submit a separate annual report to the commissioner for all diagnostic imaging services that it provided and billed. The owner of the leased capacity must provide a report listing the names and addresses of providers to whom the diagnostic imaging services and equipment were leased.

Subd. 4. **Definitions.** For purposes of this section, the following terms have the meanings given:

(a) "Diagnostic imaging facility" means a health care facility that ~~provides~~ is not a hospital or location licensed as a hospital which offers diagnostic imaging services through the use of ionizing radiation or other imaging technique including, but not limited to magnetic resonance imaging (MRI) or computerized tomography (CT) scan on a freestanding or mobile basis in Minnesota, regardless of whether the equipment used to provide the service is owned or leased. For the purposes of this section, diagnostic imaging facility includes, but is not limited to, facilities such as a physician's office, clinic, mobile transport vehicle, outpatient imaging center, or surgical center.

(b) "Diagnostic imaging service" means the use of ionizing radiation or other imaging technique on a human patient including, but not limited to, magnetic resonance imaging (MRI) or computerized tomography (CT), positron emission tomography (PET), or single photon emission computerized tomography (SPECT) scans using fixed, portable, or mobile equipment.

~~(b)~~ (c) "Financial or economic interest" means a direct or indirect:

(1) equity or debt security issued by an entity, including, but not limited to, shares of stock in a corporation, membership in a limited liability company, beneficial interest in a trust, units or other interests in a partnership, bonds, debentures, notes or other equity interests or debt instruments, or any contractual arrangements;

(2) membership, proprietary interest, or co-ownership with an individual, group, or organization to which patients, clients, or customers are referred to; or

(3) employer-employee or independent contractor relationship, including, but not limited to, those that may occur in a limited partnership, profit-sharing arrangement, or other similar arrangement with any facility to which patients are referred, including any compensation between a facility and a health care provider, the group practice of which the provider is a member or employee or a related party with respect to any of them.

~~(e) (d) "Freestanding Fixed equipment" means a stationary diagnostic imaging facility that is not located within a:~~ machine installed in a permanent location.

~~(1) hospital;~~

~~(2) location licensed as a hospital; or~~

~~(3) physician's office or clinic where the professional practice of medicine by licensed physicians is the primary purpose and not the provision of ancillary services such as diagnostic imaging.~~

~~(d) (e) "Mobile equipment" means a diagnostic imaging facility that is transported to various sites not including movement within a hospital or a physician's office or clinic~~ machine in a self-contained transport vehicle designed to be brought to a temporary offsite location to perform diagnostic imaging services.

(f) "Portable equipment" means a diagnostic imaging machine designed to be temporarily transported within a permanent location to perform diagnostic imaging services.

(g) "Provider of diagnostic imaging services" means a diagnostic imaging facility or an entity that offers and bills for diagnostic imaging services at a facility owned or leased by the entity.

Subd. 5. Reports open to public inspection. All reports filed pursuant to this section shall be open to public inspection.

Sec. 24. [144.585] METHICILLIN-RESISTANT STAPHYLOCOCCUS AUREUS CONTROL PROGRAMS.

In order to improve the prevention of hospital-associated bloodstream infections due to methicillin-resistant Staphylococcus aureus ("MRSA"), every hospital shall establish an MRSA control program that meets Minnesota Department of Health best practices standards as published January 15, 2008, including considerations of:

(1) identification of all MRSA-colonized patients in all intensive care units, and other at-risk patients identified by the hospital, through active surveillance testing;

(2) isolation of identified MRSA-colonized or MRSA-infected patients in an appropriate manner;

(3) monitoring and strict enforcement of hand hygiene requirements; and

(4) maintenance of records.

Sec. 25. Minnesota Statutes 2006, section 144.651, subdivision 9, is amended to read:

Subd. 9. **Information about treatment.** Patients and residents shall be given by their physicians complete and current information concerning their diagnosis, treatment,

alternatives, risks, and prognosis as required by the physician's legal duty to disclose. This information shall be in terms and language the patients or residents can reasonably be expected to understand. Patients and residents may be accompanied by a family member or other chosen representative, or both. This information shall include the likely medical or major psychological results of the treatment and its alternatives. In cases where it is medically inadvisable, as documented by the attending physician in a patient's or resident's medical record, the information shall be given to the patient's or resident's guardian or other person designated by the patient or resident as a representative. Individuals have the right to refuse this information.

Every patient or resident suffering from any form of breast cancer shall be fully informed, prior to or at the time of admission and during her stay, of all alternative effective methods of treatment of which the treating physician is knowledgeable, including surgical, radiological, or chemotherapeutic treatments or combinations of treatments and the risks associated with each of those methods.

Sec. 26. Minnesota Statutes 2006, section 144.651, subdivision 10, is amended to read:

Subd. 10. Participation in planning treatment; notification of family members.

(a) Patients and residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative, or both. In the event that the patient or resident cannot be present, a family member or other representative chosen by the patient or resident may be included in such conferences. A chosen representative may include a doula of the patient's choice.

(b) If a patient or resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the patient as the person to contact in an emergency that the patient or resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the patient or resident has an effective advance directive to the contrary or knows the patient or resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the patient or resident has executed an

321.1 advance directive relative to the patient or resident's health care decisions. For purposes of
321.2 this paragraph, "reasonable efforts" include:

321.3 (1) examining the personal effects of the patient or resident;

321.4 (2) examining the medical records of the patient or resident in the possession
321.5 of the facility;

321.6 (3) inquiring of any emergency contact or family member contacted under this
321.7 section whether the patient or resident has executed an advance directive and whether the
321.8 patient or resident has a physician to whom the patient or resident normally goes for
321.9 care; and

321.10 (4) inquiring of the physician to whom the patient or resident normally goes for care,
321.11 if known, whether the patient or resident has executed an advance directive. If a facility
321.12 notifies a family member or designated emergency contact or allows a family member
321.13 to participate in treatment planning in accordance with this paragraph, the facility is not
321.14 liable to the patient or resident for damages on the grounds that the notification of the
321.15 family member or emergency contact or the participation of the family member was
321.16 improper or violated the patient's privacy rights.

321.17 (c) In making reasonable efforts to notify a family member or designated emergency
321.18 contact, the facility shall attempt to identify family members or a designated emergency
321.19 contact by examining the personal effects of the patient or resident and the medical records
321.20 of the patient or resident in the possession of the facility. If the facility is unable to notify
321.21 a family member or designated emergency contact within 24 hours after the admission,
321.22 the facility shall notify the county social service agency or local law enforcement agency
321.23 that the patient or resident has been admitted and the facility has been unable to notify a
321.24 family member or designated emergency contact. The county social service agency and
321.25 local law enforcement agency shall assist the facility in identifying and notifying a family
321.26 member or designated emergency contact. A county social service agency or local law
321.27 enforcement agency that assists a facility in implementing this subdivision is not liable
321.28 to the patient or resident for damages on the grounds that the notification of the family
321.29 member or emergency contact or the participation of the family member was improper or
321.30 violated the patient's privacy rights.

321.31 Sec. 27. Minnesota Statutes 2006, section 144.651, subdivision 26, is amended to read:

321.32 Subd. 26. **Right to associate.** (a) Residents may meet with and receive visitors
321.33 and participate in activities of commercial, religious, political, as defined in section
321.34 203B.11 and community groups without interference at their discretion if the activities

322.1 do not infringe on the right to privacy of other residents or are not programmatically
322.2 contraindicated. This includes:

322.3 (1) the right to join with other individuals within and outside the facility to work for
322.4 improvements in long-term care;

322.5 (2) the right to visitation by an individual the patient has appointed as the patient's
322.6 health care agent under chapter 145C;

322.7 (3) the right to visitation and health care decision making by an individual designated
322.8 by the patient under paragraph (c).

322.9 (b) Upon admission to a facility where federal law prohibits unauthorized disclosure
322.10 of patient or resident identifying information to callers and visitors, the patient or
322.11 resident, or the legal guardian or conservator of the patient or resident, shall be given the
322.12 opportunity to authorize disclosure of the patient's or resident's presence in the facility
322.13 to callers and visitors who may seek to communicate with the patient or resident. To the
322.14 extent possible, the legal guardian or conservator of a patient or resident shall consider the
322.15 opinions of the patient or resident regarding the disclosure of the patient's or resident's
322.16 presence in the facility.

322.17 (c) Upon admission to a facility, the patient or resident, or the legal guardian
322.18 or conservator of the patient or resident, must be given the opportunity to designate
322.19 a person who is not related who will have the status of the patient's next of kin with
322.20 respect to visitation and making a health care decision. A designation must be included
322.21 in the patient's health record. With respect to making a health care decision, a health
322.22 care directive or appointment of a health care agent under chapter 145C prevails over a
322.23 designation made under this paragraph. The unrelated person may also be identified as
322.24 such by the patient or by the patient's family.

322.25 Sec. 28. Minnesota Statutes 2006, section 144D.03, subdivision 1, is amended to read:

322.26 Subdivision 1. **Registration procedures.** The commissioner shall establish forms
322.27 and procedures for annual registration of housing with services establishments. The
322.28 commissioner shall charge an annual registration fee of ~~\$35~~ \$155. No fee shall be
322.29 refunded. A registered establishment shall notify the commissioner within 30 days of the
322.30 date it is no longer required to be registered under this chapter or of any change in the
322.31 business name or address of the establishment, the name or mailing address of the owner
322.32 or owners, or the name or mailing address of the managing agent. There shall be no
322.33 fee for submission of the notice.

Sec. 29. Minnesota Statutes 2006, section 145.412, is amended by adding a subdivision to read:

Subd. 2a. **Sex selection.** It shall be unlawful to willfully perform an abortion, based on the sex of the unborn child, upon a woman known to be pregnant.

Sec. 30. **[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 Expectations Policy Information Notice 98-23, except that each eligible federally qualified health center shall receive at least two percent but no more than 30 percent of the total amount of money available under this section.

Sec. 31. Minnesota Statutes 2006, section 145C.05, is amended to read:

145C.05 SUGGESTED FORM; PROVISIONS THAT MAY BE INCLUDED.

Subdivision 1. **Content.** A health care directive executed pursuant to this chapter may, but need not, be in the form contained in section 145C.16.

Subd. 2. **Provisions that may be included.** (a) A health care directive may include provisions consistent with this chapter, including, but not limited to:

(1) the designation of one or more alternate health care agents to act if the named health care agent is not reasonably available to serve;

(2) directions to joint health care agents regarding the process or standards by which the health care agents are to reach a health care decision for the principal, and a statement whether joint health care agents may act independently of one another;

(3) limitations, if any, on the right of the health care agent or any alternate health care agents to receive, review, obtain copies of, and consent to the disclosure of the

324.1 principal's medical records or to visit the principal when the principal is a patient in a
324.2 health care facility;

324.3 (4) limitations, if any, on the nomination of the health care agent as guardian for
324.4 purposes of sections 524.5-202, 524.5-211, 524.5-302, and 524.5-303;

324.5 (5) a document of gift for the purpose of making an anatomical gift, as set forth in
324.6 sections 525.921 to 525.9224, or an amendment to, revocation of, or refusal to make
324.7 an anatomical gift;

324.8 (6) a declaration regarding intrusive mental health treatment under section 253B.03,
324.9 subdivision 6d, or a statement that the health care agent is authorized to give consent for
324.10 the principal under section 253B.04, subdivision 1a;

324.11 (7) a funeral directive as provided in section 149A.80, subdivision 2;

324.12 (8) limitations, if any, to the effect of dissolution or annulment of marriage or
324.13 termination of domestic partnership on the appointment of a health care agent under
324.14 section 145C.09, subdivision 2;

324.15 (9) specific reasons why a principal wants a health care provider or an employee
324.16 of a health care provider attending the principal to be eligible to act as the principal's
324.17 health care agent;

324.18 (10) health care instructions by a woman of child bearing age regarding how she
324.19 would like her pregnancy, if any, to affect health care decisions made on her behalf; and

324.20 (11) health care instructions regarding artificially administered nutrition or hydration.

324.21 (b) A health care directive may include a statement of the circumstances under
324.22 which the directive becomes effective other than upon the judgment of the principal's
324.23 attending physician in the following situations:

324.24 (1) a principal who in good faith generally selects and depends upon spiritual means
324.25 or prayer for the treatment or care of disease or remedial care and does not have an
324.26 attending physician, may include a statement appointing an individual who may determine
324.27 the principal's decision-making capacity; and

324.28 (2) a principal who in good faith does not generally select a physician or a health
324.29 care facility for the principal's health care needs may include a statement appointing an
324.30 individual who may determine the principal's decision-making capacity, provided that if
324.31 the need to determine the principal's capacity arises when the principal is receiving care
324.32 under the direction of an attending physician in a health care facility, the determination
324.33 must be made by an attending physician after consultation with the appointed individual.

324.34 If a person appointed under clause (1) or (2) is not reasonably available and the
324.35 principal is receiving care under the direction of an attending physician in a health care
324.36 facility, an attending physician shall determine the principal's decision-making capacity.

325.1 (c) A health care directive may authorize a health care agent to make health care
325.2 decisions for a principal even though the principal retains decision-making capacity.

325.3 Sec. 32. **[146B.01] DEFINITIONS.**

325.4 Subdivision 1. **Applicability.** The definitions in this section apply to this chapter.

325.5 Subd. 2. **Certified doula.** "Certified doula" means an individual who has received
325.6 a certification to perform doula services from the International Childbirth Education
325.7 Association, the Doulas of North America (DONA), the Association of Labor Assistants
325.8 and Childbirth Educators (ALACE), Birthworks, Childbirth and Postpartum Professional
325.9 Association (CAPPA), or Childbirth International.

325.10 Subd. 3. **Commissioner.** "Commissioner" means the commissioner of health.

325.11 Subd. 4. **Doula services.** "Doula services" means emotional and physical support
325.12 during pregnancy, labor, birth, and postpartum.

325.13 **EFFECTIVE DATE.** This section is effective July 1, 2007.

325.14 Sec. 33. **[146B.02] REGISTRY.**

325.15 Subdivision 1. **Establishment.** The commissioner of health shall maintain a registry
325.16 of certified doulas who have met the requirements listed in subdivision 2.

325.17 Subd. 2. **Qualifications.** The commissioner shall include on the registry any
325.18 individual who:

325.19 (1) submits an application on a form provided by the commissioner. The form must
325.20 include the applicant's name, address, and contact information;

325.21 (2) maintains a current certification from one of the organizations listed in section
325.22 146B.01, subdivision 2;

325.23 (3) completes a criminal background check; and

325.24 (4) pays the fees required under section 146B.04.

325.25 Subd. 3. **Renewal.** Inclusion on the registry maintained by the commissioner is
325.26 valid for three years. At the end of the three-year period, the certified doula may submit a
325.27 new application to remain on the doula registry by meeting the requirements described in
325.28 subdivision 2.

325.29 **EFFECTIVE DATE.** This section is effective July 1, 2007.

325.30 Sec. 34. **[146B.03] COMMISSIONER DUTIES.**

325.31 The commissioner shall establish and maintain the doula registry and:

325.32 (1) provide registry application forms;

326.1 (2) complete the criminal background checks on registry applicants; and
326.2 (3) maintain public access to the registry by providing a link to the registry on the
326.3 Department of Health's Web site.

326.4 **EFFECTIVE DATE.** This section is effective July 1, 2007.

326.5 Sec. 35. **[146B.04] FEES.**

326.6 The application fee is \$142 every three years, which includes the cost of a criminal
326.7 background check. This fee is nonrefundable.

326.8 **EFFECTIVE DATE.** This section is effective July 1, 2007.

326.9 Sec. 36. Minnesota Statutes 2006, section 145C.07, is amended by adding a
326.10 subdivision to read:

326.11 Subd. 5. **Visitation.** A health care agent may visit the principal when the
326.12 principal is a patient in a health care facility regardless of whether the principal retains
326.13 decision-making capacity, unless:

326.14 (1) the principal has otherwise specified in the health care directive;

326.15 (2) a principal who retains decision-making capacity indicates otherwise; or

326.16 (3) a health care provider reasonably determines that the principal must be isolated
326.17 from all visitors or that the presence of the health care agent would endanger the health or
326.18 safety of the principal, other patients, or the facility in which the care is being provided.

326.19 Sec. 37. Minnesota Statutes 2006, section 148.6445, subdivision 1, is amended to read:

326.20 Subdivision 1. **Initial licensure fee.** The initial licensure fee for occupational
326.21 therapists is ~~\$180~~ \$145. The initial licensure fee for occupational therapy assistants is
326.22 ~~\$100~~ \$80. The commissioner shall prorate fees based on the number of quarters remaining
326.23 in the biennial licensure period.

326.24 Sec. 38. Minnesota Statutes 2006, section 148.6445, subdivision 2, is amended to read:

326.25 Subd. 2. **Licensure renewal fee.** The biennial licensure renewal fee for
326.26 occupational therapists is ~~\$180~~ \$145. The biennial licensure renewal fee for occupational
326.27 therapy assistants is ~~\$100~~ \$80.

326.28 Sec. 39. **[148.785] FEES.**

326.29 The fees charged by the board are fixed at the following rates:

326.30 (1) application fee for physical therapists and physical therapist assistants, \$100;

- 327.1 (2) annual licensure for physical therapists and physical therapist assistants, \$60;
- 327.2 (3) licensure renewal late fee, \$20;
- 327.3 (4) temporary permit, \$25;
- 327.4 (5) duplicate license or registration, \$20;
- 327.5 (6) certification letter, \$25;
- 327.6 (7) education or training program approval, \$100;
- 327.7 (8) report creation and generation, \$60 per hour billed in quarter-hour increments
- 327.8 with a quarter-hour minimum; and
- 327.9 (9) examination administration:
- 327.10 (i) half day, \$50; and
- 327.11 (ii) full day, \$80.

327.12 Sec. 40. Minnesota Statutes 2006, section 148B.53, subdivision 3, is amended to read:

327.13 Subd. 3. **Fee.** Nonrefundable fees are as follows:

- 327.14 (1) initial license application fee for licensed professional counseling (LPC) - ~~\$250~~
- 327.15 \$150;
- 327.16 (2) initial license fee for LPC - \$250;
- 327.17 (3) annual active license renewal fee for LPC - ~~\$200~~ \$250 or equivalent;
- 327.18 ~~(3)~~ (4) annual inactive license renewal fee for LPC - ~~\$100~~ \$125;
- 327.19 (5) initial license application fee for licensed professional clinical counseling
- 327.20 (LPCC) - \$150;
- 327.21 (6) initial license fee for LPCC - \$250;
- 327.22 (7) annual active license renewal fee for LPCC - \$250 or equivalent;
- 327.23 (8) annual inactive license renewal fee for LPCC - \$125;
- 327.24 ~~(4)~~ (9) license renewal late fee - \$100 per month or portion thereof;
- 327.25 ~~(5)~~ (10) copy of board order or stipulation - \$10;
- 327.26 ~~(6)~~ (11) certificate of good standing or license verification - ~~\$10~~ \$25;
- 327.27 ~~(7)~~ (12) duplicate certificate fee - ~~\$10~~ \$25;
- 327.28 ~~(8)~~ (13) professional firm renewal fee - \$25;
- 327.29 ~~(9)~~ (14) sponsor application for approval of a continuing education course - \$60;
- 327.30 (15) initial registration fee - \$50; and
- 327.31 ~~(10)~~ (16) annual registration renewal fee - \$25; and
- 327.32 (17) approved supervisor application processing fee - \$30.

327.33 Sec. 41. Minnesota Statutes 2006, section 149A.52, subdivision 3, is amended to read:

Subd. 3. **Application procedure; documentation; initial inspection.** An applicant for a license to operate a crematory shall submit to the commissioner a completed application. A completed application includes:

- (1) a completed application form, as provided by the commissioner;
- (2) proof of business form and ownership; and
- (3) proof of liability insurance coverage or other financial documentation, as determined by the commissioner, that demonstrates the applicant's ability to respond in damages for liability arising from the ownership, maintenance, management, or operation of a crematory.

Upon receipt of the application and appropriate fee, the commissioner shall review and verify all information. Upon completion of the verification process and resolution of any deficiencies in the application information, the commissioner shall conduct an initial inspection of the premises to be licensed. After the inspection and resolution of any deficiencies found and any reinspections as may be necessary, the commissioner shall make a determination, based on all the information available, to grant or deny licensure. If the commissioner's determination is to grant the license, the applicant shall be notified and the license shall issue and remain valid for a period prescribed on the license, but not to exceed one calendar year from the date of issuance of the license. If the commissioner's determination is to deny the license, the commissioner must notify the applicant, in writing, of the denial and provide the specific reason for denial.

Sec. 42. **[149A.65] FEES.**

Subdivision 1. **Generally.** This section establishes the fees for registrations, examinations, initial and renewal licenses, and late fees authorized under the provisions of this chapter.

Subd. 2. **Mortuary science fees.** Fees for mortuary science are:

- (1) \$50 for the initial and renewal registration of a mortuary science intern;
- (2) \$100 for the mortuary science examination;
- (3) \$125 for issuance of initial and renewal mortuary science licenses;
- (4) \$25 late fee charge for a license renewal; and
- (5) \$200 for issuing a mortuary science license by endorsement.

Subd. 3. **Funeral directors.** The license renewal fee for funeral directors is \$125. The late fee charge for a license renewal is \$25.

Subd. 4. **Funeral establishments.** The initial and renewal fee for funeral establishments is \$300. The late fee charge for a license renewal is \$25.

329.1 Subd. 5. **Crematories.** The initial and renewal fee for a crematory is \$300. The
329.2 late fee charge for a license renewal is \$25.

329.3 Sec. 43. Minnesota Statutes 2006, section 149A.97, subdivision 7, is amended to read:

329.4 Subd. 7. **Reports to commissioner.** Every funeral provider lawfully doing business
329.5 in Minnesota that accepts funds under subdivision 2 must make a complete annual report
329.6 to the commissioner. The reports may be on forms provided by the commissioner or
329.7 substantially similar forms containing, at least, identification and the state of each trust
329.8 account, including all transactions involving principal and accrued interest, and must be
329.9 filed by March 31 of the calendar year following the reporting year along with a filing
329.10 fee of ~~\$15~~ \$25 for each report. Fees shall be paid to the commissioner of finance, state of
329.11 Minnesota, for deposit in the state government special revenue fund in the state treasury.
329.12 Reports must be signed by an authorized representative of the funeral provider and
329.13 notarized under oath. All reports to the commissioner shall be reviewed for account
329.14 inaccuracies or possible violations of this section. If the commissioner has a reasonable
329.15 belief to suspect that there are account irregularities or possible violations of this section,
329.16 the commissioner shall report that belief, in a timely manner, to the state auditor. The
329.17 commissioner shall also file an annual letter with the state auditor disclosing whether or
329.18 not any irregularities or possible violations were detected in review of the annual trust
329.19 fund reports filed by the funeral providers. This letter shall be filed with the state auditor
329.20 by May 31 of the calendar year following the reporting year.

329.21 Sec. 44. Minnesota Statutes 2006, section 157.16, subdivision 1, is amended to read:

329.22 Subdivision 1. **License required annually.** A license is required annually for every
329.23 person, firm, or corporation engaged in the business of conducting a food and beverage
329.24 service establishment, hotel, motel, lodging establishment, or resort. Any person wishing
329.25 to operate a place of business licensed in this section shall first make application, pay the
329.26 required fee specified in this section, and receive approval for operation, including plan
329.27 review approval. Seasonal and temporary food stands and special event food stands are
329.28 not required to submit plans. Nonprofit organizations operating a special event food
329.29 stand with multiple locations at an annual one-day event shall be issued only one license.
329.30 Application shall be made on forms provided by the commissioner and shall require
329.31 the applicant to state the full name and address of the owner of the building, structure,
329.32 or enclosure, the lessee and manager of the food and beverage service establishment,
329.33 hotel, motel, lodging establishment, or resort; the name under which the business is to

330.1 be conducted; and any other information as may be required by the commissioner to
330.2 complete the application for license.

330.3 Sec. 45. **HEALTH PROMOTION PROGRAM.**

330.4 The State Community Health Services Advisory Committee established in
330.5 Minnesota Statutes, section 145A.10, subdivision 10, shall develop a plan to fund and
330.6 implement an ongoing comprehensive health promotion program that can effect change
330.7 more effectively and at lower cost at a community level rather than through individual
330.8 counseling and change promotion. The program shall use proven public health strategies
330.9 to promote healthy lifestyles and behaviors in order to establish a sustainable, long-term
330.10 approach to reducing preventable disability, chronic health conditions, and disease. The
330.11 focus shall be on community based initiatives that address childhood and adult obesity,
330.12 tobacco and substance abuse, improved activity levels among senior citizens, and other
330.13 lifestyle issues that impact health and healthcare costs. Because of its population health
330.14 focus, funding shall be related to the size of the population to be served. The plan shall be
330.15 completed by September 15, 2007, and shared with the Legislative Health Care Access
330.16 Commission.

330.17 Sec. 46. **INJUNCTIVE RELIEF REPORT.**

330.18 The commissioner of health shall present to the 2008 legislature, by December 15,
330.19 2007, recommendations to fund the cost of bringing actions for injunctive relief under
330.20 Minnesota Statutes, section 144G.02, subdivision 2, paragraph (b).

330.21 Sec. 47. **DIAGNOSTIC IMAGING SERVICES ADVISORY COMMITTEE;**
330.22 **ESTABLISHMENT.**

330.23 (a) The commissioner of health shall establish a Diagnostic Imaging Services
330.24 Advisory Committee to perform the following duties:

330.25 (1) gather and analyze data to understand the factors driving utilization of diagnostic
330.26 imaging services, including computed tomography (CT), magnetic resonance imaging
330.27 (MRI), positron emission tomography (PET), magnetic resonance angiography (MRA),
330.28 and nuclear cardiology, in the state relative to evidence-based guidelines; and

330.29 (2) develop recommendations, based on the data collected, on how to improve
330.30 the delivery of evidence-based diagnostic imaging services. In developing these
330.31 recommendations, the advisory committee shall consider the impacts on patient care,
330.32 premium costs, and administrative simplicity.

331.1 (b) The members of the Diagnostic Imaging Services Advisory Committee shall
331.2 include the commissioners of health and human services or the commissioners' designees
331.3 and the following:

331.4 (1) three physicians representing speciality and geographic diversity, appointed by
331.5 the Minnesota Medical Association;

331.6 (2) two hospital representatives, one from a metropolitan hospital and one from a
331.7 rural hospital, appointed by the Minnesota Hospital Association;

331.8 (3) three health plan company representatives appointed by the Minnesota Council
331.9 of Health Plans;

331.10 (4) two representatives appointed by the Institute for Clinical System Improvement;
331.11 and

331.12 (5) one clinic manager appointed by the Minnesota Medical Group Management
331.13 Association.

331.14 (c) The Diagnostic Imaging Services Advisory Committee shall convene no later
331.15 than September 1, 2007. The commissioner shall report back to the legislature no later
331.16 than January 15, 2008. The advisory committee is governed under Minnesota Statutes,
331.17 section 15.059, except that members shall not receive a per diem and may only be
331.18 reimbursed for expenses.

331.19 (d) A strategy to improve the delivery of evidence-based diagnostic imaging services
331.20 may be developed by health plans. The commissioner of health shall report the agreement
331.21 to the chairs of the senate and house health care committees immediately.

331.22 **EFFECTIVE DATE.** This section is effective July 1, 2007.

331.23 Sec. 48. **HEARING AID DISPENSER FEES.**

331.24 Fees relating to hearing aid dispensers, as provided in Minnesota Statutes, section
331.25 153A.17, may not be increased until after the Department of Health provides a report to
331.26 the legislature regarding the need and reasons for fee increases.

331.27 Sec. 49. **REVISOR'S INSTRUCTION.**

331.28 In Minnesota Statutes and Minnesota Rules, the revisor shall change the references
331.29 in column A with the references in column B.

331.30	<u>Column A</u>	<u>Column B</u>
331.31	<u>section 144.335</u>	<u>sections 144.291 to 144.298</u>
331.32	<u>section 144.335, subdivision 1</u>	<u>section 144.291, subdivision 2</u>
331.33	<u>section 144.335, subdivision 1, paragraph</u>	<u>section 144.291, subdivision 2, paragraph</u>
331.34	<u>(b)</u>	<u>(h)</u>

~~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.

(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.** 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.

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,

335.1 may also withdraw if premiums increase ~~50 percent~~ by more than 20 percent in excess of
335.2 the Consumer Price Index for all urban consumers or more from one insurance year to
335.3 the next.

335.4 (e) The exclusive representative shall give the employer notice of intent to withdraw
335.5 ~~to the commissioner~~ at least ~~30~~ 60 days before the expiration date of a collective
335.6 bargaining agreement that includes the date on which the term of participation expires.

335.7 (f) Each participating eligible employer shall notify the commissioner of the names
335.8 of individuals who will be participating within two weeks ~~of~~ after the commissioner
335.9 ~~receiving~~ receives notice of the parties' intent to participate. The employer shall also
335.10 submit other information as required by the commissioner for administration of the
335.11 program.

335.12 (g) An employer that withdraws from the program under circumstances that do not
335.13 permit withdrawal under this subdivision is liable to the board for premiums payable by
335.14 the employer until the time that the employer is eligible to withdraw, and the employer
335.15 shall pay those premiums voluntarily and no later than their due date. If the premiums are
335.16 not paid voluntarily, the board has authority to and shall collect these premiums under any
335.17 method permitted by law for a governmental or nongovernmental creditor of the employer.

335.18 Subd. 6. **Coverage.** (a) ~~By January 1, 1989,~~ The commissioner shall announce the
335.19 benefits of the program. The program shall include employee hospital, medical, dental,
335.20 and life insurance for employees and hospital and medical benefits for dependents. Health
335.21 maintenance organization options and other delivery system options may be provided if
335.22 they are available, cost-effective, and capable of servicing the number of people covered
335.23 in the program. Participation in optional coverages may be provided by collective
335.24 bargaining agreements. For employees not represented by an exclusive representative, the
335.25 employer may offer the optional coverages to eligible employees and their dependents
335.26 provided in the program. Health coverage must include at least the benefits required of a
335.27 health plan company regulated under chapter 62A, 62C, or 62D.

335.28 (b) The commissioner, with the assistance of the Labor-Management Committee,
335.29 shall periodically assess whether it is financially feasible for the program to offer or to
335.30 continue an individual retiree program that has competitive premium rates and benefits.
335.31 If the commissioner determines it to be feasible to offer an individual retiree program,
335.32 the commissioner shall announce the applicable benefits, premium rates, and terms of
335.33 participation. Eligibility to participate in the individual retiree program is governed by
335.34 subdivision 8, but applies to retirees of eligible employers that do not participate in the
335.35 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 decide to rate specific employers separately for premium purposes, if the commissioner determines that doing so is in the best interests of the program. Each employer shall pay monthly the amounts due for employee benefits including the amounts under subdivision 8 to the commissioner no later than the dates established by the commissioner. If an employer fails to make the payments as required, the commissioner ~~may~~ shall cancel program benefits and pursue other civil remedies, as provided in subdivision 5, paragraph (d).

(b) The premium charged for an employer's first month in the program must be three times the regular monthly premium charged to that employer, to help establish and maintain the program's financial resources. The extra two months premium must be refunded to the employer if the employer leaves the program, if the refund would not reduce the program's reserves below the level determined to be appropriate by the commissioner.

Subd. 8. **Continuation of coverage.** (a) A former employee of an employer participating in the program who is receiving a public pension disability benefit or an annuity or has met the age and service requirements necessary to receive an annuity under chapter 353, 353C, 354, 354A, 356, 422A, 423, 423A, or 424, and the former employee's dependents, are eligible to participate in the program. This participation is at the person's expense unless a collective bargaining agreement or personnel policy provides otherwise. Premiums for these participants must be established by the commissioner.

The commissioner may provide policy exclusions for preexisting conditions only when there is a break in coverage between a participant's coverage under the employment-based group insurance program and the participant's coverage under this section. An employer shall notify an employee of the option to participate under this paragraph no later than the effective date of retirement. The retired employee or the employer of a participating group on behalf of a current or retired employee shall notify the commissioner within 30 days of the effective date of retirement of intent to participate in the program according to the rules established by the commissioner.

(b) The spouse of a deceased employee or former employee may purchase the benefits provided at premiums established by the commissioner if the spouse was a dependent under the employee's or former employee's coverage under this section at the time of the death. The spouse remains eligible to participate in the program as long as the group that included the deceased employee or former employee participates in the program. Coverage under this clause must be coordinated with relevant insurance benefits 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,

338.1 62D, 62E, and 62H, section 471.617, subdivisions 2 and 3, and the bidding requirements
338.2 of section 471.6161, except as otherwise provided in subdivision 6, paragraph (a).

338.3 Subd. 11. **Reinsurance.** The commissioner may, on behalf of the program,
338.4 participate in an insured or self-insured reinsurance pool.

338.5 Sec. 3. Minnesota Statutes 2006, section 62H.02, is amended to read:

338.6 **62H.02 REQUIRED PROVISIONS.**

338.7 (a) A joint self-insurance plan must include aggregate excess stop-loss coverage and
338.8 individual excess stop-loss coverage provided by an insurance company licensed by the
338.9 state of Minnesota.

338.10 (b) Aggregate excess stop-loss coverage must include provisions to cover incurred,
338.11 unpaid claim liability in the event of plan termination. ~~In addition,~~

338.12 (c) The plan of self-insurance must have participating employers fund an amount at
338.13 least equal to the point at which the excess or stop-loss insurer has contracted to assume
338.14 100 percent of additional liability.

338.15 (d) A joint self-insurance plan must submit its proposed excess or stop-loss insurance
338.16 contract to the commissioner of commerce at least 30 days prior to the proposed plan's
338.17 effective date and at least 30 days subsequent to any renewal date. The commissioner shall
338.18 review the contract to determine if they meet the standards established by sections 62H.01
338.19 to 62H.08 and respond within a 30-day period.

338.20 (e) Any excess or stop-loss insurance plan must contain a provision that the excess
338.21 or stop-loss insurer will give the plan and the commissioner of commerce a minimum of
338.22 180 days' notice of termination or nonrenewal. If the plan fails to secure replacement
338.23 coverage within 60 days after receipt of the notice of cancellation or nonrenewal, the
338.24 commissioner shall issue an order providing for the orderly termination of the plan.

338.25 (f) The commissioner may waive the requirements of this section and of any rule
338.26 relating to the requirements of this section, if the commissioner determines that a joint
338.27 self-insurance plan has established alternative arrangements that fully fund the plan's
338.28 liability or incurred but unpaid claims. The commissioner may not waive the requirement
338.29 that a joint self-insurance plan have excess stop-loss coverage.

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

338.31 Sec. 4. **[62Q.40] LANGUAGE INTERPRETER SERVICES.**

338.32 (a) A health plan must cover sign language interpreter services provided to deaf and
338.33 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.

(b) A health plan company shall pay for interpreter services as required in paragraph (a) by establishing a network of interpreter service providers and requiring use of its own network of interpreter services providers. The health plan company shall consider, as part of its interpreter service provider network, entering into an agreement with a provider for use of an interpreter service provider employed by or under contract with the provider if:

(1) the provider accepts as reimbursement for services rendered by the provider's employed or contracted interpreter service provider the lesser of either the health plan company's reimbursement rate for its in-network interpreter service providers or the provider's fee for services rendered by the provider's interpreter service provider; and

(2) the interpreter service provider meets the published quality standards of the health plan company.

(c) If a health plan company's or a provider's employed or contracted interpreter service provider is unavailable to provide interpreter services, the health plan company shall reimburse the interpreter service provider at the lesser of the health plan company's median reimbursement rate for its in-network interpreter service providers or the interpreter service provider's fee. An interpreter service provider not employed or under contract with a health plan company or provider who fails to meet the quality standards of a health plan company or as required by law, shall be ineligible for reimbursement under this section.

(d) If the health plan company pays the interpreter service provider directly, it has no obligation to pay the provider under this section.

340.1 (e) Nothing in this section requires a health plan company to establish a network
340.2 of interpreter service providers.

340.3 **EFFECTIVE DATE.** This section is effective July 1, 2008, and applies to plans
340.4 issued or renewed to provide coverage to Minnesota residents on or after that date unless
340.5 the legislature enacts alternative funding sources based on the recommendations of the
340.6 commissioner.

340.7 Sec. 5. Minnesota Statutes 2006, section 144.05, is amended by adding a subdivision
340.8 to read:

340.9 Subd. 5. **Base budget detail.** The commissioner shall provide the commissioner
340.10 of finance with the information necessary to provide base budget detail to the legislature
340.11 under section 16A.10, subdivision 2a.

340.12 Sec. 6. Minnesota Statutes 2006, section 148.235, is amended by adding a subdivision
340.13 to read:

340.14 Subd. 11. **Dispensing by protocol.** A registered nurse in a family planning agency
340.15 as defined in Minnesota Rules, part 9505.0280, subpart 3, may dispense oral contraceptives
340.16 prescribed by a licensed practitioner as defined in section 151.01, subdivision 23, pursuant
340.17 to a dispensing protocol established by the agency's medical director or under the direction
340.18 of a physician. The dispensing protocol must address the requirements of sections 151.01,
340.19 subdivision 30, and 151.212, subdivision 1.

340.20 Sec. 7. Minnesota Statutes 2006, section 151.19, subdivision 2, is amended to read:

340.21 **Subd. 2. Nonresident pharmacies.** The board shall require and provide for an
340.22 annual nonresident special pharmacy registration for all pharmacies located outside of this
340.23 state that regularly dispense medications for Minnesota residents and mail, ship, or deliver
340.24 prescription medications into this state. Nonresident special pharmacy registration shall
340.25 be granted by the board upon the disclosure and certification by a pharmacy:

340.26 (1) that it is licensed in the state in which the dispensing facility is located and from
340.27 which the drugs are dispensed;

340.28 (2) the location, names, and titles of all principal corporate officers and all
340.29 pharmacists who are dispensing drugs to residents of this state;

340.30 (3) that it complies with all lawful directions and requests for information from
340.31 the Board of Pharmacy of all states in which it is licensed or registered, except that it
340.32 shall respond directly to all communications from the board concerning emergency
340.33 circumstances arising from the dispensing of drugs to residents of this state;

341.1 (4) that it maintains its records of drugs dispensed to residents of this state so that the
341.2 records are readily retrievable from the records of other drugs dispensed;

341.3 (5) that it cooperates with the board in providing information to the Board of
341.4 Pharmacy of the state in which it is licensed concerning matters related to the dispensing
341.5 of drugs to residents of this state; ~~and~~

341.6 (6) that during its regular hours of operation, but not less than six days per week, for
341.7 a minimum of 40 hours per week, a toll-free telephone service is provided to facilitate
341.8 communication between patients in this state and a pharmacist at the pharmacy who has
341.9 access to the patients' records; the toll-free number must be disclosed on the label affixed
341.10 to each container of drugs dispensed to residents of this state; and

341.11 (7) that, upon request of a resident of a long-term care facility located within the
341.12 state of Minnesota or by an agent of the resident, the pharmacy will dispense medications
341.13 prescribed for the resident in unit-dose packaging or, alternatively, comply with the
341.14 provisions of section 151.415, subdivision 5.

341.15 Sec. 8. Minnesota Statutes 2006, section 151.37, subdivision 2, is amended to read:

341.16 Subd. 2. **Prescribing and filing.** (a) A licensed practitioner in the course of
341.17 professional practice only, may prescribe, administer, and dispense a legend drug, and may
341.18 cause the same to be administered by a nurse, a physician assistant, or medical student or
341.19 resident under the practitioner's direction and supervision, and may cause a person who
341.20 is an appropriately certified, registered, or licensed health care professional to prescribe,
341.21 dispense, and administer the same within the expressed legal scope of the person's practice
341.22 as defined in Minnesota Statutes. A licensed practitioner may prescribe a legend drug,
341.23 without reference to a specific patient, by directing a nurse, pursuant to section 148.235,
341.24 subdivisions 8 and 9, physician assistant, or medical student or resident to adhere to
341.25 a particular practice guideline or protocol when treating patients whose condition falls
341.26 within such guideline or protocol, and when such guideline or protocol specifies the
341.27 circumstances under which the legend drug is to be prescribed and administered. An
341.28 individual who verbally, electronically, or otherwise transmits a written, oral, or electronic
341.29 order, as an agent of a prescriber, shall not be deemed to have prescribed the legend drug.
341.30 This paragraph applies to a physician assistant only if the physician assistant meets the
341.31 requirements of section 147A.18.

341.32 (b) A licensed practitioner that dispenses for profit a legend drug that is to be
341.33 administered orally, is ordinarily dispensed by a pharmacist, and is not a vaccine, must
341.34 file with the practitioner's licensing board a statement indicating that the practitioner
341.35 dispenses legend drugs for profit, the general circumstances under which the practitioner

dispenses for profit, and the types of legend drugs generally dispensed. It is unlawful to dispense legend drugs for profit after July 31, 1990, unless the statement has been filed with the appropriate licensing board. For purposes of this paragraph, "profit" means (1) any amount received by the practitioner in excess of the acquisition cost of a legend drug for legend drugs that are purchased in prepackaged form, or (2) any amount received by the practitioner in excess of the acquisition cost of a legend drug plus the cost of making the drug available if the legend drug requires compounding, packaging, or other treatment. The statement filed under this paragraph is public data under section 13.03. This paragraph does not apply to a licensed doctor of veterinary medicine or a registered pharmacist. Any person other than a licensed practitioner with the authority to prescribe, dispense, and administer a legend drug under paragraph (a) shall not dispense for profit. To dispense for profit does not include dispensing by a community health clinic when the profit from dispensing is used to meet operating expenses.

(c) A prescription or drug order for a legend drug is not valid unless it is issued for a legitimate medical purpose arising from a prescriber-patient relationship that includes a documented patient evaluation adequate to establish diagnoses and identify underlying conditions and contraindications to the treatment. Treatment, including issuing a prescription or drug order, based solely on an online questionnaire does not constitute a legitimate medical purpose.

Sec. 9. [151.415] LONG-TERM CARE RESIDENT ACCESS TO PHARMACEUTICALS ACT.

Subdivision 1. **Title; citation.** This section may be cited as the "Long-Term Care Resident Access to Pharmaceuticals Act."

Subd. 2. **Definitions.** For the purposes of this section, the following terms have the meanings given them unless otherwise provided by text:

(a) "Board" means the Board of Pharmacy.

(b) "Contract pharmacy" means a pharmacy, licensed under this chapter, which is under contract to a long-term care facility.

(c) "Long-term care facility" has the meaning given in section 256.9741, subdivision 1.

(d) "Original dispensing pharmacy" shall mean a pharmacy, licensed in any state in the United States, which dispenses drugs in bulk prescription containers to a person who is a resident in a long-term care facility.

Subd. 3. **Authorization to administer and repackage drugs.** (a) A contract pharmacist or pharmacy may repackage a resident's prescription drugs, which have been

343.1 lawfully dispensed from bulk prescription containers by an original dispensing pharmacy,
343.2 into a unit-dose system compatible with the system used by the long-term care facility.

343.3 (b) A long-term care facility may administer drugs to residents of the facility that
343.4 have been repackaged according to this subdivision.

343.5 (c) Drugs may be dispensed for and administered to a resident of a long-term care
343.6 facility according to this subdivision, provided that:

343.7 (1) the drug is dispensed by the original dispensing pharmacy according to a current,
343.8 valid prescription;

343.9 (2) the original bulk prescription container for the resident is delivered by the
343.10 original dispensing pharmacy directly to the contract pharmacist or pharmacy;

343.11 (3) the contract pharmacist or pharmacy verifies the name and strength of the drug,
343.12 the name of the manufacturer of the drug, the manufacturer's lot or control number, the
343.13 manufacturer's expiration date for the drug, and the date the drug was dispensed by the
343.14 original dispensing pharmacy;

343.15 (4) the contract pharmacist or pharmacy verifies the validity and accuracy of the
343.16 current prescription order;

343.17 (5) the contract pharmacist or pharmacy repackages the drug in board-approved
343.18 unit-dose packaging, with labeling that complies with Minnesota Rules, part 6800.6300,
343.19 and that identifies that the drug has been repackaged according to this section;

343.20 (6) the resident for whom the medication is repackaged obtains medications from or
343.21 receives medications at a discounted rate from the original dispensing pharmacy under the
343.22 resident's state or federal health assistance program or a private health insurance plan; and

343.23 (7) the resident for whom the medication is to be repackaged, or the resident's
343.24 authorized representative, has signed an informed consent form provided by the facility
343.25 which includes an explanation of the repackaging process and which notifies the resident
343.26 of the immunities from liability provided in this section.

343.27 Subd. 4. **Maintenance of records.** For each drug repackaged by a contract
343.28 pharmacy under this section, the contract pharmacy shall maintain a record for at least
343.29 two years of the following information:

343.30 (1) the name, manufacturer, manufacturer's lot number, manufacturer's expiration
343.31 date, and quantity of the drug prescribed;

343.32 (2) the name and address of the resident for whom the drug was repackaged;

343.33 (3) the name and address or other identifier of the prescriber;

343.34 (4) the date the prescription was issued and the date the drug was repackaged;

343.35 (5) the date the repackaged drug was delivered to the long-term care facility;

343.36 (6) the directions for use;

344.1 (7) a copy of the label that was affixed to the repackaged drug;

344.2 (8) the initials of the packager;

344.3 (9) the initials of the supervising pharmacist; and

344.4 (10) the name and business address of the original dispensing pharmacy.

344.5 Subd. 5. **Duties of the original dispensing pharmacy.** Upon request of the
344.6 resident, the resident's authorized representative, or a contract pharmacy or licensed
344.7 health care facility acting on behalf of the resident, the original dispensing pharmacy
344.8 is required to deliver medications dispensed for the resident directly to the contract
344.9 pharmacist or pharmacy. The original dispensing pharmacy is further required to provide
344.10 the contract pharmacist or pharmacy with the name and strength of the drug, the name of
344.11 the manufacturer of the drug, the manufacturer's lot or control number, the manufacturer's
344.12 expiration date for the drug, and the date the drug was dispensed.

344.13 Subd. 6. **Redispensing of returned drugs prohibited.** Unused drugs repackaged
344.14 according to this section that are returned to any pharmacy shall not be redispensed.

