

amendment or repealer consistent with the recodification of the affected section by Laws 2005, chapter 151, article 1. In addition, the revisor shall code new sections or subdivisions enacted during the 2005 First Special Session consistent with the recodification of Laws 2005, chapter 151, article 1.

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 14. EFFECTIVE DATE; RELATIONSHIP TO OTHER APPROPRIATIONS.

Appropriations in this act are effective retroactively from July 1, 2005, and supersede and replace funding authorized by order of the Ramsey County District Court in Case No. C9-05-5928, as well as by Laws 2005, First Special Session chapter 2, which provided temporary funding through July 14, 2005.

Presented to the governor July 13, 2005

Signed by the governor July 13, 2005, 9:33 p.m.

CHAPTER 4—H.F.No. 139

An act relating to the operation of state government; making changes to health and human services programs; modifying human services policy; modifying health policy; changing licensing provisions; changing provisions for mental and chemical health; establishing treatment foster care and transitional youth intensive rehab mental health services; enhancing family support; providing training for child care providers and hospitals on dangers of shaking infants and children; establishing long-term homeless supportive services; establishing the tobacco health impact fee; establishing a cancer drug repository program; establishing a health information technology and infrastructure advisory committee and a rural pharmacy planning and transition grant program; establishing a statewide trauma system and trauma registry; changing long-term care provisions and establishing a partnership; establishing a nursing facility reimbursement system; modifying health care programs; changing certain fees; appropriating money; amending Minnesota Statutes 2004, sections 13.46, subdivision 4, as amended; 16A.724; 62J.692, subdivision 3, as amended; 62Q.251, as added; 62Q.37, subdivision 7; 103I.101, subdivision 6; 103I.208, subdivisions 1, as amended, 2, as amended; 103I.235, subdivision 1; 103I.601, subdivision 2; 119B.13, subdivision 1, by adding a subdivision; 144.122, as amended; 144.147, subdivisions 1, 2; 144.148, subdivision 1; 144.1483; 144.1501, subdivisions 1, 2, 3, 4; 144.226, subdivisions 1, as amended, 4, as amended, by adding subdivisions; 144.3831, subdivision 1; 144.551, subdivision 1; 144.562, subdivision 2; 144.9504, subdivision 2; 144.98, subdivision 3; 144A.073, subdivision 10, by adding a subdivision; 144E.101, by adding a subdivision; 145.4242; 145.56, subdivisions 2, 5; 145.9268; 147A.08; 148D.220, subdivision 8, as added; 150A.22; 157.011, by adding a subdivision; 157.15, by adding a subdivision; 157.16, subdivisions 2, 3, by adding subdivisions; 157.20, subdivisions 2, 2a; 241.01, by adding a subdivision; 243.166, subdivisions 4b, as added, 7, as amended; 245.4661, subdivisions 2, 6, by adding a subdivision; 245.4874, as amended; 245.4885, subdivisions 1, 2, by adding a subdivision; 245A.02, subdivision 17; 245A.03, subdivisions 2, 3; 245A.035, subdivisions 1, 5; 245A.04, subdivisions 7,