344.15 Subd. 7. **Immunity from civil liability.** (a) A contract pharmacist or pharmacy
344.16 and its employees or agents repackaging a drug acquired from an original dispensing
344.17 pharmacy shall be immune from civil liability arising from harm caused by the drug due
344.18 to acts or omissions of other persons outside of the contract pharmacist or pharmacy if the
344.19 contract pharmacist or pharmacy properly repackages the drug according to this section.

344.20 (b) A long-term care facility and the facility's employees or agents who properly
344.21 administer a drug repackaged by a contract pharmacist or pharmacy under this section
344.22 shall be immune from civil liability arising from harm caused by the drug due to acts or
344.23 omissions of other persons outside the long-term care facility.

344.24 Subd. 8. **Handling fee.** A contract pharmacist or pharmacy may charge a monthly
344.25 fee of no more than 250 percent of the medical assistance program dispensing fee for
344.26 each drug repackaged according to this section, but no more than \$100 per month for
344.27 each individual resident.

344.28 Sec. 10. Minnesota Statutes 2006, section 152.11, is amended by adding a subdivision
344.29 to read:

344.30 Subd. 2d. **Identification requirement for schedule II or III controlled substance.**
344.31 No person may dispense a controlled substance included in schedule II or III without
344.32 requiring the person purchasing the controlled substance, who need not be the person for
344.33 whom the controlled substance prescription is written, to present valid photographic
344.34 identification, unless the person purchasing the controlled substance, or if applicable the
344.35 person for whom the controlled substance prescription is written, is known to the dispenser.

Sec. 11. [152.126] SCHEDULE II AND III CONTROLLED SUBSTANCES
PRESCRIPTION ELECTRONIC REPORTING SYSTEM.

Subdivision 1. Definitions. For purposes of this section, the terms defined in this subdivision have the meanings given.

(a) "Board" means the Minnesota State Board of Pharmacy established under chapter 151.

(b) "Controlled substances" means those substances listed in section 152.02, subdivisions 3 and 4, and those substances defined by the board pursuant to section 152.02, subdivisions 8 and 12.

(c) "Dispense" or "dispensing" has the meaning given in section 151.01, subdivision 30. Dispensing does not include the direct administering of a controlled substance to a patient by a licensed health care professional.

(d) "Dispenser" means a person authorized by law to dispense a controlled substance, pursuant to a valid prescription. A dispenser does not include a licensed hospital pharmacy 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.

- 346.1 Subd. 3. **Prescription Electronic Reporting Advisory Committee.** (a) The
346.2 board shall convene an advisory committee. The committee must include at least one
346.3 representative of:
- 346.4 (1) the Department of Health;
 - 346.5 (2) the Department of Human Services;
 - 346.6 (3) each health-related licensing board that licenses prescribers;
 - 346.7 (4) a professional medical association, which may include an association of pain
346.8 management and chemical dependency specialists;
 - 346.9 (5) a professional pharmacy association;
 - 346.10 (6) a consumer privacy or security advocate; and
 - 346.11 (7) a consumer or patient rights organization.
- 346.12 (b) The advisory committee shall advise the board on the development and operation
346.13 of the electronic reporting system, including, but not limited to:
- 346.14 (1) technical standards for electronic prescription drug reporting;
 - 346.15 (2) proper analysis and interpretation of prescription monitoring data; and
 - 346.16 (3) an evaluation process for the program.
- 346.17 (c) The Board of Pharmacy, after consultation with the advisory committee, shall
346.18 present recommendations and draft legislation on the issues addressed by the advisory
346.19 committee under paragraph (b), to the legislature by December 15, 2007.
- 346.20 Subd. 4. **Reporting requirements and notice.** (a) Each dispenser must submit the
346.21 following data to the board or its designated vendor, subject to the notice required under
346.22 paragraph (d):
- 346.23 (1) prescriber DEA number;
 - 346.24 (2) dispenser DEA number;
 - 346.25 (3) name of the patient for whom the prescription was written;
 - 346.26 (4) date of birth of the patient for whom the prescription was written;
 - 346.27 (5) date the prescription was written;
 - 346.28 (6) date the prescription was filled;
 - 346.29 (7) NDC code for drug dispensed; and
 - 346.30 (8) quantity of controlled substance dispensed.
- 346.31 (b) The dispenser must submit the required information according to the format and
346.32 protocols specified in the "ASAP Telecommunications Format for Controlled Substances,"
346.33 May 1995 edition, published by the American Society for Automation in Pharmacy, which
346.34 is hereby adopted by reference, by a procedure established by the board.
- 346.35 (c) A dispenser is not required to submit this data for those controlled substance
346.36 prescriptions dispensed for:

347.1 (1) individuals residing in licensed skilled nursing or intermediate care facilities;
347.2 (2) individuals receiving assisted living services under chapter 144G or through a
347.3 medical assistance home and community-based waiver;
347.4 (3) individuals receiving medication intravenously;
347.5 (4) individuals receiving hospice and other palliative or end-of-life care; and
347.6 (5) individuals receiving services from a home care provider regulated under chapter
347.7 144A.

347.8 (d) A dispenser must not submit data under this subdivision unless a conspicuous
347.9 notice of the reporting requirements of this section is given to the patient for whom the
347.10 prescription was written.

347.11 Subd. 5. Use of data by board. (a) The board shall develop and maintain a database
347.12 of the data reported under subdivision 4. The board shall maintain data that could identify
347.13 an individual prescriber or dispenser in encrypted form. The database may be used by
347.14 permissible users identified under subdivision 6 for the identification of:

347.15 (1) individuals receiving prescriptions for controlled substances from prescribers
347.16 who subsequently obtain controlled substances from dispensers in quantities or with a
347.17 frequency inconsistent with generally recognized standards of dosage for those controlled
347.18 substances; and

347.19 (2) individuals presenting forged or otherwise false or altered prescriptions for
347.20 controlled substances to dispensers.

347.21 (b) No permissible user identified under subdivision 6 may access the database
347.22 for the sole purpose of identifying prescribers of controlled substances for unusual or
347.23 excessive prescribing patterns without a valid search warrant or court order.

347.24 (c) No personnel of a state or federal occupational licensing board or agency may
347.25 access the database for the purpose of obtaining information to be used to initiate or
347.26 substantiate a disciplinary action against a prescriber.

347.27 (d) Data reported under subdivision 4 shall be retained by the board in the database
347.28 for a six-month period, and shall be removed from the database six months from the
347.29 date the data was received.

347.30 Subd. 6. Access to reporting system data. (a) Except as indicated in this
347.31 subdivision, the data submitted to the board under subdivision 4 is private data on
347.32 individuals as defined in section 13.02, subdivision 12, and not subject to public disclosure.

347.33 (b) Except as specified in subdivision 5, the following persons shall be considered
347.34 permissible users and may access the data submitted under subdivision 4 in the same or
347.35 similar manner, and for the same or similar purposes, as those persons who are authorized
347.36 to access similar private data on individuals under federal and state law:

(1) a prescriber, to the extent the information relates specifically to a current patient of the prescriber, to whom the practitioner is prescribing or considering prescribing any controlled substance;

(2) a dispenser to the extent the information relates specifically to a current patient to whom that dispenser is dispensing or considering dispensing any controlled substance;

(3) an individual who is the recipient of a controlled substance prescription for which data was submitted under subdivision 4;

(4) personnel of the board specifically assigned to conduct a bona fide investigation of a specific board licensee;

(5) personnel of the board engaged in the collection of controlled substance prescription information as part of the assigned duties and responsibilities under this section;

(6) authorized personnel of a vendor under contract with the board who are engaged in the design, implementation, and maintenance of the electronic reporting system as part of the assigned duties and responsibilities of their employment, provided that access to data 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.

(b) The board shall submit the evaluation of the system to the legislature by January 15, 2010.

Subd. 9. **Immunity from liability; no requirement to obtain information.** (a) A pharmacist, prescriber, or other dispenser making a report to the program in good faith under this section is immune from any civil, criminal, or administrative liability, which might otherwise be incurred or imposed as a result of the report, or on the basis that the pharmacist or prescriber did or did not seek or obtain or use information from the program.

(b) Nothing in this section shall require a pharmacist, prescriber, or other dispenser to obtain information about a patient from the program, and the pharmacist, prescriber, or other dispenser, if acting in good faith, is immune from any civil, criminal, or administrative liability that might otherwise be incurred or imposed for requesting, receiving, or using information from the program.

EFFECTIVE DATE. This section is effective July 1, 2007, or upon receiving sufficient nonstate funds to implement the prescription electronic reporting program, whichever is later. In the event that nonstate funds are not secured by the Board of Pharmacy to adequately fund the implementation of the prescription electronic reporting program, the board is not required to implement this section without a subsequent appropriation from the legislature.

Sec. 12. Minnesota Statutes 2006, section 179A.03, subdivision 7, is amended to read:

Subd. 7. **Essential employee.** "Essential employee" means firefighters, peace officers subject to licensure under sections 626.84 to 626.863, 911 system and police and fire department public safety dispatchers, guards at correctional facilities, confidential employees, supervisory employees, assistant county attorneys, assistant city attorneys, principals, and assistant principals. However, for state employees, "essential employee" means all employees, except for nonprofessional employees employed by the Department of Human Services in mental health facilities for the treatment of psychopathic personalities, sexual predators, and the criminally insane, in law enforcement, public safety radio communications operators, health care professionals, correctional guards, professional engineering, and supervisory collective bargaining units, irrespective of severance, and no other employees. For University of Minnesota employees, "essential employee" means all employees in law enforcement, nursing professional and supervisory units, irrespective of severance, and no other employees. "Firefighters" means salaried employees of a fire department whose duties include, directly or indirectly, controlling, extinguishing, preventing, detecting, or investigating fires. Employees for whom the state court administrator is the negotiating employer are not essential employees. For Hennepin Healthcare System, Inc. employees, "essential employees" means all employees.

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

Sec. 13. Minnesota Statutes 2006, section 245.4874, is amended to read:

245.4874 DUTIES OF COUNTY BOARD.

(a) The county board must:

(1) develop a system of affordable and locally available children's mental health services according to sections 245.487 to 245.4887;

(2) establish a mechanism providing for interagency coordination as specified in section 245.4875, subdivision 6;

(3) consider the assessment of unmet needs in the county as reported by the local children's mental health advisory council under section 245.4875, subdivision 5, paragraph (b), clause (3). The county shall provide, upon request of the local children's mental health advisory council, readily available data to assist in the determination of unmet needs;

(4) assure that parents and providers in the county receive information about how to gain access to services provided according to sections 245.487 to 245.4887;

(5) coordinate the delivery of children's mental health services with services provided by social services, education, corrections, health, and vocational agencies to

351.1 improve the availability of mental health services to children and the cost-effectiveness of
351.2 their delivery;

351.3 (6) assure that mental health services delivered according to sections 245.487
351.4 to 245.4887 are delivered expeditiously and are appropriate to the child's diagnostic
351.5 assessment and individual treatment plan;

351.6 (7) provide the community with information about predictors and symptoms of
351.7 emotional disturbances and how to access children's mental health services according to
351.8 sections 245.4877 and 245.4878;

351.9 (8) provide for case management services to each child with severe emotional
351.10 disturbance according to sections 245.486; 245.4871, subdivisions 3 and 4; and 245.4881,
351.11 subdivisions 1, 3, and 5;

351.12 (9) provide for screening of each child under section 245.4885 upon admission
351.13 to a residential treatment facility, acute care hospital inpatient treatment, or informal
351.14 admission to a regional treatment center;

351.15 (10) prudently administer grants and purchase-of-service contracts that the county
351.16 board determines are necessary to fulfill its responsibilities under sections 245.487 to
351.17 245.4887;

351.18 (11) assure that mental health professionals, mental health practitioners, and case
351.19 managers employed by or under contract to the county to provide mental health services
351.20 are qualified under section 245.4871;

351.21 (12) assure that children's mental health services are coordinated with adult mental
351.22 health services specified in sections 245.461 to 245.486 so that a continuum of mental
351.23 health services is available to serve persons with mental illness, regardless of the person's
351.24 age;

351.25 (13) assure that culturally informed mental health consultants are used as necessary
351.26 to assist the county board in assessing and providing appropriate treatment for children of
351.27 cultural or racial minority heritage; and

351.28 (14) consistent with section 245.486, arrange for or provide a children's mental
351.29 health screening to a child receiving child protective services or a child in out-of-home
351.30 placement, a child for whom parental rights have been terminated, a child found to be
351.31 delinquent, and a child found to have committed a juvenile petty offense for the third
351.32 or subsequent time, unless a screening or diagnostic assessment has been performed
351.33 within the previous 180 days, or the child is currently under the care of a mental health
351.34 professional. The court or county agency must notify a parent or guardian whose
351.35 parental rights have not been terminated of the potential mental health screening and the
351.36 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.

Sec. 14. Minnesota Statutes 2006, section 253B.185, subdivision 2, is amended to read:

Subd. 2. **Transfer to correctional facility.** (a) If a person has been committed under this section and later is committed to the custody of the commissioner of corrections for any reason, including but not limited to, being sentenced for a crime or revocation of the person's supervised release or conditional release under section 244.05, ~~609.108, subdivision 6,~~ or 609.109, subdivision 7, the person shall be transferred to a facility designated by the commissioner of corrections without regard to the procedures provided in section 253B.18.

(b) If a person is committed under this section after a commitment to the commissioner of corrections, the person shall first serve the sentence in a facility designated by the commissioner of corrections. After the person has served the sentence,

353.1 the person shall be transferred to a treatment program designated by the commissioner
353.2 of human services.

353.3 Sec. 15. Minnesota Statutes 2006, section 254A.03, subdivision 3, is amended to read:

353.4 Subd. 3. **Rules for chemical dependency care.** The commissioner of human
353.5 services shall establish by rule criteria to be used in determining the appropriate level
353.6 of chemical dependency care, ~~whether outpatient, inpatient or short-term treatment~~
353.7 ~~programs~~, for each recipient of public assistance seeking treatment for alcohol or other
353.8 drug dependency and abuse problems. ~~The criteria shall address, at least, the family~~
353.9 ~~relationship, past treatment history, medical or physical problems, arrest record, and~~
353.10 ~~employment situation.~~

353.11 Sec. 16. Minnesota Statutes 2006, section 254A.16, subdivision 2, is amended to read:

353.12 Subd. 2. **Program and service guidelines.** (a) The commissioner shall provide
353.13 program and service guidelines and technical assistance to the county boards in carrying
353.14 out services authorized under ~~sections~~ section 254A.08, ~~254A.12, 254A.14, and their~~
353.15 ~~responsibilities under chapter 256E.~~

353.16 (b) The commissioner shall recommend to the governor means of improving
353.17 the efficiency and effectiveness of comprehensive program services in the state and
353.18 maximizing the use of nongovernmental funds for providing comprehensive programs.

353.19 Sec. 17. **[254A.20] CHEMICAL USE ASSESSMENTS; FINANCIAL CONFLICT**
353.20 **OF INTEREST.**

353.21 (a) Except as provided in paragraph (b), an assessor conducting a chemical use
353.22 assessment under Minnesota Rules, parts 9530.6600 to 9530.6655, may not have any
353.23 direct or shared financial interest or referral relationship resulting in shared financial
353.24 interest or referral relationship resulting in shared financial gain with a treatment provider.

353.25 (b) A county may contract with an assessor having a conflict described in paragraph
353.26 (a) if the county documents that:

353.27 (1) the assessor is employed by a culturally specific service provider or a service
353.28 provider with a program designed to treat individuals of a specific age, sex, or sexual
353.29 preference;

353.30 (2) the county does not employ a sufficient number of qualified assessors and the
353.31 only qualified assessors available in the county have a direct or shared financial interest or
353.32 a referral relationship resulting in shared financial gain with a treatment provider; or

354.1 (3) the county social service agency has an existing relationship with an assessor
354.2 or service provider and elects to enter into a contract with that assessor to provide both
354.3 assessment and treatment under circumstances specified in the county's contract, provided
354.4 the county retains responsibility for making placement decisions.

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

354.6 Sec. 18. Minnesota Statutes 2006, section 254B.02, subdivision 1, is amended to read:

354.7 Subdivision 1. **Chemical dependency treatment allocation.** The chemical
354.8 dependency funds appropriated for allocation shall be placed in a special revenue account.
354.9 The commissioner shall annually transfer funds from the chemical dependency fund to pay
354.10 for operation of the drug and alcohol abuse normative evaluation system and to pay for all
354.11 costs incurred by adding two positions for licensing of chemical dependency treatment
354.12 and rehabilitation programs located in hospitals for which funds are not otherwise
354.13 appropriated. ~~For each year of the biennium ending June 30, 1999, the commissioner shall~~
354.14 ~~allocate funds to the American Indian chemical dependency tribal account for treatment~~
354.15 ~~of American Indians by eligible vendors under section 254B.05, equal to the amount~~
354.16 ~~allocated in fiscal year 1997.~~ Six percent of the remaining money must be reserved for
354.17 tribal allocation under section 254B.09, subdivisions 4 and 5. The commissioner shall
354.18 annually divide the money available in the chemical dependency fund that is not held
354.19 in reserve by counties from a previous allocation, or allocated to the American Indian
354.20 chemical dependency tribal account. Six percent of the remaining money must be
354.21 reserved for the nonreservation American Indian chemical dependency allocation for
354.22 treatment of American Indians by eligible vendors under section 254B.05, subdivision
354.23 1. The remainder of the money must be allocated among the counties according to the
354.24 following formula, using state demographer data and other data sources determined by
354.25 the commissioner:

354.26 (a) For purposes of this formula, American Indians and children under age 14 are
354.27 subtracted from the population of each county to determine the restricted population.

354.28 (b) The amount of chemical dependency fund expenditures for entitled persons for
354.29 services not covered by prepaid plans governed by section 256B.69 in the previous year is
354.30 divided by the amount of chemical dependency fund expenditures for entitled persons for
354.31 all services to determine the proportion of exempt service expenditures for each county.

354.32 (c) The prepaid plan months of eligibility is multiplied by the proportion of exempt
354.33 service expenditures to determine the adjusted prepaid plan months of eligibility for
354.34 each county.

(d) The adjusted prepaid plan months of eligibility is added to the number of restricted population fee for service months of eligibility for the Minnesota family investment program, general assistance, and medical assistance and divided by the county restricted population to determine county per capita months of covered service eligibility.

(e) The number of adjusted prepaid plan months of eligibility for the state is added to the number of fee for service months of eligibility for the Minnesota family investment program, general assistance, and medical assistance for the state restricted population and divided by the state restricted population to determine state per capita months of covered service eligibility.

(f) The county per capita months of covered service eligibility is divided by the state per capita months of covered service eligibility to determine the county welfare caseload factor.

(g) The median married couple income for the most recent three-year period available for the state is divided by the median married couple income for the same period for each county to determine the income factor for each county.

(h) The county restricted population is multiplied by the sum of the county welfare caseload factor and the county income factor to determine the adjusted population.

(i) \$15,000 shall be allocated to each county.

(j) The remaining funds shall be allocated proportional to the county adjusted population.

Sec. 19. Minnesota Statutes 2006, section 254B.02, subdivision 5, is amended to read:

Subd. 5. **Administrative adjustment.** The commissioner may make payments to local agencies from money allocated under this section to support administrative activities under sections 254B.03 and 254B.04. The administrative payment must not exceed five percent of the first \$50,000, four percent of the next \$50,000, and three percent of the remaining payments for services from the allocation. ~~Twenty-five percent of the administrative allowance shall be advanced at the beginning of each quarter, based on the payments for services made in the most recent quarter for which data is available. Adjustment of any overestimate or underestimate based on actual expenditures shall be made by the state agency by adjusting the administrative allowance for any succeeding quarter.~~

Sec. 20. Minnesota Statutes 2006, section 254B.03, subdivision 1, is amended to read:

Subdivision 1. **Local agency duties.** (a) Every local agency shall provide chemical dependency services to persons residing within its jurisdiction who meet criteria

established by the commissioner for placement in a chemical dependency residential or nonresidential treatment service. Chemical dependency money must be administered by the local agencies according to law and rules adopted by the commissioner under sections 14.001 to 14.69.

(b) In order to contain costs, the county board shall, with the approval of the commissioner of human services, select eligible vendors of chemical dependency services who can provide economical and appropriate treatment. Unless the local agency is a social services department directly administered by a county or human services board, the local agency shall not be an eligible vendor under section 254B.05. The commissioner may approve proposals from county boards to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are provided. If a county implements a demonstration or experimental medical services funding plan, the commissioner shall transfer the money as appropriate. If a county selects a vendor located in another state, the county shall ensure that the vendor is in compliance with the rules governing licensure of programs located in the state.

~~(c) The calendar year 2002 rate for vendors may not increase more than three 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. 21. 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. 22. 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. 23. Minnesota Statutes 2006, section 256.01, is amended by adding a subdivision to read:

Subd. 25. **Base budget detail.** The commissioner shall provide the commissioner of finance with the information necessary to provide base budget detail to the legislature under section 16A.10, subdivision 2a.

Sec. 24. **[256.9675] PUBLIC BENEFITS; INELIGIBILITY.**

A person who moves into the state with a felony conviction is ineligible for public assistance, including but not limited to benefits under medical assistance, general assistance medical care, MinnesotaCare, and the Minnesota family investment program.

Sec. 25. Minnesota Statutes 2006, section 256B.0625, subdivision 23, is amended to read:

Subd. 23. **Day treatment services.** Medical assistance covers day treatment services as specified in sections 245.462, subdivision 8, and 245.4871, subdivision 10, that are provided under contract with the county board. Notwithstanding Minnesota Rules, part 9505.0323, subpart 15, the commissioner may set authorization thresholds for day treatment for adults according to section 256B.0625, subdivision 25. Notwithstanding Minnesota Rules, part 9505.0323, subpart 15, effective July 1, 2004, medical assistance covers day treatment services for children as specified under section 256B.0943.

Sec. 26. [256B.0636] PRESCRIBING OF CONTROLLED SUBSTANCES;
ABUSE PREVENTION.

The commissioner shall develop and implement a plan to:

(1) monitor the prescribing of controlled substances listed in section 152.02, subdivisions 3 and 4, and those substances defined by the Board of Pharmacy under section 152.02, subdivisions 8 and 12, by enrolled providers and providers under contract with participating managed care plans;

(2) require enrolled providers and providers under contract with participating managed care plans to report information related to potential patient abuse of the controlled substances to the commissioner, and the Board of Pharmacy; and

(3) provide education to Minnesota health care program enrollees on the proper use of controlled substances.

Sec. 27. Minnesota Statutes 2006, section 256B.0943, subdivision 6, is amended to read:

Subd. 6. **Provider entity clinical infrastructure requirements.** (a) To be an eligible provider entity under this section, a provider entity must have a clinical infrastructure that utilizes diagnostic assessment, an individualized treatment plan, service delivery, and individual treatment plan review that are culturally competent, child-centered, and family-driven to achieve maximum benefit for the client. The provider entity must review and update the clinical policies and procedures every three years and must distribute the policies and procedures to staff initially and upon each subsequent update.

(b) The clinical infrastructure written policies and procedures must include policies and procedures for:

(1) providing or obtaining a client's diagnostic assessment that identifies acute and chronic clinical disorders, co-occurring medical conditions, sources of psychological and environmental problems, and a functional assessment. The functional assessment must clearly summarize the client's individual strengths and needs;

(2) developing an individual treatment plan that is:

(i) based on the information in the client's diagnostic assessment;

(ii) developed no later than the end of the first psychotherapy session after the completion of the client's diagnostic assessment by the mental health professional who provides the client's psychotherapy;

(iii) developed through a child-centered, family-driven planning process that identifies service needs and individualized, planned, and culturally appropriate

359.1 interventions that contain specific treatment goals and objectives for the client and the
359.2 client's family or foster family;

359.3 (iv) reviewed at least once every 90 days and revised, if necessary; and

359.4 (v) signed by the client or, if appropriate, by the client's parent or other person
359.5 authorized by statute to consent to mental health services for the client;

359.6 (3) developing an individual behavior plan that documents services to be provided
359.7 by the mental health behavioral aide. The individual behavior plan must include:

359.8 (i) detailed instructions on the service to be provided;

359.9 (ii) time allocated to each service;

359.10 (iii) methods of documenting the child's behavior;

359.11 (iv) methods of monitoring the child's progress in reaching objectives; and

359.12 (v) goals to increase or decrease targeted behavior as identified in the individual
359.13 treatment plan;

359.14 (4) clinical supervision of the mental health practitioner and mental health behavioral
359.15 aide. A mental health professional must document the clinical supervision the professional
359.16 provides by cosigning individual treatment plans and making entries in the client's record
359.17 on supervisory activities. Clinical supervision does not include the authority to make or
359.18 terminate court-ordered placements of the child. A clinical supervisor must be available
359.19 for urgent consultation as required by the individual client's needs or the situation. Clinical
359.20 supervision may occur individually or in a small group to discuss treatment and review
359.21 progress toward goals. The focus of clinical supervision must be the client's treatment
359.22 needs and progress and the mental health practitioner's or behavioral aide's ability to
359.23 provide services;

359.24 (4a) CTSS certified provider entities providing day treatment programs must meet
359.25 the conditions in items (i) to (iii):

359.26 (i) the ~~provider~~ supervisor must be present and available on the premises more
359.27 than 50 percent of the time in a five-working-day period during which the supervisee is
359.28 providing a mental health service;

359.29 (ii) the diagnosis and the client's individual treatment plan or a change in the
359.30 diagnosis or individual treatment plan must be made by or reviewed, approved, and signed
359.31 by the ~~provider~~ supervisor; and

359.32 (iii) every 30 days, the supervisor must review and sign the record of the client's care
359.33 for all activities in the preceding 30-day period;

359.34 (4b) for all other services provided under CTSS, clinical supervision standards
359.35 provided in items (i) to (iii) must be used:

(i) medical assistance shall reimburse a mental health practitioner who maintains a consulting relationship with a mental health professional who accepts full professional responsibility and is present on site for at least one observation during the first 12 hours in which the mental health practitioner provides the individual, family, or group skills training to the child or the child's family;

(ii) thereafter, the mental health professional is required to be present on site for observation as clinically appropriate when the mental health practitioner is providing individual, family, or group skills training to the child or the child's family; and

(iii) the observation must be a minimum of one clinical unit. The on-site presence of the mental health professional must be documented in the child's record and signed by the mental health professional who accepts full professional responsibility;

(5) providing direction to a mental health behavioral aide. For entities that employ mental health behavioral aides, the clinical supervisor must be employed by the provider entity or other certified children's therapeutic supports and services provider entity to ensure necessary and appropriate oversight for the client's treatment and continuity of care. The mental health professional or mental health practitioner giving direction must begin with the goals on the individualized treatment plan, and instruct the mental health behavioral aide on how to construct therapeutic activities and interventions that will lead to goal attainment. The professional or practitioner giving direction must also instruct the mental health behavioral aide about the client's diagnosis, functional status, and other characteristics that are likely to affect service delivery. Direction must also include determining that the mental health behavioral aide has the skills to interact with the client and the client's family in ways that convey personal and cultural respect and that the aide actively solicits information relevant to treatment from the family. The aide must be able to clearly explain the activities the aide is doing with the client and the activities' relationship to treatment goals. Direction is more didactic than is supervision and requires the professional or practitioner providing it to continuously evaluate the mental health behavioral aide's ability to carry out the activities of the individualized treatment plan and the individualized behavior plan. When providing direction, the professional or practitioner must:

(i) review progress notes prepared by the mental health behavioral aide for accuracy and consistency with diagnostic assessment, treatment plan, and behavior goals and the professional or practitioner must approve and sign the progress notes;

(ii) identify changes in treatment strategies, revise the individual behavior plan, and communicate treatment instructions and methodologies as appropriate to ensure that treatment is implemented correctly;

(iii) demonstrate family-friendly behaviors that support healthy collaboration among the child, the child's family, and providers as treatment is planned and implemented;

(iv) ensure that the mental health behavioral aide is able to effectively communicate with the child, the child's family, and the provider; and

(v) record the results of any evaluation and corrective actions taken to modify the work of the mental health behavioral aide;

(6) providing service delivery that implements the individual treatment plan and meets the requirements under subdivision 9; and

(7) individual treatment plan review. The review must determine the extent to which the services have met the goals and objectives in the previous treatment plan. The review must assess the client's progress and ensure that services and treatment goals continue to be necessary and appropriate to the client and the client's family or foster family. Revision of the individual treatment plan does not require a new diagnostic assessment unless the client's mental health status has changed markedly. The updated treatment plan must be signed by the client, if appropriate, and by the client's parent or other person authorized by statute to give consent to the mental health services for the child.

Sec. 28. Minnesota Statutes 2006, section 256B.0943, subdivision 9, is amended to read:

Subd. 9. **Service delivery criteria.** (a) In delivering services under this section, a 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:

(1) individual, family, and group psychotherapy must be delivered as specified in Minnesota Rules, part 9505.0323;

(2) individual, family, or group skills training must be provided by a mental health professional or a mental health practitioner who has a consulting relationship with a mental health professional who accepts full professional responsibility for the training;

(3) crisis assistance must be time-limited and designed to resolve or stabilize crisis through arrangements for direct intervention and support services to the child and the child's family. Crisis assistance must utilize resources designed to address abrupt or substantial changes in the functioning of the child or the child's family as evidenced by a sudden change in behavior with negative consequences for well being, a loss of usual coping mechanisms, or the presentation of danger to self or others;

(4) medically necessary services that are provided by a mental health behavioral aide must be designed to improve the functioning of the child and support the family in activities of daily and community living. A mental health behavioral aide must document the delivery of services in written progress notes. The mental health behavioral aide must implement goals in the treatment plan for the child's emotional disturbance that

363.1 allow the child to acquire developmentally and therapeutically appropriate daily living
363.2 skills, social skills, and leisure and recreational skills through targeted activities. These
363.3 activities may include:

- 363.4 (i) assisting a child as needed with skills development in dressing, eating, and
363.5 toileting;
- 363.6 (ii) assisting, monitoring, and guiding the child to complete tasks, including
363.7 facilitating the child's participation in medical appointments;
- 363.8 (iii) observing the child and intervening to redirect the child's inappropriate behavior;
- 363.9 (iv) assisting the child in using age-appropriate self-management skills as related
363.10 to the child's emotional disorder or mental illness, including problem solving, decision
363.11 making, communication, conflict resolution, anger management, social skills, and
363.12 recreational skills;
- 363.13 (v) implementing deescalation techniques as recommended by the mental health
363.14 professional;
- 363.15 (vi) implementing any other mental health service that the mental health professional
363.16 has approved as being within the scope of the behavioral aide's duties; or
- 363.17 (vii) assisting the parents to develop and use parenting skills that help the child
363.18 achieve the goals outlined in the child's individual treatment plan or individual behavioral
363.19 plan. Parenting skills must be directed exclusively to the child's treatment; and

363.20 (5) direction of a mental health behavioral aide must include the following:

- 363.21 (i) a total of one hour of on-site observation by a mental health professional during
363.22 the first 12 hours of service provided to a child;
- 363.23 (ii) ongoing on-site observation by a mental health professional or mental health
363.24 practitioner for at least a total of one hour during every 40 hours of service provided
363.25 to a child; and
- 363.26 (iii) immediate accessibility of the mental health professional or mental health
363.27 practitioner to the mental health behavioral aide during service provision.

363.28 Sec. 29. Minnesota Statutes 2006, section 256B.0943, subdivision 11, is amended to
363.29 read:

363.30 Subd. 11. **Documentation and billing.** (a) A provider entity must document the
363.31 services it provides under this section. The provider entity must ensure that the entity's
363.32 documentation standards meet the requirements of federal and state laws. Services billed
363.33 under this section that are not documented according to this subdivision shall be subject to
363.34 monetary recovery by the commissioner. The provider entity may not bill for anything
363.35 other than direct service time.

364.1 (b) An individual mental health provider must promptly document the following
364.2 in a client's record after providing services to the client:

364.3 (1) each occurrence of the client's mental health service, including the date, type,
364.4 length, and scope of the service;

364.5 (2) the name of the person who gave the service;

364.6 (3) contact made with other persons interested in the client, including representatives
364.7 of the courts, corrections systems, or schools. The provider must document the name
364.8 and date of each contact;

364.9 (4) any contact made with the client's other mental health providers, case manager,
364.10 family members, primary caregiver, legal representative, or the reason the provider did
364.11 not contact the client's family members, primary caregiver, or legal representative, if
364.12 applicable; and

364.13 (5) required clinical supervision, as appropriate.

364.14 Sec. 30. Minnesota Statutes 2006, section 256B.0943, subdivision 12, is amended to
364.15 read:

364.16 Subd. 12. **Excluded services.** The following services are not eligible for medical
364.17 assistance payment as children's therapeutic services and supports:

364.18 (1) service components of children's therapeutic services and supports
364.19 simultaneously provided by more than one provider entity unless prior authorization is
364.20 obtained;

364.21 (2) children's therapeutic services and supports provided in violation of medical
364.22 assistance policy in Minnesota Rules, part 9505.0220;

364.23 (3) mental health behavioral aide services provided by a personal care assistant who
364.24 is not qualified as a mental health behavioral aide and employed by a certified children's
364.25 therapeutic services and supports provider entity;

364.26 (4) service components of CTSS that are the responsibility of a residential or
364.27 program license holder, including foster care providers under the terms of a service
364.28 agreement or administrative rules governing licensure; ~~and~~

364.29 (5) adjunctive activities that may be offered by a provider entity but are not
364.30 otherwise covered by medical assistance, including:

364.31 (i) a service that is primarily recreation oriented or that is provided in a setting that
364.32 is not medically supervised. This includes sports activities, exercise groups, activities
364.33 such as craft hours, leisure time, social hours, meal or snack time, trips to community
364.34 activities, and tours;

- (ii) a social or educational service that does not have or cannot reasonably be expected to have a therapeutic outcome related to the client's emotional disturbance;
- (iii) consultation with other providers or service agency staff about the care or progress of a client;
- (iv) prevention or education programs provided to the community; and
- (v) treatment for clients with primary diagnoses of alcohol or other drug abuse; and
- (6) activities that are not direct service time.

Sec. 31. **[256B.764] REIMBURSEMENT FOR FAMILY PLANNING SERVICES.**

Effective for services rendered on or after July 1, 2007, payment rates for family planning services shall be increased by 25 percent over the rates in effect July 30, 2007, when these services are provided by a community clinic as defined in section 145.9268, subdivision 1.

Sec. 32. Minnesota Statutes 2006, section 256E.35, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Family asset account" means a savings account opened by a household participating in the Minnesota family assets for independence initiative.

(c) "Fiduciary organization" means:

(1) a community action agency that has obtained recognition under section ~~268.53~~ 256E.31;

(2) a federal community development credit union serving the seven-county metropolitan area; or

(3) a women-oriented economic development agency serving the seven-county metropolitan area.

(d) "Financial institution" means a bank, bank and trust, savings bank, savings association, or credit union, the deposits of which are insured by the Federal Deposit Insurance Corporation or the National Credit Union Administration.

(e) "Permissible use" means:

(1) postsecondary educational expenses at an accredited public postsecondary institution including books, supplies, and equipment required for courses of instruction;

(2) acquisition costs of acquiring, constructing, or reconstructing a residence, including any usual or reasonable settlement, financing, or other closing costs;

(3) business capitalization expenses for expenditures on capital, plant, equipment, working capital, and inventory expenses of a legitimate business pursuant to a business plan approved by the fiduciary organization; and

(4) acquisition costs of a principal residence within the meaning of section 1034 of the Internal Revenue Code of 1986 which do not exceed 100 percent of the average area purchase price applicable to the residence determined according to section 143(e)(2) and (3) of the Internal Revenue Code of 1986.

(f) "Household" means all individuals who share use of a dwelling unit as primary quarters for living and eating separate from other individuals.

Sec. 33. **[525A.01] SHORT TITLE.**

This chapter may be cited as the "Darlene Luther Revised Uniform Anatomical Gift Act."

Sec. 34. **[525A.02] DEFINITIONS.**

Subdivision 1. **Scope.** The definitions in this section apply to this chapter.

Subd. 2. **Adult.** "Adult" means an individual who is at least 18 years of age.

Subd. 3. **Agent.** "Agent" means an individual who is:

(1) authorized to make health care decisions on the principal's behalf by a power of attorney for health care; or

(2) expressly authorized to make an anatomical gift on the principal's behalf by any other record signed by the principal.

Subd. 4. **Anatomical gift.** "Anatomical gift" means a donation of all or part of a human body to take effect after the donor's death for the purpose of transplantation, therapy, research, or education.

Subd. 5. **Decedent.** "Decedent" means a deceased individual and includes a stillborn infant or an embryo or fetus that has died of natural causes in utero.

Subd. 6. **Disinterested witness.** "Disinterested witness" means a witness other than the spouse, child, parent, sibling, grandchild, grandparent, or guardian of the individual who makes, amends, revokes, or refuses to make an anatomical gift, or another adult who exhibited special care and concern for the individual. The term does not include a person to which an anatomical gift could pass under section 525A.11.

Subd. 7. **Document of gift.** "Document of gift" means a donor card or other record used to make an anatomical gift. The term includes a statement or symbol on a driver's license, identification card, or donor registry.

Subd. 8. **Donor.** "Donor" means an individual whose body or part is the subject of an anatomical gift.

Subd. 9. **Donor registry.** "Donor registry" means a database that contains records of anatomical gifts and amendments to or revocations of anatomical gifts.

Subd. 10. **Driver's license.** "Driver's license" means a license or permit issued under chapter 171 to operate a vehicle, whether or not conditions are attached to the license or permit.

Subd. 11. **Eye bank.** "Eye bank" means a person that is licensed, accredited, or regulated under federal or state law to engage in the recovery, screening, testing, processing, storage, or distribution of human eyes or portions of human eyes.

Subd. 12. **Guardian.** "Guardian" means a person appointed by a court to make decisions regarding the support, care, education, health, or welfare of an individual. The term does not include a guardian ad litem.

Subd. 13. **Hospital.** "Hospital" means a facility licensed as a hospital under the law of any state or a facility operated as a hospital by the United States, a state, or a subdivision of a state.

Subd. 14. **Identification card.** "Identification card" means a Minnesota identification card issued under chapter 171.

Subd. 15. **Know.** "Know" means to have actual knowledge.

Subd. 16. **Medical examiner.** "Medical examiner" includes coroner.

Subd. 17. **Minor.** "Minor" means an individual who is under 18 years of age.

Subd. 18. **Organ procurement organization.** "Organ procurement organization" means a person designated by the secretary of the United States Department of Health and Human Services as an organ procurement organization.

Subd. 19. **Parent.** "Parent" means a parent whose parental rights have not been terminated.

Subd. 20. **Part.** "Part" means an organ, an eye, or tissue of a human being. The term does not include the whole body.

Subd. 21. **Person.** "Person" means an individual, corporation, business trust, estate, trust, partnership, limited liability company, association, joint venture, public corporation, government or governmental subdivision, agency, or instrumentality, or any other legal or commercial entity.

Subd. 22. **Physician.** "Physician" means an individual authorized to practice medicine or osteopathy under the law of any state.

Subd. 23. **Procurement organization.** "Procurement organization" means an eye bank, organ procurement organization, or tissue bank.

Subd. 24. **Prospective donor.** "Prospective donor" means an individual who is dead or near death and has been determined by a procurement organization to have a part that could be medically suitable for transplantation, therapy, research, or education. The term does not include an individual who has made a refusal.

Subd. 25. **Reasonably available.** "Reasonably available" means able to be contacted by a procurement organization without undue effort and willing and able to act in a timely manner consistent with existing medical criteria necessary for the making of an anatomical gift.

Subd. 26. **Recipient.** "Recipient" means an individual into whose body a decedent's part has been or is intended to be transplanted.

Subd. 27. **Record.** "Record" means information that is inscribed on a tangible medium or that is stored in an electronic or other medium and is retrievable in perceivable form.

Subd. 28. **Refusal.** "Refusal" means a record created under section 525A.07 that expressly states an intent to bar other persons from making an anatomical gift of an individual's body or part.

Subd. 29. **Sign.** "Sign" means, with the present intent to authenticate or adopt a record:

(1) to execute or adopt a tangible symbol; or

(2) to attach to or logically associate with the record an electronic symbol, sound, or process.

Subd. 30. **State.** "State" means a state of the United States, the District of Columbia, Puerto Rico, the United States Virgin Islands, or any territory or insular possession subject to the jurisdiction of the United States.

Subd. 31. **Technician.** "Technician" means an individual determined to be qualified to remove or process parts by an appropriate organization that is licensed, accredited, or regulated under federal or state law. The term includes an enucleator.

Subd. 32. **Tissue.** "Tissue" means a portion of the human body other than an organ or an eye. The term does not include blood unless the blood is donated for the purpose of research or education.

Subd. 33. **Tissue bank.** "Tissue bank" means a person that is licensed, accredited, or regulated under federal or state law to engage in the recovery, screening, testing, processing, storage, or distribution of tissue.

Subd. 34. **Transplant hospital.** "Transplant hospital" means a hospital that furnishes organ transplants and other medical and surgical specialty services required for the care of transplant patients.

Sec. 35. **[525A.03] APPLICABILITY.**

This chapter applies to an anatomical gift or amendment to, revocation of, or refusal to make an anatomical gift, whenever made.

Sec. 36. **[525A.04] WHO MAY MAKE ANATOMICAL GIFT BEFORE
DONOR'S DEATH.**

Subject to section 525A.08, an anatomical gift of a donor's body or part may be made during the life of the donor for the purpose of transplantation, therapy, research, or education in the manner provided in section 525A.05 by:

- (1) the donor, if the donor is an adult or if the donor is a minor and is:
 - (i) emancipated; or
 - (ii) authorized under state law to apply for a driver's license because the donor is at least 16 years of age;
- (2) an agent of the donor, unless the power of attorney for health care or other record prohibits the agent from making an anatomical gift;
- (3) a parent of the donor, if the donor is an unemancipated minor; or
- (4) the donor's guardian.

Sec. 37. **[525A.05] MANNER OF MAKING ANATOMICAL GIFT BEFORE
DONOR'S DEATH.**

- (a) A donor may make an anatomical gift:
 - (1) by authorizing a statement or symbol indicating that the donor has made an anatomical gift to be imprinted on the donor's driver's license or identification card;
 - (2) in a will;
 - (3) during a terminal illness or injury of the donor, by any form of communication addressed to at least two adults, at least one of whom is a disinterested witness; or
 - (4) as provided in paragraph (b).
- (b) A donor or other person authorized to make an anatomical gift under section 525A.04 may make a gift by a donor card or other record signed by the donor or other person making the gift or by authorizing that a statement or symbol indicating that the donor has made an anatomical gift be included on a donor registry. If the donor or other person is physically unable to sign a record, the record may be signed by another individual at the direction of the donor or other person and 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) Revocation, suspension, expiration, or cancellation of a driver's license or identification card upon which an anatomical gift is indicated does not invalidate the gift.

370.1 (d) An anatomical gift made by will takes effect upon the donor's death whether or
370.2 not the will is probated. Invalidation of the will after the donor's death does not invalidate
370.3 the gift.

370.4 (e) The making of an anatomical gift shall not itself authorize or direct the denial
370.5 of health care.

370.6 Sec. 38. **[525A.06] AMENDING OR REVOKING ANATOMICAL GIFT**
370.7 **BEFORE DONOR'S DEATH.**

370.8 (a) Subject to section 525A.08, a donor or other person authorized to make an
370.9 anatomical gift under section 525A.04 may amend or revoke an anatomical gift by:

370.10 (1) a record signed by:

370.11 (i) the donor;

370.12 (ii) the other person; or

370.13 (iii) subject to paragraph (b), another individual acting at the direction of the donor
370.14 or the other person if the donor or other person is physically unable to sign; or

370.15 (2) a later-executed document of gift that amends or revokes a previous anatomical
370.16 gift or portion of an anatomical gift, either expressly or by inconsistency.

370.17 (b) A record signed pursuant to paragraph (a), clause (1), item (iii), must:

370.18 (1) be witnessed by at least two adults, at least one of whom is a disinterested
370.19 witness, who have signed at the request of the donor or the other person; and

370.20 (2) state that it has been signed and witnessed as provided in clause (1).

370.21 (c) Subject to section 525A.08, a donor or other person authorized to make an
370.22 anatomical gift under section 525A.04 may revoke an anatomical gift by the destruction or
370.23 cancellation of the document of gift, or the portion of the document of gift used to make
370.24 the gift, with the intent to revoke the gift.

370.25 (d) A donor may amend or revoke an anatomical gift that was not made in a will
370.26 by any form of communication during a terminal illness or injury addressed to at least
370.27 two adults, at least one of whom is a disinterested witness.

370.28 (e) A donor who makes an anatomical gift in a will may amend or revoke the gift in
370.29 the manner provided for amendment or revocation of wills or as provided in paragraph (a).

370.30 Sec. 39. **[525A.07] REFUSAL TO MAKE ANATOMICAL GIFT; EFFECT OF**
370.31 **REFUSAL.**

370.32 (a) An individual may refuse to make an anatomical gift of the individual's body
370.33 or part by:

370.34 (1) a record signed by:

- 371.1 (i) the individual; or
371.2 (ii) subject to paragraph (b), another individual acting at the direction of the
371.3 individual if the individual is physically unable to sign;
371.4 (2) the individual's will, whether or not the will is admitted to probate or invalidated
371.5 after the individual's death; or
371.6 (3) any form of communication made by the individual during the individual's
371.7 terminal illness or injury addressed to at least two adults, at least one of whom is a
371.8 disinterested witness.
371.9 (b) A record signed pursuant to paragraph (a), clause (1), item (ii), must:
371.10 (1) be witnessed by at least two adults, at least one of whom is a disinterested
371.11 witness, who have signed at the request of the individual; and
371.12 (2) state that it has been signed and witnessed as provided in clause (1).
371.13 (c) An individual who has made a refusal may amend or revoke the refusal:
371.14 (1) in the manner provided in paragraph (a) for making a refusal;
371.15 (2) by subsequently making an anatomical gift pursuant to section 525A.05 that is
371.16 inconsistent with the refusal; or
371.17 (3) by destroying or canceling the record evidencing the refusal, or the portion of the
371.18 record used to make the refusal, with the intent to revoke the refusal.
371.19 (d) Except as otherwise provided in section 525A.08, paragraph (h), in the absence
371.20 of an express, contrary indication by the individual set forth in the refusal, an individual's
371.21 unrevoked refusal to make an anatomical gift of the individual's body or part bars all other
371.22 persons from making an anatomical gift of the individual's body or part.