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13; 245A.06, by adding a subdivision; 245A.07, subdivisions 1, 3, by adding a subdivision; 245A.08, subdivisions 2a, 5; 245A.10, subdivisions 4, 5; 245A.14, by adding subdivisions; 245A.144; 245A.16, subdivisions 1, 4; 245A.18; 245B.02, subdivision 10; 245B.055, subdivision 7; 245B.07, subdivision 8; 245C.03, subdivision 1; 245C.07; 245C.08, subdivisions 1, 2; 245C.10, subdivisions 2, 3; 245C.15, subdivisions 1, as amended, 2, 3, 4; 245C.21, subdivision 2; 245C.22, subdivisions 3, 4, 7, as added; 245C.23, subdivision 1; 245C.24, subdivisions 2, as amended, 3; 245C.27, subdivision 1; 245C.28, subdivision 3; 245C.30, subdivisions 1, 2; 245C.32, subdivision 2; 246.0136, subdivision 1; 246.13, as amended; 252.27, subdivision 2a; 253.20; 254A.035, subdivision 2; 254A.04; 256.01, subdivision 2, by adding subdivisions; 256.019, subdivision 1; 256.045, subdivisions 3, as amended, 3a; 256.046, subdivision 1; 256.741, subdivision 4; 256.9657, by adding a subdivision; 256.969, subdivisions 3a, 9, 26, by adding a subdivision; 256.975, subdivision 9; 256B.02, subdivision 12; 256B.04, by adding a subdivision; 256B.055, by adding a subdivision; 256B.056, subdivisions 5, 5a, 5b, 7, by adding subdivisions; 256B.057, subdivision 9; 256B.0575; 256B.06, subdivision 4; 256B.0621, subdivisions 2, 3, 4, 5, 6, 7, by adding a subdivision; 256B.0622, subdivision 2; 256B.0625, subdivisions 2, 3a, 9, 13, 13a, 13c, 13d, 13e, as amended, 13f, as amended, 17, 19c, by adding subdivisions; 256B.0627, subdivisions 1, as amended, 4, 5, as amended, 9, by adding a subdivision; 256B.0631, subdivisions 1, 3; 256B.075, subdivision 2; 256B.0911, subdivision 1a; 256B.0913, subdivisions 2, 4, 5, 5a; 256B.0916, by adding a subdivision; 256B.0924, subdivision 3; 256B.093, subdivision 1; 256B.0943, subdivision 3; 256B.095; 256B.0951, subdivision 1; 256B.0952, subdivision 5; 256B.0953, subdivision 1; 256B.15, subdivisions 1, 4, by adding subdivisions; 256B.19, subdivisions 1, 1c; 256B.195, subdivision 3; 256B.431, by adding subdivisions; 256B.432, subdivisions 1, 2, 5, by adding subdivisions; 256B.434, subdivisions 3, 4, by adding a subdivision; 256B.49, subdivision 16; 256B.5012, by adding a subdivision; 256B.69, subdivisions 4, 23; 256D.03, subdivisions 3, as amended, 4; 256D.045; 256D.06, subdivisions 5, 7; 256D.44, subdivision 5; 256I.05, subdivision 1e; 256I.06, by adding a subdivision; 256J.37, subdivision 3b; 256J.515; 256L.01, subdivisions 4, 5; 256L.03, subdivisions 1, 1b, 5; 256L.035; 256L.04, subdivision 2, by adding subdivisions; 256L.05, subdivisions 2, 3, 3a, by adding a subdivision; 256L.06, subdivision 3; 256L.07, subdivisions 1, as amended, 3, by adding subdivisions; 256L.12, by adding a subdivision; 256L.15, subdivisions 2, as amended, 3, by adding a subdivision; 256L.17, by adding a subdivision; 256M.40, subdivision 2; 260.835; 260B.163, subdivision 6; 260C.163, subdivision 5; 295.582, as amended; 297F.185; 299C.093, as amended; 325D.32, subdivision 9; 326.42, subdivision 2; 471.61, by adding a subdivision; 514.981, subdivision 6; 518.165, by adding subdivisions; 549.02, by adding a subdivision; 549.04; 609A.03, subdivision 7, as amended; 626.556, subdivision 10i, as amended; 626.557, subdivisions 9d, 14, as amended; 641.15, subdivision 2; Laws 2003, First Special Session chapter 14, article 12, section 93; Laws 2003, First Special Session chapter 14, article 13C, section 2, subdivision 6; Laws 2005, chapter 107, article 1, section 6; Laws 2005, chapter 159, article 1, section 14; proposing coding for new law in Minnesota Statutes, chapters 16A; 62J; 144; 145; 151; 245A; 245C; 256; 256B; 256K; 641; repealing Minnesota Statutes 2004, sections 119B.074, as amended; 144.1486; 144.1502; 157.215; 256.955; 256B.075, subdivision 5; 256D.54, subdivision 3; 256L.04, subdivision 11; 256M.40, subdivision 2; 514.991; 514.992; 514.993; 514.994; 514.995; Laws 2003, First Special Session chapter 14, article 9, section 34; Laws 2005, chapter 107, article 2, section 51.