371.23 Sec. 40. **[525A.08] PRECLUSIVE EFFECT OF ANATOMICAL GIFT,**
371.24 **AMENDMENT, OR REVOCATION.**

- 371.25 (a) Except as otherwise provided in paragraph (g) and subject to paragraph (f), in the
371.26 absence of an express, contrary indication by the donor, a person other than the donor is
371.27 barred from making, amending, or revoking an anatomical gift of a donor's body or part if
371.28 the donor made an anatomical gift of the donor's body or part under section 525A.05 or an
371.29 amendment to an anatomical gift of the donor's body or part under section 525A.06. An
371.30 anatomical gift made in a will, a designation on a driver's license or identification card, or
371.31 a health care directive under chapter 145C, and not revoked, establishes the intent of the
371.32 person making the designation and may not be overridden by any other person.
371.33 (b) A donor's revocation of an anatomical gift of the donor's body or part under
371.34 section 525A.06 is not a refusal and does not bar another person specified in section

372.1 525A.04 or 525A.09 from making an anatomical gift of the donor's body or part under
372.2 section 525A.05 or 525A.10.

372.3 (c) If a person other than the donor makes an unrevoked anatomical gift of the
372.4 donor's body or part under section 525A.05 or an amendment to an anatomical gift of the
372.5 donor's body or part under section 525A.06, another person may not make, amend, or
372.6 revoke the gift of the donor's body or part under section 525A.10.

372.7 (d) A revocation of an anatomical gift of a donor's body or part under section
372.8 525A.06 by a person other than the donor does not bar another person from making an
372.9 anatomical gift of the body or part under section 525A.05 or 525A.10.

372.10 (e) In the absence of an express, contrary indication by the donor or other person
372.11 authorized to make an anatomical gift under section 525A.04, an anatomical gift of a part
372.12 is neither a refusal to give another part nor a limitation on the making of an anatomical gift
372.13 of another part at a later time by the donor or another person.

372.14 (f) In the absence of an express, contrary indication by the donor or other person
372.15 authorized to make an anatomical gift under section 525A.04, an anatomical gift of a
372.16 part for one or more of the purposes set forth in section 525A.04 is not a limitation on
372.17 the making of an anatomical gift of the part for any of the other purposes by the donor
372.18 or any other person under section 525A.05 or 525A.10.

372.19 (g) If a donor who is an unemancipated minor dies, a parent of the donor who is
372.20 reasonably available may revoke or amend an anatomical gift of the donor's body or part.

372.21 (h) If an unemancipated minor who signed a refusal dies, a parent of the minor who
372.22 is reasonably available may revoke the minor's refusal.

372.23 **Sec. 41. [525A.09] WHO MAY MAKE ANATOMICAL GIFT OF DECEDENT'S**
372.24 **BODY OR PART.**

372.25 (a) Subject to paragraphs (b) and (c) and unless barred by section 525A.07 or
372.26 525A.08, an anatomical gift of a decedent's body or part for the purpose of transplantation,
372.27 therapy, research, or education may be made by any member of the following classes of
372.28 persons who is reasonably available, in the order of priority listed:

372.29 (1) an agent of the decedent at the time of death who could have made an anatomical
372.30 gift under section 525A.04, clause (2), immediately before the decedent's death;

372.31 (2) the spouse of the decedent;

372.32 (3) adult children of the decedent;

372.33 (4) parents of the decedent;

372.34 (5) adult siblings of the decedent;

372.35 (6) adult grandchildren of the decedent;

373.1 (7) grandparents of the decedent;

373.2 (8) an adult who exhibited special care and concern for the decedent;

373.3 (9) the persons who were acting as the guardians of the person of the decedent
373.4 at the time of death; and

373.5 (10) any other person having the authority to dispose of the decedent's body.

373.6 (b) If there is more than one member of a class listed in paragraph (a), clause (1),
373.7 (3), (4), (5), (6), (7), or (9), entitled to make an anatomical gift, an anatomical gift may
373.8 be made by a member of the class unless that member or a person to which the gift may
373.9 pass under section 525A.11 knows of an objection by another member of the class. If
373.10 an objection is known, the gift may be made only by a majority of the members of the
373.11 class who are reasonably available.

373.12 (c) A person may not make an anatomical gift if, at the time of the decedent's death,
373.13 a person in a prior class under paragraph (a) is reasonably available to make or to object to
373.14 the making of an anatomical gift.

373.15 Sec. 42. **[525A.10] MANNER OF MAKING, AMENDING, OR REVOKING**
373.16 **ANATOMICAL GIFT OF DECEDENT'S BODY OR PART.**

373.17 (a) A person authorized to make an anatomical gift under section 525A.09 may
373.18 make an anatomical gift by a document of gift signed by the person making the gift or by
373.19 that person's oral communication that is electronically recorded or is contemporaneously
373.20 reduced to a record and signed by the individual receiving the oral communication.

373.21 (b) Subject to paragraph (c), an anatomical gift by a person authorized under section
373.22 525A.09 may be amended or revoked orally or in a record by any member of a prior class
373.23 who is reasonably available. If more than one member of the prior class is reasonably
373.24 available, the gift made by a person authorized under section 525A.09 may be:

373.25 (1) amended only if a majority of the reasonably available members agree to the
373.26 amending of the gift; or

373.27 (2) revoked only if a majority of the reasonably available members agree to the
373.28 revoking of the gift or if they are equally divided as to whether to revoke the gift.

373.29 (c) A revocation under paragraph (b) is effective only if, before an incision has been
373.30 made to remove a part from the donor's body or before invasive procedures have begun to
373.31 prepare the recipient, the procurement organization, transplant hospital, or physician or
373.32 technician knows of the revocation.

373.33 Sec. 43. **[525A.11] PERSONS THAT MAY RECEIVE ANATOMICAL GIFT;**
373.34 **PURPOSE OF ANATOMICAL GIFT.**

374.1 (a) An anatomical gift may be made to the following persons named in the document
374.2 of gift:

374.3 (1) a hospital; accredited medical school, dental school, college, or university; organ
374.4 procurement organization; or nonprofit organization in medical education or research,
374.5 for research or education;

374.6 (2) subject to paragraph (b), an individual designated by the person making the
374.7 anatomical gift if the individual is the recipient of the part; and

374.8 (3) an eye bank or tissue bank.

374.9 (b) If an anatomical gift to an individual under paragraph (a), clause (2), cannot be
374.10 transplanted into the individual, the part passes in accordance with paragraph (g) in the
374.11 absence of an express, contrary indication by the person making the anatomical gift.

374.12 (c) If an anatomical gift of one or more specific parts or of all parts is made in a
374.13 document of gift that does not name a person described in paragraph (a) but identifies the
374.14 purpose for which an anatomical gift may be used, the following rules apply:

374.15 (1) if the part is an eye and the gift is for the purpose of transplantation or therapy,
374.16 the gift passes to the appropriate eye bank;

374.17 (2) if the part is tissue and the gift is for the purpose of transplantation or therapy, the
374.18 gift passes to the appropriate tissue bank;

374.19 (3) if the part is an organ and the gift is for the purpose of transplantation or therapy,
374.20 the gift passes to the appropriate organ procurement organization as custodian of the
374.21 organ; and

374.22 (4) if the part is an organ, an eye, or tissue and the gift is for the purpose of research
374.23 or education, the gift passes to the appropriate procurement organization.

374.24 (d) For the purpose of paragraph (c), if there is more than one purpose of an
374.25 anatomical gift set forth in the document of gift but the purposes are not set forth in any
374.26 priority, the gift must be used for transplantation or therapy, if suitable. If the gift cannot
374.27 be used for transplantation or therapy, the gift may be used for research or education.

374.28 (e) If an anatomical gift of one or more specific parts is made in a document of gift
374.29 that does not name a person described in paragraph (a) and does not identify the purpose
374.30 of the gift, the gift may be used only for transplantation or therapy, and the gift passes in
374.31 accordance with paragraph (g).

374.32 (f) If a document of gift specifies only a general intent to make an anatomical gift
374.33 by words such as "donor," "organ donor," or "body donor," or by a symbol or statement
374.34 of similar import, the gift may be used only for transplantation or therapy, and the gift
374.35 passes in accordance with paragraph (g).

374.36 (g) For purposes of paragraphs (b), (e), and (f), the following rules apply:

375.1 (1) if the part is an eye, the gift passes to the appropriate eye bank;
375.2 (2) if the part is tissue, the gift passes to the appropriate tissue bank; and
375.3 (3) if the part is an organ, the gift passes to the appropriate organ procurement
375.4 organization as custodian of the organ.

375.5 (h) An anatomical gift of an organ for transplantation or therapy, other than
375.6 an anatomical gift under paragraph (a), clause (2), passes to the organ procurement
375.7 organization as custodian of the organ.

375.8 (i) If an anatomical gift does not pass pursuant to paragraphs (a) to (h) or the
375.9 decedent's body or part is not used for transplantation, therapy, research, or education,
375.10 custody of the body or part passes to the person under obligation to dispose of the body or
375.11 part.

375.12 (j) A person may not accept an anatomical gift if the person knows that the gift was
375.13 not effectively made under section 525A.05 or 525A.10 or if the person knows that the
375.14 decedent made a refusal under section 525A.07 that was not revoked. For purposes of
375.15 this paragraph, if a person knows that an anatomical gift was made on a document of gift,
375.16 the person is deemed to know of any amendment or revocation of the gift or any refusal
375.17 to make an anatomical gift on the same document of gift.

375.18 (k) Except as otherwise provided in paragraph (a), clause (2), nothing in this chapter
375.19 affects the allocation of organs for transplantation or therapy.

375.20 Sec. 44. **[525A.12] SEARCH AND NOTIFICATION.**

375.21 (a) The following persons shall make a reasonable search of an individual who
375.22 the person reasonably believes is dead or near death for a document of gift or other
375.23 information identifying the individual as a donor or as an individual who made a refusal:

375.24 (1) a law enforcement officer, firefighter, paramedic, or other emergency rescuer
375.25 finding the individual; and

375.26 (2) if no other source of the information is immediately available, a hospital, as soon
375.27 as practical after the individual's arrival at the hospital.

375.28 (b) If a document of gift or a refusal to make an anatomical gift is located by the
375.29 search required by paragraph (a), clause (1), and the individual or deceased individual to
375.30 whom it relates is taken to a hospital, the person responsible for conducting the search
375.31 shall send the document of gift or refusal to the hospital. If a body is transferred to
375.32 the custody of the medical examiner, the person who discovered the body must notify
375.33 the person's dispatcher. A dispatcher notified under this section must notify the state's
375.34 federally designated organ procurement organization and inform the organization of the
375.35 deceased's name, donor status, and location.

376.1 (c) A person is not subject to criminal or civil liability for failing to discharge the
376.2 duties imposed by this section but may be subject to administrative sanctions.

376.3 Sec. 45. **[525A.13] DELIVERY OF DOCUMENT OF GIFT NOT REQUIRED;**
376.4 **RIGHT TO EXAMINE.**

376.5 (a) A document of gift need not be delivered during the donor's lifetime to be
376.6 effective.

376.7 (b) Upon or after an individual's death, a person in possession of a document of
376.8 gift or a refusal to make an anatomical gift with respect to the individual shall allow
376.9 examination and copying of the document of gift or refusal by a person authorized to
376.10 make or object to the making of an anatomical gift with respect to the individual or by a
376.11 person to which the gift could pass under section 525A.11.

376.12 Sec. 46. **[525A.14] RIGHTS AND DUTIES OF PROCUREMENT**
376.13 **ORGANIZATION AND OTHERS.**

376.14 (a) When a hospital refers an individual at or near death to a procurement
376.15 organization, the organization shall make a reasonable search of the records of the
376.16 Department of Public Safety and any donor registry that it knows exists for the
376.17 geographical area in which the individual resides to ascertain whether the individual has
376.18 made an anatomical gift.

376.19 (b) A procurement organization must be allowed reasonable access to information
376.20 in the records of the Department of Public Safety to ascertain whether an individual at
376.21 or near death is a donor.

376.22 (c) When a hospital refers an individual at or near death to a procurement
376.23 organization, the organization may conduct any reasonable examination necessary to
376.24 ensure the medical suitability of a part that is or could be the subject of an anatomical gift
376.25 for transplantation, therapy, research, or education from a donor or a prospective donor.
376.26 During the examination period, measures necessary to ensure the medical suitability of the
376.27 part may not be withdrawn unless the hospital or procurement organization knows that
376.28 the individual expressed a contrary intent.

376.29 (d) Unless prohibited by law other than this chapter, at any time after a donor's death,
376.30 the person to which a part passes under section 525A.11 may conduct any reasonable
376.31 examination necessary to ensure the medical suitability of the body or part for its intended
376.32 purpose.

377.1 (e) Unless prohibited by law other than this chapter, an examination under paragraph
377.2 (c) or (d) may include an examination of all medical and dental records of the donor or
377.3 prospective donor.

377.4 (f) Upon the death of a minor who was a donor or had signed a refusal, unless a
377.5 procurement organization knows the minor is emancipated, the procurement organization
377.6 shall conduct a reasonable search for the parents of the minor and provide the parents with
377.7 an opportunity to revoke or amend the anatomical gift or revoke the refusal.

377.8 (g) Upon referral by a hospital under paragraph (a), a procurement organization shall
377.9 make a reasonable search for any person listed in section 525A.09 having priority to make
377.10 an anatomical gift on behalf of a prospective donor. If a procurement organization receives
377.11 information that an anatomical gift to any other person was made, amended, or revoked, it
377.12 shall promptly advise the other person of all relevant information.

377.13 (h) Subject to sections 525A.11, paragraph (i), and 525A.23, the rights of the person
377.14 to which a part passes under section 525A.11 are superior to the rights of all others with
377.15 respect to the part. The person may accept or reject an anatomical gift in whole or in part.
377.16 Subject to the terms of the document of gift and this chapter, a person that accepts an
377.17 anatomical gift of an entire body may allow embalming, burial, or cremation, and use of
377.18 remains in a funeral service. If the gift is of a part, the person to which the part passes
377.19 under section 525A.11, upon the death of the donor and before embalming, burial, or
377.20 cremation, shall cause the part to be removed without unnecessary mutilation.

377.21 (i) Neither the physician who attends the decedent at death nor the physician who
377.22 determines the time of the decedent's death may participate in the procedures for removing
377.23 or transplanting a part from the decedent.

377.24 (j) A physician or technician may remove a donated part from the body of a donor
377.25 that the physician or technician is qualified to remove.

377.26 Sec. 47. **[525A.15] COORDINATION OF PROCUREMENT AND USE.**

377.27 Each hospital in this state shall enter into agreements or affiliations with procurement
377.28 organizations for coordination of procurement and use of anatomical gifts.

377.29 Sec. 48. **[525A.16] SALE OR PURCHASE OF PARTS PROHIBITED; FELONY.**

377.30 (a) Except as otherwise provided in paragraph (b), a person that, for valuable
377.31 consideration, knowingly purchases or sells a part for transplantation or therapy if removal
377.32 of a part from an individual is intended to occur after the individual's death, commits a
377.33 felony and upon conviction is subject to a fine not exceeding \$10,000 or imprisonment
377.34 not exceeding five years, or both.

378.1 (b) A person may charge a reasonable amount for the removal, processing,
378.2 preservation, quality control, storage, transportation, implantation, or disposal of a part.

378.3 Sec. 49. **[525A.17] PROHIBITED ACTS; FELONY.**

378.4 A person that, in order to obtain a financial gain, intentionally falsifies, forges,
378.5 conceals, defaces, or obliterates a document of gift, an amendment or revocation of a
378.6 document of gift, or a refusal commits a felony and upon conviction is subject to a fine not
378.7 exceeding \$10,000 or imprisonment not exceeding five years, or both.

378.8 Sec. 50. **[525A.18] IMMUNITY.**

378.9 (a) A person that acts in accordance with this chapter or with the applicable
378.10 anatomical gift law of another state, or attempts in good faith to do so, is not liable for the
378.11 act in a civil action, criminal prosecution, or administrative proceeding.

378.12 (b) Neither the person making an anatomical gift nor the donor's estate is liable for
378.13 any injury or damage that results from the making or use of the gift.

378.14 (c) In determining whether an anatomical gift has been made, amended, or revoked
378.15 under this chapter, a person may rely upon representations of an individual listed in
378.16 section 525A.09, paragraph (a), clause (2), (3), (4), (5), (6), (7), or (8), relating to the
378.17 individual's relationship to the donor or prospective donor unless the person knows that
378.18 the representation is untrue.

378.19 (d) An anatomical gift under this chapter is not a sale of goods as that term is defined
378.20 in section 336.2-105, paragraph (1), or the sale of a product.

378.21 Sec. 51. **[525A.19] LAW GOVERNING VALIDITY; CHOICE OF LAW AS TO**
378.22 **EXECUTION OF DOCUMENT OF GIFT; PRESUMPTION OF VALIDITY.**

378.23 (a) A document of gift is valid if executed in accordance with:

378.24 (1) this chapter;

378.25 (2) the laws of the state or country where it was executed; or

378.26 (3) the laws of the state or country where the person making the anatomical gift
378.27 was domiciled, has a place of residence, or was a national at the time the document of
378.28 gift was executed.

378.29 (b) If a document of gift is valid under this section, the law of this state governs
378.30 the interpretation of the document of gift.

378.31 (c) A person may presume that a document of gift or amendment of an anatomical
378.32 gift is valid unless that person knows that it was not validly executed or was revoked.

Sec. 52. [525A.20] DONOR REGISTRY.

(a) The Department of Health may establish or contract for the establishment of a donor registry.

(b) The Department of Public Safety shall cooperate with a person that administers any donor registry that this state establishes, contracts for, or recognizes for the purpose of transferring to the donor registry all relevant information regarding a donor's making, amendment to, or revocation of an anatomical gift.

(c) A donor registry must:

(1) allow a donor or other person authorized under section 525A.04 to include on the donor registry a statement or symbol that the donor has made, amended, or revoked an anatomical gift;

(2) be accessible to a procurement organization to allow it to obtain relevant information on the donor registry to determine, at or near death of the donor or a prospective donor, whether the donor or prospective donor has made, amended, or revoked an anatomical gift; and

(3) be accessible, for purposes of clauses (1) and (2), seven days a week on a 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. 53. [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. 54. **[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. 55. **[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

381.1 disclosure of the postmortem examination results or other information received from the
381.2 medical examiner only if relevant to transplantation or therapy.

381.3 (b) The medical examiner may conduct a medicolegal examination by reviewing
381.4 all medical records, laboratory test results, x-rays, other diagnostic results, and other
381.5 information that any person possesses about a donor or prospective donor whose body is
381.6 under the jurisdiction of the medical examiner which the medical examiner determines
381.7 may be relevant to the investigation.

381.8 (c) A person that has any information requested by a medical examiner pursuant
381.9 to paragraph (b) shall provide that information as expeditiously as possible to allow the
381.10 medical examiner to conduct the medicolegal investigation within a period compatible
381.11 with the preservation of parts for the purpose of transplantation, therapy, research, or
381.12 education.

381.13 (d) If an anatomical gift has been or might be made of a part of a decedent whose
381.14 body is under the jurisdiction of the medical examiner and a postmortem examination
381.15 is not required, or the medical examiner determines that a postmortem examination is
381.16 required but that the recovery of the part that is the subject of an anatomical gift will
381.17 not interfere with the examination, the medical examiner and procurement organization
381.18 shall cooperate in the timely removal of the part from the decedent for the purpose of
381.19 transplantation, therapy, research, or education.

381.20 (e) If an anatomical gift of a part from the decedent under the jurisdiction of
381.21 the medical examiner has been or might be made, but the medical examiner initially
381.22 believes that the recovery of the part could interfere with the postmortem investigation
381.23 into the decedent's cause or manner of death, the medical examiner shall consult with
381.24 the procurement organization or physician or technician designated by the procurement
381.25 organization about the proposed recovery. After consultation, the medical examiner may
381.26 allow the recovery.

381.27 (f) Following the consultation under paragraph (e), in the absence of mutually
381.28 agreed-upon protocols to resolve conflict between the medical examiner and the
381.29 procurement organization, if the medical examiner intends to deny recovery of an organ
381.30 for transplantation, the medical examiner or designee, at the request of the procurement
381.31 organization, shall attend the removal procedure for the part before making a final
381.32 determination not to allow the procurement organization to recover the part. During
381.33 the removal procedure, the medical examiner or designee may allow recovery by the
381.34 procurement organization to proceed, or, if the medical examiner or designee reasonably
381.35 believes that the part may be involved in determining the decedent's cause or manner of
381.36 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. 56. **[525A.24] RELATION TO ELECTRONIC SIGNATURES IN GLOBAL AND NATIONAL COMMERCE ACT.**

This chapter modifies, limits, and supersedes the Electronic Signatures in Global and National Commerce Act, United States Code, title 15, section 7001 et seq., but does not modify, limit, or supersede section 101(a) of that act, United States Code, title 15, section 7001, or authorize electronic delivery of any of the notices described in section 103(b) of that act, United States Code, title 15, section 7003(b).

Sec. 57. Laws 2005, chapter 98, article 3, section 25, is amended to read:

Sec. 25. **REPEALER.**

Minnesota Statutes 2004, sections 245.713, ~~subdivisions 2 and~~ subdivision 4; 245.716; and 626.5551, subdivision 4, are repealed.

EFFECTIVE DATE. This section is effective retroactively from August 1, 2005.

Sec. 58. **SOBER HOUSES.**

Subdivision 1. Sober house defined. For purposes of this section, a "sober house" means a cooperative living residence that:

(1) provides temporary housing to persons with alcohol or other drug dependency and abuse problems in exchange for compensation;

(2) stipulates residents must abstain from using alcohol or drugs and meet other requirements as a condition of living in the residence; and

(3) does not provide counseling or treatment services to those residents within the meaning of Minnesota Statutes, chapter 148C or 254A.

Subd. 2. Work group creation; membership. The commissioner of human services shall convene a sober house work group which is comprised of the following members:

- (1) sober house landlords;
- (2) sober house residents;
- (3) community members with knowledge of sober housing;
- (4) representatives of cities and counties;
- (5) a representative from the Department of Human Services, Chemical Health Division;
- (6) a representative from the Department of Human Services, Licensing Division;
- (7) a representative of chemical dependency treatment providers;
- (8) a representative from the Department of Health;
- (9) a representative from the Minnesota Association of Sober Homes; and
- (10) a representative from the Association of Halfway House Alcoholism Programs of North America.

Subd. 3. Report. The work group created in subdivision 2 is directed to study the issue of sober houses in the state and determine whether state licensing or other regulation of sober houses is appropriate. The work group shall also study and include recommendations for minimum housing standards, client rights, and ways to ensure transition to safe housing for vulnerable evicted tenants. 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. 59. 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;

- 384.1 (8) dental providers;
384.2 (9) clinic administrators;
384.3 (10) state agency staff from the Departments of Health, Human Services, and
384.4 Employee Relations;
384.5 (11) Minnesota Registry of Interpreters for the Deaf;
384.6 (12) local county social services agencies;
384.7 (13) local public health agencies;
384.8 (14) interpreting stakeholders group;
384.9 (15) one interpreter trainer; and
384.10 (16) one interpreter certification examiner.
384.11 (b) The work group shall develop findings and recommendations on the following:
384.12 (1) assuring access to interpreter services;
384.13 (2) compliance with requirements of federal law and guidance;
384.14 (3) developing a quality assurance program to ensure the quality of health care
384.15 interpreting services, including requirements for training and establishing a certification
384.16 process; and
384.17 (4) identifying broad-based funding mechanisms for interpreter services.
384.18 (c) Based on the discussions of the work group, the commissioner shall make
384.19 recommendations to the chairs of the health policy and finance committees in the house
384.20 and senate by January 15, 2008, on how to ensure high quality interpreter services for
384.21 patients in medical and dental settings, and for a broad-based funding mechanism for
384.22 delivering these services.

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

384.24 Sec. 60. **FEDERAL GRANTS.**

384.25 The Board of Pharmacy shall apply for any applicable federal grants or other nonstate
384.26 funds to establish and fully implement the prescription electronic reporting system.

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

384.28 Sec. 61. **BOARD OF PHARMACY.**

384.29 The Board of Pharmacy shall not increase the license fees of pharmacists or
384.30 pharmacies in order to adequately fund the prescription electronic reporting system under
384.31 Minnesota Statutes, section 152.126, without specific authority from the legislature.

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

Sec. 62. **BOARD OF MEDICAL PRACTICE.**

The Board of Medical Practice shall convene a work group to discuss the appropriate prescribing of controlled substances listed in Minnesota Statutes, section 152.02, subdivisions 3 and 4, and those substances defined by the Board of Pharmacy under Minnesota Statutes, section 152.02, subdivisions 7, 8, and 12, for pain management, and shall report to the legislature by December 15, 2007.

Sec. 63. **AGRICULTURAL COOPERATIVE HEALTH PLAN FOR FARMERS.**

Subdivision 1. Pilot project requirements. The commissioner of commerce shall authorize a joint self-insurance pilot project administered by a trust sponsored by one or more agricultural cooperatives organized under Minnesota Statutes, chapter 308A, or under a federal charter for the purpose of offering health coverage to members of the cooperatives and their families, provided the project satisfies the requirements of Minnesota Statutes, chapter 62H, except as follows:

(1) Minnesota Statutes, section 62H.02, paragraph (b), does not apply;

(2) the notice period required under Minnesota Statutes, section 62H.02, paragraph (e), is 90 days;

(3) the commissioner shall grant necessary waivers and approve an alternative arrangement that fully funds the plan's liability or incurred but unpaid claims under 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

386.1 compliance with the requirements of this section and other applicable laws and rules. If the
386.2 commissioner determines that the operation of the trust has not improved access, expanded
386.3 health plan choices, or improved affordability of health coverage for farm families, or
386.4 that it has significantly damaged access, choice, or affordability for other consumers not
386.5 enrolled in the trust, the commissioner shall provide at least 180 days' advance written
386.6 notice to the trust and to the chairs of the senate and house finance and policy committees
386.7 with jurisdiction over health and insurance matters of the commissioner's intention not to
386.8 renew the pilot project at the expiration of a four-year period.

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

386.10 Sec. 64. **HEALTH PLAN PURCHASING POOL STUDY GROUP.**

386.11 Subdivision 1. **Creation; membership.** A health care purchasing pool study group
386.12 is created to study and make recommendations regarding the creation of a voluntary,
386.13 statewide health care purchasing pool that would contract directly with providers to
386.14 provide affordable health coverage to eligible Minnesota residents. The study group is
386.15 composed of:

386.16 (1) the chief house and senate authors of this act;

386.17 (2) the chairs of the senate Committee on Health, Housing, and Family Security and
386.18 the Health and Human Services Budget Division;

386.19 (3) the chairs of the house Health Care and Human Services Committee and the
386.20 Health Care and Human Services Division;

386.21 (4) the attorney general or the attorney general's designated representative;

386.22 (5) three representatives of health care providers appointed as follows:

386.23 (i) one member appointed by the governor;

386.24 (ii) one member appointed by the speaker of the house; and

386.25 (iii) one member appointed by the Subcommittee on Committees of the senate
386.26 Committee on Rules and Administration; and

386.27 (6) two consumers of health care appointed by the governor.

386.28 All appointments to be made under this subdivision must be made within 30 days
386.29 of the effective date of this act.

386.30 Subd. 2. **Study; report.** The study group shall study and make recommendations
386.31 on the following issues related to the creation, maintenance, and funding of a voluntary,
386.32 statewide health plan purchasing pool to provide comprehensive, cost-effective, and
386.33 medically appropriate health coverage to all public and private employees in Minnesota
386.34 and all Minnesota residents:

386.35 (1) the creation of an independent public entity to administer the pool;

(2) eligibility and participation requirements for existing public and private health care purchasing pools, public and private employers, and residents of this state;

(3) how to contract directly with providers to provide comprehensive coverage for preventive, mental health, dental and other medical services, and comprehensive drug benefits to enrollees and maximize the cost savings and other efficiencies that a large purchasing pool would be expected to generate without the need for a public subsidy;

(4) provisions that allow the pool to contract directly with health care providers to provide coverage to enrollees;

(5) incentives designed to attract and retain the maximum number of enrollees;

(6) recommendations for the administration of the pool and the plans that will be available to enrollees including, but not limited to, recommendations to keep the pool solvent and profitable so that public subsidies are not necessary; and

(7) other elements the study group concludes are necessary or desirable for the pool to possess.

The study group shall submit its report and the draft legislation necessary to implement its recommendations to the chairs of the legislative committees and divisions with jurisdiction over health care policy and finance, the Health Care Access Commission, 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. 65. **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 coverage to children in families with household incomes in excess of 300 percent of the federal poverty guidelines.

Subd. 3. Residency. Program participants must meet the residency requirements of section 256B.056, subdivision 1.

Subd. 4. Enrollment voluntary. Enrollment in the children's health security program is voluntary. Parents or guardians may retain private sector or Medicare coverage for a child as the sole source of coverage. Parents or guardians who have private sector or Medicare coverage for children may also enroll children in the children's health security program. If private sector or Medicare coverage is available, coverage under the children's health security program is secondary to the private sector or Medicare coverage.

Subd. 5. Emergency services. Payment must be made for care and services that are furnished to noncitizens, regardless of immigration status, who otherwise meet the eligibility requirements of this chapter, if the care and services are necessary for the treatment of an emergency medical condition, except for organ transplants and related care and services and routine prenatal care. For purposes of this subdivision, "emergency medical condition" means a medical condition that meets the requirements of United States Code, title 42, section 1396b(v).

Subd. 6. Medical assistance standards and procedures. (a) Unless otherwise specified in this chapter, the commissioner shall use medical assistance procedures and

390.3 methodology when determining initial eligibility and redetermining eligibility for the
390.4 children's health security program.

390.5 (b) The procedures and income standard specified in section 256B.056, subdivisions
390.6 5 and 5c, paragraph (a), apply to children who would be eligible for the children's health
390.7 security program, except for excess income.

390.8 (c) Retroactive coverage for the children's health security program must be provided
390.9 as specified in section 256B.056, subdivision 7.

390.10 Sec. 7. **[256N.07] COVERED SERVICES.**

390.11 Covered services under the children's health security program must consist of all
390.12 covered services under chapter 256B.

390.13 Sec. 8. **[256N.09] NO ENROLLEE PREMIUMS OR COST SHARING.**

390.14 In order to ensure broad access to coverage, the children's health security program
390.15 has no enrollee premium or cost-sharing requirements.

390.16 Sec. 9. **[256N.11] APPLICATION PROCEDURES; ELIGIBILITY**
390.17 **DETERMINATION.**

390.18 Subdivision 1. **Application procedure.** The application form for the program
390.19 must be easily understandable and must not exceed two pages in length. Applications for
390.20 the program must be made available to provider offices, local human services agencies,
390.21 school districts, schools, community health offices, and other sites willing to cooperate in
390.22 program outreach. These sites may accept applications and forward applications to the
390.23 commissioner, and counties where applicable. Applications may also be made directly to
390.24 the commissioner and to counties that determine eligibility.

390.25 Subd. 2. **Eligibility determination.** Counties that determine eligibility for
390.26 MinnesotaCare as of March 1, 2007, shall determine eligibility for the children's health
390.27 security program. The commissioner, and counties where applicable, shall determine an
390.28 applicant's eligibility for the program within 30 days of the date the application is received,
390.29 according to the procedures in Code of Federal Regulations, title 42, section 435.911.

390.30 Subd. 3. **Presumptive eligibility.** Coverage under the program is available during a
390.31 presumptive eligibility period for children under age 19 whose family income does not
390.32 exceed the applicable income standard. The presumptive eligibility period begins on the
390.33 date on which a health care provider enrolled in the program, or other entity designated by
391.1 the commissioner, determines, based on preliminary information, that the child's family
391.2 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 must be delivered by the commissioner. State and federal funding to support these services must be the same, whether delivered by the state or by a county or group of counties.

Sec. 11. **[256N.13] SERVICE DELIVERY.**

Subdivision 1. **Contracts for service delivery.** The commissioner, within each county, may contract with managed care organizations, including health maintenance organizations licensed under chapter 62D, community integrated service networks licensed under chapter 62N, accountable provider networks licensed under chapter 62T, and county-based purchasing plans established under section 256B.692, to provide covered health care services to program enrollees under a managed care system, and may contract with health care and social service providers to provide services on a fee-for-service basis. Section 256B.69, subdivision 26, applies to contracts with managed care organizations. In determining the method for service delivery, the commissioner shall consider the cost and quality of health care services; the breadth of services offered, including medical, dental and mental health services; the breadth of choice of medical providers for enrollees; the ease of access to quality medical care for enrollees; the efficiency and cost-effectiveness of service delivery; and the integration of best medical practice standards into the children's health security program.

392.1 Subd. 2. **Managed care organization requirements.** (a) Managed care
392.2 organizations under contract are responsible for coordinating covered health care services
392.3 provided to eligible individuals. Managed care organizations under contract:

392.4 (1) shall authorize and arrange for the provision of all needed covered health
392.5 services under chapter 256B, with the exception of services available only under a medical
392.6 assistance home and community-based waiver, in order to ensure appropriate health care
392.7 is delivered to enrollees;

392.8 (2) shall comply with the requirements of section 256B.69, subdivision 26;

392.9 (3) shall accept the prospective, per capita payment from the commissioner in return
392.10 for the provision of comprehensive and coordinated health care services for enrollees;

392.11 (4) may contract with health care and social service providers to provide covered
392.12 services to enrollees; and

392.13 (5) shall institute enrollee grievance procedures according to the method established
392.14 by the commissioner, utilizing applicable requirements of chapter 62D and Code of
392.15 Federal Regulations, title 42, section 438, subpart F. Disputes may also be appealed to
392.16 the commissioner using the procedures in section 256.045.

392.17 (b) Upon implementation of the children's health security program, the commissioner
392.18 shall withhold five percent of managed care organization payments pending completion
392.19 of performance targets, including lead screening, well child services, immunizations,
392.20 vision screening, and customer service performance targets. Effective January 1, 2011,
392.21 the commissioner shall add treatment of asthma and screening for mental health as new
392.22 performance targets. Each performance target must apply uniformly to all managed care
392.23 organizations, and be qualitative, objective, measurable, and reasonably attainable, except
392.24 in the case of a performance target based on federal or state law or rule. Criteria for
392.25 assessment of each performance target must be outlined in writing prior to the contract
392.26 effective date. The withhold funds must be returned no sooner than July of the following
392.27 year if performance targets in the contract are achieved. The success of each managed care
392.28 organization in reaching performance targets must be reported to the legislature annually.

392.29 Subd. 3. **Fee-for-service delivery.** Disputes related to services provided under
392.30 the fee-for-service system may be appealed to the commissioner using the procedures
392.31 in section 256.045.

392.32 Subd. 4. **Contracts for waiver services.** The commissioner, when services
392.33 are delivered through managed care, may contract with health care and social service
392.34 providers on a fee-for-service basis to provide program enrollees with covered services
392.35 available only under a medical assistance home and community-based waiver. The
392.36 commissioner shall determine eligibility for home and community-based waiver services

393.1 using the criteria and procedures in chapter 256B. Disputes related to services provided
393.2 on a fee-for-service basis may be appealed to the commissioner using the procedures
393.3 in section 256.045.

393.4 Subd. 5. **Service delivery for Minnesota disabilities health option recipient.**
393.5 Individuals who voluntarily enroll in the Minnesota Disability Health Option (MnDHO),
393.6 established under section 256B.69, subdivision 23, shall continue to receive their home
393.7 and community-based waiver services through MnDHO.

393.8 Subd. 6. **Disabled or blind children.** Children eligible for medical assistance due
393.9 to blindness or disability as determined by the Social Security Administration or the state
393.10 medical review team are exempt from enrolling in a managed care organization and shall
393.11 be provided health benefits on a fee-for-service basis.

393.12 Sec. 12. **[256N.15] PAYMENT RATES.**

393.13 Subdivision 1. **Establishment.** The commissioner, in consultation with a health
393.14 care actuary, shall establish the method and amount of payments for services. The
393.15 commissioner shall annually contract with eligible entities to provide services to program
393.16 enrollees. The commissioner, in consultation with the Risk Adjustment Association
393.17 established under section 62Q.03, subdivision 6, shall develop and implement a risk
393.18 adjustment system for the program.

393.19 Subd. 2. **Provider rates.** In establishing the payment amount under subdivision
393.20 1, the commissioner shall ensure that fee-for-service payment rates for preventative
393.21 care services provided on or after October 1, 2008, are at least five percent above the
393.22 medical assistance rates for preventative services in effect on September 30, 2008, and
393.23 shall ensure that fee-for-service payment rates for all other services provided on or after
393.24 October 1, 2008, are at least three percent above the medical assistance rates for those
393.25 services in effect on September 30, 2008. The commissioner shall adjust managed care
393.26 capitation rates to reflect these increases, and shall require managed care organizations, as
393.27 a condition of contract, to pass these increases on to providers under contract.

393.28 Sec. 13. **[256N.17] CONSUMER ASSISTANCE.**

393.29 Subdivision 1. **Assistance to applicants.** The commissioner shall assist applicants
393.30 in choosing a managed care organization or fee-for-service provider by:

393.31 (1) establishing a Web site to provide information about managed care organizations
393.32 and fee-for-service providers and to allow online enrollment;

393.33 (2) make information on managed care organizations and fee-for-service providers
393.34 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.

(a) The commissioner, as a condition of contract, shall require each participating managed care organization and participating provider to submit, in the form and manner specified by the commissioner, data required for assessing enrollee satisfaction, quality of care, cost, and utilization of services. The commissioner shall evaluate this data, in order to:

(1) make summary information on the quality of care across managed care organizations, medical clinics, and providers available to consumers;

(2) require managed care organizations and providers, as a condition of contract, to implement quality improvement plans; and

(3) compare the cost and quality of services under the program to the cost and quality of services provided to private sector enrollees.

(b) The commissioner shall implement this section to the extent allowed by federal and state laws on data privacy.

Sec. 15. [256N.21] FEDERAL APPROVAL.

The commissioner shall seek all federal waivers and approvals necessary to implement this chapter including, but not limited to, waivers and approvals necessary to:

(1) coordinate medical assistance and MinnesotaCare coverage for children with the children's health security program;

395.1 (2) use federal medical assistance and MinnesotaCare dollars to pay for health care
395.2 services under the children's health security program;

395.3 (3) maximize receipt of the federal medical assistance match for covered children,
395.4 by increasing income standards through the use of more liberal income methodologies as
395.5 provided under United States Code, title 42, sections 1396a and 1396u-1;

395.6 (4) extend presumptive eligibility and continuous eligibility to children under age
395.7 21; and

395.8 (5) use federal medical assistance and MinnesotaCare dollars to provide benefits to
395.9 dependent children.

395.10 Sec. 16. **[256N.23] RULEMAKING.**

395.11 The commissioner shall adopt rules to implement this chapter.

395.12 Sec. 17. **[256N.25] CHILDREN'S HEALTH SECURITY PROGRAM**
395.13 **OUTREACH.**

395.14 Subdivision 1. **Grant awards.** The commissioner shall award grants to public or
395.15 private organizations to:

395.16 (1) provide information, in areas of the state with high uninsured populations, on the
395.17 importance of maintaining insurance coverage and on how to obtain coverage through
395.18 the children's health security program; and

395.19 (2) monitor and provide ongoing support to ensure enrolled children remain covered.

395.20 Subd. 2. **Criteria.** In awarding the grants, the commissioner shall consider the
395.21 following:

395.22 (1) geographic areas and populations with high uninsured rates;

395.23 (2) the ability to raise matching funds;

395.24 (3) the ability to contact, effectively communicate with, or serve eligible populations;

395.25 and

395.26 (4) the applicant's plan to monitor and provide support to ensure enrolled children
395.27 remain covered.

395.28 Subd. 3. **Monitoring and termination.** The commissioner shall monitor the grants
395.29 and may terminate a grant if the outreach effort does not increase enrollment in the
395.30 children's health security program.

395.31 Sec. 18. **IMPLEMENTATION PLAN.**

395.32 The commissioner of human services shall develop an implementation plan for the
395.33 children's health security program, which includes a health delivery plan based on the

396.1 criteria specified in Minnesota Statutes, section 256N.13, subdivision 1. The commissioner
396.2 shall present this plan, any necessary draft legislation, and a draft of proposed rules
396.3 to the legislature by December 15, 2007. The plan must include recommendations
396.4 for any additional legislative changes necessary to coordinate medical assistance and
396.5 MinnesotaCare coverage for children with the children's health security program. The
396.6 commissioner shall evaluate the provision of services under the program to children with
396.7 disabilities and shall present recommendations to the legislature by December 15, 2009,
396.8 for any program changes necessary to ensure the quality and continuity of care.

396.9 Sec. 19. **LEGISLATIVE TASK FORCE ON CHILDREN'S HEALTH CARE**
396.10 **COVERAGE.**

396.11 Subdivision 1. Establishment; membership. (a) The Legislative Task Force on
396.12 Children's Health Care Coverage is established. The task force is made up of 12 voting
396.13 members and six nonvoting members.

396.14 (b) The voting members are:

396.15 (1) six members of the house of representatives appointed by the speaker, three from
396.16 the majority party and three from the minority party; and

396.17 (2) six members of the senate appointed by the Subcommittee on Committees of the
396.18 senate Committee on Rules and Administration, three from the majority party and three
396.19 from the minority party.

396.20 (c) The nonvoting members are one representative selected by each of the following
396.21 organizations:

396.22 (1) the American Academy of Pediatrics, Minnesota chapter;

396.23 (2) the Minnesota Nurses Association;

396.24 (3) the Minnesota Council of Health Plans;

396.25 (4) the Minnesota Children's Platform Coalition;

396.26 (5) the Minnesota Universal Health Care Coalition; and

396.27 (6) the Minnesota Business Partnership.

396.28 (d) The task force members must be appointed by September 1, 2007. The majority
396.29 leader of the senate and the speaker of the house of representatives must each designate
396.30 a chair from their appointments. The chair appointed by the speaker of the house of
396.31 representatives shall convene and chair the first meeting of the task force. The chair
396.32 appointed by the majority leader of the senate shall chair the next meeting of the task
396.33 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:

(1) health care coverage must include preventive care and all other medically necessary services;

(2) health care coverage must be affordable for families, with the family share of premium costs and cost-sharing in total not exceeding five percent of family income;

(3) the system of coverage must give priority to ensuring access to and the quality and continuity of care; and

(4) enrollment must be simple and seamless for families.

Subd. 4. **Expiration.** This section expires December 16, 2009.

ARTICLE 9

HEALTH CARE REFORM

Section 1. Minnesota Statutes 2006, section 62A.65, subdivision 3, is amended to read:

Subd. 3. **Premium rate restrictions.** No individual health plan may be offered, sold, issued, or renewed to a Minnesota resident unless the premium rate charged is determined in accordance with the following requirements:

(a) Premium rates must be no more than 25 percent above and no more than 25 percent below the index rate charged to individuals for the same or similar coverage,

adjusted pro rata for rating periods of less than one year. The premium variations permitted by this paragraph must be based only upon health status, claims experience, and occupation. For purposes of this paragraph, health status includes refraining from tobacco use or other actuarially valid lifestyle factors associated with good health, provided that the lifestyle factor and its effect upon premium rates have been determined by the commissioner to be actuarially valid and have been approved by the commissioner. Variations permitted under this paragraph must not be based upon age or applied differently at different ages. This paragraph does not prohibit use of a constant percentage adjustment for factors permitted to be used under this paragraph.

(b) Premium rates may vary based upon the ages of covered persons only as provided in this paragraph. In addition to the variation permitted under paragraph (a), each health carrier may use an additional premium variation based upon age for adults aged 19 and above of up to plus or minus 50 percent of the index rate. Premium rates for children under the age of 19 may not vary based on age, regardless of whether the child is covered as a dependent or as a primary insured.

(c) A health carrier may request approval by the commissioner to establish separate geographic regions determined by the health carrier and to establish separate index rates for each such region. The commissioner shall grant approval if the following conditions are met:

(1) the geographic regions must be applied uniformly by the health carrier;

(2) each geographic region must be composed of no fewer than seven counties that create a contiguous region; and

(3) the health carrier provides actuarial justification acceptable to the commissioner for the proposed geographic variations in index rates, establishing that the variations are based upon differences in the cost to the health carrier of providing coverage.

(d) Health carriers may use rate cells and must file with the commissioner the rate cells they use. Rate cells must be based upon the number of adults or children covered under the policy and may reflect the availability of Medicare coverage. The rates for different rate cells must not in any way reflect generalized differences in expected costs between principal insureds and their spouses.

(e) In developing its index rates and premiums for a health plan, a health carrier shall take into account only the following factors:

(1) actuarially valid differences in rating factors permitted under paragraphs (a) and (b); and

(2) actuarially valid geographic variations if approved by the commissioner as provided in paragraph (c).

(f) All premium variations must be justified in initial rate filings and upon request of the commissioner in rate revision filings. All rate variations are subject to approval by the commissioner.

(g) The loss ratio must comply with the section 62A.021 requirements for individual health plans.

(h) The rates must not be approved, unless the commissioner has determined that the rates are reasonable. In determining reasonableness, the commissioner shall consider the growth rates applied under section 62J.04, subdivision 1, paragraph (b), to the calendar year or years that the proposed premium rate would be in effect, actuarially valid changes in risks associated with the enrollee populations, and actuarially valid changes as a result of statutory changes in Laws 1992, chapter 549.

(i) An insurer may, as part of a minimum lifetime loss ratio guarantee filing under section 62A.02, subdivision 3a, include a rating practices guarantee as provided in this paragraph. The rating practices guarantee must be in writing and must guarantee that the policy form will be offered, sold, issued, and renewed only with premium rates and premium rating practices that comply with subdivisions 2, 3, 4, and 5. The rating practices guarantee must be accompanied by an actuarial memorandum that demonstrates that the premium rates and premium rating system used in connection with the policy form will 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.

400.1 (b) "Commissioner" means:

400.2 (1) the commissioner of commerce for health insurers subject to the jurisdiction
400.3 of the Department of Commerce;

400.4 (2) the commissioner of health for health insurers subject to the jurisdiction of the
400.5 Department of Health; or

400.6 (3) either commissioner's designated representative.

400.7 (c) "Exchange" means the Minnesota Health Insurance Exchange.

400.8 (d) "HIPAA" means the Health Insurance Portability and Accountability Act of 1996.

400.9 (e) "Individual market health plans," unless otherwise specified, means individual
400.10 market health plans defined in section 62A.011.

400.11 (f) "Section 125 Plan" means a cafeteria or Premium Only Plan under section 125 of
400.12 the Internal Revenue Code that allows employees to pay for health insurance premiums
400.13 with pretax dollars.

400.14 Subd. 4. **Insurer and health plan participation.** All health plans as defined in
400.15 section 62A.011, subdivision 3, issued or renewed in the individual market shall participate
400.16 in the exchange. No health plans in the individual market may be issued or renewed
400.17 outside of the exchange. Group health plans as defined in section 62A.10 shall not be
400.18 offered through the exchange. Health plans offered through the Minnesota Comprehensive
400.19 Health Association as defined in section 62E.10 are offered through the exchange to
400.20 eligible enrollees as determined by the Minnesota Comprehensive Health Association.
400.21 Health plans offered through MinnesotaCare under chapter 256L are offered through the
400.22 exchange to eligible enrollees as determined by the commissioner of human services.

400.23 Subd. 5. **Approval of health plans.** No health plan may be offered through the
400.24 exchange unless the commissioner has first certified that:

400.25 (1) the insurer seeking to offer the health plan is licensed to issue health insurance in
400.26 the state; and

400.27 (2) the health plan meets the requirements of this section, and the health plan and the
400.28 insurer are in compliance with all other applicable health insurance laws.

400.29 Subd. 6. **Individual market health plans.** Individual market health plans offered
400.30 through the exchange continue to be regulated by the commissioner as specified in
400.31 chapters 62A, 62C, 62D, 62E, 62Q, and 72A, and must include the following provisions
400.32 that apply to all health plans issued or renewed through the exchange:

400.33 (1) premiums for children under the age of 19 shall not vary by age in the exchange;
400.34 and

400.35 (2) premiums for children under the age of 19 must be excluded from rating factors
400.36 under section 62A.65, subdivision 3, paragraph (b).

401.1 Subd. 7. **Individual participation and eligibility.** Individuals are eligible to
401.2 purchase health plans directly through the exchange or through an employer Section
401.3 125 Plan under section 62A.68. Nothing in this section requires guaranteed issue of
401.4 individual market health plans offered through the exchange. Individuals are eligible to
401.5 purchase individual market health plans through the exchange by meeting one or more
401.6 of the following qualifications:

401.7 (1) the individual is a Minnesota resident, meaning the individual is physically
401.8 residing on a permanent basis in a place that is the person's principal residence and from
401.9 which the person is absent only for temporary purposes;

401.10 (2) the individual is a student attending an institution outside of Minnesota and
401.11 maintains Minnesota residency;

401.12 (3) the individual is not a Minnesota resident but is employed by an employer
401.13 physically located within the state and the individual's employer is required to offer a
401.14 Section 125 Plan under section 62A.68;

401.15 (4) the individual is not a Minnesota resident but is self-employed and the
401.16 individual's principal place of business is in the state; or

401.17 (5) the individual is a dependent as defined in section 62L.02, of another individual
401.18 who is eligible to participate in the exchange.

401.19 Subd. 8. **Continuation of coverage.** Enrollment in a health plan may be canceled
401.20 for nonpayment of premiums, fraud, or changes in eligibility for MinnesotaCare under
401.21 chapter 256L. Enrollment in an individual market health plan may not be canceled or
401.22 nonrenewed because of any change in employer or employment status, marital status,
401.23 health status, age, residence, or any other change that does not affect eligibility as defined
401.24 in this section.

401.25 Subd. 9. **Responsibilities of the exchange.** The exchange shall serve as the sole
401.26 entity for enrollment and collection and transfer of premium payments for health plans
401.27 sold to individuals through the exchange. The exchange shall be responsible for the
401.28 following functions:

401.29 (1) publicize the exchange, including but not limited to its functions, eligibility
401.30 rules, and enrollment procedures;

401.31 (2) provide assistance to employers to establish Section 125 Plans under section
401.32 62A.68;

401.33 (3) provide education and assistance to employers to help them understand the
401.34 requirements of Section 125 Plans and compliance with applicable regulations;

401.35 (4) create a system to allow individuals to compare and enroll in health plans offered
401.36 through the exchange;

- 402.1 (5) create a system to collect and transmit to the applicable plans all premium
402.2 payments made by individuals, including developing mechanisms to receive and process
402.3 automatic payroll deductions for individuals who purchase coverage through employer
402.4 Section 125 Plans;
- 402.5 (6) not accept premium payments for individual market health plans from an
402.6 employer Section 125 Plan if the employer offers a group health plan as defined in section
402.7 62A.10, or if the employer is a self-insurer as defined in section 62E.02;
- 402.8 (7) provide jointly with health insurers a cancellation notice directly to the primary
402.9 insured at least ten days prior to termination of coverage for nonpayment of premium;
- 402.10 (8) bill the employer for the premiums payable by an employee, provided that the
402.11 employer is not liable for payment except from payroll deductions for that purpose;
- 402.12 (9) refer individuals interested in MinnesotaCare under chapter 256L to the
402.13 Department of Human Services to determine eligibility;
- 402.14 (10) establish a mechanism with the Department of Human Services to transfer
402.15 premiums and subsidies for MinnesotaCare to qualify for federal matching payments;
- 402.16 (11) upon request, issue certificates of previous coverage according to the provisions
402.17 of HIPAA and as referenced in section 62Q.181 to all such individuals who cease to be
402.18 covered by a participating health plan through the exchange;
- 402.19 (12) establish procedures to account for all funds received and disbursed by the
402.20 exchange for individual participants of the exchange;
- 402.21 (13) make available to the public, at the end of each calendar year, a report of an
402.22 independent audit of the exchange's accounts; and
- 402.23 (14) provide copies of written and signed statements from employers stating that
402.24 the employer is not contributing to the employee's premiums for health plans purchased
402.25 by an employee through the exchange to all health insurers with enrolled employees of
402.26 the employer.
- 402.27 Health insurers may rely on the employer's statement in clause (4) provided by the
402.28 Minnesota Health Insurance Exchange and are not required to guarantee-issue individual
402.29 health plans to the employer's employees.
- 402.30 Subd. 10. **State not liable.** The state of Minnesota shall not be liable for the actions
402.31 of the Minnesota Health Insurance Exchange.
- 402.32 Subd. 11. **Powers of the exchange.** The exchange shall have the power to:
- 402.33 (1) contract with insurance producers licensed in accident and health insurance
402.34 under chapter 60K and vendors to perform one or more of the functions specified in
402.35 subdivision 10;

- 403.1 (2) contract with employers to collect premiums through a Section 125 Plan for
403.2 eligible individuals who purchase an individual market health plan through the exchange;
- 403.3 (3) establish and assess fees on health plan premiums of health plans purchased
403.4 through the exchange to fund the cost of administering the exchange;
- 403.5 (4) seek and directly receive grant funding from government agencies or private
403.6 philanthropic organizations to defray the costs of operating the exchange;
- 403.7 (5) establish and administer rules and procedures governing the operations of the
403.8 exchange;
- 403.9 (6) establish one or more service centers within Minnesota;
- 403.10 (7) sue or be sued or otherwise take any necessary or proper legal action;
- 403.11 (8) establish bank accounts and borrow money; and
- 403.12 (9) enter into agreements with the commissioners of commerce, health, human
403.13 services, revenue, employment and economic development, and other state agencies as
403.14 necessary for the exchange to implement the provisions of this section.

403.15 Subd. 12. **Dispute resolution.** The exchange shall establish procedures for
403.16 resolving disputes with respect to the eligibility of an individual to participate in the
403.17 exchange. The exchange does not have the authority or responsibility to intervene in or
403.18 resolve disputes between an individual and a health plan or health insurer. The exchange
403.19 shall refer complaints from individuals participating in the exchange to the commissioner
403.20 to be resolved according to sections 62Q.68 to 62Q.73.

403.21 Subd. 13. **Governance.** The exchange shall be governed by a board of directors
403.22 with 11 members. The board shall convene on or before July 1, 2007, after the initial board
403.23 members have been selected. The initial board membership consists of the following:

403.24 (1) the commissioner of commerce;

403.25 (2) the commissioner of human services;

403.26 (3) the commissioner of health;

403.27 (4) four members appointed by a joint committee of the Minnesota senate and the
403.28 Minnesota house of representatives to serve three-year terms; and

403.29 (5) four members appointed by the governor to serve three-year terms.

403.30 Subd. 14. **Subsequent board membership.** Ongoing membership of the exchange
403.31 consists of the following effective July 1, 2010:

403.32 (1) the commissioner of commerce;

403.33 (2) the commissioner of human services;

403.34 (3) the commissioner of health;

403.35 (4) two members appointed by the governor with the approval of a joint committee
403.36 of the senate and house of representatives to serve two-year terms; and

404.1 (5) six members elected by the membership of the exchange of which three
404.2 are elected to serve a two-year term and three are elected to serve a three-year term.
404.3 Appointed and elected members may serve more than one term.

404.4 Subd. 15. **Operations of the board.** Officers of the board of directors are elected by
404.5 members of the board and serve one-year terms. Six members of the board constitutes a
404.6 quorum, and the affirmative vote of six members of the board is necessary and sufficient
404.7 for any action taken by the board. Board members serve without pay, but are reimbursed
404.8 for actual expenses incurred in the performance of their duties.

404.9 Subd. 16. **Operations of the exchange.** The board of directors shall appoint an
404.10 exchange director who shall:

- 404.11 (1) be a full-time employee of the exchange;
404.12 (2) administer all of the activities and contracts of the exchange; and
404.13 (3) hire and supervise the staff of the exchange.

404.14 Subd. 17. **Insurance producers.** An individual has the right to choose any
404.15 insurance producer licensed in accident and health insurance under chapter 60K to assist
404.16 them in purchasing an individual market health plan through the exchange. When a
404.17 producer licensed in accident and health insurance under chapter 60K enrolls an eligible
404.18 individual in the exchange, the health plan chosen by an individual may pay the producer
404.19 a commission.

404.20 Subd. 18. **Implementation.** Health plan coverage through the exchange begins on
404.21 January 1, 2009. The exchange must be operational to assist employers and individuals
404.22 by September 1, 2008, and be prepared for enrollment by December 1, 2008. Enrollees
404.23 of individual market health plans, MinnesotaCare, and the Minnesota Comprehensive
404.24 Health Association as of December 2, 2008, are automatically enrolled in the exchange
404.25 on January 1, 2009, in the same health plan and at the same premium that they were
404.26 enrolled as of December 2, 2008, subject to the provisions of this section. As of January 1,
404.27 2009, all enrollees of individual market health plans, MinnesotaCare, and the Minnesota
404.28 Comprehensive Health Association shall make premium payments to the exchange.

404.29 Sec. 3. [62A.68] **SECTION 125 PLANS.**

404.30 Subdivision 1. **Definitions.** The following terms have the meanings given unless
404.31 otherwise provided in text:

404.32 (a) "Current employee" means an employee currently on an employer's payroll other
404.33 than a retiree or disabled former employee.

(b) "Employer" means a person, firm, corporation, partnership, association, business trust, or other entity employing one or more persons, including a political subdivision of the state, filing payroll tax information on such employed person or persons.

(c) "Section 125 Plan" means a cafeteria or Premium Only Plan under section 125 of the Internal Revenue Code that allows employees to purchase health insurance with pretax dollars.

(d) "Exchange" means the Minnesota Health Insurance Exchange under section 62A.67.

(e) "Exchange director" means the appointed director under section 62A.67, subdivision 16.

Subd. 2. Section 125 Plan requirement. (a) Effective January 1, 2009, all employers with 11 or more current employees shall establish a Section 125 Plan to allow their employees to purchase individual market health plan coverage with pretax dollars. Nothing in this section requires or mandates employers to offer or purchase health insurance coverage for their employees. The following employers are exempt from the Section 125 Plan requirement:

(1) employers that offer a group health insurance plan as defined in 62A.10;

(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 necessary to cover conditions that are subject to an unexpired preexisting condition limitation, preexisting condition exclusion, or exclusionary rider under the employer's health plan. This section does not apply to persons enrolled in the Comprehensive Health Association as of June 30, 1993. With respect to persons eligible to enroll in the health plan of an employer that has more than 29 current employees, as defined in section 62L.02, this section does not apply to persons enrolled in the Comprehensive Health Association as of December 31, 1994.

Sec. 5. Minnesota Statutes 2006, section 62J.04, subdivision 3, is amended to read:

Subd. 3. Cost containment duties. The commissioner shall:

(1) establish statewide and regional cost containment goals for total health care spending under this section ~~and~~ collect data as described in sections 62J.38 to 62J.41 to monitor statewide achievement of the cost containment goals, and annually report to the legislature on whether the goals were achieved and, if not, what action should be taken to ensure that goals are achieved in the future;

(2) divide the state into no fewer than four regions, with one of those regions being the Minneapolis/St. Paul metropolitan statistical area but excluding Chisago, Isanti, Wright, and Sherburne Counties, for purposes of fostering the development of regional

health planning and coordination of health care delivery among regional health care systems and working to achieve the cost containment goals;

(3) monitor the quality of health care throughout the state and take action as necessary to ensure an appropriate level of quality;

(4) issue recommendations regarding uniform billing forms, uniform electronic billing procedures and data interchanges, patient identification cards, and other uniform claims and administrative procedures for health care providers and private and public sector payers. In developing the recommendations, the commissioner shall review the work of the work group on electronic data interchange (WEDI) and the American National Standards Institute (ANSI) at the national level, and the work being done at the state and local level. The commissioner may adopt rules requiring the use of the Uniform Bill 82/92 form, the National Council of Prescription Drug Providers (NCPDP) 3.2 electronic version, the Centers for Medicare and Medicaid Services 1500 form, or other standardized forms or procedures;

(5) undertake health planning responsibilities;

(6) authorize, fund, or promote research and experimentation on new technologies 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. [62J.431] EVIDENCE-BASED HEALTH CARE GUIDELINES.

Evidence-based guidelines must meet the following criteria:

(1) the scope and application are clear;

(2) authorship is stated and any conflicts of interest disclosed;

(3) authors represent all pertinent clinical fields or other means of input have been used;

- (4) the development process is explicitly stated;
- (5) the guideline is grounded in evidence;
- (6) the evidence is cited and graded;
- (7) the document itself is clear and practical;
- (8) the document is flexible in use, with exceptions noted or provided for with
general statements;
- (9) measures are included for use in systems improvement; and
- (10) the guideline has scheduled reviews and updating.

Sec. 7. 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. 8. [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

410.1 (5) other providers of health or health care services approved by the commissioner
410.2 for which interoperable electronic health record capability would improve quality of
410.3 care, patient safety, or community health.

410.4 (b) To be eligible for a loan under this section, the applicant must submit a loan
410.5 application to the commissioner of health on forms prescribed by the commissioner. The
410.6 application must include, at a minimum:

410.7 (1) the amount of the loan requested and a description of the purpose or project
410.8 for which the loan proceeds will be used;

410.9 (2) a quote from a vendor;

410.10 (3) a description of the health care entities and other groups participating in the
410.11 project;

410.12 (4) evidence of financial stability and a demonstrated ability to repay the loan; and

410.13 (5) a description of how the system to be financed interconnects or plans in the
410.14 future to interconnect with other health care entities and provider groups located in the
410.15 same geographical area.

410.16 Subd. 3. **Loans.** (a) The commissioner of health may make a no interest loan
410.17 to a provider or provider group who is eligible under subdivision 2 on a first-come,
410.18 first-served basis provided that the applicant is able to comply with this section. The total
410.19 accumulative loan principal must not exceed \$1,500,000 per loan. The commissioner of
410.20 health has discretion over the size and number of loans made.

410.21 (b) The commissioner of health may prescribe forms and establish an application
410.22 process and, notwithstanding section 16A.1283, may impose a reasonable nonrefundable
410.23 application fee to cover the cost of administering the loan program.

410.24 (c) The borrower must begin repaying the principal no later than two years from the
410.25 date of the loan. Loans must be amortized no later than six years from the date of the loan.

410.26 (d) Repayments must be credited to the account.

410.27 Subd. 4. **Data classification.** Data collected by the commissioner of health on the
410.28 application to determine eligibility under subdivision 2 and to monitor borrowers' default
410.29 risk or collect payments owed under subdivision 3 are (1) private data on individuals as
410.30 defined in section 13.02, subdivision 12; and (2) nonpublic data as defined in section
410.31 13.02, subdivision 9. The names of borrowers and the amounts of the loans granted are
410.32 public data.

410.33 Sec. 9. **[62J.536] UNIFORM ELECTRONIC TRANSACTIONS AND**
410.34 **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

412.1 component of the single, uniform companion guides required in paragraph (e) and the
412.2 implementation guides described under Code of Federal Regulations, title 45, part 162.

412.3 Subd. 2. **Establishing uniform, standard companion guides.** (a) At least 12
412.4 months prior to the timelines required in subdivision 1, the commissioner of health shall
412.5 promulgate rules pursuant to section 62J.61 establishing and requiring group purchasers
412.6 and health care providers to use the transactions and the uniform, standard companion
412.7 guides required under subdivision 1, paragraph (e).

412.8 (b) The commissioner of health must consult with the Minnesota Administrative
412.9 Uniformity Committee on the development of the single, uniform companion guides
412.10 required under subdivision 1, paragraph (e), for each of the transactions in subdivision 1.
412.11 The single uniform companion guides required under subdivision 1, paragraph (e), must
412.12 specify uniform billing and coding standards. The commissioner of health shall base the
412.13 companion guides required under subdivision 1, paragraph (e), billing and coding rules,
412.14 and standards on the Medicare program, with modifications that the commissioner deems
412.15 appropriate after consulting the Minnesota Administrative Uniformity Committee.

412.16 (c) No group purchaser or health care provider may add to or modify the single,
412.17 uniform companion guides defined in subdivision 1, paragraph (e), through additional
412.18 companion guides or other requirements.

412.19 (d) In promulgating the rules in paragraph (a), the commissioner shall not require
412.20 data content that is not essential to accomplish the purpose of the transactions in
412.21 subdivision 1.

412.22 Sec. 10. Minnesota Statutes 2006, section 62J.60, is amended by adding a subdivision
412.23 to read:

412.24 Subd. 3a. **Required statement.** An identification card issued to an enrollee by a
412.25 health plan company or other entity governed by Minnesota health coverage laws must
412.26 contain the following statement: "Subject to Minnesota law."

412.27 Sec. 11. Minnesota Statutes 2006, section 62J.692, subdivision 1, is amended to read:

412.28 Subdivision 1. **Definitions.** For purposes of this section, the following definitions
412.29 apply:

412.30 (a) "Accredited clinical training" means the clinical training provided by a
412.31 medical education program that is accredited through an organization recognized by the
412.32 Department of Education, the Centers for Medicare and Medicaid Services, or another
412.33 national body who reviews the accrediting organizations for multiple disciplines and
412.34 whose standards for recognizing accrediting organizations are reviewed and approved by

413.1 the commissioner of health in consultation with the Medical Education and Research
413.2 Advisory Committee.

413.3 (b) "Commissioner" means the commissioner of health.

413.4 (c) "Clinical medical education program" means the accredited clinical training of
413.5 physicians (medical students and residents), doctor of pharmacy practitioners, doctors
413.6 of chiropractic, dentists, advanced practice nurses (clinical nurse specialists, certified
413.7 registered nurse anesthetists, nurse practitioners, and certified nurse midwives), and
413.8 physician assistants.

413.9 (d) "Sponsoring institution" means a hospital, school, or consortium located in
413.10 Minnesota that sponsors and maintains primary organizational and financial responsibility
413.11 for a clinical medical education program in Minnesota and which is accountable to the
413.12 accrediting body.

413.13 (e) "Teaching institution" means a hospital, medical center, clinic, or other
413.14 organization that conducts a clinical medical education program in Minnesota.

413.15 (f) "Trainee" means a student or resident involved in a clinical medical education
413.16 program.

413.17 (g) "Eligible trainee FTEs" means the number of trainees, as measured by full-time
413.18 equivalent counts, that are at training sites located in Minnesota with ~~a~~ currently
413.19 active medical assistance provider number enrollment status and a National Provider
413.20 Identification (NPI) number where training occurs in either an inpatient or ambulatory
413.21 patient care setting and where the training is funded, in part, by patient care revenues.

413.22 Sec. 12. Minnesota Statutes 2006, section 62J.692, subdivision 4, is amended to read:

413.23 Subd. 4. **Distribution of funds.** (a) The commissioner shall annually distribute
413.24 90 percent of ~~available medical education~~ funds transferred according to section
413.25 256B.69, subdivision 5c, paragraph (a), clause (1), to all qualifying applicants based on a
413.26 distribution formula that reflects a summation of two factors:

413.27 (1) an education factor, which is determined by the total number of eligible trainee
413.28 FTEs and the total statewide average costs per trainee, by type of trainee, in each clinical
413.29 medical education program; and

413.30 (2) a public program volume factor, which is determined by the total volume of
413.31 public program revenue received by each training site as a percentage of all public
413.32 program revenue received by all training sites in the fund pool.

413.33 In this formula, the education factor is weighted at 67 percent and the public program
413.34 volume factor is weighted at 33 percent.

414.1 Public program revenue for the distribution formula includes revenue from medical
414.2 assistance, prepaid medical assistance, general assistance medical care, and prepaid
414.3 general assistance medical care. Training sites that receive no public program revenue
414.4 are ineligible for funds available under this paragraph. Total statewide average costs per
414.5 trainee for medical residents is based on audited clinical training costs per trainee in
414.6 primary care clinical medical education programs for medical residents. Total statewide
414.7 average costs per trainee for dental residents is based on audited clinical training costs
414.8 per trainee in clinical medical education programs for dental students. Total statewide
414.9 average costs per trainee for pharmacy residents is based on audited clinical training costs
414.10 per trainee in clinical medical education programs for pharmacy students.

414.11 (b) The commissioner shall annually distribute ten percent of ~~total available medical~~
414.12 ~~education~~ funds transferred according to section 256B.69, subdivision 5c, paragraph (a),
414.13 clause (1), to all qualifying applicants based on the percentage received by each applicant
414.14 under paragraph (a). These funds are to be used to offset clinical education costs at
414.15 eligible clinical training sites based on criteria developed by the clinical medical education
414.16 program. Applicants may choose to distribute funds allocated under this paragraph based
414.17 on the distribution formula described in paragraph (a).

414.18 (c) The commissioner shall annually distribute \$5,000,000 of the funds dedicated
414.19 to the commissioner under section 297F.10, subdivision 1, clause (2), plus any federal
414.20 financial participation on these funds and on funds transferred under subdivision 10, to all
414.21 qualifying applicants based on a distribution formula that gives 100 percent weight to a
414.22 public program volume factor, which is determined by the total volume of public program
414.23 revenue received by each training site as a percentage of all public program revenue
414.24 received by all training sites in the fund pool. If federal approval is not obtained for
414.25 federal financial participation on any portion of funds distributed under this paragraph,
414.26 90 percent of the unmatched funds shall be distributed by the commissioner based on
414.27 the formula described in paragraph (a) and ten percent of the unmatched funds shall be
414.28 distributed by the commissioner based on the formula described in paragraph (b).

414.29 (d) The commissioner shall annually distribute \$3,060,000 of funds dedicated to the
414.30 commissioner under section 297F.10, subdivision 1, clause (2), through a formula giving
414.31 100 percent weight to an education factor, which is determined by the total number of
414.32 eligible trainee full-time equivalents and the total statewide average costs per trainee, by
414.33 type of trainee, in each clinical medical education program. If no matching funds are
414.34 received on funds distributed under paragraph (c), funds distributed under this paragraph
414.35 shall be distributed by the commissioner based on the formula described in paragraph (a).

415.1 (e) The commissioner shall annually distribute \$340,000 of funds dedicated to the
415.2 commissioner under section 297F.10, subdivision 1, clause (2), to all qualifying applicants
415.3 based on the percentage received by each applicant under paragraph (a). These funds are
415.4 to be used to offset clinical education costs at eligible clinical training sites based on
415.5 criteria developed by the clinical medical education program. Applicants may choose to
415.6 distribute funds allocated under this paragraph based on the distribution formula described
415.7 in paragraph (a). If no matching funds are received on funds distributed under paragraph
415.8 (c), funds distributed under this paragraph shall be distributed by the commissioner based
415.9 on the formula described in paragraph (b).

415.10 ~~(e)~~ (f) Funds distributed shall not be used to displace current funding appropriations
415.11 from federal or state sources.

415.12 ~~(d)~~ (g) Funds shall be distributed to the sponsoring institutions indicating the amount
415.13 to be distributed to each of the sponsor's clinical medical education programs based on
415.14 the criteria in this subdivision and in accordance with the commissioner's approval letter.
415.15 Each clinical medical education program must distribute funds allocated under paragraph
415.16 (a) to the training sites as specified in the commissioner's approval letter. Sponsoring
415.17 institutions, which are accredited through an organization recognized by the Department
415.18 of Education or the Centers for Medicare and Medicaid Services, may contract directly
415.19 with training sites to provide clinical training. To ensure the quality of clinical training,
415.20 those accredited sponsoring institutions must:

415.21 (1) develop contracts specifying the terms, expectations, and outcomes of the clinical
415.22 training conducted at sites; and

415.23 (2) take necessary action if the contract requirements are not met. Action may
415.24 include the withholding of payments under this section or the removal of students from
415.25 the site.

415.26 ~~(e)~~ (h) Any funds not distributed in accordance with the commissioner's approval
415.27 letter must be returned to the medical education and research fund within 30 days of
415.28 receiving notice from the commissioner. The commissioner shall distribute returned funds
415.29 to the appropriate training sites in accordance with the commissioner's approval letter.

415.30 ~~(f)~~ (i) The commissioner shall distribute by June 30 of each year an amount equal to
415.31 the funds transferred under subdivision 10, ~~plus five percent interest~~ to the University of
415.32 Minnesota Board of Regents for the instructional costs of health professional programs
415.33 at the Academic Health Center and for interdisciplinary academic initiatives within the
415.34 Academic Health Center.

416.1 ~~(g)~~ (j) A maximum of \$150,000 of the funds dedicated to the commissioner
416.2 under section 297F.10, subdivision 1, ~~paragraph (b)~~, clause (2), may be used by the
416.3 commissioner for administrative expenses associated with implementing this section.

416.4 Sec. 13. Minnesota Statutes 2006, section 62J.692, subdivision 7a, is amended to read:

416.5 Subd. 7a. **Clinical medical education innovations grants.** (a) The commissioner
416.6 shall award grants to teaching institutions and clinical training sites for projects that
416.7 increase dental access for underserved populations and promote innovative clinical
416.8 training of dental professionals.

416.9 (b) The commissioner shall award grants to teaching institutions and clinical training
416.10 sites for projects that increase mental health access for underserved populations, promote
416.11 innovative clinical training of mental health professionals, increase the number of mental
416.12 health providers in rural or underserved areas, and promote the incorporation of patient
416.13 safety principles into clinical medical education programs.

416.14 (c) In awarding the grants, the commissioner, in consultation with the commissioner
416.15 of human services, shall consider the following:

- 416.16 (1) potential to successfully increase access to an underserved population;
416.17 (2) the long-term viability of the project to improve access beyond the period
416.18 of initial funding;
416.19 (3) evidence of collaboration between the applicant and local communities;
416.20 (4) the efficiency in the use of the funding; ~~and~~
416.21 (5) the priority level of the project in relation to state clinical education, access,
416.22 patient safety, and workforce goals; and
416.23 (6) the potential of the project to impact the number or distribution of the health
416.24 care workforce.

416.25 ~~(b)~~ (d) The commissioner shall periodically evaluate the priorities in awarding the
416.26 innovations grants in order to ensure that the priorities meet the changing workforce
416.27 needs of the state.

416.28 Sec. 14. Minnesota Statutes 2006, section 62J.692, subdivision 8, is amended to read:

416.29 Subd. 8. **Federal financial participation.** (a) The commissioner of human
416.30 services shall seek to maximize federal financial participation in payments for medical
416.31 education and research costs. ~~If the commissioner of human services determines that~~
416.32 ~~federal financial participation is available for the medical education and research, the~~
416.33 ~~commissioner of health shall transfer to the commissioner of human services the amount~~
416.34 ~~of state funds necessary to maximize the federal funds available. The amount transferred~~

417.1 ~~to the commissioner of human services, plus the amount of federal financial participation,~~
417.2 ~~shall be distributed to medical assistance providers in accordance with the distribution~~
417.3 ~~methodology described in subdivision 4.~~

417.4 (b) For the purposes of paragraph (a), the commissioner shall use physician clinic
417.5 rates where possible to maximize federal financial participation.

417.6 Sec. 15. Minnesota Statutes 2006, section 62J.692, subdivision 10, is amended to read:

417.7 Subd. 10. **Transfers from University of Minnesota.** Of the funds dedicated to the
417.8 Academic Health Center under section 297F.10, subdivision 1, clause (1), \$4,850,000
417.9 shall be transferred annually to the commissioner of health no later than April 15 of each
417.10 year for distribution under subdivision 4, paragraph ~~(f)~~ (i).

417.11 Sec. 16. Minnesota Statutes 2006, section 62J.81, subdivision 1, is amended to read:

417.12 Subdivision 1. **Required disclosure of estimated payment.** (a) A health care
417.13 provider, as defined in section 62J.03, subdivision 8, or the provider's designee as agreed
417.14 to by that designee, shall, at the request of a consumer, provide that consumer with a good
417.15 faith estimate of the reimbursement allowable payment the provider ~~expects to receive~~
417.16 ~~from the health plan company in which the consumer is enrolled~~ has agreed to accept from
417.17 the consumer's health plan company for the services specified by the consumer, specifying
417.18 the amount of the allowable payment due from the health plan company. Health plan
417.19 companies must allow contracted providers, or their designee, to release this information.
417.20 ~~A good faith estimate must also be made available at the request of a consumer who~~
417.21 ~~is not enrolled in a health plan company.~~ If a consumer has no applicable public or
417.22 private coverage, the health care provider must give the consumer a good faith estimate
417.23 of the average allowable reimbursement the provider accepts as payment from private
417.24 third-party payers for the services specified by the consumer and the estimated amount
417.25 the noncovered consumer will be required to pay. Payment information provided by a
417.26 provider, or by the provider's designee as agreed to by that designee, to a patient pursuant
417.27 to this subdivision does not constitute a legally binding estimate of the allowable charge
417.28 for or cost to the consumer of services.

417.29 (b) A health plan company, as defined in section 62J.03, subdivision 10, shall, at
417.30 the request of an enrollee or the enrollee's designee, provide that enrollee with a good
417.31 faith estimate of the reimbursement allowable amount the health plan company ~~would~~
417.32 ~~expect to pay to~~ has contracted for with a specified provider within the network as total
417.33 payment for a health care service specified by the enrollee and the portion of the allowable
417.34 amount due from the enrollee and the enrollee's out-of-pocket costs. ~~If requested by the~~

418.1 ~~enrollee, the health plan company shall also provide to the enrollee a good faith estimate~~
418.2 ~~of the enrollee's out-of-pocket cost for the health care service.~~ An estimate provided to
418.3 an enrollee under this paragraph is not a legally binding estimate of the ~~reimbursement~~
418.4 allowable amount or enrollee's out-of-pocket cost.

418.5 **EFFECTIVE DATE.** This section is effective August 1, 2007.

418.6 Sec. 17. Minnesota Statutes 2006, section 62J.82, is amended to read:

418.7 **62J.82 HOSPITAL CHARGE INFORMATION REPORTING DISCLOSURE.**

418.8 **Subdivision 1. Required information.** The Minnesota Hospital Association shall
418.9 develop a Web-based system, available to the public free of charge, for reporting ~~charge~~
418.10 ~~information~~ the following, for Minnesota residents:

418.11 (1) hospital-specific performance on the measures of care developed under section
418.12 256B.072 for acute myocardial infarction, heart failure, and pneumonia;

418.13 (2) by January 1, 2009, hospital-specific performance on the public reporting
418.14 measures for hospital-acquired infections as published by the National Quality Forum
418.15 and collected by the Minnesota Hospital Association and Stratis Health in collaboration
418.16 with infection control practitioners; and

418.17 (3) charge information, including, but not limited to, number of discharges, average
418.18 length of stay, average charge, average charge per day, and median charge, for each of the
418.19 50 most common inpatient diagnosis-related groups and the 25 most common outpatient
418.20 surgical procedures as specified by the Minnesota Hospital Association.

418.21 **Subd. 2. Web site.** The Web site must provide information that compares
418.22 hospital-specific data to hospital statewide data. The Web site must be ~~established by~~
418.23 ~~October 1, 2006, and must be~~ updated annually. The commissioner shall provide a link to
418.24 this reporting information on the department's Web site.

418.25 **Subd. 3. Enforcement.** The commissioner shall provide a link to this information
418.26 on the department's Web site. If a hospital does not provide this information to the
418.27 Minnesota Hospital Association, the commissioner of health may require the hospital to
418.28 do so in accordance with section 144.55, subdivision 6. ~~The commissioner shall provide a~~
418.29 ~~link to this information on the department's Web site.~~

418.30 Sec. 18. **[62J.84] HEALTH CARE TRANSFORMATION TASK FORCE.**

418.31 **Subdivision 1. Task force.** The governor shall convene a health care transformation
418.32 task force to advise and assist the governor and the Minnesota legislature. The task force
418.33 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. 19. 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.

421.1 (e) A health carrier may sell, issue, or renew individual health plans if the coverage
421.2 is appropriate due to an unexpired preexisting condition limitation or exclusion applicable
421.3 to the person under the employer's group health plan or due to the person's need for health
421.4 care services not covered under the employer's group health plan.

421.5 (f) A health carrier may sell, issue, or renew an individual health plan, if the
421.6 individual has elected to buy the individual health plan not as part of a general plan to
421.7 substitute individual health plans for a group health plan nor as a result of any violation of
421.8 subdivision 3 or 4.

421.9 (g) Nothing in this subdivision relieves a health carrier of any obligation to provide
421.10 continuation or conversion coverage otherwise required under federal or state law.

421.11 (h) Nothing in this chapter restricts the offer, sale, issuance, or renewal of coverage
421.12 issued as a supplement to Medicare under sections 62A.3099 to 62A.44, or policies or
421.13 contracts that supplement Medicare issued by health maintenance organizations, or those
421.14 contracts governed by sections 1833, 1851 to 1859, 1860D, or 1876 of the federal Social
421.15 Security Act, United States Code, title 42, section 1395 et seq., as amended.

421.16 (i) Nothing in this chapter restricts the offer, sale, issuance, or renewal of individual
421.17 health plans necessary to comply with a court order.

421.18 (j) A health carrier may offer, issue, sell, or renew an individual health plan to
421.19 persons eligible for an employer group health plan, if the individual health plan is a high
421.20 deductible health plan for use in connection with an existing health savings account, in
421.21 compliance with the Internal Revenue Code, section 223. In that situation, the same or
421.22 a different health carrier may offer, issue, sell, or renew a group health plan to cover
421.23 the other eligible employees in the group.

421.24 (k) A health carrier may offer, sell, issue, or renew an individual health plan to one
421.25 or more employees of a small employer if the individual health plan is marketed ~~directly~~
421.26 through the Minnesota Health Insurance Exchange under section 62A.67 or 62A.68 to
421.27 all employees of the small employer and the small employer does not contribute directly
421.28 or indirectly to the premiums or facilitate the administration of the individual health
421.29 plan. The requirement to market an individual health plan to all employees through the
421.30 Minnesota Health Insurance Exchange under section 62A.67 or 62A.68 does not require
421.31 the health carrier to offer or issue an individual health plan to any employee. For purposes
421.32 of this paragraph, an employer is not contributing to the premiums or facilitating the
421.33 administration of the individual health plan if the employer does not contribute to the
421.34 premium and merely collects the premiums from an employee's wages or salary through
421.35 payroll deductions and submits payment for the premiums of one or more employees ~~in a~~
421.36 ~~lump sum to the health carrier~~ to the Minnesota Health Insurance Exchange under section

422.1 62A.67 or 62A.68. Except for coverage under section 62A.65, subdivision 5, paragraph
422.2 (b), or 62E.16, at the request of an employee, the ~~health carrier~~ Minnesota Health Insurance
422.3 Exchange under section 62A.67 or 62A.68 may bill the employer for the premiums
422.4 payable by the employee, provided that the employer is not liable for payment except
422.5 from payroll deductions for that purpose. If an employer is submitting payments under
422.6 this paragraph, the health carrier and the Minnesota Health Insurance Exchange under
422.7 section 62A.67 or 62A.68 shall jointly provide a cancellation notice directly to the primary
422.8 insured at least ten days prior to termination of coverage for nonpayment of premium.

422.9 ~~Individual coverage under this paragraph may be offered only if the small employer has~~
422.10 ~~not provided coverage under section 62L.03 to the employees within the past 12 months.~~

422.11 The employer must provide a written and signed statement to the ~~health carrier~~
422.12 Minnesota Health Insurance Exchange under section 62A.67 or 62A.68 that the employer
422.13 is not contributing directly or indirectly to the employee's premiums. The Minnesota
422.14 Health Insurance Exchange under section 62A.67 or 62A.68 shall provide all health
422.15 carriers with enrolled employees of the employer with a copy of the employer's statement.
422.16 The health carrier may rely on the employer's statement provided by the Minnesota Health
422.17 Insurance Exchange under section 62A.67 or 62A.68 and is not required to guarantee-issue
422.18 individual health plans to the employer's ~~other current or future~~ employees.

422.19 Sec. 20. Minnesota Statutes 2006, section 62L.12, subdivision 4, is amended to read:

422.20 Subd. 4. **Employer prohibition.** A small employer offering a health benefit plan
422.21 shall not encourage or direct an employee or applicant to:

422.22 (1) refrain from filing an application for health coverage when other similarly
422.23 situated employees may file an application for health coverage;

422.24 (2) file an application for health coverage during initial eligibility for coverage,
422.25 the acceptance of which is contingent on health status, when other similarly situated
422.26 employees may apply for health coverage, the acceptance of which is not contingent on
422.27 health status;

422.28 (3) seek coverage from another health carrier, including, but not limited to, MCHA;
422.29 or

422.30 (4) cause coverage to be issued on different terms because of the health status or
422.31 claims experience of that person or the person's dependents.

422.32 Sec. 21. **[62Q.101] EVALUATION OF PROVIDER PERFORMANCE.**

423.1 A health plan company, or a vendor of risk management services as defined under
423.2 section 60A.23, subdivision 8, shall, in evaluating the performance of a health care
423.3 provider:

423.4 (1) conduct the evaluation using a bona fide baseline based upon practice experience
423.5 of the provider group; and

423.6 (2) disclose the baseline to the health care provider in writing and prior to the
423.7 beginning of the time period used for the evaluation.

423.8 Sec. 22. Minnesota Statutes 2006, section 62Q.165, subdivision 1, is amended to read:

423.9 Subdivision 1. **Definition.** It is the commitment of the state to achieve universal
423.10 health coverage for all Minnesotans by the year 2011. Universal coverage is achieved
423.11 when:

423.12 (1) every Minnesotan has access to a full range of quality health care services;

423.13 (2) every Minnesotan is able to obtain affordable health coverage which pays for the
423.14 full range of services, including preventive and primary care; and

423.15 (3) every Minnesotan pays into the health care system according to that person's
423.16 ability.

423.17 **EFFECTIVE DATE.** This section is effective July 1, 2007.

423.18 Sec. 23. Minnesota Statutes 2006, section 62Q.165, subdivision 2, is amended to read:

423.19 Subd. 2. **Goal.** It is the goal of the state to make continuous progress toward
423.20 reducing the number of Minnesotans who do not have health coverage so that by January
423.21 1, 2000, ~~fewer than four percent of the state's population will be without health coverage~~
423.22 2011, all Minnesota residents have access to affordable health care. The goal will be
423.23 achieved by improving access to private health coverage through insurance reforms and
423.24 market reforms, by making health coverage more affordable for low-income Minnesotans
423.25 through purchasing pools and state subsidies, and by reducing the cost of health coverage
423.26 through cost containment programs and methods of ensuring that all Minnesotans are
423.27 paying into the system according to their ability.

423.28 **EFFECTIVE DATE.** This section is effective July 1, 2007.

423.29 Sec. 24. Minnesota Statutes 2006, section 62Q.80, subdivision 3, is amended to read:

423.30 Subd. 3. **Approval.** (a) Prior to the operation of a community-based health care
423.31 coverage program, a community-based health initiative shall submit to the commissioner
423.32 of health for approval the community-based health care coverage program developed by

the initiative. ~~The commissioner shall only approve a program that has been awarded a community access program grant from the United States Department of Health and Human Services.~~ The commissioner shall ensure that the program meets the federal grant requirements and any requirements described in this section and is actuarially sound based on a review of appropriate records and methods utilized by the community-based health initiative in establishing premium rates for the community-based health care coverage program.

(b) Prior to approval, the commissioner shall also ensure that:

(1) the benefits offered comply with subdivision 8 and that there are adequate numbers of health care providers participating in the community-based health network to deliver the benefits offered under the program;

(2) the activities of the program are limited to activities that are exempt under this section or otherwise from regulation by the commissioner of commerce;

(3) the complaint resolution process meets the requirements of subdivision 10; and

(4) the data privacy policies and procedures comply with state and federal law.

Sec. 25. 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. 26. 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;

- 425.1 (2) a description of the health care benefits offered and the services utilized;
- 425.2 (3) the number of employers participating, the number of employees and dependents
- 425.3 covered under the program, and the number of health care providers participating;
- 425.4 (4) a description of the health outcomes to be achieved by the program and a status
- 425.5 report on the performance measurements to be used and collected; and
- 425.6 (5) any other information requested by the commissioner of health or commerce or
- 425.7 the legislature.
- 425.8 (b) The initiative shall contract with an independent entity to conduct an evaluation
- 425.9 of the program to be submitted to the commissioners of health and commerce and the
- 425.10 legislature by January 15, ~~2009~~ 2010. The evaluation shall include:
- 425.11 (1) an analysis of the health outcomes established by the initiative and the
- 425.12 performance measurements to determine whether the outcomes are being achieved;
- 425.13 (2) an analysis of the financial status of the program, including the claims to
- 425.14 premiums loss ratio and utilization and cost experience;
- 425.15 (3) the demographics of the enrollees, including their age, gender, family income,
- 425.16 and the number of dependents;
- 425.17 (4) the number of employers and employees who have been denied access to the
- 425.18 program and the basis for the denial;
- 425.19 (5) specific analysis on enrollees who have aggregate medical claims totaling over
- 425.20 \$5,000 per year, including data on the enrollee's main diagnosis and whether all the
- 425.21 medical claims were covered by the program;
- 425.22 (6) number of enrollees referred to state public assistance programs;
- 425.23 (7) a comparison of employer-subsidized health coverage provided in a comparable
- 425.24 geographic area to the designated community-based geographic area served by the
- 425.25 program, including, to the extent available:
- 425.26 (i) the difference in the number of employers with 50 or fewer employees offering
- 425.27 employer-subsidized health coverage;
- 425.28 (ii) the difference in uncompensated care being provided in each area; and
- 425.29 (iii) a comparison of health care outcomes and measurements established by the
- 425.30 initiative; and
- 425.31 (8) any other information requested by the commissioner of health or commerce.

425.32 Sec. 27. Minnesota Statutes 2006, section 62Q.80, subdivision 14, is amended to read:

425.33 Subd. 14. **Sunset.** This section expires December 31, ~~2011~~ 2012.

425.34 Sec. 28. Minnesota Statutes 2006, section 144.698, subdivision 1, is amended to read:

Subdivision 1. **Yearly reports.** (a) Each hospital and each outpatient surgical center, which has not filed the financial information required by this section with a voluntary, nonprofit reporting organization pursuant to section 144.702, shall file annually with the commissioner of health after the close of the fiscal year:

(1) a balance sheet detailing the assets, liabilities, and net worth of the hospital or outpatient surgical center;

(2) a detailed statement of income and expenses;

(3) a copy of its most recent cost report, if any, filed pursuant to requirements of Title XVIII of the United States Social Security Act;

(4) a copy of all changes to articles of incorporation or bylaws;

(5) information on services provided to benefit the community, including services provided at no cost or for a reduced fee to patients unable to pay, teaching and research activities, or other community or charitable activities;

(6) information required on the revenue and expense report form set in effect on July 1, 1989, or as amended by the commissioner in rule;

(7) information on changes in ownership or control; ~~and~~

(8) other information required by the commissioner in rule;

(9) information on the number of available hospital beds that are dedicated to certain specialized services, as designated by the commissioner, and annual occupancy rates for those beds, separately for adult and pediatric care;

(10) from outpatient surgical centers, the total number of surgeries; and

(11) a report on health care capital expenditures during the previous year, as required by section 62J.17.

(b) Beginning with hospital fiscal year 2009, each nonprofit hospital shall report on community benefits under paragraph (a), clause (5). "Community benefit" means the costs of community care, underpayment for services provided under state health care programs, research costs, community health services costs, financial and in-kind contributions, costs of community building activities, costs of community benefit operations, education, and the cost of operating subsidized services. The cost of bad debts and underpayment for Medicare services are not included in the calculation of community benefit.

Sec. 29. Minnesota Statutes 2006, section 144.699, is amended by adding a subdivision to read:

Subd. 5. **Annual reports on community benefit, community care amounts, and state program underfunding.** (a) For each hospital reporting health care cost information under section 144.698 or 144.702, the commissioner shall report annually

427.1 on the hospital's community benefit, community care, and underpayment for state public
427.2 health care programs.

427.3 (b) For purposes of this subdivision, "community benefits" has the definition given
427.4 in section 144.698, paragraph (b).

427.5 (c) For purposes of this subdivision, "community care" means the costs for medical
427.6 care for which a hospital has determined is charity care, as defined under Minnesota Rules,
427.7 part 4650.0115, or for which the hospital determines after billing for the services that there
427.8 is a demonstrated inability to pay. Any costs forgiven under a hospital's community care
427.9 plan or under section 62J.83 may be counted in the hospital's calculation of community
427.10 care. Bad debt expenses and discounted charges available to the uninsured shall not be
427.11 included in the calculation of community care. The amount of community care is the value
427.12 of costs incurred and not the charges made for services.

427.13 (d) For purposes of this subdivision, underpayment for services provided by state
427.14 public health care programs is the difference between hospital costs and public program
427.15 payments. The information shall be reported in terms of total dollars and as a percentage
427.16 of total operating costs for each hospital.

427.17 Sec. 30. **[145.985] HEALTH PROMOTION AND WELLNESS.**

427.18 Community health boards as defined in section 145A.02, subdivision 5, may work
427.19 with schools, health care providers, and others to coordinate health and wellness programs
427.20 in their communities. In order to meet the requirements of this section, community
427.21 health boards may:

427.22 (1) provide instruction, technical assistance, and recommendations on how to
427.23 evaluate project outcomes;

427.24 (2) assist with on-site health and wellness programs utilizing volunteers and others
427.25 addressing health and wellness topics including smoking, nutrition, obesity, and others; and

427.26 (3) encourage health and wellness programs consistent with the Centers for Disease
427.27 Control and Prevention's Community Guide and goals consistent with the Centers for
427.28 Disease Control and Prevention's Healthy People 2010 initiative.

427.29 Sec. 31. Minnesota Statutes 2006, section 256.01, subdivision 2b, is amended to read:

427.30 Subd. 2b. **Performance payments.** (a) The commissioner shall develop and
427.31 implement a pay-for-performance system to provide performance payments to:

427.32 (1) eligible medical groups and clinics that demonstrate optimum care in serving
427.33 individuals with chronic diseases who are enrolled in health care programs administered
427.34 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. 32. 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 clients, evaluation mechanisms, and quality improvement processes to qualify for reimbursement. For purposes of this subdivision, a primary care clinic is a medical clinic designated as the patient's first point of contact for medical care, available 24 hours a day, seven days a week, that provides or arranges for the patient's comprehensive health care needs, and provides overall integration, coordination and continuity over time and referrals for specialty care.

Sec. 33. **HEALTH CARE PAYMENT SYSTEM REFORM.**

Subdivision 1. Payment reform plan. The commissioners of employee relations, human services, commerce, and health shall develop a plan for promoting and facilitating 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;

(3) discourage underutilization, overuse, and misuse;

(4) reward the use of the most cost-effective settings, drugs, devices, providers, and treatments; and

(5) encourage consumers to maintain good health and use the health care system appropriately.

In developing the plan, the commissioners shall analyze existing data to determine specific services and health conditions for which changes in payment rates and methods would lead to significant improvements in quality of care. The commissioners shall include a definition of the term "quality" for uniform understanding of the plan's impact.

Subd. 2. Report. The commissioners shall submit a report to the legislature by December 15, 2007, describing the payment reform plan. The report must include proposed legislation for implementing those components of the plan requiring legislative action or appropriations of money.

EFFECTIVE DATE. This section is effective July 1, 2007.

Sec. 34. **COMMUNITY COLLABORATIVE PILOT PROJECTS TO COVER THE UNINSURED.**

Subdivision 1. Community collaboratives. The commissioner of human services shall provide grants to and authorization for up to three community collaboratives that satisfy the requirements in this section. To be eligible to receive a grant and authorization under this section, a community collaborative must include:

(1) one or more counties;

(2) one or more local hospitals;

(3) one or more local employers who collectively provide at least 300 jobs in the community;

(4) one or more health care clinics or physician groups; and

(5) a third-party payer, which may be a county-based purchasing plan operating under Minnesota Statutes, section 256B.692, a self-insured employer, or a health plan company as defined in Minnesota Statutes, section 62Q.01, subdivision 4.

430.1 Subd. 2. **Pilot project requirements.** (a) Community collaborative pilot projects
430.2 must:

430.3 (1) identify and enroll persons in the community who are uninsured, and who have,
430.4 or are at risk of developing, one of the following chronic conditions: mental illness,
430.5 diabetes, asthma, hypertension, or other chronic condition designated by the project;

430.6 (2) assist uninsured persons to obtain private-sector health insurance coverage if
430.7 possible or to enroll in any public health care programs for which they are eligible. If the
430.8 uninsured individual is unable to obtain health coverage, the community collaborative
430.9 must enroll the individual in a local health care assistance program that provides specified
430.10 services to prevent or effectively manage the chronic condition;

430.11 (3) include components to help uninsured persons retain employment or to become
430.12 employable, if currently unemployed;

430.13 (4) ensure that each uninsured person enrolled in the program has a medical home
430.14 responsible for providing, or arranging for, health care services and assisting in the
430.15 effective management of the chronic condition;

430.16 (5) coordinate services between all providers and agencies serving an enrolled
430.17 individual; and

430.18 (6) be coordinated with the state's Q-Care initiative and improve the use of
430.19 evidence-based treatments and effective disease management programs in the broader
430.20 community, beyond those individuals enrolled in the project.

430.21 (b) Projects established under this section are not insurance and are not subject to
430.22 state-mandated benefit requirements or insurance regulations.

430.23 Subd. 3. **Criteria.** Proposals must be evaluated by actuarial, financial, and clinical
430.24 experts based on the likelihood that the project would produce a positive return on
430.25 investment for the community. In awarding grants, the commissioner of human services
430.26 shall give preference to proposals that:

430.27 (1) have broad community support from local businesses, provider counties, and
430.28 other public and private organizations;

430.29 (2) would provide services to uninsured persons who have, or are at risk of
430.30 developing, multiple, co-occurring chronic conditions;

430.31 (3) integrate or coordinate resources from multiple sources, such as employer
430.32 contributions, county funds, social service programs, and provider financial or in-kind
430.33 support;

430.34 (4) provide continuity of treatment and services when uninsured individuals in
430.35 the program become eligible for public or private health insurance or when insured
430.36 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. 35. 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;

(3) reward coordination of care for patients with chronic conditions;

(4) discourage overuse and misuse;

(5) reward the use of the most cost-effective settings, drugs, devices, providers, and treatments;

(6) encourage consumers to maintain good health and use the health care system appropriately.

(b) The pilot projects must involve the use of designated care professionals or clinics to serve as a patient's medical home and be responsible for coordinating health care services across the continuum of care. The pilot projects must evaluate different payment reform models and must be coordinated with the Minnesota senior health options program and the Minnesota disability health options program. To the extent possible, the commissioners shall coordinate state purchasing activities with other public employers and with private purchasers, self-insured groups, and health plan companies to promote the use of pilot projects encompassing both public and private purchasers and markets.

Subd. 2. Payment methods and incentives. The commissioners shall modify existing payment methods and rates for those enrollees and health care providers participating in the pilot project in order to provide incentives for care management, team-based care, and practice redesign, and increase resources for primary care, chronic condition care, and care provided to complex patients. The commissioners may create financial incentives for patients to select a medical home under the pilot project by reducing, modifying, or eliminating deductibles and co-payments for certain services, or through other incentives. The commissioners may require patients to remain with their designated medical home for a specified period of time. Alternative payment methods may include complete or partial capitation, fee-for-service payments, or other payment methodologies. The payment methods may provide for the payment of bonuses to medical home providers or other providers, or to patients, for the achievement of performance goals. The payment methods may include allocating a portion of the payment that would otherwise be paid to health plans under state prepaid health care programs to the designated medical home for specified services.

Subd. 3. Requirements. In order to be designated a medical home under the pilot project, health care professionals or clinics must demonstrate their ability to:

(1) be the patient's first point of contact by telephone or other means, 24 hours a day, seven days a week;

(2) provide or arrange for patients' comprehensive health care needs, including the ability to structure planned chronic disease visits and to manage chronic disease through the use of disease registries;

(3) coordinate patients' care when care must be provided outside the medical home;

(4) provide longitudinal care, not just episodic care, including meeting long-term and unique personal needs;

(5) utilize an electronic health record and incorporate a plan to develop and make available to patients that choose a medical home an electronic personal health record that

433.1 is prepopulated with the patient's data, consumer-directed, connected to the provider,
433.2 24-hour accessible, and owned and controlled by the patient;

433.3 (6) systematically improve quality of care using, among other inputs, patient
433.4 feedback; and

433.5 (7) create a provider network that provides for increased reimbursement for a
433.6 medical home in a cost-neutral manner.

433.7 Subd. 4. **Evaluation.** Pilot projects must be evaluated based on patient satisfaction,
433.8 provider satisfaction, clinical process and outcome measures, program costs and savings,
433.9 and economic impact on health care providers. Pilot projects must be evaluated based
433.10 on the extent to which the medical home:

433.11 (1) coordinated health care services across the continuum of care and thereby
433.12 reduced duplication of services and enhanced communication across providers;

433.13 (2) provided safe and high-quality care by increasing utilization of effective
433.14 treatments, reduced use of ineffective treatments, reduced barriers to essential care and
433.15 services, and eliminated barriers to access;

433.16 (3) reduced unnecessary hospitalizations and emergency room visits and increased
433.17 use of cost-effective care and settings;

433.18 (4) encouraged long-term patient and provider relationships by shifting from
433.19 episodic care to consistent, coordinated communication and care with a specified team of
433.20 providers or individual providers;

433.21 (5) engaged and educated consumers by encouraging shared patient and provider
433.22 responsibility and accountability for disease prevention, health promotion, chronic
433.23 disease management, acute care, and overall well-being, encouraging informed medical
433.24 decision-making, ensuring the availability of accurate medical information, and facilitated
433.25 the transfer of accurate medical information;

433.26 (6) encouraged innovation in payment methodologies by using patient and provider
433.27 incentives to coordinate care and utilize medical home services and fostering the
433.28 expansion of a technology infrastructure that supports collaboration; and

433.29 (7) reduced overall health care costs as compared to conventional payment methods
433.30 for similar patient populations.

433.31 Subd. 5. **Rulemaking.** The commissioners are exempt from administrative
433.32 rulemaking under chapter 14 for purposes of developing, administering, contracting
433.33 for, and evaluating pilot projects under this section. The commissioner shall publish a
433.34 proposed request for proposals in the State Register and allow 30 days for comment
433.35 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. 36. **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 include a definition of the terms "quality of care" and "access to care" to provide uniform understanding of the study's findings. 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. 37. **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:

Subd. 21. **Birth defects registry system.** Data on individuals collected by the birth defects registry system are private data on individuals and classified pursuant to section 144.2215.

Sec. 2. Minnesota Statutes 2006, section 16B.61, is amended by adding a subdivision to read:

Subd. 3b. **Window fall prevention device code.** The commissioner of labor and industry shall adopt rules for window fall prevention devices as part of the state Building Code. Window fall prevention devices include, but are not limited to, safety screens, hardware, guards, and other devices that comply with the standards established by the commissioner of labor and industry. The rules must require compliance with standards for window fall prevention devices developed by ASTM International, contained in the International Building Code as the model language with amendments deemed necessary to coordinate with the other adopted building codes in Minnesota. The rules must establish a scope that includes the applicable building occupancies, and the types, locations, and sizes of windows that will require the installation of fall devices. The rules will be effective July 1, 2009. The commissioner shall report to the legislature on the status of the rulemaking on or before February 15, 2008.

Sec. 3. Minnesota Statutes 2006, section 103I.101, subdivision 6, is amended to read:

Subd. 6. **Fees for variances.** The commissioner shall charge a nonrefundable application fee of ~~\$175~~ \$215 to cover the administrative cost of processing a request for a variance or modification of rules adopted by the commissioner under this chapter.

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

Sec. 4. Minnesota Statutes 2006, section 103I.208, subdivision 1, is amended to read:

Subdivision 1. **Well notification fee.** The well notification fee to be paid by a property owner is:

(1) for a new water supply well, ~~\$175~~ \$215, which includes the state core function fee;

(2) for a well sealing, ~~\$35~~ \$50 for each well, which includes the state core function fee, except that for monitoring wells constructed on a single property, having depths within a 25 foot range, and sealed within 48 hours of start of construction, a single fee of ~~\$35~~ \$50; and

(3) for construction of a dewatering well, ~~\$175~~ \$215, which includes the state core function fee, for each dewatering well except a dewatering project comprising five or more dewatering wells shall be assessed a single fee of ~~\$875~~ \$1,075 for the dewatering wells recorded on the notification.

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

Sec. 5. Minnesota Statutes 2006, section 103I.208, subdivision 2, is amended to read:

Subd. 2. **Permit fee.** The permit fee to be paid by a property owner is:

(1) for a water supply well that is not in use under a maintenance permit, ~~\$150~~ \$175 annually;

(2) for construction of a monitoring well, ~~\$175~~ \$215, which includes the state core function fee;

(3) for a monitoring well that is unsealed under a maintenance permit, ~~\$150~~ \$175 annually;

(4) for monitoring wells used as a leak detection device at a single motor fuel retail outlet, a single petroleum bulk storage site excluding tank farms, or a single agricultural chemical facility site, the construction permit fee is ~~\$175~~ \$215, which includes the state core function fee, per site regardless of the number of wells constructed on the site, and the annual fee for a maintenance permit for unsealed monitoring wells is ~~\$150~~ \$175 per site regardless of the number of monitoring wells located on site;

(5) for a groundwater thermal exchange device, in addition to the notification fee for water supply wells, ~~\$175~~ \$215, which includes the state core function fee;

(6) for a vertical heat exchanger, ~~\$175~~ \$215;

(7) for a dewatering well that is unsealed under a maintenance permit, ~~\$150~~ \$175 annually for each dewatering well, except a dewatering project comprising more than five dewatering wells shall be issued a single permit for ~~\$750~~ \$875 annually for dewatering wells recorded on the permit; and

(8) for an elevator boring, ~~\$175~~ \$215 for each boring.

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

Sec. 6. Minnesota Statutes 2006, section 103I.235, subdivision 1, is amended to read:

Subdivision 1. **Disclosure of wells to buyer.** (a) Before signing an agreement to sell or transfer real property, the seller must disclose in writing to the buyer information about the status and location of all known wells on the property, by delivering to the buyer either a statement by the seller that the seller does not know of any wells on the property, or a disclosure statement indicating the legal description and county, and a map drawn from available information showing the location of each well to the extent practicable.

In the disclosure statement, the seller must indicate, for each well, whether the well is in use, not in use, or sealed.

(b) At the time of closing of the sale, the disclosure statement information, name and mailing address of the buyer, and the quartile, section, township, and range in which each

well is located must be provided on a well disclosure certificate signed by the seller or a person authorized to act on behalf of the seller.

(c) A well disclosure certificate need not be provided if the seller does not know of any wells on the property and the deed or other instrument of conveyance contains the statement: "The Seller certifies that the Seller does not know of any wells on the described real property."

(d) If a deed is given pursuant to a contract for deed, the well disclosure certificate required by this subdivision shall be signed by the buyer or a person authorized to act on behalf of the buyer. If the buyer knows of no wells on the property, a well disclosure certificate is not required if the following statement appears on the deed followed by the signature of the grantee or, if there is more than one grantee, the signature of at least one of the grantees: "The Grantee certifies that the Grantee does not know of any wells on the described real property." The statement and signature of the grantee may be on the front or back of the deed or on an attached sheet and an acknowledgment of the statement by the grantee is not required for the deed to be recordable.

(e) This subdivision does not apply to the sale, exchange, or transfer of real property:

(1) that consists solely of a sale or transfer of severed mineral interests; or

(2) that consists of an individual condominium unit as described in chapters 515 and 515B.

(f) For an area owned in common under chapter 515 or 515B the association or other responsible person must report to the commissioner by July 1, 1992, the location and status of all wells in the common area. The association or other responsible person must notify the commissioner within 30 days of any change in the reported status of wells.

(g) For real property sold by the state under section 92.67, the lessee at the time of the sale is responsible for compliance with this subdivision.

(h) If the seller fails to provide a required well disclosure certificate, the buyer, or a person authorized to act on behalf of the buyer, may sign a well disclosure certificate based on the information provided on the disclosure statement required by this section or based on other available information.

(i) A county recorder or registrar of titles may not record a deed or other instrument of conveyance dated after October 31, 1990, for which a certificate of value is required 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

438.1 must not accept a certificate unless it contains all the required information. The county
438.2 recorder or registrar of titles shall note on each deed or other instrument of conveyance
438.3 accompanied by a well disclosure certificate that the well disclosure certificate was
438.4 received. The notation must include the statement "No wells on property" if the disclosure
438.5 certificate states there are no wells on the property. The well disclosure certificate shall not
438.6 be filed or recorded in the records maintained by the county recorder or registrar of titles.
438.7 After noting "No wells on property" on the deed or other instrument of conveyance, the
438.8 county recorder or registrar of titles shall destroy or return to the buyer the well disclosure
438.9 certificate. The county recorder or registrar of titles shall collect from the buyer or the
438.10 person seeking to record a deed or other instrument of conveyance, a fee of ~~\$40~~ \$45
438.11 for receipt of a completed well disclosure certificate. By the tenth day of each month,
438.12 the county recorder or registrar of titles shall transmit the well disclosure certificates
438.13 to the commissioner of health. By the tenth day after the end of each calendar quarter,
438.14 the county recorder or registrar of titles shall transmit to the commissioner of health
438.15 ~~\$32.50~~ \$37.50 of the fee for each well disclosure certificate received during the quarter.
438.16 The commissioner shall maintain the well disclosure certificate for at least six years. The
438.17 commissioner may store the certificate as an electronic image. A copy of that image
438.18 shall be as valid as the original.

438.19 (j) No new well disclosure certificate is required under this subdivision if the buyer
438.20 or seller, or a person authorized to act on behalf of the buyer or seller, certifies on the deed
438.21 or other instrument of conveyance that the status and number of wells on the property
438.22 have not changed since the last previously filed well disclosure certificate. The following
438.23 statement, if followed by the signature of the person making the statement, is sufficient
438.24 to comply with the certification requirement of this paragraph: "I am familiar with the
438.25 property described in this instrument and I certify that the status and number of wells on
438.26 the described real property have not changed since the last previously filed well disclosure
438.27 certificate." The certification and signature may be on the front or back of the deed or on
438.28 an attached sheet and an acknowledgment of the statement is not required for the deed or
438.29 other instrument of conveyance to be recordable.

438.30 (k) The commissioner in consultation with county recorders shall prescribe the form
438.31 for a well disclosure certificate and provide well disclosure certificate forms to county
438.32 recorders and registrars of titles and other interested persons.

438.33 (l) Failure to comply with a requirement of this subdivision does not impair:

438.34 (1) the validity of a deed or other instrument of conveyance as between the parties
438.35 to the deed or instrument or as to any other person who otherwise would be bound by
438.36 the deed or instrument; or

439.1 (2) the record, as notice, of any deed or other instrument of conveyance accepted for
439.2 filing or recording contrary to the provisions of this subdivision.

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

439.4 Sec. 7. Minnesota Statutes 2006, section 144.123, is amended to read:

439.5 **144.123 FEES FOR DIAGNOSTIC LABORATORY SERVICES;**
439.6 **EXCEPTIONS.**

439.7 Subdivision 1. **Who must pay.** Except for the limitation contained in this section,
439.8 the commissioner of health shall charge a handling fee for each specimen submitted to
439.9 the Department of Health for analysis for diagnostic purposes by any hospital, private
439.10 laboratory, private clinic, or physician. No fee shall be charged to any entity which
439.11 receives direct or indirect financial assistance from state or federal funds administered by
439.12 the Department of Health, including any public health department, nonprofit community
439.13 clinic, ~~venereal~~ sexually transmitted disease clinic, ~~family planning clinic~~, or similar
439.14 entity. No fee will be charged for any biological materials submitted to the Department
439.15 of Health as a requirement of Minnesota Rules, part 4605.7040, or for those biological
439.16 materials requested by the department to gather information for disease prevention or
439.17 control purposes. The commissioner of health may establish ~~by rule~~ other exceptions to
439.18 the handling fee as may be necessary to ~~gather information for epidemiologic purposes~~
439.19 protect the public's health. All fees collected pursuant to this section shall be deposited in
439.20 the state treasury and credited to the state government special revenue fund.

439.21 Subd. 2. ~~Rules for Fee amounts.~~ The commissioner of health shall ~~promulgate~~
439.22 ~~rules, in accordance with chapter 14, which shall specify the amount of the charge a~~
439.23 ~~handling fee prescribed in subdivision 1. The fee shall approximate the costs to the~~
439.24 ~~department of handling specimens including reporting, postage, specimen kit preparation,~~
439.25 ~~and overhead costs. The fee prescribed in subdivision 1 shall be \$15 \$25 per specimen~~
439.26 ~~until the commissioner promulgates rules pursuant to this subdivision.~~

439.27 Sec. 8. Minnesota Statutes 2006, section 144.125, is amended to read:

439.28 **144.125 TESTS OF INFANTS FOR HERITABLE AND CONGENITAL**
439.29 **DISORDERS.**

439.30 Subdivision 1. **Duty to perform testing.** It is the duty of (1) the administrative
439.31 officer or other person in charge of each institution caring for infants 28 days or less
439.32 of age, (2) the person required in pursuance of the provisions of section 144.215, to
439.33 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 be recorded on a form that is signed by a parent or legal guardian and made part of the infant's medical record. A written objection exempts an infant from the requirements of this section and section 144.128.

Sec. 9. Minnesota Statutes 2006, section 144.2215, subdivision 1, is amended to read:

Subdivision 1. **Establishment.** Within the limits of available appropriations, the commissioner of health shall establish and maintain an information system containing data on the cause, treatment, prevention, and cure of major birth defects. The commissioner shall consult with representatives and experts in epidemiology, medicine, insurance, health maintenance organizations, genetics, consumers, and voluntary organizations in developing the system and may phase in the implementation of the system. After the parents have provided informed consent under section 144.2216, subdivision 4, the commissioner shall offer the parents with their informed consent a visit by a trained health care worker to interview the parents about:

(1) all previous home addresses, occupations, and places of work including from childhood;

(2) the time and place of any military service; and

(3) known occasions or sites of toxic exposures.

Sec. 10. Minnesota Statutes 2006, section 144.672, subdivision 1, is amended to read:

Subdivision 1. **Rule authority.** The commissioner of health shall collect cancer incidence information, analyze the information, and conduct special studies designed to determine the potential public health significance of an increase in cancer incidence.

The commissioner shall adopt rules to administer the system, collect information, and distribute data. The rules must include, but not be limited to, the following:

(1) the type of data to be reported, which must include current and previous occupational and residential data;

(2) standards for reporting specific types of data;

(3) payments allowed to hospitals, pathologists, and registry systems to defray their costs in providing information to the system;

(4) criteria relating to contracts made with outside entities to conduct studies using data collected by the system. The criteria may include requirements for a written protocol outlining the purpose and public benefit of the study, the description, methods, and projected results of the study, peer review by other scientists, the methods and facilities to protect the privacy of the data, and the qualifications of the researcher proposing to undertake the study; and

(5) specification of fees to be charged under section 13.03, subdivision 3, for all out-of-pocket expenses for data summaries or specific analyses of data requested by public and private agencies, organizations, and individuals, and which are not otherwise

442.1 included in the commissioner's annual summary reports. Fees collected are appropriated
442.2 to the commissioner to offset the cost of providing the data.

442.3 Sec. 11. Minnesota Statutes 2006, section 144.9502, subdivision 3, is amended to read:

442.4 Subd. 3. **Reports of blood lead analysis required.** (a) Every hospital, medical
442.5 clinic, medical laboratory, other facility, or individual performing blood lead analysis
442.6 shall report the results after the analysis of each specimen analyzed, for both capillary
442.7 and venous specimens, and epidemiologic information required in this section to the
442.8 commissioner of health, within the time frames set forth in clauses (1) and (2):

442.9 (1) within two working days by telephone, fax, or electronic transmission, with
442.10 written or electronic confirmation within one month, for a venous blood lead level equal to
442.11 or greater than ~~15~~ ten micrograms of lead per deciliter of whole blood; or

442.12 (2) within one month in writing or by electronic transmission, for any capillary
442.13 result or for a venous blood lead level less than ~~15~~ ten micrograms of lead per deciliter of
442.14 whole blood.

442.15 (b) If a blood lead analysis is performed outside of Minnesota and the facility
442.16 performing the analysis does not report the blood lead analysis results and epidemiological
442.17 information required in this section to the commissioner, the provider who collected the
442.18 blood specimen must satisfy the reporting requirements of this section. For purposes of
442.19 this section, "provider" has the meaning given in section 62D.02, subdivision 9.

442.20 (c) The commissioner shall coordinate with hospitals, medical clinics, medical
442.21 laboratories, and other facilities performing blood lead analysis to develop a universal
442.22 reporting form and mechanism.

442.23 Sec. 12. Minnesota Statutes 2006, section 144.9504, subdivision 2, is amended to read:

442.24 Subd. 2. **Lead risk assessment.** (a) An assessing agency shall conduct a lead risk
442.25 assessment of a residence according to the venous blood lead level and time frame set
442.26 forth in clauses (1) to (4) for purposes of secondary prevention:

442.27 (1) within 48 hours of a child or pregnant female in the residence being identified to
442.28 the agency as having a venous blood lead level equal to or greater than ~~60~~ 45 micrograms
442.29 of lead per deciliter of whole blood;

442.30 (2) within five working days of a child or pregnant female in the residence being
442.31 identified to the agency as having a venous blood lead level equal to or greater than ~~45~~ 15
442.32 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.~~

~~(c) "Commissioner" means the commissioner of health, or the commissioner of the Minnesota Housing Finance Agency as authorized by section 462A.05, subdivision 15c.~~

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, where lead orders were not issued, and for purposes of primary prevention in census~~

~~tracts known to be in areas at high risk for toxic lead exposure as described in section 144.9503, subdivision 2.~~

~~(c) Any additional money must be used for grants to establish swab teams for primary prevention under section 144.9503, in census tracts in areas at high risk for toxic lead exposure as determined under section 144.9503, subdivision 2.~~

~~(d) In evaluating grant applications, the commissioner must consider the following criteria:~~

~~(1) the use of lead contractors and lead workers for residential swab team services;~~

~~(2) the participation of neighborhood groups and individuals, as swab team workers, in areas at high risk for toxic lead exposure;~~

~~(3) plans for the provision of swab team services for primary and secondary prevention as required under subdivision 4;~~

~~(4) plans for supervision, training, career development, and postprogram placement of swab team members;~~

~~(5) plans for resident and property owner education on lead safety;~~

~~(6) plans for distributing cleaning supplies to area residents and educating residents and property owners on cleaning techniques;~~

~~(7) sources of other funding and cost estimates for training, lead inspections, swab team services, equipment, monitoring, testing, and administration;~~

~~(8) measures of program effectiveness;~~

~~(9) coordination of program activities with other federal, state, and local public health, job training, apprenticeship, and housing renovation programs including programs under sections 116L.86 to 116L.881; and~~

~~(10) prior experience in providing swab team services.~~

Subd. 4. ~~Lead supervisor or certified firm~~ **Eligible grant activities.** (a) ~~Eligible organizations and lead supervisors or certified firms may participate in the swab team program. An eligible organization~~ The nonprofit receiving a grant under this section must ~~assure~~ ensure that all participating lead supervisors or certified firms are licensed and that all swab team workers are certified by the Department of Health under section 144.9505. ~~Eligible organizations and lead supervisors or certified firms may distinguish between interior and exterior services in assigning duties and~~ The nonprofit organization may participate in the program by:

(1) providing on-the-job training for swab team workers;

(2) providing swab team services to meet the requirements of sections 144.9503, 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.

~~Subd. 6. **On-the-job training component.** (a) Programs established under this section must provide on-the-job training for swab team workers.~~

~~(b) Swab team workers must receive monetary compensation equal to the prevailing wage as defined in section 177.42, subdivision 6, for comparable jobs in the licensed contractor's principal business.~~

~~Subd. 7. **Removal and replacement component.** (a) Within the limits of the available appropriation and if a need is identified by a lead inspector, the commissioner may establish a component for removal and replacement of deteriorated paint in residential properties according to the following criteria:~~

~~(1) components within a residence must have both deteriorated lead-based paint and substrate damage beyond repair or rotting wooden framework to be eligible for removal and replacement;~~

~~(2) all removal and replacement must be done using least-cost methods and following lead-safe directives;~~

~~(3) whenever windows and doors or other components covered with deteriorated lead-based paint have sound substrate or are not rotting, those components should be repaired, sent out for stripping, planed down to remove deteriorated lead-based paint, or covered with protective guards instead of being replaced, provided that such an activity is the least-cost method of providing the swab team service;~~

~~(4) removal and replacement or repair must be done by lead contractors using skilled craft workers or trained swab team members; and~~

~~(5) all craft work that requires a state license must be supervised by a person with a state license in the craft work being supervised. The grant recipient may contract for this supervision.~~

~~(b) The program design must:~~

~~(1) identify the need for on-the-job training of swab team workers to be removal and replacement workers; and~~

~~(2) describe plans to involve appropriate groups in designing methods to meet the need for training swab team workers.~~

~~Subd. 8. **Testing and evaluation.** (a) Testing of the environment is not necessary by swab teams whose work is assigned by the commissioner of health or a designated board of health under section 144.9504. The commissioner of health or designated board of health must share the analytical testing data collected on each residence for purposes of secondary prevention under section 144.9504 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).~~

~~(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.

450.1 (b) "False positive rate" means the proportion of infants identified as having a
450.2 significant hearing loss by the screening process who are ultimately found to not have a
450.3 significant hearing loss.

450.4 (c) "False negative rate" means the proportion of infants not identified as having
450.5 a significant hearing loss by the screening process who are ultimately found to have a
450.6 significant hearing loss.

450.7 (d) "Hearing screening test" means automated auditory brain stem response,
450.8 otoacoustic emissions, or another appropriate screening test approved by the Department
450.9 of Health.

450.10 (e) "Hospital" means a birthing health care facility or birthing center licensed in
450.11 this state that provides obstetrical services.

450.12 (f) "Infant" means a child who is not a newborn and has not attained the age of
450.13 one year.

450.14 (g) "Newborn" means an infant 28 days old or younger.

450.15 (h) "Parent" means a natural parent, stepparent, adoptive parent, guardian, or
450.16 custodian of a newborn or infant.

450.17 Subd. 2. Newborn Hearing Screening Advisory Committee. (a) The
450.18 commissioner of health shall appoint a Newborn Hearing Screening Advisory Committee
450.19 to advise and assist the Department of Health and the Department of Education in:

450.20 (1) developing protocols and timelines for screening, rescreening, and diagnostic
450.21 audiological assessment and early medical, audiological, and educational intervention
450.22 services for children who are deaf or hard-of-hearing;

450.23 (2) designing protocols for tracking children from birth through age three that may
450.24 have passed newborn screening but are at risk for delayed or late onset of permanent
450.25 hearing loss;

450.26 (3) designing a technical assistance program to support facilities implementing the
450.27 screening program and facilities conducting rescreening and diagnostic audiological
450.28 assessment;

450.29 (4) designing implementation and evaluation of a system of follow-up and tracking;
450.30 and

450.31 (5) evaluating program outcomes to increase effectiveness and efficiency and ensure
450.32 culturally appropriate services for children with a confirmed hearing loss and their families.

450.33 (b) Membership of the committee shall include at least one member from each of the
450.34 following groups with no less than two of the members being deaf or hard-of-hearing:

450.35 (1) a representative from a consumer organization representing culturally deaf
450.36 persons;

- 451.1 (2) a parent with a child with hearing loss representing a parent organization;
451.2 (3) a consumer from an organization representing oral communication options;
451.3 (4) a consumer from an organization representing cued speech communication
451.4 options;
451.5 (5) an audiologist who has experience in evaluation and intervention of infants
451.6 and young children;
451.7 (6) a speech-language pathologist who has experience in evaluation and intervention
451.8 of infants and young children;
451.9 (7) two primary care providers who have experience in the care of infants and young
451.10 children, one of which shall be a pediatrician;
451.11 (8) a representative from the early hearing detection intervention teams;
451.12 (9) a representative from the Department of Education resource center for the deaf
451.13 and hard-of-hearing or their designee;
451.14 (10) a representative of the Minnesota Commission Serving Deaf and Hard of
451.15 Hearing People;
451.16 (11) a representative from the Department of Human Services Deaf and Hard of
451.17 Hearing Services Division;
451.18 (12) one or more of the Part C coordinators from the Department of Education, the
451.19 Department of Health, or the Department of Human Services or their designee;
451.20 (13) the Department of Health early hearing detection and intervention coordinators;
451.21 (14) two birth hospital representatives from one rural and one urban hospital;
451.22 (15) a pediatric geneticist;
451.23 (16) an otolaryngologist;
451.24 (17) a representative from the Newborn Screening Advisory Committee under
451.25 this subdivision; and
451.26 (18) a representative of the Department of Education regional low-incidence
451.27 facilitators.
451.28 The Department of Health member shall chair the first meeting of the committee.
451.29 At the first meeting, the committee shall elect a chairperson from its membership. The
451.30 committee shall meet at the call of the chairperson, at least four times a year. The
451.31 committee shall adopt written bylaws to govern its activities. The Department of Health
451.32 shall provide technical and administrative support services as required by the committee.
451.33 These services shall include technical support from individuals qualified to administer
451.34 infant hearing screening, rescreening, and diagnostic audiological assessments.

452.1 Members of the committee shall receive no compensation for their service, but
452.2 shall be reimbursed for expenses incurred as a result of their duties as members of the
452.3 committee.

452.4 Subd. 3. **Early hearing detection and intervention programs.** All hospitals
452.5 shall establish a Early Hearing Detection and Intervention (EHDI) program. Each EHDI
452.6 program shall:

452.7 (1) in advance of any hearing screening testing, provide to the newborn's or infant's
452.8 parents or parent information concerning the nature of the screening procedure, applicable
452.9 costs of the screening procedure, the potential risks and effects of hearing loss, and the
452.10 benefits of early detection and intervention;

452.11 (2) comply with parental consent under section 144.125, subdivision 3;

452.12 (3) develop policies and procedures for screening and rescreening based on
452.13 Department of Health recommendations;

452.14 (4) provide appropriate training and monitoring of individuals responsible for
452.15 performing hearing screening tests as recommended by the Department of Health;

452.16 (5) test the newborn's hearing prior to discharge, or, if the newborn is expected to
452.17 remain in the hospital for a prolonged period, testing shall be performed prior to three
452.18 months of age, or when medically feasible;

452.19 (6) develop and implement procedures for documenting the results of all hearing
452.20 screening tests;

452.21 (7) inform the baby's parents or parent, primary care physician, and the Department
452.22 of Health according to recommendations of the Department of Health of the results of the
452.23 hearing screening test or rescreening if conducted, or if the newborn or infant was not
452.24 successfully tested. The hospital that discharges the baby to home is responsible for
452.25 the screening; and

452.26 (8) collect performance data specified by the Department of Health.

452.27 Subd. 4. **Notification and information.** (a) Notification to the parents, primary
452.28 care provider, and Department of Health shall occur prior to discharge or no later than ten
452.29 days following the date of testing. Notification shall include information recommended by
452.30 the Department of Health.

452.31 (b) A physician, nurse, midwife, or other health professional attending a birth outside
452.32 a hospital or institution shall provide information, orally and in writing, as established by
452.33 the Department of Health, to parents regarding places where the parents may have their
452.34 infants' hearing screened and the importance of such screening.

453.1 (c) The professional conducting the diagnostic procedure to confirm the hearing loss
453.2 must report the results to the parents, primary care provider, and Department of Health
453.3 according to the Department of Health recommendations.

453.4 Subd. 5. **Oversight responsibility.** The Department of Health shall exercise
453.5 oversight responsibility for EHDI programs, including establishing a performance data set
453.6 and reviewing performance data collected by each hospital.

453.7 Subd. 6. **Civil and criminal immunity and penalties.** (a) No physician or hospital
453.8 shall be civilly or criminally liable for failure to conduct hearing screening testing.

453.9 (b) No physician, midwife, nurse, other health professional, or hospital acting in
453.10 compliance with this section shall be civilly or criminally liable for any acts conforming
453.11 with this section, including furnishing information required according to this section.

453.12 Subd. 7. **Fees.** The commissioner shall charge a fee according to section 16A.1285
453.13 so that the total of fees collected will approximate the costs of implementing and
453.14 maintaining a system to follow up infants, provide technical assistance, a tracking system,
453.15 data management, and evaluation.

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

453.17 Sec. 16. **[144.967] ARSENIC HEALTH RISK STANDARD.**

453.18 Subdivision 1. **Arsenic health risk standard established.** The commissioner of
453.19 health in cooperation with the commissioners of agriculture and the Pollution Control
453.20 Agency responsible for monitoring land and water cleanup and soil contamination
453.21 information shall determine a health risk standard for human exposure to arsenic. The
453.22 commissioner of health shall ensure that the established arsenic health risk standard is
453.23 included in all information provided to the public.

453.24 Subd. 2. **Information.** The commissioner of health, in consultation with the
453.25 commissioners of agriculture and the Pollution Control Agency with jurisdiction over
453.26 soil and water contamination, shall establish a central information source available to
453.27 the public to provide accurate information on arsenic soil and water contamination in
453.28 residential areas.

453.29 Subd. 3. **Testing for arsenic.** (a) The commissioner of health shall ensure access
453.30 to medical testing for arsenical pesticide exposure to persons living within one mile of
453.31 the CMC Heartland Lite Yard Superfund site who are not covered by health insurance or
453.32 medical assistance.

453.33 (b) Through an agreement with the United States Environmental Protection Agency,
453.34 the commissioner shall ensure soil testing is available to households within one mile of the
453.35 CMC Heartland Lite Yard Superfund site at no cost to the residents.

454.1 Subd. 4. **Evaluation.** The commissioner of health shall evaluate the cumulative
454.2 health impact burdens of environmental toxins in the residential communities impacted by
454.3 arsenic-contaminated soil from the CMC Heartland Lite Yard Superfund site. The first
454.4 priority shall be to evaluate health burdens to those communities experiencing health
454.5 disparities as documented by the Minority and Multicultural Health Division of the
454.6 Minnesota Department of Health.

454.7 Sec. 17. **[144.995] DEFINITIONS.**

454.8 (a) For purposes of sections 144.995 to 144.998, the terms in this section have
454.9 the meanings given.

454.10 (b) "Advisory panel" means the Environmental Health Tracking and Biomonitoring
454.11 Advisory Panel established under section 144.998.

454.12 (c) "Biomonitoring" means the process by which chemicals and their metabolites are
454.13 identified and measured within a biospecimen.

454.14 (d) "Biospecimen" means a sample of human fluid, serum, or tissue that is reasonably
454.15 available as a medium to measure the presence and concentration of chemicals or their
454.16 metabolites in a human body.

454.17 (e) "Commissioner" means the commissioner of the Department of Health.

454.18 (f) "Community" means geographically or nongeographically-based populations
454.19 that may participate in the biomonitoring program. A "nongeographical community"
454.20 includes, but is not limited to, populations that may share a common chemical exposure
454.21 through similar occupations, populations experiencing a common health outcome that
454.22 may be linked to chemical exposures, or populations that may experience similar chemical
454.23 exposures because of comparable consumption, lifestyle, product use, or subpopulations
454.24 that share ethnicity, age, or gender.

454.25 (g) "Department" means the Department of Health.

454.26 (h) "Designated chemicals" means those chemicals that are known to, or strongly
454.27 suspected of, adversely impacting human health or development, based upon scientific,
454.28 peer-reviewed animal, human, or in vitro studies, and baseline human exposure data,
454.29 and consists of chemical families or metabolites that are included in the federal Centers
454.30 for Disease Control and Prevention studies that are known collectively as the National
454.31 Reports on Human Exposure to Environmental Chemicals program and any substances
454.32 specified under section 144.998, subdivision 3, clause (6).

454.33 (i) "Environmental hazard" means a chemical, metal, or other substance for which
454.34 scientific, peer-reviewed studies of humans, animals, or cells have demonstrated that the
454.35 chemical is known or reasonably anticipated to adversely impact human health.

455.1 (j) "Environmental health tracking" means collection, integration, analysis, and
455.2 dissemination of data on human exposures to chemicals in the environment and on
455.3 diseases potentially caused or aggravated by those chemicals.

455.4 Sec. 18. **[144.996] ENVIRONMENTAL HEALTH TRACKING;**
455.5 **BIOMONITORING.**

455.6 Subdivision 1. Environmental health tracking. In cooperation with the
455.7 commissioner of the Pollution Control Agency, the commissioner shall establish an
455.8 environmental health tracking program to:

455.9 (1) coordinate data collection activities with the Pollution Control Agency,
455.10 Department of Agriculture, University of Minnesota, and any other relevant state agency
455.11 and work to promote the sharing of and access to health and environmental databases
455.12 in order to develop an environmental health tracking system for Minnesota, consistent
455.13 with applicable data practices laws;

455.14 (2) facilitate the dissemination of aggregate public health tracking data to the public
455.15 and researchers in accessible format and provide technical assistance on interpreting
455.16 the data;

455.17 (3) develop written data sharing agreements with the Minnesota Pollution Control
455.18 Agency, Department of Agriculture, and other relevant state agencies and organizations,
455.19 and develop additional procedures as needed to protect individual privacy;

455.20 (4) develop a strategic plan that includes a mission statement, the identification
455.21 of core priorities for research and epidemiologic surveillance, and the identification of
455.22 internal and external stakeholders, and a work plan describing future program development
455.23 and addressing issues having to do with compatibility with the Centers for Disease Control
455.24 and Prevention's National Environmental Public Health Tracking Program;

455.25 (5) organize, analyze, and interpret available data, in order to:

455.26 (i) characterize statewide and localized trends and geographic patterns of
455.27 population-based measures of chronic diseases, including, but not limited to, cancer,
455.28 respiratory diseases, reproductive problems, birth defects, neurologic diseases, and
455.29 developmental disorders;

455.30 (ii) recommend to the commissioner methods to improve data collection on
455.31 statewide population rates of chronic diseases and the occurrence of environmental
455.32 hazards and exposures;

455.33 (iii) characterize statewide and localized trends and geographic patterns in the
455.34 occurrence of environmental hazards and exposures;

(iv) assess the feasibility of integrating disease rate data and indicators of exposure such as biomonitoring data, and other health and environmental data;

(v) incorporate newly collected and existing health tracking and biomonitoring data into efforts to identify communities with elevated rates of chronic disease, higher likelihood of exposure to environmental pollutants, or both;

(vi) analyze occurrence of environmental hazards, exposures, and diseases with relation to socioeconomic status, race, and ethnicity;

(vii) develop and implement targeted plans to conduct more intensive health tracking and biomonitoring among communities;

(viii) work with the Pollution Control Agency, the Department of Agriculture, and other relevant state agency personnel and organizations to develop, implement, and evaluate preventive measures to reduce elevated rates of diseases and exposures identified through activities performed under sections 144.995 to 144.998; and

(ix) provide baseline data and present descriptive information relevant to policy formation that are consistent with existing goals of the department; and

(6) submit a biennial report to the legislature by January 15, beginning January 15, 2009, on the status of environmental health tracking activities and related research programs, and making recommendations regarding the continuation and improvement of the programs.

Subd. 2. **Biomonitoring.** The commissioner shall:

(1) conduct biomonitoring of communities on a voluntary basis by collecting and analyzing biospecimens, as appropriate, to assess environmental exposures to designated chemicals;

(2) conduct biomonitoring of pregnant women and minors on a voluntary basis, when scientifically appropriate;

(3) communicate findings to the public, and plan ensuing stages of biomonitoring and disease tracking work to further develop and refine the integrated analysis;

(4) share analytical results with the advisory panel and work with the panel to interpret results, communicate findings to the public, and plan ensuing stages of biomonitoring work; and

(5) submit a biennial report to the legislature by January 15, beginning January 15, 2009, on the status of the biomonitoring program and any recommendations for improvement.

Subd. 3. **Health data.** Data collected under the biomonitoring program are health data under section 13.3805.

Sec. 19. [144.997] BIOMONITORING PILOT PROGRAM.

Subdivision 1. Pilot program. With advice from the advisory panel and after the program guidelines in subdivision 4 are developed, the commissioner shall develop a biomonitoring pilot program. The program shall collect one biospecimen from each of the voluntary participants. The biospecimen selected must be the biospecimen that most accurately represents body concentration of the chemical of interest. Each biospecimen from the voluntary participants must be analyzed for one type or class of related chemicals or metals, based on recommendations from the advisory panel. The panel shall determine the chemical or class of chemicals that community members were most likely exposed to. The program shall collect and assess biospecimens in accordance with the following:

(1) 30 voluntary participants from each of three communities that the advisory panel identifies as likely to have been exposed to a designated chemical;

(2) 100 voluntary participants from each of two communities: (i) that the advisory panel identifies as likely to have been exposed to arsenic and (ii) that the advisory panel identifies as likely to have been exposed to mercury; and

(3) 100 voluntary participants from each of two communities that the advisory panel identifies as likely to have been exposed to perfluorinated chemicals.

Subd. 2. Base program. Following the conclusion of the pilot program and within the appropriations available, the commissioner shall:

(1) work with the advisory panel to assess the usefulness of continuing biomonitoring among members of communities assessed during the pilot program and to identify other communities and other designated chemicals to be assessed via biomonitoring;

(2) work with the advisory panel to assess the pilot program, including but not limited to, the validity and accuracy of the analytical measurements and adequacy of the guidelines and protocols;

(3) communicate the results of the pilot program to the public; and

(4) after consideration of the findings and recommendations in clauses (1) and (2), and within the appropriations available, develop and implement a base program.

Subd. 3. Participation. (a) Participation in the biomonitoring program by providing biospecimens is voluntary and requires written, informed consent. Minors may participate in the program if a written consent is signed by the minor's parent or legal guardian. The written consent must include the information required to be provided under this subdivision to all voluntary participants.

(b) All participants shall be evaluated for the presence of the designated chemical of interest as a component of the biomonitoring process. Participants shall be provided with information and fact sheets about the program's activities and its findings.

Individual participants shall, if requested, receive their complete results. Any results provided to participants shall be subject to the Department of Health Institutional Review Board protocols and guidelines. When either physiological or chemical data 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 commissioner and the advisory panel shall be guided by protocols and guidelines developed by the Centers for Disease Control and Prevention and the National Biomonitoring Program;

(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.

459.1 (b) The commissioner may enter into contractual agreements with health clinics,
459.2 community-based organizations, or experts in a particular field to perform any of the
459.3 activities described under this section.

459.4 Sec. 20. **[144.998] ENVIRONMENTAL HEALTH TRACKING AND**
459.5 **BIOMONITORING ADVISORY PANEL.**

459.6 Subdivision 1. **Creation.** The commissioner shall establish the Environmental
459.7 Health Tracking and Biomonitoring Advisory Panel. The commissioner shall appoint,
459.8 from the panel's membership, a chair. The panel shall meet as often as it deems necessary
459.9 but, at a minimum, on a quarterly basis. Members of the panel shall serve without
459.10 compensation but shall be reimbursed for travel and other necessary expenses incurred
459.11 through performance of their duties. Members appointed under this subdivision are
459.12 appointed for a three-year term and may be reappointed.

459.13 Subd. 2. **Members.** The commissioner shall appoint eight members, none of whom
459.14 may be lobbyists registered under chapter 10A, who have backgrounds or training in
459.15 designing, implementing, and interpreting health tracking and biomonitoring studies or
459.16 in related fields of science, including epidemiology, biostatistics, environmental health,
459.17 laboratory sciences, occupational health, industrial hygiene, toxicology, and public health,
459.18 including:

459.19 (1) two scientists who represent nongovernmental organizations with a focus on
459.20 environmental health, environmental justice, children's health, or on specific chronic
459.21 diseases; and

459.22 (2) one scientist who is a representative of the University of Minnesota.

459.23 In addition, the commissioner shall appoint one member representing each of the
459.24 following departments or divisions: the department's health promotion and chronic disease
459.25 division, the Pollution Control Agency, and the Department of Agriculture.

459.26 Subd. 3. **Duties.** The advisory panel shall make recommendations to the
459.27 commissioner and the legislature on:

459.28 (1) priorities for health tracking;

459.29 (2) priorities for biomonitoring that are based on sound science and practice, and
459.30 that will advance the state of public health in Minnesota;

459.31 (3) specific chronic diseases to study under the environmental health tracking system;

459.32 (4) specific environmental pollutant exposures to study under the environmental
459.33 health tracking system, with the agreement of at least seven of the advisory panel members;

459.34 (5) specific communities and geographic areas on which to focus environmental
459.35 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

462.1 compartment, the individual must be trained to use the equipment in the ambulance and be
462.2 knowledgeable of the ambulance service protocols.

462.3 Sec. 23. Minnesota Statutes 2006, section 144E.35, subdivision 1, is amended to read:

462.4 Subdivision 1. **Repayment for volunteer training.** ~~Any political subdivision, or~~
462.5 ~~nonprofit hospital or nonprofit corporation operating~~ A licensed ambulance service shall
462.6 be reimbursed by the board for the necessary expense of the initial training of a volunteer
462.7 ambulance attendant upon successful completion by the attendant of a basic emergency
462.8 care course, or a continuing education course for basic emergency care, or both, which has
462.9 been approved by the board, pursuant to section 144E.285. Reimbursement may include
462.10 tuition, transportation, food, lodging, hourly payment for the time spent in the training
462.11 course, and other necessary expenditures, except that in no instance shall a volunteer
462.12 ambulance attendant be reimbursed more than ~~\$450~~ \$600 for successful completion of a
462.13 basic course, and ~~\$225~~ \$275 for successful completion of a continuing education course.

462.14 Sec. 24. **[145.958] BISPHENOL-A IN PRODUCTS FOR CHILDREN.**

462.15 Subdivision. 1. **Bisphenol-A and phthalates committee.** The commissioner of
462.16 health shall create a committee under the direction of the environmental health division
462.17 of the Department of Health to study the scientific literature and make recommendations
462.18 to the legislature on the health impact of bisphenol-A and phthalates on children in
462.19 products intended for use by young children, including, but not limited to, toys, pacifiers,
462.20 baby bottles, and teethers, and report back by January 15, 2008. The committee shall
462.21 also identify least harmful alternatives. Of the seven committee members at least one
462.22 shall be a representative of the Department of Health, one shall be a representative of
462.23 environmental health sciences research, one shall be a representative of the Minnesota
462.24 Nurses Association, one shall be a representative of environmental health consumer
462.25 advocates, one shall be a member of a children's product manufacturer's association,
462.26 and one shall be a representative of the University of Minnesota, chemical engineering
462.27 and material science department.

462.28 Subd. 2. **Definitions.** For the purposes of this section, the following terms have
462.29 the meanings given them:

462.30 (a) "Toy" means all products designed or intended by the manufacturer to be used by
462.31 children when they play.

462.32 (b) "Child care article" means all products designed or intended by the manufacturer
462.33 to facilitate sleep, relaxation, or the feeding of children or to help children with sucking or
462.34 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

464.1 families. The plan must be submitted on forms provided by the commissioner. At a
464.2 minimum, the plan must include the following:

- 464.3 (1) a description of outreach strategies to families prenatally or at birth;
464.4 (2) provisions for the seamless delivery of health, safety, and early learning services;
464.5 (3) methods to promote continuity of services when families move within the state;
464.6 (4) a description of the community demographics;
464.7 (5) a plan for meeting outcome measures; and
464.8 (6) a proposed work plan that includes:
464.9 (i) coordination to ensure nonduplication of services for children and families;
464.10 (ii) a description of the strategies to ensure that children and families at greatest risk
464.11 receive appropriate services; and
464.12 (iii) collaboration with multidisciplinary partners including public health,
464.13 ECFE, Head Start, community health workers, social workers, community home
464.14 visiting programs, school districts, and other relevant partners. Letters of intent from
464.15 multidisciplinary partners must be submitted with the plan.

464.16 (b) Each program that receives funds must accomplish the following program
464.17 requirements:

- 464.18 (1) use ~~either a broad community-based or selective community-based~~ strategy to
464.19 provide preventive and early intervention home visiting services;
464.20 (2) offer a home visit by a trained home visitor. If a home visit is accepted, the first
464.21 home visit must occur prenatally or as soon after birth as possible and must include a
464.22 public health nursing assessment by a public health nurse;
464.23 (3) offer, at a minimum, information on infant care, child growth and development,
464.24 positive parenting, preventing diseases, preventing exposure to environmental hazards,
464.25 and support services available in the community;
464.26 (4) provide information on and referrals to health care services, if needed, including
464.27 information on and assistance in applying for health care coverage for which the child or
464.28 family may be eligible; and provide information on preventive services, developmental
464.29 assessments, and the availability of public assistance programs as appropriate;
464.30 (5) provide youth development programs when appropriate;
464.31 (6) recruit home visitors who will represent, to the extent possible, the races,
464.32 cultures, and languages spoken by families that may be served;
464.33 (7) train and supervise home visitors in accordance with the requirements established
464.34 under subdivision 4;
464.35 (8) maximize resources and minimize duplication by coordinating ~~activities or~~
464.36 contracting with local social and human services organizations, education organizations,

465.1 and other appropriate governmental entities and community-based organizations and
465.2 agencies; ~~and~~

465.3 (9) utilize appropriate racial and ethnic approaches to providing home visiting
465.4 services; and

465.5 (10) connect eligible families, as needed, to additional resources available in the
465.6 community, including, but not limited to, early care and education programs, health or
465.7 mental health services, family literacy programs, employment agencies, social services,
465.8 and child care resources and referral agencies.

465.9 (c) When available, programs that receive funds under this section must offer or
465.10 provide the family with a referral to center-based or group meetings that meet at least
465.11 once per month for those families identified with additional needs. The meetings must
465.12 focus on further enhancing the information, activities, and skill-building addressed during
465.13 home visitation; offering opportunities for parents to meet with and support each other;
465.14 and offering infants and toddlers a safe, nurturing, and stimulating environment for
465.15 socialization and supervised play with qualified teachers.

465.16 ~~(b)~~ (d) Funds available under this section shall not be used for medical services. The
465.17 commissioner shall establish an administrative cost limit for recipients of funds. The
465.18 outcome measures established under subdivision 6 must be specified to recipients of
465.19 funds at the time the funds are distributed.

465.20 ~~(c)~~ (e) Data collected on individuals served by the home visiting programs must
465.21 remain confidential and must not be disclosed by providers of home visiting services
465.22 without a specific informed written consent that identifies disclosures to be made.
465.23 Upon request, agencies providing home visiting services must provide recipients with
465.24 information on disclosures, including the names of entities and individuals receiving the
465.25 information and the general purpose of the disclosure. Prospective and current recipients
465.26 of home visiting services must be told and informed in writing that written consent for
465.27 disclosure of data is not required for access to home visiting services.

465.28 Subd. 4. **Training.** The commissioner shall establish training requirements for
465.29 home visitors and minimum requirements for supervision ~~by a public health nurse~~. The
465.30 requirements for nurses must be consistent with chapter 148. The commissioner must
465.31 provide training for home visitors. Training must include ~~child development, positive~~
465.32 ~~parenting techniques, screening and referrals for child abuse and neglect, and diverse~~
465.33 ~~cultural practices in child rearing and family systems~~ the following:

465.34 (1) effective relationships for engaging and retaining families and ensuring family
465.35 health, safety, and early learning;

(2) effective methods of implementing parent education, conducting home visiting, and promoting quality early childhood development;
(3) early childhood development from birth to age five;
(4) diverse cultural practices in child rearing and family systems;
(5) recruiting, supervising, and retaining qualified staff;
(6) increasing services for underserved populations; and
(7) relevant issues related to child welfare and protective services, with information provided being consistent with state child welfare agency training.

Subd. 5. **Technical assistance.** The commissioner shall provide administrative and technical assistance to each program, including assistance in data collection and other activities related to conducting short- and long-term evaluations of the programs as required under subdivision 7. The commissioner may request research and evaluation support from the University of Minnesota.

Subd. 6. **Outcome and performance measures.** The commissioner shall establish ~~outcomes~~ measures to determine the impact of family home visiting programs funded under this section on the following areas:

(1) appropriate utilization of preventive health care;
(2) rates of substantiated child abuse and neglect;
(3) rates of unintentional child injuries;
(4) rates of children who are screened and who pass early childhood screening; ~~and~~
(5) rates of children accessing early care and educational services;
(6) program retention rates;
(7) number of home visits provided compared to the number of home visits planned;
(8) participant satisfaction;
(9) rates of at-risk populations reached; and
(10) any additional qualitative goals and quantitative measures established by the commissioner.

Subd. 7. **Evaluation.** Using the qualitative goals and quantitative outcome and performance measures established under subdivisions 1 and 6, the commissioner shall conduct ongoing evaluations of the programs funded under this section. Community health boards and tribal governments shall cooperate with the commissioner in the evaluations and shall provide the commissioner with the information necessary to conduct the evaluations. As part of the ongoing evaluations, the commissioner shall rate the impact of the programs on the outcome measures listed in subdivision 6, and shall periodically determine whether home visiting programs are the best way to achieve the qualitative goals established under subdivisions 1 and 6. If the commissioner determines that home

visiting programs are not the best way to achieve these goals, the commissioner shall provide the legislature with alternative methods for achieving them.

Subd. 8. **Report.** By January 15, 2002, and January 15 of each even-numbered 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.

The application shall contain the information and material required by subdivision 2 and any other information that the board may, in its sound judgment, require. The application shall be filed with the board at least 60 days before the date of the examination. If the board deems it advisable, it may require that such application be verified by the oath of the applicant.

Sec. 29. Minnesota Statutes 2006, section 156.02, subdivision 2, is amended to read:

Subd. 2. **Required with application.** Every application shall contain the following information and material:

(1) the application fee set by the board in the form of a check or money order payable to the board, which fee is not returnable in the event permission to take the examination is denied for good cause;

(2) a copy of a diploma from an accredited or approved college of veterinary medicine or a certificate from the dean or secretary of an accredited or approved college of veterinary medicine showing the time spent in the school and the date when the applicant was duly and regularly graduated or will duly and regularly graduate or verification of ECFVG or PAVE certification;

(3) affidavits of at least two veterinarians and three adults who are not related to the applicant setting forth how long a time, when, and under what circumstances they have known the applicant, and any other facts as may be proper to enable the board to determine the qualifications of the applicant; and

(4) if the applicant has served in the armed forces, a copy of discharge papers.

Sec. 30. Minnesota Statutes 2006, section 156.04, is amended to read:

156.04 BOARD TO ISSUE LICENSE.

The Board of Veterinary Medicine shall issue to every applicant who has successfully passed the required examination, who has received a diploma conferring the degree of doctor of veterinary medicine or an equivalent degree from an accredited or approved college of veterinary medicine or an ECFVG or PAVE certificate, and who shall have been adjudged to be duly qualified to practice veterinary medicine, a license to practice.

Sec. 31. Minnesota Statutes 2006, section 156.072, subdivision 2, is amended to read:

Subd. 2. **Required with application.** Such doctor of veterinary medicine shall accompany the application by the following:

(1) a copy of a diploma from an accredited or approved college of veterinary 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

470.1 issued. No temporary permit may be issued to any applicant who has previously failed
470.2 the national examination and is currently not licensed in any licensing jurisdiction of the
470.3 United States or Canada or to any person whose license has been revoked or suspended
470.4 or who is currently subject to a disciplinary order in any licensing jurisdiction of the
470.5 United States or Canada.

470.6 Sec. 33. Minnesota Statutes 2006, section 156.12, subdivision 2, is amended to read:

470.7 Subd. 2. **Authorized activities.** No provision of this chapter shall be construed to
470.8 prohibit:

470.9 (a) a person from rendering necessary gratuitous assistance in the treatment of any
470.10 animal when the assistance does not amount to prescribing, testing for, or diagnosing,
470.11 operating, or vaccinating and when the attendance of a licensed veterinarian cannot be
470.12 procured;

470.13 (b) a person who is a regular student in an accredited or approved college of
470.14 veterinary medicine from performing duties or actions assigned by instructors or
470.15 preceptors or working under the direct supervision of a licensed veterinarian;

470.16 (c) a veterinarian regularly licensed in another jurisdiction from consulting with a
470.17 licensed veterinarian in this state;

470.18 (d) the owner of an animal and the owner's regular employee from caring for and
470.19 administering to the animal belonging to the owner, except where the ownership of the
470.20 animal was transferred for purposes of circumventing this chapter;

470.21 (e) veterinarians who are in compliance with subdivision 6 and who are employed by
470.22 the University of Minnesota from performing their duties with the College of Veterinary
470.23 Medicine, College of Agriculture, Agricultural Experiment Station, Agricultural Extension
470.24 Service, Medical School, School of Public Health, or other unit within the university; or
470.25 a person from lecturing or giving instructions or demonstrations at the university or in
470.26 connection with a continuing education course or seminar to veterinarians or pathologists
470.27 at the University of Minnesota Veterinary Diagnostic Laboratory;

470.28 (f) any person from selling or applying any pesticide, insecticide or herbicide;

470.29 (g) any person from engaging in bona fide scientific research or investigations which
470.30 reasonably requires experimentation involving animals;

470.31 (h) any employee of a licensed veterinarian from performing duties other than
470.32 diagnosis, prescription or surgical correction under the direction and supervision of the
470.33 veterinarian, who shall be responsible for the performance of the employee;

470.34 (i) a graduate of a foreign college of veterinary medicine from working under the
470.35 direct personal instruction, control, or supervision of a veterinarian faculty member of

471.1 the College of Veterinary Medicine, University of Minnesota in order to complete the
471.2 requirements necessary to obtain an ECFVG or PAVE certificate.

471.3 Sec. 34. Minnesota Statutes 2006, section 156.12, subdivision 4, is amended to read:

471.4 Subd. 4. **Titles.** It is unlawful for a person who has not received a professional
471.5 degree from an accredited or approved college of veterinary medicine, or ECFVG or PAVE
471.6 certification, to use any of the following titles or designations: Veterinary, veterinarian,
471.7 animal doctor, animal surgeon, animal dentist, animal chiropractor, animal acupuncturist,
471.8 or any other title, designation, word, letter, abbreviation, sign, card, or device tending to
471.9 indicate that the person is qualified to practice veterinary medicine.

471.10 Sec. 35. Minnesota Statutes 2006, section 156.12, subdivision 6, is amended to read:

471.11 Subd. 6. **Faculty licensure.** (a) Veterinary Medical Center clinicians at the College
471.12 of Veterinary Medicine, University of Minnesota, who are engaged in the practice of
471.13 veterinary medicine as defined in subdivision 1 and who treat animals owned by clients of
471.14 the Veterinary Medical Center must possess the same license required by other veterinary
471.15 practitioners in the state of Minnesota except for persons covered by paragraphs (b) and (c).

471.16 (b) A specialty practitioner in a hard-to-fill faculty position who has been employed
471.17 at the College of Veterinary Medicine, University of Minnesota, for five years or
471.18 more prior to 2003 or is specialty board certified by the American Veterinary Medical
471.19 Association or the European Board of Veterinary Specialization may be granted a specialty
471.20 faculty Veterinary Medical Center clinician license which will allow the licensee to
471.21 practice veterinary medicine in the state of Minnesota in the specialty area of the licensee's
471.22 training and only within the scope of employment at the Veterinary Medical Center.

471.23 (c) A specialty practitioner in a hard-to-fill faculty position at the College of
471.24 Veterinary Medicine, University of Minnesota, who has graduated from a board-approved
471.25 foreign veterinary school may be granted a temporary faculty Veterinary Medical Center
471.26 clinician license. The temporary faculty Veterinary Medical Center clinician license
471.27 expires in two years and allows the licensee to practice veterinary medicine as defined
471.28 in subdivision 1 and treat animals owned by clients of the Veterinary Medical Center.
471.29 The temporary faculty Veterinary Medical Center clinician license allows the licensee to
471.30 practice veterinary medicine in the state of Minnesota in the specialty area of the licensee's
471.31 training and only within the scope of employment at the Veterinary Medical Center while
471.32 under the direct supervision of a veterinarian currently licensed and actively practicing
471.33 veterinary medicine in Minnesota, as defined in section 156.04. The direct supervising
471.34 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.

474.1 (g) This section does not limit the authority of the Minnesota Racing Commission to
474.2 regulate veterinarians providing services at a licensed racetrack.

474.3 Sec. 40. Minnesota Statutes 2006, section 156.18, subdivision 2, is amended to read:

474.4 Subd. 2. **Label of dispensed veterinary drugs.** (a) A veterinarian or the
474.5 veterinarian's authorized agent or employee dispensing a veterinary prescription drug
474.6 ~~or prescribing the extra-label use of an over-the-counter drug, an over-the-counter drug~~
474.7 for extra-label use, or a human drug for extra-label use must provide written information
474.8 which includes the name and address of the veterinarian, date of filling, species of patient,
474.9 name or names of drug, strength of drug or drugs, directions for use, withdrawal time,
474.10 and cautionary statements, if any, appropriate for the drug.

474.11 (b) If the veterinary drug has been prepared, mixed, formulated, or packaged by the
474.12 dispenser, all of the information required in paragraph (a) must be provided on a label
474.13 affixed to the container.

474.14 (c) If the veterinary drug is in the manufacturer's original package, the information
474.15 required in paragraph (a) must be supplied in writing but need not be affixed to the
474.16 container. Information required in paragraph (a) that is provided by the manufacturer on
474.17 the original package does not need to be repeated in the separate written information.
474.18 Written information required by this paragraph may be written on the sales invoice.

474.19 Sec. 41. Minnesota Statutes 2006, section 156.19, is amended to read:

474.20 **156.19 EXTRA-LABEL USE.**

474.21 A person, other than a veterinarian or ~~a person working under the control~~ an
474.22 employee of a veterinarian, must not make extra-label use of a veterinary drug in or
474.23 on a food-producing animal, unless permitted by the prescription of a veterinarian. A
474.24 veterinarian may prescribe the extra-label use of a ~~veterinary~~ drug if:

474.25 (1) the veterinarian makes a careful medical diagnosis within the context of a valid
474.26 veterinarian-client-patient relationship;

474.27 (2) the veterinarian determines that there is no marketed drug specifically labeled to
474.28 treat the condition diagnosed, or that drug therapy as recommended by the labeling has, in
474.29 the judgment of the attending veterinarian, been found to be clinically ineffective;

474.30 (3) the veterinarian recommends procedures to ensure that the identity of the treated
474.31 animal will be carefully maintained; ~~and~~

474.32 (4) the veterinarian prescribes a significantly extended time period for drug
474.33 withdrawal before marketing meat, milk, or eggs; and

475.1 (5) the veterinarian has met the criteria established in Code of Federal Regulations,
475.2 title 21, part 530, which define the extra-label use of medication in or on animals.

475.3 Sec. 42. Minnesota Statutes 2006, section 198.075, is amended to read:

475.4 **198.075 MINNESOTA VETERANS HOME EMPLOYEES; EXCLUDED**
475.5 **FROM COMMISSARY PRIVILEGES.**

475.6 Except as provided in this section, no commissary privileges including food, laundry
475.7 service, janitorial service, and household supplies shall be furnished to any employee of
475.8 the Minnesota veterans homes. An employee of the Minnesota veterans homes who works
475.9 a second shift that is consecutive with a regularly scheduled shift may be allowed one free
475.10 meal at the veterans home on the day of that extra shift.

475.11 Sec. 43. Minnesota Statutes 2006, section 256B.0625, subdivision 14, is amended to
475.12 read:

475.13 Subd. 14. **Diagnostic, screening, and preventive services.** (a) Medical assistance
475.14 covers diagnostic, screening, and preventive services.

475.15 (b) "Preventive services" include services related to pregnancy, including:

475.16 (1) services for those conditions which may complicate a pregnancy and which may
475.17 be available to a pregnant woman determined to be at risk of poor pregnancy outcome;

475.18 (2) prenatal HIV risk assessment, education, counseling, and testing; and

475.19 (3) alcohol abuse assessment, education, and counseling on the effects of alcohol
475.20 usage while pregnant. Preventive services available to a woman at risk of poor pregnancy
475.21 outcome may differ in an amount, duration, or scope from those available to other
475.22 individuals eligible for medical assistance.

475.23 (c) "Screening services" include, but are not limited to, blood lead tests. Screening
475.24 services also include, for children with blood lead levels equal to or greater than ten
475.25 micrograms of lead per deciliter of whole blood, environmental investigations to
475.26 determine the source of lead exposure. Reimbursement is limited to a health professional's
475.27 time and activities during an on-site investigation of a child's home or primary residence.

475.28 Sec. 44. Minnesota Statutes 2006, section 256B.0625, is amended by adding a
475.29 subdivision to read:

475.30 Subd. 49. **Lead risk assessments.** (a) Effective October 1, 2007, or six months after
475.31 federal approval, whichever is later, medical assistance covers lead risk assessments
475.32 provided by a lead risk assessor who is licensed by the commissioner of health under
475.33 section 144.9505 and employed by an assessing agency as defined in section 144.9501.

476.1 Medical assistance covers a onetime on-site investigation of a recipient's home or primary
476.2 residence to determine the existence of lead so long as the recipient is under the age
476.3 of 21 and has a venous blood lead level specified in section 144.9504, subdivision 2,
476.4 paragraph (a).

476.5 (b) Medical assistance reimbursement covers the lead risk assessor's time to
476.6 complete the following activities:

476.7 (1) gathering samples;

476.8 (2) interviewing family members;

476.9 (3) gathering data, including meter readings; and

476.10 (4) providing a report with the results of the investigation and options for reducing
476.11 lead-based paint hazards.

476.12 Medical assistance coverage of lead risk assessment does not include testing of
476.13 environmental substances such as water, paint, or soil or any other laboratory services.

476.14 Medical assistance coverage of lead risk assessments is not included in the capitated
476.15 services for children enrolled in health plans through the prepaid medical assistance
476.16 program and the MinnesotaCare program.

476.17 (c) Payment for lead risk assessment must be cost-based and must meet the criteria
476.18 for federal financial participation under the Medicaid program. The rate must be based
476.19 on allowable expenditures from cost information gathered. Under section 144.9507,
476.20 subdivision 5, federal medical assistance funds may not replace existing funding for
476.21 lead-related activities. The nonfederal share of costs for services provided under this
476.22 subdivision must be from state or local funds and is the responsibility of the agency
476.23 providing the risk assessment. Eligible expenditures for the nonfederal share of costs may
476.24 not be made from federal funds or funds used to match other federal funds. Any federal
476.25 disallowances are the responsibility of the agency providing risk assessment services.

476.26 Sec. 45. [325E.385] PRODUCTS CONTAINING POLYBROMINATED
476.27 DIPHENYL ETHER.

476.28 Subdivision 1. Definitions. For the purposes of sections 325E.386 to 325E.388,
476.29 the terms in this section have the meanings given them.

476.30 Subd. 2. Commercial decabromodiphenyl ether. "Commercial
476.31 decabromodiphenyl ether" means the chemical mixture of decabromodiphenyl ether,
476.32 including associated polybrominated diphenyl ether impurities not intentionally added.

476.33 Subd. 3. Commissioner. "Commissioner" means the commissioner of the Pollution
476.34 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 and section 325E.387, subdivision 2:

(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;

(6) medical devices; or

(7) the manufacture, sale, repair, distribution, maintenance, refurbishment, or modification of telecommunications equipment containing polybrominated diphenyl ethers used by entities eligible to hold authorization in the Public Safety Pool under Code of Federal Regulations, title 47, part 90.

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**

Summary by Fund			
General	40,413,000	40,382,000	
State Government			
Special Revenue	141,000	128,000	
Health Care Access	3,510,000	3,516,000	
Federal TANF	6,000,000	6,000,000	

~~Family Planning Base Reduction. Base level funding for the family planning special projects grant program is reduced by \$1,877,000 each year of the biennium beginning July 1, 2007, provided that this reduction shall only take place upon full implementation of the family planning project section of the 1115 waiver. Notwithstanding Minnesota Statutes, section 145.925, the commissioner shall give priority to community health care clinics providing family planning services that either serve a high number of women who do not qualify for medical assistance or are unable to participate in the medical assistance program as a medical assistance provider when allocating the remaining appropriations. Notwithstanding section 15, this paragraph shall not expire.~~

Shaken Baby Video. Of the state government special revenue fund appropriation, \$13,000 in 2006 is appropriated to the commissioner of health to provide a video to hospitals on shaken baby syndrome. The commissioner of health shall assess a fee to hospitals to cover the cost of the approved shaken baby video and

480.1 the revenue received is to be deposited in the
480.2 state government special revenue fund.

480.3 Sec. 50. **WATER LEVEL STANDARDS.**

480.4 (a) Until the commissioner of health adopts rules setting the health risk limits
480.5 required in paragraph (c), the health risk limit for all contaminants in private wells and
480.6 public water systems must be the more stringent of the state standards or the federal
480.7 standards determined by the United States Environmental Protection Agency.

480.8 (b) The legislature finds:

480.9 (1) the child-based standards became effective in 2001, under Minnesota Statutes,
480.10 section 144.0751;

480.11 (2) Minnesota Statutes, section 103H.201, subdivision 3, requires the commissioner
480.12 to update standards every four years; and

480.13 (3) the commissioner of health has not complied with Minnesota Statutes, section
480.14 103H.201, subdivision 3.

480.15 (c) By March 1, 2008, the commissioner of health must publish in the State Register
480.16 notice of intent to adopt rules relating to health risk limits for commonly detected
480.17 contaminants. The commissioner of health shall review current scientific information to
480.18 establish health risk limits for commonly detected contaminants in groundwater and
480.19 in private wells that provides a reasonable margin of safety to adequately protect the
480.20 health of developing fetuses, infants, and children, in accordance with the requirements
480.21 of section 144.0751. Nothing in paragraph (a) prohibits the commissioner from setting
480.22 standards that are stricter than the federal standards.

480.23 Sec. 51. **FUNDING FOR ENVIRONMENTAL JUSTICE MAPPING.**

480.24 The commissioner of health, in conjunction with the commissioner of the Pollution
480.25 Control Agency, shall establish an environmental justice mapping program and shall
480.26 apply for federal funding to renew and expand the state's environmental justice mapping
480.27 capacity in order to promote public health tracking. The commissioner shall coordinate
480.28 the project with the Pollution Control Agency and the Department of Agriculture in order
480.29 to explore possible links between environmental health and toxic exposures and to help
480.30 create a system for environmental public health tracking. The commissioner shall also
480.31 make recommendations to the legislature for additional sources of funding within the state.

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

480.33 Sec. 52. **LEGISLATIVE FINDINGS AND PURPOSE.**

481.1 The legislature hereby finds that hearing loss occurs in newborn infants more
481.2 frequently than any other health condition for which newborn infant screening is required.
481.3 Early detection of hearing loss in a child and early intervention and treatment has been
481.4 demonstrated to be highly effective in facilitating a child's healthy development in a
481.5 manner consistent with the child's age, language acquisition, and cognitive ability.
481.6 Without early hearing detection and intervention, children with hearing loss experience
481.7 serious delays in language acquisition and social and cognitive development. With
481.8 appropriate testing and identification of newborn infants, hearing loss screening will
481.9 facilitate early intervention and treatment and will serve the public purpose of promoting
481.10 the healthy development of children.

481.11 For these reasons, the legislature hereby determines that it is beneficial and in the
481.12 best interests of the development of the children of the state of Minnesota that newborn
481.13 infants' hearing be screened.

481.14 Sec. 53. **INFORMATION SHARING.**

481.15 By August 1, 2007, the commissioner of health, the Pollution Control Agency, the
481.16 commissioner of agriculture, and the University of Minnesota are requested to jointly
481.17 develop and sign a memorandum of understanding declaring their intent to share new
481.18 and existing environmental hazard, exposure, and health outcome data, consistent with
481.19 applicable data practices laws, and to cooperate and communicate effectively to ensure
481.20 sufficient clarity and understanding of the data between these organizations.

481.21 Sec. 54. **COMMISSIONER OF HEALTH REPORT; ROUTINE RADIATION**
481.22 **EMISSIONS.**

481.23 The commissioner of health, within the limits of available appropriations, in
481.24 cooperation with the utilities that own the Monticello and Prairie Island nuclear plants,
481.25 shall issue a report detailing where routine radiation releases go and the health impacts of
481.26 the radiation emissions on affected communities. By April 1, 2008, the report must be
481.27 distributed to house and senate committees having jurisdiction over public health and to
481.28 all communities that are part of the emergency response planning.

481.29 Sec. 55. **FRAGRANCE-FREE SCHOOLS EDUCATION PILOT PROJECT.**

481.30 Subdivision 1. **Purpose.** Recognizing that scented products may trigger asthma or
481.31 chemical sensitivity reactions in students and school staff, which can contribute to learning
481.32 and breathing problems, the commissioner of health shall develop a fragrance-free schools
481.33 education pilot project.

482.1 Subd. 2. **Education.** The commissioner of health, in collaboration with the
482.2 commissioner of education and the Minneapolis Board of Education, shall establish a
482.3 working group composed of at least three students, two teachers, one school administrator,
482.4 and one member of the Minneapolis Board of Education to recommend an education
482.5 campaign in Minneapolis public schools to inform students and parents about the
482.6 potentially harmful effects of the use of fragrance products on sensitive students and
482.7 school personnel in Minneapolis schools. The commissioner shall report findings to the
482.8 legislature by February 1, 2008.

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

482.10 Sec. 56. **LINDANE COMMITTEE.**

482.11 The commissioner of health shall create a committee of stakeholders, including
482.12 at least one environmental health research scientist and at least one parent consumer
482.13 advocate, to review the scientific literature and make recommendations to the legislature
482.14 on the health impact of Lindane on children and report back by January 15, 2008.

482.15 Sec. 57. **MEDICAL ASSISTANCE COVERAGE FOR ARSENIC TESTING.**

482.16 The commissioner of human services shall ensure that testing for arsenic under
482.17 Minnesota Statutes, section 144.967, is covered under medical assistance.

482.18 Sec. 58. **BLOOD LEAD TESTING STUDY.**

482.19 The commissioner of health, in consultation with the Department of Human
482.20 Services; cities of the first class; health care providers; and other interested parties shall
482.21 conduct a study to evaluate blood lead testing methods used to confirm elevated blood
482.22 lead status. The study shall examine and/or develop:

482.23 (1) the false positive rate of capillary tests for children less than 72 months old;

482.24 (2) current protocols for conducting capillary testing, including filter paper
482.25 methodology;

482.26 (3) existing guidelines and regulations from other states and federal agencies
482.27 regarding lead testing;

482.28 (4) recommendations regarding the use of capillary tests to initiate environmental
482.29 investigations and case management, including number and timing of tests and fiscal
482.30 implications for state and local lead programs; and

482.31 (5) recommendations regarding reducing the state mandatory intervention to ten
482.32 micrograms of lead per deciliter of whole blood.

483.1 The commissioner shall submit the results of the study and any recommendations,
483.2 including any necessary legislative changes, to the legislature by February 15, 2008.

483.3 **Sec. 59. WINDOW SAFETY EDUCATION.**

The commissioner of health shall create in the department's current educational safety program a component targeted at parents and caregivers of young children to provide awareness of the need to take precautions to prevent children from falling through open windows. The commissioner of health shall consult with representatives of the residential building industry, the window products industry, the child safety advocacy community, and the Department of Labor and Industry to create the window safety program component. The program must include the gathering of data about falls from windows that result in severe injury in order to measure the effectiveness of the safety program. The commissioner of health may consult with other child safety advocacy groups, experts, and interested parties in the development and implementation of the window safety program. The commissioner of health shall prepare and submit a final report on the window safety program to the legislature by March 1, 2011. The commissioner shall prepare and submit a yearly progress report to the legislature by March 1 of each year beginning in 2008 until the submission of the final report. The final report must include a summary of the safety program, the impact of the program on children falling from windows, and any recommendations for further study or action.

483.20 **Sec. 60. REVISOR'S INSTRUCTION.**

483.21 The revisor of statutes shall change the range reference "144.9501 to 144.9509"
483.22 to "144.9501 to 144.9512" wherever the reference appears in Minnesota Statutes and
483.23 Minnesota Rules.

483.24 **Sec. 61. REPEALER.**

483.25 Laws 2004, chapter 288, article 6, section 27, is repealed.

483.26 ARTICLE 11

483.27 **HUMAN SERVICES FORECAST ADJUSTMENTS**

483.28 Section 1. SUMMARY OF APPROPRIATIONS; DEPARTMENT OF HUMAN
483.29 SERVICES FORECAST ADJUSTMENT.

483.30 The dollar amounts shown are added to or, if shown in parentheses, are subtracted
483.31 from the appropriations in Laws 2006, chapter 282, from the general fund, or any other
483.32 fund named, to the Department of Human Services for the purposes specified in this

484.1 article, to be available for the fiscal year indicated for each purpose. The figure "2007"
484.2 used in this article means that the appropriation or appropriations listed are available
484.3 for the fiscal year ending June 30, 2007.

484.4		<u>2007</u>
484.5	<u>General Fund</u>	\$ <u>(25,226,000)</u>
484.6	<u>Health Care Access</u>	\$ <u>(53,980,000)</u>
484.7	<u>TANF</u>	\$ <u>(24,805,000)</u>
484.8	<u>Total</u>	\$ <u>(104,011,000)</u>

484.9 Sec. 2. COMMISSIONER OF HUMAN
484.10 SERVICES

484.11 Subdivision 1. Total Appropriation \$ (104,011,000)

484.12 Appropriations by Fund

484.13	<u>2007</u>
484.14	<u>General</u> <u>(25,226,000)</u>
484.15	<u>Health Care Access</u> <u>(53,980,000)</u>
484.16	<u>TANF</u> <u>(24,805,000)</u>

484.17 Subd. 2. Revenue and Pass Through

484.18 TANF (106,000)

484.19 Subd. 3. Children and Economic Assistance
484.20 Grants

484.21	<u>General</u>	<u>3,221,000</u>
484.22	<u>TANF</u>	<u>(24,699,000)</u>

484.23 The amounts that may be spent from this
484.24 appropriation for each purpose are as follows:

484.25 (a) MFIP/DWP Grants

484.26	<u>General</u>	<u>13,827,000</u>
484.27	<u>TANF</u>	<u>(24,699,000)</u>

484.28 (b) MFIP Child Care Assistance Grants

484.29	<u>General</u>	<u>(4,733,000)</u>

484.30 (c) General Assistance Grants

484.31	<u>General</u>	<u>1,081,000</u>

484.32 (d) Minnesota Supplemental Aid Grants

484.33	<u>General</u>	<u>(1,099,000)</u>

484.34 (e) Group Residential Housing Grants

484.35	<u>General</u>	<u>(5,855,000)</u>

485.1	Subd. 4. <u>Basic Health Care Grants</u>			
485.2	<u>General</u>			<u>17,592,000</u>
485.3	<u>Health Care Access</u>			<u>(53,980,000)</u>
485.4	<u>The amounts that may be spent from this</u>			
485.5	<u>appropriation for each purpose are as follows:</u>			
485.6	<u>(a) MinnesotaCare Health Care Access</u>			<u>(53,980,000)</u>
485.7	<u>(b) MA Basic Health Care - Families and Children</u>			
485.8	<u>General</u>			<u>15,729,000</u>
485.9	<u>(c) MA Basic Health Care - Elderly and Disabled</u>			
485.10	<u>General</u>			<u>(4,540,000)</u>
485.11	<u>(d) General Assistance Medical Care</u>			
485.12	<u>General</u>			<u>6,403,000</u>
485.13	Subd. 5. <u>Continuing Care Grants</u>			
485.14	<u>General</u>			<u>(46,039,000)</u>
485.15	<u>The amounts that may be spent from this</u>			
485.16	<u>appropriation for each purpose are as follows:</u>			
485.17	<u>(a) MA Long-Term Care Facilities</u>			
485.18	<u>General</u>			<u>(15,028,000)</u>
485.19	<u>(b) MA Long-Term Care Waivers</u>			
485.20	<u>General</u>			<u>(20,677,000)</u>
485.21	<u>(c) Chemical Dependency Entitlement Grants</u>			
485.22	<u>General</u>			<u>(10,334,000)</u>
485.23	Sec. 3. <u>EFFECTIVE DATE.</u>			
485.24	<u>Sections 1 and 2 are effective the day following final enactment.</u>			
485.25	ARTICLE 12			
485.26	HUMAN SERVICES APPROPRIATIONS			
485.27	Section 1. <u>SUMMARY OF APPROPRIATIONS.</u>			
485.28	<u>The amounts shown in this section summarize direct appropriations, by fund, made</u>			
485.29	<u>in this article.</u>			
485.30		<u>2008</u>	<u>2009</u>	<u>Total</u>
485.31	<u>General</u>	<u>\$ 4,836,759,000</u>	<u>\$ 5,194,751,000</u>	<u>\$ 10,031,510,000</u>

486.1	<u>State Government Special</u>			
486.2	<u>Revenue</u>	<u>55,737,000</u>	<u>56,428,000</u>	<u>112,165,000</u>
486.3	<u>Health Care Access</u>	<u>436,050,000</u>	<u>549,573,000</u>	<u>985,623,000</u>
486.4	<u>Federal TANF</u>	<u>266,864,000</u>	<u>277,866,000</u>	<u>544,730,000</u>
486.5	<u>Environment Fund</u>	<u>300,000</u>	<u>300,000</u>	<u>600,000</u>
486.6	<u>Lottery Prize Fund</u>	<u>2,184,000</u>	<u>1,787,000</u>	<u>3,971,000</u>
486.7	Total	\$ 5,597,894,000	\$ 6,080,705,000	\$ 11,678,599,000

486.8 **Sec. 2. HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

486.9 The sums shown in the columns marked "Appropriations" are appropriated to the
486.10 agencies and for the purposes specified in this article. The appropriations are from the
486.11 general fund, or another named fund, and are available for the fiscal years indicated
486.12 for each purpose. The figures "2008" and "2009" used in this article mean that the
486.13 appropriations listed under them are available for the fiscal year ending June 30, 2008, or
486.14 June 30, 2009, respectively. "The first year" is fiscal year 2008. "The second year" is fiscal
486.15 year 2009. "The biennium" is fiscal years 2008 and 2009. Appropriations for the fiscal
486.16 year ending June 30, 2007, are effective the day following final enactment.

486.17	<u>APPROPRIATIONS</u>	
486.18	<u>Available for the Year</u>	
486.19	<u>Ending June 30</u>	
486.20	2008	2009

486.21 Sec. 3. **HUMAN SERVICES**

486.22	Subdivision 1. Total Appropriation	\$ 5,356,970,000	\$ 5,848,682,000

486.23	<u>Appropriations by Fund</u>		
486.24		<u>2008</u>	<u>2009</u>
486.25	<u>General</u>	<u>4,688,475,000</u>	<u>5,050,169,000</u>
486.26	<u>State Government</u>		
486.27	<u>Special Revenue</u>	<u>545,000</u>	<u>555,000</u>
486.28	<u>Health Care Access</u>	<u>409,602,000</u>	<u>529,655,000</u>
486.29	<u>Federal TANF</u>	<u>255,514,000</u>	<u>265,866,000</u>
486.30	Lottery Prize Fund	2,184,000	1,787,000

486.31 The amounts that may be spent for each
486.32 purpose are specified in the following
486.33 subdivisions.

486.34 **Receipts for Systems Projects.**

486.35 Appropriations and federal receipts for
486.36 information system projects for MAXIS,

487.1 PRISM, MMIS, and SSIS must be deposited
487.2 in the state system account authorized in
487.3 Minnesota Statutes, section 256.014. Money
487.4 appropriated for computer projects approved
487.5 by the Minnesota Office of Enterprise
487.6 Technology, funded by the legislature, and
487.7 approved by the commissioner of finance,
487.8 may be transferred from one project to
487.9 another and from development to operations
487.10 as the commissioner of human services
487.11 considers necessary. Any unexpended
487.12 balance in the appropriation for these
487.13 projects does not cancel but is available for
487.14 ongoing development and operations.

487.15 **Systems Continuity.** In the event of
487.16 disruption of technical systems or computer
487.17 operations, the commissioner may use
487.18 available grant appropriations to ensure
487.19 continuity of payments for maintaining the
487.20 health, safety, and well-being of clients
487.21 served by programs administered by the
487.22 Department of Human Services. Grant funds
487.23 must be used in a manner consistent with the
487.24 original intent of the appropriation.

487.25 **Nonfederal Share Transfers.** The
487.26 nonfederal share of activities for which
487.27 federal administrative reimbursement is
487.28 appropriated to the commissioner may be
487.29 transferred to the special revenue fund.

487.30 **Gifts.** Notwithstanding Minnesota
487.31 Statutes, sections 16A.013 to 16A.016, the
487.32 commissioner may accept, on behalf of the
487.33 state, additional funding from sources other
487.34 than state funds for the purpose of financing
487.35 the cost of assistance program grants or

488.1 nongrant administration. All additional
488.2 funding is appropriated to the commissioner
488.3 for use as designated by the grantor of
488.4 funding.

488.5 **TANF Funds Appropriated to Other**
488.6 **Entities.** Any expenditures from the TANF
488.7 block grant shall be expended according
488.8 to the requirements and limitations of part
488.9 A of title IV of the Social Security Act, as
488.10 amended, and any other applicable federal
488.11 requirement or limitation. Prior to any
488.12 expenditure of these funds, the commissioner
488.13 shall ensure that funds are expended in
488.14 compliance with the requirements and
488.15 limitations of federal law and that any
488.16 reporting requirements of federal law are
488.17 met. It shall be the responsibility of any entity
488.18 to which these funds are appropriated to
488.19 implement a memorandum of understanding
488.20 with the commissioner that provides the
488.21 necessary assurance of compliance prior to
488.22 any expenditure of funds. The commissioner
488.23 shall receipt TANF funds appropriated
488.24 to other state agencies and coordinate all
488.25 related interagency accounting transactions
488.26 necessary to implement these appropriations.

488.27 Unexpended TANF funds appropriated to
488.28 any state, local, or nonprofit entity cancel
488.29 at the end of the state fiscal year unless
488.30 appropriating or statutory language permits
488.31 otherwise.

488.32 **TANF Block Grant.** Of this amount,
488.33 \$750,000 the first year and \$750,000 the
488.34 second year are onetime appropriations
488.35 from the state's federal TANF block grant
488.36 under Title I of Public Law 104-193. If the

489.1 appropriation in either year is insufficient, the
489.2 appropriation for the other year is available.

489.3 **TANF Maintenance of Effort.** (a) In
489.4 order to meet the basic maintenance of
489.5 effort (MOE) requirements of the TANF
489.6 block grant specified under Code of Federal
489.7 Regulations, title 45, section 263.1, the
489.8 commissioner may only report nonfederal
489.9 money expended for allowable activities
489.10 listed in the following clauses as TANF/MOE
489.11 expenditures:

489.12 (1) MFIP cash, diversionary work program,
489.13 and food assistance benefits under Minnesota
489.14 Statutes, chapter 256J;

489.15 (2) the child care assistance programs
489.16 under Minnesota Statutes, sections 119B.03
489.17 and 119B.05, and county child care
489.18 administrative costs under Minnesota
489.19 Statutes, section 119B.15;

489.20 (3) state and county MFIP administrative
489.21 costs under Minnesota Statutes, chapters
489.22 256J and 256K;

489.23 (4) state, county, and tribal MFIP
489.24 employment services under Minnesota
489.25 Statutes, chapters 256J and 256K;

489.26 (5) expenditures made on behalf of
489.27 noncitizen MFIP recipients who qualify
489.28 for the medical assistance without federal
489.29 financial participation program under
489.30 Minnesota Statutes, section 256B.06,
489.31 subdivision 4, paragraphs (d), (e), and (j);
489.32 and

490.1 (6) qualifying working family credit
490.2 expenditures under Minnesota Statutes,
490.3 section 290.0671.

490.4 (b) The commissioner shall ensure that
490.5 sufficient qualified nonfederal expenditures
490.6 are made each year to meet the state's
490.7 TANF/MOE requirements. For the activities
490.8 listed in paragraph (a), clauses (2) to
490.9 (6), the commissioner may only report
490.10 expenditures that are excluded from the
490.11 definition of assistance under Code of
490.12 Federal Regulations, title 45, section 260.31.

490.13 (c) The commissioner shall ensure that
490.14 the maintenance of effort used by the
490.15 commissioner of finance for the February
490.16 and November forecasts required under
490.17 Minnesota Statutes, section 16A.103,
490.18 contains expenditures under paragraph (a),
490.19 clause (1), equal to at least 25 percent of
490.20 the total required under Code of Federal
490.21 Regulations, title 45, section 263.1.

490.22 (d) Minnesota Statutes, section 256.011,
490.23 subdivision 3, which requires that federal
490.24 grants or aids secured or obtained under that
490.25 subdivision be used to reduce any direct
490.26 appropriations provided by law, does not
490.27 apply if the grants or aids are federal TANF
490.28 funds.

490.29 (e) Notwithstanding section 13, this rider
490.30 expires June 30, 2011.

490.31 **Working Family Credit Expenditures**
490.32 **as TANF/MOE.** The commissioner may
490.33 claim as TANF maintenance of effort up
490.34 to \$6,707,000 per year for fiscal year 2008

491.1 through fiscal year 2011. Notwithstanding
491.2 section 13, this rider expires June 30, 2011.

491.3 **Additional Working Family Credit**
491.4 **Expenditures to be Claimed for**
491.5 **TANF/MOE.** In addition to the amounts
491.6 provided in this section, the commissioner
491.7 may count the following amounts of working
491.8 family credit expenditure as TANF/MOE:

491.9 (1) fiscal year 2008, \$4,269,000; and
491.10 (2) fiscal year 2009, \$4,889,000.

491.11 Notwithstanding section 13, this rider expires
491.12 June 30, 2011.

491.13 **Capitation Rate Increase.** Of the health care
491.14 access fund appropriations to the University
491.15 of Minnesota in the higher education
491.16 omnibus appropriation bill, \$2,157,000 in
491.17 fiscal year 2008 and \$2,157,000 in fiscal year
491.18 2009 are to be used to increase the capitation
491.19 payments under Minnesota Statutes, section
491.20 256B.69.

491.21 **Health Care Access Fund Transfer.**
491.22 Notwithstanding Minnesota Statutes, section
491.23 295.581, in addition to the transfers in
491.24 Minnesota Statutes, section 16A.724,
491.25 subdivision 2, the commissioner of finance
491.26 shall transfer up to the following amounts
491.27 from the health care access fund to the
491.28 general fund on June 30 of each fiscal year:

491.29 (1) fiscal year 2008, \$6,416,000;
491.30 (2) fiscal year 2009, \$5,643,000;
491.31 (3) fiscal year 2010, \$6,677,000; and
491.32 (4) fiscal year 2011, \$7,866,000.

492.1 Notwithstanding section 13, this rider expires
492.2 June 30, 2011.

492.3 Subd. 2. Agency Management 57,727,000 58,161,000

492.4	<u>Appropriations by Fund</u>		
492.5	<u>General</u>	<u>48,413,000</u>	<u>48,882,000</u>
492.6	<u>State Government</u>		
492.7	<u>Special Revenue</u>	<u>424,000</u>	<u>432,000</u>
492.8	<u>Health Care Access</u>	<u>8,018,000</u>	<u>7,975,000</u>
492.9	<u>Federal TANF</u>	<u>222,000</u>	<u>222,000</u>

492.10 The amounts that may be spent from the
492.11 appropriation for each purpose are as follows:

492.12 (a) Financial Operations

492.13	<u>Appropriations by Fund</u>		
492.14	<u>General</u>	<u>7,102,000</u>	<u>7,523,000</u>
492.15	<u>Health Care Access</u>	<u>889,000</u>	<u>880,000</u>
492.16	<u>Federal TANF</u>	<u>122,000</u>	<u>122,000</u>

492.17 (b) Legal and Regulation Operations

492.18	<u>Appropriations by Fund</u>		
492.19	<u>General</u>	<u>13,037,000</u>	<u>13,138,000</u>
492.20	<u>State Government</u>		
492.21	<u>Special Revenue</u>	<u>424,000</u>	<u>432,000</u>
492.22	<u>Health Care Access</u>	<u>891,000</u>	<u>908,000</u>
492.23	<u>Federal TANF</u>	<u>100,000</u>	<u>100,000</u>

492.24 Base Adjustment. The general fund base is
492.25 decreased by \$177,000 in fiscal year 2010
492.26 and \$353,000 in fiscal year 2011 for legal
492.27 and regulatory.

492.28 Child Care Licensing. \$697,000 is
492.29 appropriated from the general fund to
492.30 the commissioner of human services for
492.31 the biennium beginning July 1, 2007, for
492.32 purposes of completing background studies
492.33 for family and group family child care
492.34 providers under Minnesota Statutes, chapter
492.35 245C. This appropriation will be \$288,000 in

493.1	<u>fiscal year 2010 and \$112,000 in fiscal year</u>		
493.2	<u>2011.</u>		
493.3	<u>(c) Management Operations</u>		
493.4	<u>Appropriations by Fund</u>		
493.5	<u>General</u>	<u>4,390,000</u>	<u>4,433,000</u>
493.6	<u>Health Care Access</u>	<u>234,000</u>	<u>238,000</u>
493.7	<u>(d) Information Technology Operations</u>		
493.8	<u>Appropriations by Fund</u>		
493.9	<u>General</u>	<u>23,884,000</u>	<u>23,788,000</u>
493.10	<u>Health Care Access</u>	<u>6,004,000</u>	<u>5,949,000</u>
493.11	<u>Subd. 3. Revenue and Pass-Through</u>		
493.12	<u>Expenditures</u>	<u>66,842,000</u>	<u>69,723,000</u>
493.13	<u>Federal TANF</u>	<u>66,842,000</u>	<u>69,723,000</u>
493.14	<u>TANF Transfer to Federal Child Care</u>		
493.15	<u>and Development Fund.</u> <u>The following</u>		
493.16	<u>TANF fund amounts are appropriated to</u>		
493.17	<u>the commissioner for the purposes of MFIP</u>		
493.18	<u>transition year child care under MFIP,</u>		
493.19	<u>Minnesota Statutes, section 119B.05:</u>		
493.20	<u>(1) fiscal year 2008, \$10,333,000</u>		
493.21	<u>(2) fiscal year 2009, \$12,826,000</u>		
493.22	<u>(3) fiscal year 2010, \$4,104,000 and</u>		
493.23	<u>(4) fiscal year 2011, \$5,460,000.</u>		
493.24	<u>The commissioner shall authorize transfer</u>		
493.25	<u>of sufficient TANF funds to the federal</u>		
493.26	<u>child care and development fund to meet</u>		
493.27	<u>this appropriation and shall ensure that all</u>		
493.28	<u>transferred funds are expended according</u>		
493.29	<u>the federal child care and development fund</u>		
493.30	<u>regulations.</u>		
493.31	<u>Subd. 4. Children and Economic Assistance</u>		
493.32	<u>Grants</u>	<u>747,318,000</u>	<u>730,623,000</u>
493.33	<u>Appropriations by Fund</u>		
493.34	<u>General</u>	<u>559,814,000</u>	<u>535,898,000</u>

494.1	<u>Federal TANF</u>	<u>187,254,000</u>	<u>194,725,000</u>
494.2	<u>Health Care Access</u>	<u>250,000</u>	<u>-0-</u>

494.3 The amounts that may be spent from this
494.4 appropriation for each purpose are as follows:

494.5 (a) MFIP/DWP Grants

494.6	<u>Appropriations by Fund</u>		
494.7	<u>General</u>	<u>62,000,000</u>	<u>61,911,000</u>
494.8	<u>Federal TANF</u>	<u>82,532,000</u>	<u>90,003,000</u>

494.9 (b) Support Services Grants

494.10	<u>Appropriations by Fund</u>		
494.11	<u>General</u>	<u>8,815,000</u>	<u>9,465,000</u>
494.12	<u>Federal TANF</u>	<u>103,382,000</u>	<u>103,382,000</u>

494.13 **TANF Prior Appropriation Cancellation.**
494.14 Notwithstanding Laws 2001, First Special
494.15 Session chapter 9, article 17, section
494.16 2, subdivision 11, paragraph (b), any
494.17 unexpended TANF funds appropriated to the
494.18 commissioner to contract with the Board of
494.19 Trustees of Minnesota State Colleges and
494.20 Universities, to provide tuition waivers to
494.21 employees of health care and human service
494.22 providers that are members of qualifying
494.23 consortia operating under Minnesota
494.24 Statutes, sections 116L.10 to 116L.15, must
494.25 cancel at the end of fiscal year 2007.

494.26 **MFIP Pilot Program.** Of the general fund
494.27 appropriation, \$100,000 in fiscal year 2008
494.28 and \$750,000 in fiscal year 2009 are for a
494.29 grant to the Stearns-Benton Employment and
494.30 Training Council for the Workforce U pilot
494.31 program.

494.32 **Work Study.** \$750,000 in fiscal year
494.33 2008 and \$750,000 in fiscal year 2009 are
494.34 appropriated from the TANF reserve account

495.1 to the Minnesota Office of Higher Education
495.2 for work study grants under Minnesota
495.3 Statutes, section 136A.233, specifically
495.4 for low-income individuals who receive
495.5 assistance under Minnesota Statutes, chapter
495.6 256J.

495.7 **(c) MFIP Child Care Assistance Grants**

495.8	<u>General</u>	<u>74,797,000</u>	<u>73,699,000</u>

495.9 **(d) Basic Sliding Fee Child Care Assistance**
495.10 **Grants**

495.11	<u>General</u>	<u>43,012,000</u>	<u>45,432,000</u>

495.12 **Base Adjustment.** The general fund base
495.13 is increased by \$1,262,000 in fiscal year
495.14 2010 and decreased by \$951,000 in fiscal
495.15 year 2011 for basic sliding fee child care
495.16 assistance grants.

495.17 **(e) Child Care Development Grants**

495.18	<u>General</u>	<u>5,865,000</u>	<u>5,865,000</u>

495.19 **Child Care Services Grants.** \$5,000,000
495.20 is appropriated from the general fund to
495.21 the commissioner of human services for
495.22 the biennium beginning July 1, 2007, for
495.23 purposes of providing child care services
495.24 grants under Minnesota Statutes, section
495.25 119B.21, subdivision 5. This appropriation
495.26 is for the 2008-2009 biennium only, and does
495.27 not increase the base funding.

495.28 **Early Childhood Professional**

495.29 **Development System.** \$2,000,000 is
495.30 appropriated from the general fund to
495.31 the commissioner of human services for
495.32 the biennium beginning July 1, 2007, for
495.33 purposes of the early childhood professional
495.34 development system, which increases the

496.1 quality and continuum of professional
496.2 development opportunities for child care
496.3 practitioners. This appropriation is for the
496.4 2008-2009 biennium only, and does not
496.5 increase the base funding.

496.6 **Family, Friend, and Neighbor Grant**
496.7 **Program.** \$750,000 in fiscal year 2008 and
496.8 \$750,000 in fiscal year 2009 are appropriated
496.9 from the general fund to the commissioner
496.10 of human services for the family, friend, and
496.11 neighbor grant program in article 1, section
496.12 94. Any balance in the first year does not
496.13 cancel but is available in the second year.
496.14 This appropriation is for the 2008-2009
496.15 biennium only, and does not increase the
496.16 base funding.

496.17 **(f) Increased Child Care Provider**
496.18 **Connections.** (1) \$200,000 is appropriated
496.19 from the general fund to the commissioner of
496.20 human services for the biennium beginning
496.21 July 1, 2007, for the following purposes:
496.22 \$100,000 each year is for a grant to Hennepin
496.23 County, and \$100,000 each year is for a grant
496.24 to Ramsey County. The two counties shall
496.25 each contract with a nonprofit organization
496.26 to work with the contracting county
496.27 and county-based licensed family child
496.28 care providers to facilitate county-based
496.29 information regarding family and children's
496.30 resources and to make training and peer
496.31 support available to licensed family child
496.32 care providers consistent with clause (2).
496.33 These appropriations are available until
496.34 June 30, 2009, and shall not become part
496.35 of base-level funding for the biennium
496.36 beginning July 1, 2009.

497.1 (2) Programs to improve child care provider
497.2 connections to county services shall be
497.3 established in Hennepin and Ramsey
497.4 counties to:

497.5 (i) improve county contact activities
497.6 with county-licensed family child care
497.7 providers that facilitate utilization of county
497.8 educational, social service, public health,
497.9 and economic assistance services by eligible
497.10 families, parents, and children using licensed
497.11 family child care; and

497.12 (ii) support licensed family child care
497.13 providers to qualify as quality-rated child
497.14 care providers through peer support and
497.15 coaching networks.

497.16 Hennepin and Ramsey Counties shall
497.17 contract with a nonprofit organization under
497.18 clause (1) that utilizes licensed family child
497.19 care providers as contacts for families using
497.20 licensed family child care and to provide
497.21 peer support to licensed family child care
497.22 providers.

497.23 (3) Hennepin and Ramsey Counties must
497.24 report back on successful strategies for
497.25 increasing contact with county-based
497.26 licensed family child care providers and
497.27 report their findings to the appropriate
497.28 legislative committees by February 15, 2010.

497.29 **Base Adjustment.** The general fund base
497.30 is \$1,515,000 for each of fiscal years 2010
497.31 and 2011.

497.32 **(g) Child Support Enforcement Grants**

497.33 General 9,038,000 3,705,000

498.1 **Child Support Enforcement.** \$5,333,000
498.2 for fiscal year 2008 is to make grants to
498.3 counties for child support enforcement
498.4 programs to make up for the loss under the
498.5 2006 federal Deficit Reduction Act of federal
498.6 matching funds for federal incentive funds
498.7 passed on to the counties by the state.
498.8 This appropriation is available until spent.
498.9 **(h) Children's Services Grants**

498.10	<u>Appropriations by Fund</u>		
498.11	<u>General</u>	<u>62,745,000</u>	<u>73,133,000</u>
498.12	<u>Health Care Access</u>	<u>250,000</u>	<u>-0-</u>

498.13 **Base Adjustment.** The general fund base
498.14 is decreased by \$673,000 in fiscal year
498.15 2010 and \$670,000 in fiscal year 2011 for
498.16 children's services grants.
498.17 **Privatized Adoption Grants.** Federal
498.18 reimbursement for privatized adoption grant
498.19 and foster care recruitment grant expenditures
498.20 is appropriated to the commissioner for
498.21 adoption grants and foster care and adoption
498.22 administrative purposes.
498.23 **Adoption Assistance Incentive Grants.**
498.24 Federal funds available during fiscal year
498.25 2008 and fiscal year 2009 for the adoption
498.26 incentive grants are appropriated to the
498.27 commissioner for these purposes.
498.28 **Adoption Assistance and Relative Custody**
498.29 **Assistance.** The commissioner may transfer
498.30 unencumbered appropriation balances for
498.31 adoption assistance and relative custody
498.32 assistance between fiscal years and between
498.33 programs.

499.1 **Adoption Assistance and Relative**
499.2 **Custody Assistance Subsidy Payment**
499.3 **Increase.** Notwithstanding Minnesota
499.4 Rules, part 9560.0083, subparts 5 and 6, the
499.5 commissioner shall increase the payment
499.6 schedules for basic and supplemental
499.7 maintenance needs subsidies by 3.95 percent
499.8 effective July 1, 2007. The commissioner
499.9 may make cost-neutral adjustments between
499.10 schedules and between brackets within
499.11 schedules to allow for whole-dollar bracket
499.12 levels and account for differential cost
499.13 increases in caring for children with special
499.14 needs. Counties have until December 31,
499.15 2007, to implement the relative custody
499.16 assistance payment increases and shall make
499.17 payment adjustments retroactive to July 1,
499.18 2007.

499.19 **Crisis Nurseries.** \$1,100,000 in fiscal year
499.20 2008 and \$1,100,000 in fiscal year 2009 are
499.21 appropriated from the general fund for the
499.22 crisis nurseries program. Of this amount,
499.23 \$100,000 each year is to be made available
499.24 for capacity development and technical
499.25 support for crisis nurseries.

499.26 **Respite Care.** Of the general fund
499.27 appropriation, \$1,250,000 in fiscal year
499.28 2008 and \$2,500,000 in fiscal year 2009 are
499.29 to the commissioner of human services to
499.30 fund respite care for children who have a
499.31 diagnosis of emotional disturbance or severe
499.32 emotional disturbance.

499.33 **Childhood Trauma; Grants.** Of the general
499.34 fund appropriation, \$125,000 in fiscal year
499.35 2008 and \$250,000 in fiscal year 2009 are

500.1 to the commissioner of human services to
500.2 make grants for the purpose of maintaining
500.3 and expanding evidence-based practices that
500.4 support children and youth who have been
500.5 exposed to violence or who are refugees.

500.6 **Collaborative Services for High-Risk**
500.7 **Children.** Of the general fund appropriation,
500.8 \$2,632,000 in fiscal year 2008 and
500.9 \$6,150,000 in fiscal year 2009 are to the
500.10 commissioner of human services to fund
500.11 early intervention collaborative programs.

500.12 **Evidence-Based Practice.** Of the general
500.13 fund appropriation, \$2,175,000 in fiscal year
500.14 2008 and \$4,350,000 in fiscal year 2009
500.15 are to the commissioner of human services
500.16 to develop and implement evidence-based
500.17 practice in children's mental health care and
500.18 treatment.

500.19 **MFIP and Children's Mental Health Pilot**
500.20 **Project.** Of the general fund appropriation,
500.21 \$100,000 in fiscal year 2008 and \$200,000
500.22 in fiscal year 2009 are to the commissioner
500.23 of human services to fund the MFIP and
500.24 children's mental health pilot project.

500.25 **Regional Children's Mental Health**
500.26 **Initiative.** \$700,000 in fiscal year 2008 and
500.27 \$700,000 in fiscal year 2009 are appropriated
500.28 to the commissioner of human services to
500.29 fund the Regional Children's Mental Health
500.30 Initiative pilot project. This is a onetime
500.31 appropriation.

500.32 **Child Safety Efforts.** \$1,000,000 in fiscal
500.33 year 2008 and \$1,000,000 in fiscal year 2009
500.34 are appropriated to counties based on their
500.35 population of residents under age 18. Funds

501.1 are to be used to maintain and improve child
501.2 safety services. By February 1, 2008, each
501.3 county shall submit a report regarding current
501.4 child safety efforts, child safety funding, and
501.5 unmet needs including investments needed.
501.6 The report shall also include methods and
501.7 community partners available to ensure
501.8 early identification of at-risk families. The
501.9 Association of Minnesota Counties and
501.10 county agencies shall develop a uniform
501.11 report structure so that statewide data can
501.12 be easily summarized. This is a onetime
501.13 appropriation.

501.14 **Fetal Alcohol Syndrome.** Of the general
501.15 fund appropriation, \$75,000 in fiscal year
501.16 2008 and \$75,000 in fiscal year 2009 are
501.17 for three programs that provide services
501.18 to reduce fetal alcohol syndrome under
501.19 Minnesota Statutes, section 145.9266. The
501.20 three program grantees are the University
501.21 of Minnesota, the Meeker-McLeod-Sibley
501.22 Community, and the American Indian Family
501.23 Center. This appropriation shall become part
501.24 of the base appropriation.

501.25 **Base Adjustment.** The general fund base is
501.26 increased by \$366,000 in fiscal year 2010 and
501.27 \$369,000 in fiscal year 2011 for children's
501.28 services grants.

501.29 **(i) Children and Community Services Grants**

501.30	<u>General</u>	<u>108,802,000</u>	<u>69,567,000</u>

501.31 **Base Adjustment.** The general fund base is
501.32 increased by \$99,000 in each of fiscal years
501.33 2010 and 2011 for children and community
501.34 services grants.

502.1 **Targeted Case Management Temporary**
502.2 **Funding.** Of the general fund appropriation,
502.3 \$38,000,000 in fiscal year 2008 is allocated to
502.4 counties and tribes affected by reductions in
502.5 targeted case management federal Medicaid
502.6 revenue as a result of the provisions in
502.7 the federal Deficit Reduction Act of 2005,
502.8 Public Law 109-171. The commissioner
502.9 shall distribute the funds proportionate
502.10 to each affected county or tribe's targeted
502.11 case management federal earnings for
502.12 calendar year 2005. Prior to distribution
502.13 of funds, the commissioner shall estimate
502.14 and certify the amount by which the federal
502.15 regulations will reduce case management
502.16 revenue over the 2008-2009 biennium. The
502.17 commissioner may provide grants up to the
502.18 amount of the estimated reduction, not to
502.19 exceed \$38,000,000 for the biennium. The
502.20 commissioner may determine the timing and
502.21 frequency of payments to counties. These
502.22 funds are available in either year of the
502.23 biennium. Counties shall use these funds to
502.24 pay for social service-related costs, but the
502.25 funds are not subject to provisions of the
502.26 Children and Community Services Act grant
502.27 under Minnesota Statutes, chapter 256M.
502.28 **Child Welfare Project.** Of the general fund
502.29 appropriation, \$2,000,000 for the biennium
502.30 beginning July 1, 2007, is for expanding
502.31 the American Indian child welfare project
502.32 under Minnesota Statutes, section 256.01,
502.33 subdivision 14b, to include the Red Lake
502.34 Band of Chippewa Indians Tribe, provided
502.35 the tribe meets the criteria in Minnesota
502.36 Statutes, section 256.01, subdivision 14b.

503.1	<u>(j) General Assistance Grants</u>		
503.2	<u>General</u>	<u>37,876,000</u>	<u>38,253,000</u>
503.3	<u>General Assistance Standard. The</u>		
503.4	<u>commissioner shall set the monthly standard</u>		
503.5	<u>of assistance for general assistance units</u>		
503.6	<u>consisting of an adult recipient who is</u>		
503.7	<u>childless and unmarried or living apart</u>		
503.8	<u>from parents or a legal guardian at \$203.</u>		
503.9	<u>The commissioner may reduce this amount</u>		
503.10	<u>according to Laws 1997, chapter 85, article</u>		
503.11	<u>3, section 54.</u>		
503.12	<u>Emergency General Assistance. The</u>		
503.13	<u>amount appropriated for emergency general</u>		
503.14	<u>assistance funds is limited to no more</u>		
503.15	<u>than \$7,889,812 in fiscal year 2008 and</u>		
503.16	<u>\$7,889,812 in fiscal year 2009. Funds</u>		
503.17	<u>to counties must be allocated by the</u>		
503.18	<u>commissioner using the allocation method</u>		
503.19	<u>specified in Minnesota Statutes, section</u>		
503.20	<u>256D.06.</u>		
503.21	<u>(k) Minnesota Supplemental Aid Grants</u>		
503.22	<u>General</u>	<u>30,798,000</u>	<u>31,439,000</u>
503.23	<u>Emergency Minnesota Supplemental</u>		
503.24	<u>Aid Funds. The amount appropriated for</u>		
503.25	<u>emergency Minnesota supplemental aid</u>		
503.26	<u>funds is limited to no more than \$1,100,000</u>		
503.27	<u>in fiscal year 2008 and \$1,100,000 in fiscal</u>		
503.28	<u>year 2009. Funds to counties must be</u>		
503.29	<u>allocated by the commissioner using the</u>		
503.30	<u>allocation method specified in Minnesota</u>		
503.31	<u>Statutes, section 256D.46.</u>		
503.32	<u>(l) Group Residential Housing Grants</u>		
503.33	<u>General</u>	<u>91,441,000</u>	<u>99,304,000</u>

504.1 **Base Adjustment.** The general fund base is
504.2 increased by \$6,665,000 in fiscal year 2010
504.3 and \$13,419,000 in fiscal year 2011.

504.4 **People Incorporated.** \$460,000 in fiscal
504.5 year 2008 and \$460,000 in fiscal year 2009
504.6 are appropriated from the general fund to the
504.7 commissioner of human services to augment
504.8 community support and mental health
504.9 services provided to individuals residing in
504.10 facilities under Minnesota Statutes, section
504.11 256I.05, subdivision 1h.

504.12 **(m) Other Children and Economic Assistance**
504.13 **Grants**

504.14	<u>General</u>	<u>24,625,000</u>	<u>24,125,000</u>

504.15	<u>Federal TANF</u>	<u>1,340,000</u>	<u>1,340,000</u>

504.16 **Base Adjustment.** The general fund base
504.17 shall be \$20,447,000 in each of fiscal years
504.18 2010 and 2011.

504.19 **New Chance.** \$140,000 in fiscal year
504.20 2008 and \$140,000 in fiscal year 2009 are
504.21 appropriated from federal TANF funds to the
504.22 Hennepin County new chance program.

504.23 **Mothers First.** Of the TANF appropriation,
504.24 \$450,000 in fiscal year 2008 and \$450,000
504.25 in fiscal year 2009 are to fund the Ramsey
504.26 County mothers first program. The
504.27 appropriations are available until spent and
504.28 are a onetime appropriation.

504.29 **Homeless and Runaway Youth.** \$3,500,000
504.30 in the first year and \$3,500,000 in the second
504.31 year are for the Runaway and Homeless
504.32 Youth Act under Minnesota Statutes, section
504.33 256K.45. Funds shall be spent in each area
504.34 of the continuum of care to ensure that

505.1 programs are meeting the greatest need. The
505.2 base is decreased by \$2,000,000 each year in
505.3 fiscal year 2010 and fiscal year 2011.

505.4 **Transitional Housing and Emergency**
505.5 **Services.**

505.6 (1) \$750,000 each year from the federal
505.7 TANF fund is for transitional housing
505.8 programs under Minnesota Statutes, section
505.9 256E.33. The TANF appropriations
505.10 are onetime. The general fund base for
505.11 transitional housing is increased by \$422,000
505.12 each year for the fiscal 2010-2011 biennium.
505.13 Up to ten percent of this appropriation may
505.14 be used for housing and services which
505.15 extend beyond 24 months. \$300,000 in each
505.16 year of this amount is for grants for safe
505.17 housing pilot projects for battered women
505.18 and families in Anoka County, Houston
505.19 County, and Beltrami County; and

505.20 (2) \$527,000 each year is added to the
505.21 base for emergency services grants under
505.22 Laws 1997, chapter 162, article 3, section
505.23 7. The base for emergency services grants
505.24 is decreased each year by \$300,000 in fiscal
505.25 year 2010 and fiscal year 2011.

505.26 **Foodshelf Programs.** \$575,000 each year
505.27 is added to the base for foodshelf programs
505.28 under Minnesota Statutes, section 256E.34.
505.29 The base is decreased by \$250,000 each year
505.30 in fiscal year 2010 and fiscal year 2011.

505.31 **Long-term Homeless Services.** \$2,440,000
505.32 each year is added to the base for the
505.33 long-term homeless services under
505.34 Minnesota Statutes, section 256K.26. The

506.1 base is decreased by \$1,000,000 each year in
506.2 fiscal year 2010 and fiscal year 2011.

506.3 **Minnesota Community Action Grants.**
506.4 \$1,500,000 each year is added to the base for
506.5 the purposes of Minnesota community action
506.6 grants under Minnesota Statutes, sections
506.7 256E.30 to 256E.32. The base is reduced by
506.8 \$500,000 each year in fiscal year 2010 and
506.9 fiscal year 2011.

506.10 **Tenant Hotline Services Program. \$50,000**
506.11 each year is added to the base for a grant to
506.12 HOME Line for the tenant hotline services
506.13 program. This is a onetime appropriation.

506.14 <u>Subd. 5. Children and Economic Assistance</u>		
506.15 <u>Management</u>	<u>47,035,000</u>	<u>46,884,000</u>

506.16	<u>Appropriations by Fund</u>		
506.17 <u>General</u>	<u>45,492,000</u>	<u>45,335,000</u>	
506.18 <u>Health Care Access</u>	<u>347,000</u>	<u>354,000</u>	
506.19 <u>Federal TANF</u>	<u>1,196,000</u>	<u>1,196,000</u>	

506.20 The amounts that may be spent from the
506.21 appropriation for each purpose are as follows:

506.22 **(a) Children and Economic Assistance**
506.23 **Administration**

506.24	<u>Appropriations by Fund</u>		
506.25 <u>General</u>	<u>9,725,000</u>	<u>9,612,000</u>	
506.26 <u>Federal TANF</u>	<u>1,196,000</u>	<u>1,196,000</u>	

506.27 **Base Adjustment.** The general fund base is
506.28 \$9,574,000 in each of fiscal years 2010 and
506.29 2011.

506.30 **(b) Children and Economic Assistance**
506.31 **Operations**

506.32	<u>Appropriations by Fund</u>		
506.33 <u>General</u>	<u>35,767,000</u>	<u>35,722,000</u>	
506.34 <u>Health Care Access</u>	<u>347,000</u>	<u>354,000</u>	

507.1 **Spending Authority for Food Stamps**

507.2 **Bonus Awards.** In the event that Minnesota
507.3 qualifies for the United States Department
507.4 of Agriculture Food and Nutrition Services
507.5 Food Stamp Program performance bonus
507.6 awards, the funding is appropriated to the
507.7 commissioner. The commissioner shall
507.8 retain 25 percent of the funding, with the
507.9 other 75 percent divided among the counties
507.10 according to a formula that takes into account
507.11 each county's impact on state performance in
507.12 the applicable bonus categories.

507.13 **Child Support Payment Center.** Payments
507.14 to the commissioner from other governmental
507.15 units, private enterprises, and individuals
507.16 for services performed by the child support
507.17 payment center must be deposited in the state
507.18 systems account authorized under Minnesota
507.19 Statutes, section 256.014. These payments
507.20 are appropriated to the commissioner for the
507.21 operation of the child support payment center
507.22 or system, according to Minnesota Statutes,
507.23 section 256.014.

507.24 **Financial Institution Data Match and**
507.25 **Payment of Fees.** The commissioner is
507.26 authorized to allocate up to \$310,000 each
507.27 year in fiscal years 2008 and 2009 from the
507.28 PRISM special revenue account to make
507.29 payments to financial institutions in exchange
507.30 for performing data matches between account
507.31 information held by financial institutions
507.32 and the public authority's database of child
507.33 support obligors as authorized by Minnesota
507.34 Statutes, section 13B.06, subdivision 7.

508.1 **Base Adjustment.** The general fund base is
508.2 decreased by \$22,000 in each of fiscal years
508.3 2010 and 2011.

508.4	<u>Subd. 6. Basic Health Care Grants</u>	<u>2,397,260,000</u>	<u>2,739,194,000</u>

508.5	<u>Appropriations by Fund</u>		
508.6	<u>General</u>	<u>2,019,435,000</u>	<u>2,246,743,000</u>
508.7	<u>Health Care Access</u>	<u>377,825,000</u>	<u>492,451,000</u>

508.8 The amounts that may be spent from the
508.9 appropriation for each purpose are as follows:

508.10 **(a) MinnesotaCare Grants**

508.11	<u>Health Care Access</u>	<u>376,938,000</u>	<u>459,891,000</u>

508.12 **MinnesotaCare Federal Receipts.** Receipts
508.13 received as a result of federal participation
508.14 in administering costs of the Minnesota
508.15 health care reform waiver must be deposited
508.16 as nondedicated revenue in the health care
508.17 access fund. Receipts received as a result of
508.18 federal participation in making grants must
508.19 be deposited in the federal fund and must
508.20 offset health care access funds for payments
508.21 to providers.

508.22 **MinnesotaCare Funding.** The
508.23 commissioner may expend money
508.24 appropriated from the health care access fund
508.25 for MinnesotaCare in either fiscal year of the
508.26 biennium.

508.27 **HealthMatch Delay.** Of this appropriation,
508.28 \$2,560,000 in fiscal year 2008 and
508.29 \$29,647,000 in fiscal year 2009 are for
508.30 MinnesotaCare program costs related to
508.31 implementation of the HealthMatch program.

508.32 **(b) MA Basic Health Care - Families and**
508.33 **Children**

509.1	<u>Appropriations by Fund</u>		
509.2	<u>General</u>	<u>758,212,000</u>	<u>847,163,000</u>
509.3	<u>Health Care Access</u>	<u>-0-</u>	<u>31,661,000</u>

509.4 **(c) MA Basic Health Care - Elderly and**
509.5 **Disabled**

509.6	<u>General</u>	<u>1,019,297,000</u>	<u>1,145,789,000</u>

509.7 **Provider-Directed Care Coordination. In**
509.8 **addition to medical assistance reimbursement**
509.9 **under Minnesota Statutes, sections**
509.10 **256B.0625 and 256B.76, clinics participating**
509.11 **in provider-directed care coordination under**
509.12 **Minnesota Statutes, section 256B.0625, also**
509.13 **receive a monthly payment per client when**
509.14 **the clinic serves an eligible client. The**
509.15 **payments across the program must average**
509.16 **\$50 per month per client.**

509.17 **Services for Developmentally Disabled.**
509.18 **The commissioner must serve: an additional**
509.19 **200 persons in the MR/RC waiver program;**
509.20 **an additional 200 persons in the family**
509.21 **support grant program under Minnesota**
509.22 **Statutes, section 252.32; and an additional**
509.23 **200 persons in the semi-independent living**
509.24 **services program under Minnesota Statutes,**
509.25 **section 252.275.**

509.26 **County CADI allocation adjustment. (1)**
509.27 **The commissioner shall adjust 2007 home**
509.28 **and community-based allocations under**
509.29 **section 256B.49 to qualifying counties**
509.30 **that transferred persons to the community**
509.31 **alternatives for disabled individuals**
509.32 **(CADI) waiver program under Laws 2006,**
509.33 **chapter 282, article 20, section 35. The**
509.34 **adjustment shall reflect the amount that**
509.35 **county-authorized funding for CADI waiver**

510.1 services exceeded the allowable amount
510.2 as shown in the Medicaid Management
510.3 Information System (MMIS) on March 1,
510.4 2007.

510.5 (2) A county that may qualify under
510.6 paragraph (1) shall apply to the commissioner
510.7 by June 10, 2007. Following a review of the
510.8 county request and the MMIS documentation,
510.9 the commissioner shall adjust the county
510.10 allocation, as appropriate, by June 25, 2007.

510.11 (3) The amounts provided to a county under
510.12 this section shall become part of the county's
510.13 base level state allocation for the CADI
510.14 waiver for the biennium beginning July 1,
510.15 2007.

510.16 (4) This rider is effective the day following
510.17 final enactment.

510.18 **(d) General Assistance Medical Care Grants**

510.19	<u>General</u>	<u>238,887,000</u>	<u>251,082,000</u>

510.20 **(e) Other Health Care Grants**

510.21	<u>General</u>	<u>3,039,000</u>	<u>2,709,000</u>
510.22	<u>Health Care Access</u>	<u>887,000</u>	<u>899,000</u>

510.23 **Care Coordination.** Of the general fund
510.24 appropriation, \$500,000 in fiscal year 2008
510.25 and \$1,000,000 in fiscal year 2009 are for
510.26 the commissioner of human services for
510.27 contracting for care coordination with the
510.28 U special kids program under Minnesota
510.29 Statutes, section 256B.0751.

510.30 **Community-Based Health Care.** Of the
510.31 general fund appropriation, \$1,050,000
510.32 for the biennium beginning July 1, 2007,
510.33 is to the commissioner of human services
510.34 for the demonstration project grant

511.1	<u>described in Minnesota Statutes, section</u>		
511.2	<u>62Q.80, subdivision 1a. This is a onetime</u>		
511.3	<u>appropriation and is available until June 30,</u>		
511.4	<u>2012.</u>		
511.5	<u>Health Care Payment Reform Pilot. Of</u>		
511.6	<u>the general fund appropriation, \$1,018,000</u>		
511.7	<u>in fiscal year 2008 and \$1,027,000 in fiscal</u>		
511.8	<u>year 2009 are for the health care payment</u>		
511.9	<u>reform pilot project. These are onetime</u>		
511.10	<u>appropriations.</u>		
511.11	<u>Patient Incentive Programs. Of the general</u>		
511.12	<u>fund appropriation, \$500,000 in fiscal year</u>		
511.13	<u>2008 and \$500,000 in fiscal year 2009 are</u>		
511.14	<u>for patient incentive programs.</u>		
511.15	<u>State Health Policies Grant. Of the general</u>		
511.16	<u>fund appropriation, \$300,000 in fiscal year</u>		
511.17	<u>2008 is to provide a grant to a research center</u>		
511.18	<u>associated with a safety net hospital and</u>		
511.19	<u>county-affiliated health system to develop</u>		
511.20	<u>the capabilities necessary for evaluating the</u>		
511.21	<u>effects of changes in state health policies</u>		
511.22	<u>on low-income and uninsured individuals,</u>		
511.23	<u>including the impact on state health care</u>		
511.24	<u>program costs, health outcomes, cost-shifting</u>		
511.25	<u>to different units and levels of government,</u>		
511.26	<u>and utilization patterns including use of</u>		
511.27	<u>emergency room care and hospitalization</u>		
511.28	<u>rates.</u>		
511.29	<u>Neighborhood Health Care Network. Of</u>		
511.30	<u>the general fund appropriation, \$150,000 in</u>		
511.31	<u>fiscal year 2008 and \$150,000 in fiscal year</u>		
511.32	<u>2009 are for a grant to the Neighborhood</u>		
511.33	<u>Health Care Network to maintain and staff a</u>		
511.34	<u>toll-free health care access telephone number.</u>		
511.35	<u>Subd. 7. Health Care Management</u>	<u>54,536,000</u>	<u>58,696,000</u>

512.1	<u>Appropriations by Fund</u>		
512.2	<u>General</u>	<u>32,416,000</u>	<u>30,571,000</u>
512.3	<u>Health Care Access</u>	<u>22,120,000</u>	<u>28,125,000</u>

512.4 The amounts that may be spent from the
512.5 appropriation for each purpose are as follows:

512.6 **(a) Health Care Policy Administration**

512.7	<u>Appropriations by Fund</u>		
512.8	<u>General</u>	<u>10,236,000</u>	<u>8,813,000</u>
512.9	<u>Health Care Access</u>	<u>2,323,000</u>	<u>10,074,000</u>

512.10 **Minnesota Senior Health Options**

512.11 **Reimbursement.** Federal administrative
512.12 reimbursement resulting from the Minnesota
512.13 senior health options project is appropriated
512.14 to the commissioner for this activity.

512.15 **Utilization Review.** Federal administrative
512.16 reimbursement resulting from prior
512.17 authorization and inpatient admission
512.18 certification by a professional review
512.19 organization is dedicated to the commissioner
512.20 for these purposes. A portion of these funds
512.21 must be used for activities to decrease
512.22 unnecessary pharmaceutical costs in medical
512.23 assistance.

512.24 **Dental Access for Persons with Disabilities.**

512.25 Of the general fund appropriation, \$82,000
512.26 in fiscal year 2008 is for a study on access to
512.27 dental services for persons with disabilities.

512.28 **Base Adjustment.** The health care access
512.29 fund base is \$10,716,000 in fiscal year 2010
512.30 and \$8,870,000 in fiscal year 2011, for health
512.31 care administration.

512.32 **(b) Health Care Operations**

513.1	<u>Appropriations by Fund</u>		
513.2	<u>General</u>	<u>22,180,000</u>	<u>21,758,000</u>
513.3	<u>Health Care Access</u>	<u>19,797,000</u>	<u>18,051,000</u>
513.4	<u>Base Adjustment.</u> The general fund base is		
513.5	decreased by \$214,000 in fiscal year 2010		
513.6	for health care operations.		
513.7	<u>Subd. 8. Continuing Care Grants</u>	<u>1,699,359,000</u>	<u>1,858,283,000</u>
513.8	<u>Appropriations by Fund</u>		
513.9	<u>General</u>	<u>1,696,876,000</u>	<u>1,855,900,000</u>
513.10	<u>Health Care Access</u>	<u>750,000</u>	<u>750,000</u>
513.11	<u>Lottery Prize</u>	<u>1,733,000</u>	<u>1,633,000</u>
513.12	<u>The amounts that may be spent from the</u>		
513.13	<u>appropriation for each purpose are as follows:</u>		
513.14	<u>(a) Aging and Adult Services Grants</u>		
513.15	<u>General</u>	<u>15,986,000</u>	<u>16,605,000</u>
513.16	<u>Information and Assistance</u>		
513.17	<u>Reimbursement.</u> Federal administrative		
513.18	<u>reimbursement obtained from information</u>		
513.19	<u>and assistance services provided by the</u>		
513.20	<u>Senior LinkAge Line to people who are</u>		
513.21	<u>identified as eligible for medical assistance</u>		
513.22	<u>are appropriated to the commissioner for this</u>		
513.23	<u>activity.</u>		
513.24	<u>Senior Companion Program.</u> Of the		
513.25	<u>general fund appropriation, \$191,000 in</u>		
513.26	<u>fiscal year 2008 and \$191,000 in fiscal year</u>		
513.27	<u>2009 are for the senior companion program</u>		
513.28	<u>under Minnesota Statutes, section 256.977.</u>		
513.29	<u>Volunteer Senior Citizens.</u> Of the general		
513.30	<u>fund appropriation, \$192,000 in fiscal year</u>		
513.31	<u>2008 and \$192,000 in fiscal year 2009 are</u>		
513.32	<u>for the volunteer programs for retired senior</u>		
513.33	<u>citizens under Minnesota Statutes, section</u>		
513.34	<u>256.9753.</u>		

514.1 **Foster Grandparent Program.** Of the
514.2 general fund appropriation, \$192,000 in
514.3 fiscal year 2008 and \$192,000 in fiscal year
514.4 2009 are for the foster grandparent program
514.5 in Minnesota Statutes, section 256.976.

514.6 **Senior Nutrition.** Of the general fund
514.7 appropriation, \$250,000 in fiscal year
514.8 2008 and \$250,000 in fiscal year 2009 are
514.9 for the senior nutrition programs under
514.10 Minnesota Statutes, section 256.9752.
514.11 The commissioner shall give priority to
514.12 increase services to: (1) persons facing
514.13 language or cultural barriers, (2) persons with
514.14 special diets, (3) persons living in isolated
514.15 rural areas, and (4) other hard-to-serve
514.16 populations.

514.17 **Living At Home/Block Nurse Program.** Of
514.18 the general fund appropriation, \$580,000 in
514.19 fiscal year 2008 and \$655,000 in fiscal year
514.20 2009 are for the living at home/block nurse
514.21 program. The purpose of the appropriation is
514.22 to increase base funding levels to \$25,000
514.23 per program year, provide base funding for
514.24 nine programs currently operating without
514.25 base funding, provide base funding for five
514.26 new programs beginning July 1, 2007, and
514.27 provide base funding for six additional
514.28 programs beginning July 1, 2008.

514.29 \$76,000 in fiscal year 2008 and \$62,000 in
514.30 fiscal year 2009 are for increased staff for
514.31 the ombudsman for older Minnesotans and
514.32 related costs.

514.33 \$150,000 in fiscal year 2008 and \$150,000 in
514.34 fiscal year 2009 are to increase the base of
514.35 the Senior LinkAge line program.

515.1 **Minnesota Kinship Caregivers**
515.2 **Association.** (1) Of the general fund
515.3 appropriation, \$175,000 in fiscal year
515.4 2008 and \$175,000 in fiscal year 2009
515.5 are transferred to a nonprofit organization
515.6 experienced in kinship caregiver programs,
515.7 with at least 50 percent of its board
515.8 composed of kinship caregivers for purposes
515.9 of providing support to grandparents or
515.10 relatives who are raising kinship children.

515.11 (2) The demonstration grant sites must
515.12 include the Minnesota Kinship Caregivers
515.13 Association central site in the metropolitan
515.14 area and another site in the Bemidji region.
515.15 The support must provide a one-stop services
515.16 program. The services that may be provided
515.17 include but are not limited to legal services,
515.18 education, information, family activities,
515.19 support groups, mental health access,
515.20 advocacy, mentors, and information related
515.21 to foster care licensing. The funds may also
515.22 be used for a media campaign to inform
515.23 kinship families about available information
515.24 and services, support sites, and other program
515.25 development. The general fund base for the
515.26 program shall be \$160,000 in fiscal year
515.27 2010 and \$160,000 in fiscal year 2011.

515.28 **Base Adjustment.** The general fund base
515.29 is increased by \$72,000 in fiscal year 2010
515.30 and \$72,000 in fiscal year 2011 for aging and
515.31 adult services grants.

515.32 **(b) Alternative Care Grants**

515.33

<u>General</u>	<u>50,063,000</u>	<u>52,511,000</u>

515.34 **Alternative Care Transfer.** Any money
515.35 allocated to the alternative care program that

516.1 is not spent for the purposes indicated does
516.2 not cancel but is transferred to the medical
516.3 assistance account.

516.4 **Base Adjustment.** The general fund base is
516.5 increased by \$547,000 in fiscal year 2010 and
516.6 \$784,000 in fiscal year 2011 for alternative
516.7 care grants.

516.8 **(c) Medical Assistance Grants - Long-Term**
516.9 **Care Facilities**

516.10 General 501,278,000 513,016,000

516.11 **New Nursing Facility Reimbursement**

516.12 **System Delay.** Notwithstanding Minnesota
516.13 Statutes, section 256B.441, subdivision 1,
516.14 paragraph (c), the commissioner shall begin
516.15 to phase in the new reimbursement system
516.16 for nursing facilities on or after October 1,
516.17 2009.

516.18 **Long-Term Care Consultation Funding**

516.19 **Increase.** For the rate year beginning
516.20 October 1, 2008, the county long-term
516.21 care consultation allocations in Minnesota
516.22 Statutes, section 256B.0911, subdivision
516.23 6, must be increased based on the number
516.24 of transitional long-term care consultation
516.25 visits projected by the commissioner in
516.26 each county. For the rate year beginning
516.27 October 1, 2009, final allocations must be
516.28 determined based on the average between
516.29 the actual number of transitional long-term
516.30 care visits that were conducted in the prior
516.31 12-month period and the projected number
516.32 of consultations that will be provided in
516.33 the rate year beginning October 1, 2009.
516.34 Notwithstanding section 13, this rider expires
516.35 June 30, 2010.

517.1 **Life Safety Code Compliance.** (1) Of the
517.2 general fund appropriation, \$1,000,000 in
517.3 fiscal year 2008 is for payments to nursing
517.4 facilities for life safety code compliance
517.5 under Minnesota Statutes, section 256B.434,
517.6 subdivision 4, paragraph (e). This is a
517.7 onetime appropriation and available until
517.8 spent.

517.9 (2) Of the general fund appropriation,
517.10 \$2,000,000 for the biennium beginning July
517.11 1, 2007, is for nursing facility rate adjustment
517.12 assistance grants for the commissioner of
517.13 human services to provide rate adjustment
517.14 to nursing facilities in a financial danger of
517.15 closing. This is a onetime appropriation and
517.16 shall not become part of the agency base.

517.17 **(d) Medical Assistance Grants - Long-Term**
517.18 **Care Waivers and Home Care Grants**

517.19	<u>General</u>	<u>966,623,000</u>	<u>1,099,540,000</u>

517.20 **(e) Mental Health Grants**

517.21	<u>Appropriations by Fund</u>		
517.22	<u>General</u>	<u>57,522,000</u>	<u>60,678,000</u>
517.23	<u>Health Care Access</u>	<u>750,000</u>	<u>750,000</u>
517.24	<u>Lottery Prize</u>	<u>1,733,000</u>	<u>1,633,000</u>

517.25 **Dual Diagnosis; Demonstration Project.**
517.26 Of the general fund appropriation, \$800,000
517.27 in fiscal year 2008 and \$1,600,000 in fiscal
517.28 year 2009 are to the commissioner of
517.29 human services to fund the dual diagnosis
517.30 demonstration project.

517.31 **Mobile Mental Health Crisis Services.** Of
517.32 the general fund appropriation, \$2,500,000
517.33 in fiscal year 2008 and \$3,625,000 in fiscal
517.34 year 2009 are to the commissioner of human
517.35 services for statewide funding of adult mobile

518.1 mental health crisis services. Providers must
518.2 utilize all available funding streams.

518.3 **National Council on Problem Gambling.**
518.4 (1) \$225,000 in fiscal year 2008 and \$225,000
518.5 in fiscal year 2009 are appropriated from
518.6 the lottery prize fund to the commissioner
518.7 of human services for a grant to the state
518.8 affiliate recognized by the National Council
518.9 on Problem Gambling. The affiliate must
518.10 provide services to increase public awareness
518.11 of problem gambling, education, and training
518.12 for individuals and organizations providing
518.13 effective treatment services to problem
518.14 gamblers and their families, and research
518.15 relating to problem gambling. These
518.16 services must be complementary to and not
518.17 duplicative of the services provided through
518.18 the problem gambling program administered
518.19 by the commissioner of human services. This
518.20 grant does not prevent the commissioner
518.21 from regular monitoring and oversight of the
518.22 grant or the ability to reallocate the funds to
518.23 other services within the problem gambling
518.24 program for nonperformance of duties by
518.25 the grantee.

518.26 (2) Of this appropriation, \$100,000 in
518.27 fiscal year 2008 and \$100,000 in fiscal year
518.28 2009 are contingent on the contribution
518.29 of nonstate matching funds. Matching
518.30 funds may be either cash or qualifying
518.31 in-kind contributions. The commissioner of
518.32 finance may disburse the state portion of the
518.33 matching funds in increments of \$25,000
518.34 upon receipt of a commitment for an equal
518.35 amount of matching nonstate funds. The

519.1 general fund base shall be \$100,000 in fiscal
519.2 year 2010 and \$100,000 in fiscal year 2011
519.3 (3) \$100,000 in fiscal year 2008 is
519.4 appropriated from the lottery prize fund to
519.5 the commissioner of human services for a
519.6 grant or grants to be awarded competitively
519.7 to develop programs and services for
519.8 problem gambling treatment, prevention,
519.9 and education in immigrant communities.
519.10 This appropriation is available until June
519.11 30, 2009, at which time the project must
519.12 be completed and final products delivered,
519.13 unless an earlier completion date is specified
519.14 in the work program.

519.15 **Compulsive Gambling.** \$300,000 in fiscal
519.16 year 2008 and \$100,000 in fiscal year 2009
519.17 are appropriated from the lottery prize fund
519.18 to the commissioner of human services for
519.19 purposes of compulsive gambling education,
519.20 assessment, and treatment under Minnesota
519.21 Statutes, section 245.98.

519.22 **Compulsive Gambling Study.** \$100,000
519.23 in fiscal year 2008 is to continue the
519.24 study currently being done on compulsive
519.25 gambling treatment effectiveness and
519.26 long-term effects of gambling.

519.27 **Base Adjustment.** The general fund base is
519.28 increased by \$266,000 in fiscal year 2010.

519.29 **(f) Deaf and Hard-of-Hearing Grants**

519.30	<u>General</u>	<u>1,932,000</u>	<u>2,380,000</u>

519.31 **Hearing Loss Mentors.** Of the general fund
519.32 appropriation, \$80,000 is to provide mentors
519.33 who have a hearing loss to parents of newly

520.1 identified infants and children with hearing
520.2 loss.

520.3 **Base Adjustment.** The general fund base
520.4 is increased by \$7,000 in fiscal year 2010
520.5 and \$7,000 in fiscal year 2011 for deaf and
520.6 hard-of-hearing grants.

520.7 **(g) Chemical Dependency Entitlement Grants**

520.8	<u>General</u>	<u>78,749,000</u>	<u>89,946,000</u>

520.9 **(h) Chemical Dependency Nonentitlement**
520.10 **Grants**

520.11	<u>General</u>	<u>1,055,000</u>	<u>1,055,000</u>

520.12 **(i) Other Continuing Care Grants**

520.13	<u>Appropriations by Fund</u>		
520.14	<u>General</u>	<u>23,668,000</u>	<u>20,169,000</u>

520.15 **Native American Juvenile Treatment**

520.16 **Center.** Of the general fund appropriation,
520.17 \$50,000 is to conduct a feasibility study
520.18 of and to predesign a Native American
520.19 juvenile treatment center on or near the
520.20 White Earth Reservation. The facility must
520.21 house and treat Native American juveniles
520.22 and provide culturally specific programming
520.23 to juveniles placed in the treatment center.
520.24 The commissioner of human services may
520.25 contract with parties who have experience
520.26 in the design and construction of juvenile
520.27 treatment centers to assist in the feasibility
520.28 study and predesign. On or before January
520.29 15, 2008, the commissioner shall present
520.30 the results of the feasibility study and the
520.31 predesign of the facility to the chairs of house
520.32 of representatives and senate committees
520.33 having jurisdiction over human services

521.1	<u>finance, public safety finance, and capital</u>		
521.2	<u>investment.</u>		
521.3	<u>Leech Lake Youth Treatment Center.</u> <u>Of</u>		
521.4	<u>the general fund appropriation, \$75,000 in</u>		
521.5	<u>fiscal year 2008 and \$75,000 in fiscal year</u>		
521.6	<u>2009 are for a grant to the Leech Lake Youth</u>		
521.7	<u>Treatment Center project partners, in order</u>		
521.8	<u>to pay the salaries and other directly related</u>		
521.9	<u>costs associated with the development of this</u>		
521.10	<u>project.</u>		
521.11	<u>Assistive Technology.</u> <u>Of the general fund</u>		
521.12	<u>appropriation, \$300,000 in fiscal year 2008 is</u>		
521.13	<u>to the Minnesota State Council on Disability</u>		
521.14	<u>for the purposes of providing \$100,000</u>		
521.15	<u>in financial support to the Minnesota</u>		
521.16	<u>Regions Assistive Technology Collaborative</u>		
521.17	<u>and \$200,000 in fiscal year 2008 is for</u>		
521.18	<u>a local match required to access the</u>		
521.19	<u>federal Technology-Related Assistance for</u>		
521.20	<u>Individuals with Disabilities Act, alternate</u>		
521.21	<u>finance project.</u>		
521.22	<u>Repayment.</u> <u>For the fiscal year ending June</u>		
521.23	<u>30, 2008, \$5,287,000 is appropriated to the</u>		
521.24	<u>commissioner of human services to repay</u>		
521.25	<u>the amount of overspending in the waiver</u>		
521.26	<u>program for persons with developmental</u>		
521.27	<u>disabilities incurred by affected counties in</u>		
521.28	<u>calendar years 2004 and 2005.</u>		
521.29	<u>Base Adjustment.</u> <u>The general fund base</u>		
521.30	<u>is \$20,276,000 in fiscal year 2010 and</u>		
521.31	<u>\$20,332,000 in fiscal year 2011 for other</u>		
521.32	<u>continuing care grants.</u>		
521.33	<u>Subd. 9. Continuing Care Management</u>	<u>20,248,000</u>	<u>19,400,000</u>

522.1	<u>Appropriations by Fund</u>		
522.2	<u>General</u>	<u>19,384,000</u>	<u>19,123,000</u>
522.3	<u>State Government</u>		
522.4	<u>Special Revenue</u>	<u>121,000</u>	<u>123,000</u>
522.5	<u>Health Care Access</u>	<u>292,000</u>	<u>-0-</u>
522.6	<u>Lottery Prize</u>	<u>451,000</u>	<u>154,000</u>

522.7 **Community Trainee and Consultation.**

522.8 Of the general fund appropriation, \$125,000

522.9 in fiscal year 2008 is to the commissioner

522.10 of human services to contract for training

522.11 and consultation for clinical supervisors and

522.12 staff of community mental health centers

522.13 who provide services to children and adults.

522.14 The purpose of the training and consultation

522.15 is to improve clinical supervision of

522.16 staff, strengthen compliance with federal

522.17 and state rules and regulations, and to

522.18 recommend strategies for standardization and

522.19 simplification of administrative functions

522.20 among community mental health centers.

522.21 **Mental Health Tracking System.** Of the

522.22 general fund appropriation, \$448,000 in fiscal

522.23 year 2008 and \$324,000 in fiscal year 2009

522.24 are to the commissioner of human services

522.25 to fund implementation of the mental health

522.26 services outcomes and tracking system.

522.27 **Quality Management; Assurance; and**

522.28 **Improvement System for Minnesotans**

522.29 **Receiving Disability Services.** Of the

522.30 general fund appropriation, up to \$300,000

522.31 for the biennium beginning July 1, 2007,

522.32 may be used for the purposes of the quality

522.33 management, assurance, and improvement

522.34 system for Minnesotans receiving disability

522.35 services. Federal Medicaid matching funds

523.1 obtained for this purpose shall be dedicated
523.2 to the commissioner for this purpose.

523.3 **Base Adjustment.** The health care access
523.4 fund base is \$0 in each of the fiscal years 2010
523.5 and 2011 for continuing care management.

523.6 **Disability Linkage Line.** Of the general
523.7 fund appropriation, \$650,000 in fiscal year
523.8 2008 and \$626,000 in fiscal year 2009 are to
523.9 establish and maintain the disability linkage
523.10 line.

523.11	<u>Subd. 10. State-Operated Services</u>	<u>266,645,000</u>	<u>267,718,000</u>
523.12	<u>General</u>	<u>266,645,000</u>	<u>267,718,000</u>

523.13 **Remembering With Dignity Project. (1)**
523.14 \$200,000 is appropriated from the general
523.15 fund to the commissioner of human services
523.16 to be available until September 30, 2008, to
523.17 make a grant to Advocating Change Together
523.18 for the purposes of the Remembering With
523.19 Dignity project in paragraph (2).

523.20 **(2) As part of the Remembering With Dignity**
523.21 **project, the grant recipient shall:**

523.22 **(i) conduct necessary research on persons**
523.23 **buried in state cemeteries who were residents**
523.24 **of state hospitals or regional treatment**
523.25 **centers and buried in numbered or unmarked**
523.26 **graves;**

523.27 **(ii) purchase and install headstones that are**
523.28 **properly inscribed with their names on the**
523.29 **graves of those persons; and**

523.30 **(iii) collaborate with community groups**
523.31 **and state and local government agencies to**
523.32 **build community involvement and public**
523.33 **awareness, ensure public access to the**

524.1 graves, and ensure appropriate perpetual
524.2 maintenance of state cemeteries.

524.3 (3) This rider is effective the day following
524.4 final enactment.

524.5 **Transfer Authority Related to**
524.6 **State-Operated Services. Money**
524.7 appropriated to finance state-operated
524.8 services programs and administrative
524.9 services may be transferred between fiscal
524.10 years of the biennium with the approval of
524.11 the commissioner of finance.

524.12 The amounts that may be spent from the
524.13 appropriation for each purpose are as follows:

524.14 **(a) Mental Health Services**

524.15	<u>General</u>	<u>116,270,000</u>	<u>120,095,000</u>

524.16 **Appropriation Limitation.** No part of
524.17 the appropriation in this article to the
524.18 commissioner for mental health treatment
524.19 services at the regional treatment centers
524.20 shall be used for the Minnesota sex offender
524.21 program.

524.22 **(b) Minnesota Sex Offender Services**

524.23	<u>General</u>	<u>67,719,000</u>	<u>62,787,000</u>

524.24 **(c) Minnesota Security Hospital and METO**
524.25 **Services**

524.26	<u>General</u>	<u>82,656,000</u>	<u>84,836,000</u>

524.27 **Minnesota Security Hospital.** For the
524.28 purposes of enhancing the safety of
524.29 the public, improving supervision, and
524.30 enhancing community-based mental health
524.31 treatment, state-operated services may
524.32 establish additional community capacity
524.33 for providing treatment and supervision

525.1 of clients who have been ordered into a
525.2 less restrictive alternative care from the
525.3 state-operated services transitional services
525.4 program consistent with Minnesota Statutes,
525.5 section 246.014.

525.6 Sec. 4. **COMMISSIONER OF HEALTH**

525.7	<u>Subdivision 1. Total Appropriation</u>	<u>\$ 176,686,000</u>	<u>\$ 165,689,000</u>

525.8 Appropriations by Fund

525.9		<u>2008</u>	<u>2009</u>
525.10	<u>General</u>	<u>98,737,000</u>	<u>92,829,000</u>
525.11	<u>State Government</u>		
525.12	<u>Special Revenue</u>	<u>39,851,000</u>	<u>40,642,000</u>
525.13	<u>Health Care Access</u>	<u>26,448,000</u>	<u>19,918,000</u>
525.14	<u>Federal TANF</u>	<u>11,350,000</u>	<u>12,000,000</u>
525.15	Environment	300,000	300,000

525.16 Subd. 2. Community and Family Health
525.17 Promotion

525.18 Appropriations by Fund

525.19	<u>General</u>	<u>59,881,000</u>	<u>59,978,000</u>
525.20	<u>State Government</u>		
525.21	<u>Special Revenue</u>	<u>468,000</u>	<u>471,000</u>
525.22	<u>Health Care Access</u>	<u>3,539,000</u>	<u>3,562,000</u>
525.23	<u>Federal TANF</u>	<u>8,667,000</u>	<u>9,002,000</u>

525.24 **TANF Appropriations.** (a) \$3,579,000 of
525.25 the TANF funds is appropriated in each year
525.26 of the biennium to the commissioner for
525.27 home visiting and nutritional services listed
525.28 under Minnesota Statutes, section 145.882,
525.29 subdivision 7, clauses (6) and (7). Funding
525.30 shall be distributed to community health
525.31 boards based on Minnesota Statutes, section
525.32 145A.131, subdivision 1.

525.33 (b) \$5,088,000 in the first year and \$5,423,000
525.34 in the second year are appropriated to the
525.35 commissioner of health for the family home
525.36 visiting grant program. The commissioner
525.37 shall distribute funds to community health

526.1 boards using a formula developed in
526.2 conjunction with the state Community
526.3 Health Services Advisory Committee. The
526.4 commissioner may use five percent of the
526.5 funds appropriated in each fiscal year to
526.6 conduct the ongoing evaluations required
526.7 under Minnesota Statutes, section 145A.17,
526.8 subdivision 7, and may use ten percent of
526.9 the funds appropriated each fiscal year to
526.10 provide training and technical assistance as
526.11 required under Minnesota Statutes, section
526.12 145A.17, subdivisions 4 and 5.

526.13 **TANF Carryforward.** Any unexpended
526.14 balance of the TANF appropriation in the
526.15 first year of the biennium does not cancel but
526.16 is available for the second year.

526.17 **Loan Forgiveness.** \$605,000 the first year
526.18 and \$775,000 the second year and thereafter
526.19 are for the loan forgiveness program under
526.20 Minnesota Statutes, section 144.1501. This
526.21 funding is in addition to the loan forgiveness
526.22 program base.

526.23 **MN ENABL.** Base level funding for the MN
526.24 ENABL program, under Minnesota Statutes,
526.25 section 145.9255, is reduced by \$220,000
526.26 each year of the biennium beginning July 1,
526.27 2007.

526.28 **Fetal Alcohol Spectrum Disorder.** (a)
526.29 \$900,000 each year is added to the base for
526.30 fetal alcohol spectrum disorder. On July 1
526.31 each fiscal year, the portion of the general
526.32 fund appropriation to the commissioner of
526.33 health for fetal alcohol spectrum disorder
526.34 administration and grants shall be transferred
526.35 to a statewide organization that focuses

527.1 solely on prevention of and intervention with
527.2 fetal alcohol spectrum disorder as follows:
527.3 (1) on July 1, 2007, \$2,090,000; and
527.4 (2) on July 2, 2008, and annually thereafter,
527.5 \$2,090,000.
527.6 (b) The money shall be used for prevention
527.7 and intervention services and programs,
527.8 including, but not limited to, community
527.9 grants, professional education, public
527.10 awareness, and diagnosis. The organization
527.11 may retain \$60,000 of the transferred money
527.12 for administrative costs. The organization
527.13 shall report to the commissioner annually
527.14 by January 15 on the services and programs
527.15 funded by the appropriation.
527.16 **Deaf or Hearing Loss Support. \$100,000**
527.17 for the first year and \$100,000 for the second
527.18 year is for the purpose of providing family
527.19 support and assistance to families with
527.20 children who are deaf or have a hearing
527.21 loss. The family support provided must
527.22 include direct parent-to-parent assistance and
527.23 information on communication, educational,
527.24 and medical options. The commissioner
527.25 may contract with a nonprofit organization
527.26 that has the ability to provide these services
527.27 throughout the state.
527.28 **Heart Disease and Stroke Prevention.**
527.29 \$200,000 is appropriated in the first year for
527.30 the heart disease and stroke prevention unit
527.31 of the Department of Health to fund data
527.32 collection and other activities to improve
527.33 cardiovascular health and reduce the burden
527.34 of heart disease and stroke in Minnesota.
527.35 This is a onetime appropriation.

528.1 **Family Planning Grants.** \$1,000,000 each
528.2 year is for family planning grants under
528.3 Minnesota Statutes, section 145.925. This
528.4 funding is in addition to the family planning
528.5 grants base funding.

528.6 **Bright Smiles Pilot Project.** (a) \$384,000
528.7 in the first year and \$50,000 in the second
528.8 year is to fund a grant for the Bright Smiles
528.9 pilot project.

528.10 (b) Of these amounts, \$50,000 each year is to
528.11 fund a dental health coordinator position at
528.12 the Minnesota Department of Health.

528.13 (c) The commissioner of health shall
528.14 establish a pilot project to fund a Bright
528.15 Smiles program designed to increase access
528.16 to oral health care for low-income and
528.17 immigrant children, ages birth to five
528.18 years, and their families and to build the
528.19 knowledge and ability of parents to care
528.20 for the oral health of their children. Under
528.21 this pilot project, a Bright Smiles program
528.22 shall serve the medically underserved areas
528.23 in Minneapolis and the Bemidji area, as
528.24 determined by the commissioner of health.

528.25 (d) A grant shall be used to fund costs related
528.26 to improving oral health outreach, education,
528.27 screening, and access to care for families
528.28 with children, ages birth to five years.

528.29 (e) Grant applicants shall submit to
528.30 the commissioner a written plan that
528.31 demonstrates the ability to provide the
528.32 following:

528.33 (1) new programs or continued expansion
528.34 of current access programs that have
528.35 demonstrated success in providing dental

529.1 services in underserved areas of Minneapolis
529.2 and the Bemidji area;

529.3 (2) programs for screening children entering
529.4 the Minneapolis and the Bemidji area public
529.5 school systems and facilitating access to care
529.6 for their families;

529.7 (3) programs testing new models of care
529.8 that are sensitive to cultural needs of the
529.9 recipients;

529.10 (4) programs creating new educational
529.11 campaigns that inform individuals of the
529.12 importance of good oral health and the
529.13 link between dental diseases, overall health
529.14 status, and success in school; and

529.15 (5) programs testing new delivery models
529.16 by creating partnerships between local early
529.17 childhood and school-age education and
529.18 community clinic dental providers.

529.19 (f) Qualified applicants are partnerships
529.20 among early childhood experts, Minneapolis
529.21 or Bemidji area public schools, and nonprofit
529.22 clinics that are established to provide health
529.23 services to low-income patients, provide
529.24 preventive and dental care services, and
529.25 utilize a sliding-scale fee or other method of
529.26 providing charity care that ensures that no
529.27 person is denied services because of inability
529.28 to pay.

529.29 (g) Applicants shall submit to the
529.30 commissioner an application and supporting
529.31 documentation, in the form and manner
529.32 specified by the commissioner. Applicants
529.33 must be able to provide culturally appropriate
529.34 outreach, screenings, and access to dental
529.35 care for children, ages birth to five years,

530.1 their parents, and pregnant women most at
530.2 risk of poor oral health due to lack of access
530.3 to dental care. Applicants must also meet the
530.4 following criteria:
530.5 (1) have the potential to successfully increase
530.6 access to families with children, ages birth
530.7 to five years;
530.8 (2) incorporate quality program evaluation;
530.9 (3) maximize use of grant funds; and
530.10 (4) have experience in providing services to
530.11 the target populations of this program.
530.12 (h) The commissioner shall evaluate the
530.13 effectiveness of this pilot program on the
530.14 oral health of children and their families and
530.15 report to the house of representatives and
530.16 senate committees with jurisdiction over
530.17 public health policy and finance by January
530.18 1, 2009, with recommendations as to how to
530.19 develop programs throughout Minnesota that
530.20 provide education and access to oral health
530.21 care for low-income and immigrant children.
530.22 **Suicide prevention programs. \$600,000**
530.23 each year is to fund the suicide prevention
530.24 program. The base for fiscal years 2010 and
530.25 2011 is reduced by \$300,000.
530.26 **Hearing Aid Loan Bank. Of the general**
530.27 fund appropriation, \$70,000 in fiscal year
530.28 2008 and \$70,000 in fiscal year 2009 are
530.29 for the purpose of providing a statewide
530.30 hearing aid and instrument loan bank to
530.31 families with children newly diagnosed with
530.32 hearing loss from birth to the age of ten. This
530.33 appropriation shall cover the administrative
530.34 costs of the program.

531.1	<u>Medical Home Learning Collaborative.</u>		
531.2	<u>Of the general fund appropriation, \$500,000</u>		
531.3	<u>in fiscal year 2008 and \$500,000 in fiscal</u>		
531.4	<u>year 2009 are to expand the medical</u>		
531.5	<u>home learning collaborative initiative in</u>		
531.6	<u>collaboration with the commissioner of</u>		
531.7	<u>human services. Services provided under this</u>		
531.8	<u>funding must support a medical home model</u>		
531.9	<u>for children with special health care needs.</u>		
531.10	<u>The collaborative shall report back to the</u>		
531.11	<u>legislature on use of the funds by January 15,</u>		
531.12	<u>2010. This appropriation shall not become</u>		
531.13	<u>part of the base funding for the 2010-2011</u>		
531.14	<u>biennium.</u>		
531.15	<u>Community Collaboratives.</u> <u>Of the general</u>		
531.16	<u>fund appropriation, \$330,000 in fiscal year</u>		
531.17	<u>2008 and \$850,000 in fiscal year 2009 are to</u>		
531.18	<u>provide grants to community collaboratives</u>		
531.19	<u>to cover the uninsured. These are onetime</u>		
531.20	<u>appropriations.</u>		
531.21	<u>Base Adjustment.</u> <u>General fund base is</u>		
531.22	<u>\$46,143,000 in each of fiscal years 2010 and</u>		
531.23	<u>2011.</u>		
531.24	<u>Subd. 3. Policy, Quality, and Compliance</u>	<u>51,209,000</u>	<u>45,590,000</u>
531.25	<u>Appropriations by Fund</u>		
531.26	<u>General</u>	<u>14,897,000</u>	<u>15,737,000</u>
531.27	<u>State Government</u>		
531.28	<u>Special Revenue</u>	<u>13,403,000</u>	<u>13,497,000</u>
531.29	<u>Health Care Access</u>	<u>22,909,000</u>	<u>16,356,000</u>
531.30	<u>Health Care Access Survey.</u> <u>Of the</u>		
531.31	<u>health care access fund appropriation,</u>		
531.32	<u>\$600,000 in fiscal year 2008 is appropriated</u>		
531.33	<u>to the commissioner to conduct a health</u>		
531.34	<u>insurance survey of Minnesota households,</u>		
531.35	<u>in partnership with the State Health Access</u>		
531.36	<u>Data Assistance Center at the University</u>		

532.1 of Minnesota. The commissioner shall
532.2 contract with the State Health Access Data
532.3 Assistance Center to conduct a survey that
532.4 provides information on the characteristics
532.5 of the uninsured in Minnesota and the
532.6 reasons for changing patterns of insurance
532.7 coverage and access to health care services.
532.8 This appropriation shall become part of the
532.9 agency's base budget for even-numbered
532.10 fiscal years.

532.11 **MERC.** Of the general fund appropriation,
532.12 \$8,000,000 each fiscal year is for distribution
532.13 of MERC grants as follows:

532.14 (1) \$5,000,000 according to Minnesota
532.15 Statutes, section 62J.692, subdivision 4,
532.16 paragraph (c);

532.17 (2) \$900,000 according to Minnesota
532.18 Statutes, section 62J.692, subdivision 4,
532.19 paragraph (d);

532.20 (3) \$100,000 according to Minnesota
532.21 Statutes, section 62J.692, subdivision 4,
532.22 paragraph (e); and

532.23 (4) \$2,000,000 according to Minnesota
532.24 Statutes, section 62J.692, subdivision 7a,
532.25 paragraph (b).

532.26 **Health Information Technology.** Of
532.27 the health care access fund appropriation,
532.28 \$6,750,000 each fiscal year is to implement
532.29 Minnesota Statutes, section 144.3345. Up
532.30 to \$350,000 each fiscal year is available for
532.31 grant administration and health information
532.32 technology technical assistance and
532.33 \$6,400,000 each year is to be transferred
532.34 to the commissioner of finance to establish
532.35 and implement a revolving account under

533.1 Minnesota Statutes, section 62J.496. This
533.2 appropriation shall not be included in the
533.3 agency's base budget for the fiscal year
533.4 beginning July 1, 2009.

533.5 **Health Insurance Exchange.** Of the health
533.6 care access fund appropriation, \$6,000,000
533.7 in fiscal year 2008 is appropriated to
533.8 the commissioner to establish the health
533.9 insurance exchange in Minnesota Statutes,
533.10 section 62A.76. Up to \$50,000 in fiscal year
533.11 2008 is available for administrative costs
533.12 incurred by the Department of Health in
533.13 establishing and providing grant funding to
533.14 the legal entity responsible for implementing
533.15 the health insurance exchange. This is a
533.16 onetime appropriation.

533.17 **Uncompensated Care Fund.** Of the general
533.18 fund appropriation, \$65,000 in fiscal year
533.19 2008 is for the commissioner of health to
533.20 study and present recommendations to the
533.21 governor and the legislature by January
533.22 15, 2008, on the design, operation, and
533.23 funding of an uncompensated care fund to
533.24 be used to provide subsidies to hospitals,
533.25 community clinics, federally qualified health
533.26 centers, community mental health centers,
533.27 and other health care providers that serve
533.28 a disproportionately large percentage of
533.29 uninsured patients. An organization must not
533.30 provide or perform abortion services under
533.31 this program.

533.32 **Uniform Electronic Transactions.** Of the
533.33 general fund appropriation, \$146,000 in fiscal
533.34 year 2008 is for development of uniform
533.35 electronic transactions and implementation

534.1 guide standards under Minnesota Statutes,
534.2 section 62J.536.
534.3 **Federally Qualified Health Centers.** Of the
534.4 general fund appropriation, \$3,000,000 in
534.5 fiscal year 2008 and \$3,900,000 in fiscal year
534.6 2009 are for subsidies to federally qualified
534.7 health centers under Minnesota Statutes,
534.8 section 145.9269.

534.9 **Base Adjustment.** The general fund base
534.10 is reduced \$500,000 in each of fiscal years
534.11 2010 and 2011. The health care access fund
534.12 base is \$3,456,000 in fiscal year 2010 and
534.13 \$2,856,000 in fiscal year 2011.

534.14 **Subd. 4. Health Protection**

534.15	<u>Appropriations by Fund</u>		
534.16	<u>General</u>	<u>20,544,000</u>	<u>13,900,000</u>
534.17	<u>State Government</u>		
534.18	<u>Special Revenue</u>	<u>25,980,000</u>	<u>26,674,000</u>
534.19	<u>Environment</u>	<u>300,000</u>	<u>300,000</u>

534.20 **Pandemic Influenza Preparedness.** Of
534.21 the general fund appropriation to the
534.22 commissioner, \$6,035,000 in fiscal year 2008
534.23 is for preparation, planning, and response
534.24 to a pandemic influenza outbreak. This
534.25 appropriation is available until June 30, 2009.
534.26 Base funding for the 2010-2011 biennium is
534.27 \$0 each fiscal year.

534.28 **Environmental Health Tracking and**
534.29 **Biomonitoring.** (a) \$500,000 in the first
534.30 year and \$900,000 in the second year are
534.31 for the environmental health tracking and
534.32 biomonitoring program. The base for fiscal
534.33 year 2010 and fiscal year 2011 is increased
534.34 by \$300,000 each year.

535.1 (b) \$300,000 each year is from the
535.2 environmental fund to the Pollution Control
535.3 Agency for transfer to the Department
535.4 of Health for the health tracking and
535.5 biomonitoring program. The base for the
535.6 environmental fund is \$0 in fiscal year 2010
535.7 and after.

535.8 **AIDS Prevention Initiative Focusing**
535.9 **on African-born Residents. \$300,000 in**
535.10 **2008 is for an AIDS prevention initiative**
535.11 **focusing on African-born residents. This**
535.12 **appropriation is a onetime appropriation**
535.13 **and shall not become part of the base-level**
535.14 **funding for the 2010-2011 biennium.**

535.15 The commissioner of health shall award
535.16 grants in accordance with Minnesota Statutes,
535.17 section 145.924, paragraph (b), for a public
535.18 education and awareness campaign targeting
535.19 communities of African-born Minnesota
535.20 residents. The grants shall be designed to
535.21 promote knowledge and understanding about
535.22 HIV and to increase knowledge in order
535.23 to eliminate and reduce the risk for HIV
535.24 infection; to encourage screening and testing
535.25 for HIV; and to link individuals to public
535.26 health and health care resources. The grants
535.27 must be awarded to collaborative efforts that
535.28 bring together nonprofit community-based
535.29 groups with demonstrated experience in
535.30 addressing the public health, health care,
535.31 and social service needs of African-born
535.32 communities.

535.33 **Arsenic Health Risk Standard. \$920,000 in**
535.34 **the first year and \$461,000 in the second year**
535.35 **is to fund the study relating to arsenic health**

536.1 risk standards, under Minnesota Statutes,
536.2 section 144.967. Of this amount, \$100,000
536.3 in 2008 is for a study relating to water supply
536.4 health risk limit standards under Minnesota
536.5 Statutes, section 103H.201. This is a onetime
536.6 appropriation.

536.7 **Lindane and Bisphenol-A Studies.**

536.8 \$114,000 in the first year is for the Lindane
536.9 committee and the study of bisphenol-A,
536.10 under Minnesota Statutes, section 145.958.
536.11 This is a onetime appropriation.

536.12 **Decabromodiphenyl Ether Study.**

536.13 \$118,000 in the first year is for transfer to the
536.14 commissioner of the pollution control agency
536.15 for the study of decabromodiphenyl ether
536.16 under Minnesota Statutes, section 325E.387.
536.17 This is a onetime appropriation.

536.18 **Radiation Study.** \$45,000 in the first year
536.19 from the general fund and \$15,000 in the
536.20 first year from the state government special
536.21 revenue fund are for the radiation study in
536.22 article 10, section 53. This is a onetime
536.23 appropriation.

536.24 **Lead Abatement.** \$925,000 in the first
536.25 year and \$950,000 in the second year are
536.26 for changes in lead abatement requirements.
536.27 Of this amount, \$6,000 in the first year and
536.28 \$11,000 in the second year are for transfer
536.29 to the commissioner of human services for
536.30 increased medical assistance costs. A portion
536.31 of this amount may be used to reimburse
536.32 local governments for costs of implementing
536.33 the new requirements.

536.34 **Water Treatment.** \$40,000 in fiscal year
536.35 2008 is to augment any appropriation from the

537.1 remediation fund to conduct an evaluation of
537.2 point of use water treatment units at removing
537.3 perfluorooctanoic acid, perfluorooctane
537.4 sulfonate, and perfluorobutanoic acid from
537.5 known concentrations of these compounds
537.6 in drinking water. The evaluation shall be
537.7 completed by December 31, 2007, and the
537.8 commissioner may contract for services to
537.9 complete the evaluation. This is a onetime
537.10 appropriation.

537.11 **Environmental Justice Mapping. \$137,000**
537.12 in the first year and \$53,000 in the second
537.13 year is for environmental justice mapping.

537.14 **HIV Information. \$80,000 each year**
537.15 is to fund a community-based nonprofit
537.16 organization with demonstrated capacity to
537.17 operate a statewide HIV information and
537.18 referral service using telephone, Internet, and
537.19 other appropriate technologies.

537.20 **Lead Hazard Reduction. \$250,000 is**
537.21 appropriated each year of the biennium for a
537.22 grant to a nonprofit organization operating
537.23 the CLEARCorps to conduct a pilot project
537.24 to determine the incidence of lead hazards in
537.25 pre-1978 rental property. Any balance in the
537.26 first year does not cancel but is available in
537.27 the second year.

537.28 **Minnesota Birth Defects Information**
537.29 **System. \$750,000 each year is to maintain**
537.30 the birth defects information system that was
537.31 established by Minnesota Statutes, section
537.32 144.2215.

537.33 **Subd. 5. Minority and Multicultural Health**

538.1	<u>Appropriations by Fund</u>		
538.2	<u>General</u>	<u>5,042,000</u>	<u>5,052,000</u>
538.3	<u>Federal TANF</u>	<u>2,683,000</u>	<u>2,998,000</u>

538.4 **TANF Appropriations.** (a) \$2,421,000 of
538.5 the TANF funds is appropriated in each year
538.6 of the biennium to the commissioner for
538.7 home visiting and nutritional services listed
538.8 under Minnesota Statutes, section 145.882,
538.9 subdivision 7, clauses (6) and (7). Funding
538.10 shall be distributed to tribal governments
538.11 based on Minnesota Statutes, section
538.12 145A.14, subdivision 2a, paragraph (b).
538.13 (b) \$262,000 in the first year and \$577,000
538.14 in the second year are appropriated
538.15 to the commissioner of health for the
538.16 family home visiting grant program. The
538.17 commissioner shall distribute funds to tribal
538.18 governments using a formula developed in
538.19 conjunction with tribal governments. The
538.20 commissioner may use five percent of the
538.21 funds appropriated in each fiscal year to
538.22 conduct the ongoing evaluations required
538.23 under Minnesota Statutes, section 145A.17,
538.24 subdivision 7, and may use ten percent of
538.25 the funds appropriated each fiscal year to
538.26 provide training and technical assistance as
538.27 required under Minnesota Statutes, section
538.28 145A.17, subdivisions 4 and 5.

538.29 **TANF Carryforward.** Any unexpended
538.30 balance of the TANF appropriation in the
538.31 first year of the biennium does not cancel but
538.32 is available for the second year.

538.33 **Subd. 6. Administrative Support Services**

538.34	<u>Appropriations by Fund</u>		
538.35	<u>General</u>	<u>11,047,000</u>	<u>11,197,000</u>

539.1 **Disease Surveillance.** \$2,000,000 each fiscal
539.2 year is for redesigning and implementing
539.3 coordinated and modern disease surveillance
539.4 systems for the department, and for ensuring
539.5 that occupational and residential histories
539.6 are included in the Minnesota Cancer
539.7 Surveillance database. Base level funding for
539.8 the 2012-2013 biennium will be \$600,000
539.9 each fiscal year for maintaining and operating
539.10 the systems.

539.11	Sec. 5. <u>VETERANS NURSING HOMES</u>			
539.12	<u>BOARD</u>	\$	<u>44,124,000</u>	\$ <u>46,244,000</u>

539.13 **Veterans Homes Special Revenue Account.**
539.14 The general fund appropriations made to
539.15 the board may be transferred to a veterans
539.16 homes special revenue account in the
539.17 special revenue fund in the same manner
539.18 as other receipts are deposited according to
539.19 Minnesota Statutes, section 198.34, and are
539.20 appropriated to the board for the operation of
539.21 board facilities and programs.

539.22 **Repair and Betterment.** Of this
539.23 appropriation, \$4,000,000 in fiscal year
539.24 2008 and \$4,000,000 in fiscal year 2009
539.25 are to be used for repair, maintenance,
539.26 rehabilitation, and betterment activities at
539.27 facilities statewide.

539.28 **Base Adjustment.** The general fund base is
539.29 decreased by \$2,000,000 in fiscal year 2010
539.30 and \$2,000,000 in fiscal year 2011.

539.31	Sec. 6. <u>HEALTH-RELATED BOARDS</u>			
539.32	Subdivision 1. <u>Total Appropriation; State</u>			
539.33	<u>Government Special Revenue Fund</u>	\$	<u>14,654,000</u>	\$ <u>14,527,000</u>

540.1	<u>The commissioner of finance shall not permit</u>		
540.2	<u>the allotment, encumbrance, or expenditure</u>		
540.3	<u>of money appropriated in this section in</u>		
540.4	<u>excess of the anticipated biennial revenues</u>		
540.5	<u>or accumulated surplus revenues from fees</u>		
540.6	<u>collected by the boards.</u>		
540.7	<u>Subd. 2. Board of Chiropractic Examiners</u>	<u>450,000</u>	<u>447,000</u>
540.8	<u>Subd. 3. Board of Dentistry</u>	<u>987,000</u>	<u>1,009,000</u>
540.9	<u>Subd. 4. Board of Dietetic and Nutrition</u>		
540.10	<u>Practice</u>	<u>103,000</u>	<u>119,000</u>
540.11	<u>Base Adjustment.</u> <u>Of this appropriation in</u>		
540.12	<u>fiscal year 2009, \$14,000 is onetime.</u>		
540.13	<u>Subd. 5. Board of Marriage and Family</u>		
540.14	<u>Therapy</u>	<u>134,000</u>	<u>154,000</u>
540.15	<u>Base Adjustment.</u> <u>Of this appropriation in</u>		
540.16	<u>fiscal year 2009, \$17,000 is onetime.</u>		
540.17	<u>Subd. 6. Board of Medical Practice</u>	<u>4,120,000</u>	<u>3,674,000</u>
540.18	<u>Subd. 7. Board of Nursing</u>	<u>3,985,000</u>	<u>4,146,000</u>
540.19	<u>Subd. 8. Board of Nursing Home</u>		
540.20	<u>Administrators</u>	<u>633,000</u>	<u>647,000</u>
540.21	<u>Administrative Services Unit.</u> <u>Of this</u>		
540.22	<u>appropriation, \$430,000 in fiscal year</u>		
540.23	<u>2008 and \$439,000 in fiscal year 2009 are</u>		
540.24	<u>for the administrative services unit. The</u>		
540.25	<u>administrative services unit may receive</u>		
540.26	<u>and expend reimbursements for services</u>		
540.27	<u>performed by other agencies.</u>		
540.28	<u>Subd. 9. Board of Optometry</u>	<u>98,000</u>	<u>114,000</u>
540.29	<u>Base Adjustment.</u> <u>Of this appropriation in</u>		
540.30	<u>fiscal year 2009, \$13,000 is onetime.</u>		
540.31	<u>Subd. 10. Board of Pharmacy</u>	<u>1,375,000</u>	<u>1,442,000</u>
540.32	<u>Base Adjustment.</u> <u>Of this appropriation in</u>		
540.33	<u>fiscal year 2009, \$29,000 is onetime.</u>		

541.1	Subd. 11. <u>Board of Physical Therapy</u>	<u>306,000</u>	<u>295,000</u>
541.2	Subd. 12. <u>Board of Podiatry</u>	<u>54,000</u>	<u>63,000</u>
541.3	<u>Base Adjustment.</u> Of this appropriation in		
541.4	fiscal year 2009, \$7,000 is onetime.		
541.5	Subd. 13. <u>Board of Psychology</u>	<u>788,000</u>	<u>806,000</u>
541.6	Subd. 14. <u>Board of Social Work</u>	<u>997,000</u>	<u>1,022,000</u>
541.7	Subd. 15. <u>Board of Veterinary Medicine</u>	<u>230,000</u>	<u>195,000</u>
541.8	Subd. 16. <u>Board of Behavioral Health and</u>		
541.9	<u>Therapy</u>	<u>394,000</u>	<u>394,000</u>
541.10	Sec. 7. <u>EMERGENCY MEDICAL SERVICES</u>		
541.11	<u>BOARD</u>	<u>\$ 4,617,000</u>	<u>\$ 4,645,000</u>
541.12	<u>Appropriations by Fund</u>		
541.13		<u>2008</u>	<u>2009</u>
541.14	<u>General</u>	<u>3,023,000</u>	<u>3,041,000</u>
541.15	<u>State Government</u>		
541.16	<u>Special Revenue</u>	<u>687,000</u>	<u>704,000</u>
541.17	<u>Regional Emergency Medical Services</u>		
541.18	<u>Programs.</u> \$400,000 each year is for		
541.19	<u>regional emergency medical services</u>		
541.20	<u>programs, to be distributed equally to the</u>		
541.21	<u>eight emergency medical service regions.</u>		
541.22	<u>This amount shall be added to the base</u>		
541.23	<u>funding. Notwithstanding Minnesota</u>		
541.24	<u>Statutes, section 144E.50, 100 percent of</u>		
541.25	<u>the appropriation shall be passed on to the</u>		
541.26	<u>emergency medical service regions.</u>		
541.27	<u>Health Professional Services Program.</u>		
541.28	<u>\$687,000 in fiscal year 2008 and \$704,000 in</u>		
541.29	<u>fiscal year 2009 from the state government</u>		
541.30	<u>special revenue fund are for the health</u>		
541.31	<u>professional services program.</u>		
541.32	Sec. 8. <u>COUNCIL ON DISABILITY</u>	<u>\$ 582,000</u>	<u>\$ 590,000</u>

542.1 **Options Too.** (a) \$75,000 for the first
542.2 year and \$75,000 for the second year are
542.3 to continue the work of the Options Too
542.4 disability services interagency work group
542.5 established under Laws 2005, First Special
542.6 Session chapter 4, article 7, section 57.
542.7 Funds shall be used to monitor and assist the
542.8 work group and the Options Too Steering
542.9 Committee in the implementation of the
542.10 recommendations in the Options Too report
542.11 dated February 15, 2007.

542.12 (b) For purposes of this section, the Options
542.13 Too Steering Committee shall consist of the
542.14 following members:

542.15 (1) a representative from the Minnesota
542.16 Housing Finance Agency;

542.17 (2) a representative from the Minnesota State
542.18 Council on Disability;

542.19 (3) a representative from the Department of
542.20 Veterans Affairs;

542.21 (4) a representative from the Department of
542.22 Transportation;

542.23 (5) a representative from the Department of
542.24 Human Services; and

542.25 (6) representatives from interested
542.26 stakeholders including counties, local
542.27 public housing authorities, the Metropolitan
542.28 Council, disability service providers, and
542.29 disability advocacy organizations who are
542.30 appointed by the Minnesota State Council on
542.31 Disability for two-year terms.

542.32 (c) Notwithstanding Laws 2005, First Special
542.33 Session chapter 4, article 7, section 57, the
542.34 interagency work group shall be administered

543.1 by the Minnesota Housing Finance Agency,
543.2 the Minnesota State Council on Disability,
543.3 Department of Human Services, and the
543.4 Department of Transportation.

543.5 (d) The Options Too Steering Committee
543.6 shall report to the chairs of the health
543.7 and human services policy and finance
543.8 committees of the senate and house of
543.9 representatives by October 15, 2007, and
543.10 October 15, 2008, on the continued progress
543.11 of the work group towards implementing the
543.12 recommendations in the Options Too report
543.13 dated February 15, 2007.

543.14	Sec. 9. <u>OMBUDSMAN FOR MENTAL</u>			
543.15	<u>HEALTH AND DEVELOPMENTAL</u>			
543.16	<u>DISABILITIES</u>	\$	<u>1,567,000</u>	\$ <u>1,621,000</u>

543.17	Sec. 10. <u>OMBUDSMAN FOR FAMILIES</u>	\$	<u>251,000</u>	\$ <u>257,000</u>

543.18 Sec. 11. TRANSFERS.

543.19 Subdivision 1. Grants. The commissioner of human services, with the approval
543.20 of the commissioner of finance and after notifying the chairs of the senate and house
543.21 committees with jurisdiction, may transfer unencumbered appropriation balances for the
543.22 biennium ending June 30, 2009, within fiscal years among the MFIP; general assistance;
543.23 general assistance medical care; medical assistance; MFIP child care assistance under
543.24 Minnesota Statutes, section 119B.05; Minnesota supplemental aid and group residential
543.25 housing programs; and the entitlement portion of the chemical dependency consolidated
543.26 treatment fund and between fiscal years of the biennium.

543.27 Subd. 2. Administration. Positions, salary money, and nonsalary administrative
543.28 money may be transferred within the Departments of Human Services and Health and
543.29 within the programs operated by the Veterans Nursing Homes Board as the commissioners
543.30 and the board consider necessary, with the advance approval of the commissioner of
543.31 finance. The commissioner or the board shall inform the chairs of the house and senate
543.32 committees with jurisdiction quarterly about transfers made under this provision.

543.33 Sec. 12. INDIRECT COSTS NOT TO FUND PROGRAMS.

544.1 The commissioners of health and of human services shall not use indirect cost
544.2 allocations to pay for the operational costs of any program for which they are responsible.

544.3 Sec. 13. **SUNSET OF UNCODIFIED LANGUAGE.**

544.4 All uncodified language contained in this article expires on June 30, 2009, unless a
544.5 different expiration date is explicit.

544.6 Sec. 14. **EFFECTIVE DATE.**

544.7 The provisions in this article are effective July 1, 2007, unless a different effective
544.8 date is specified.

APPENDIX
Article locations in ues2171-4

ARTICLE 1	CHILDREN AND FAMILY	Page.Ln 3.10
ARTICLE 2	LICENSING	Page.Ln 116.5
ARTICLE 3	HEALTH CARE	Page.Ln 141.17
ARTICLE 4	CONTINUING CARE	Page.Ln 173.15
ARTICLE 5	MENTAL HEALTH	Page.Ln 271.28
ARTICLE 6	DEPARTMENT OF HEALTH	Page.Ln 292.17
ARTICLE 7	MISCELLANEOUS	Page.Ln 332.15
ARTICLE 8	CHILDREN'S HEALTH SECURITY PROGRAM	Page.Ln 388.1
ARTICLE 9	HEALTH CARE REFORM	Page.Ln 397.28
ARTICLE 10	PUBLIC HEALTH	Page.Ln 434.26
ARTICLE 11	HUMAN SERVICES FORECAST ADJUSTMENTS	Page.Ln 483.26
ARTICLE 12	HUMAN SERVICES APPROPRIATIONS	Page.Ln 485.25