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

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ARTICLE 1

LICENSING PROVISIONS

Section 1. Minnesota Statutes 2004, section 13.46, subdivision 4, as amended by Laws 2005, chapter 163, section 40, is amended to read:

Subd. 4. **LICENSING DATA.** (a) As used in this subdivision:

(1) "licensing data" means all data collected, maintained, used, or disseminated by the welfare system pertaining to persons licensed or registered or who apply for licensure or registration or who formerly were licensed or registered under the authority of the commissioner of human services;

(2) "client" means a person who is receiving services from a licensee or from an applicant for licensure; and

(3) "personal and personal financial data" means Social Security numbers, identity of and letters of reference, insurance information, reports from the Bureau of Criminal Apprehension, health examination reports, and social/home studies.

(b)(1) Except as provided in paragraph (c), the following data on current and former licensees are public: name, address, telephone number of licensees, date of receipt of a completed application, dates of licensure, licensed capacity, type of client preferred, variances granted, record of training and education in child care and child development, type of dwelling, name and relationship of other family members, previous license history, class of license, the existence and status of complaints, and the number of serious injuries to or deaths of individuals in the licensed program as reported to the commissioner of human services, the local social services agency, or any other county welfare agency. For purposes of this clause, a serious injury is one that is treated by a physician. When a correction order or fine has been issued, a license is suspended, immediately suspended, revoked, denied, or made conditional, or a complaint is resolved, the following data on current and former licensees are public: the substance and investigative findings of the licensing or maltreatment complaint, licensing violation, or substantiated maltreatment; the record of informal resolution of a licensing violation; orders of hearing; findings of fact; conclusions of law; specifications of the final correction order, fine, suspension, immediate suspension, revocation, denial, or conditional license contained in the record of licensing action; and the status of any appeal of these actions.

(2) Notwithstanding sections 626.556, subdivision 11, and 626.557, subdivision 12b, when any person subject to disqualification under section 245C.14 in connection with a license to provide family day care for children, child care center services, foster care for children in the provider's home, or foster care or day care services for adults in the provider's home is a substantiated perpetrator of maltreatment, and the substantiated maltreatment is a reason for a licensing action, the identity of the substantiated perpetrator of maltreatment is public data. For purposes of this clause, a

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person is a substantiated perpetrator if the maltreatment determination has been upheld under section 256.045; 626.556, subdivision 10i; 626.557, subdivision 9d; or chapter 14, or if an individual or facility has not timely exercised appeal rights under these sections.

(3) For applicants who withdraw their application prior to licensure or denial of a license, the following data are public: the name of the applicant, the city and county in which the applicant was seeking licensure, the dates of the commissioner's receipt of the initial application and completed application, the type of license sought, and the date of withdrawal of the application.

(4) For applicants who are denied a license, the following data are public: the name of the applicant, the city and county in which the applicant was seeking licensure, the dates of the commissioner's receipt of the initial application and completed application, the type of license sought, the date of denial of the application, the nature of the basis for the denial, and the status of any appeal of the denial.

(5) The following data on persons subject to disqualification under section 245C.14 in connection with a license to provide family day care for children, child care center services, foster care for children in the provider's home, or foster care or day care services for adults in the provider's home, are public: the nature of any disqualification set aside under section 245C.22, subdivisions 2 and 4, and the reasons for setting aside the disqualification; the nature of any disqualification for which a variance was granted under sections 245A.04, subdivision 9; and 245C.30, and the reasons for granting any variance under section 245A.04, subdivision 9; and, if applicable, the disclosure that any person subject to a background study under section 245C.03, subdivision 1, has successfully passed a background study.

(6) When maltreatment is substantiated under section 626.556 or 626.557 and the victim and the substantiated perpetrator are affiliated with a program licensed under chapter 245A, the commissioner of human services, local social services agency, or county welfare agency may inform the license holder where the maltreatment occurred of the identity of the substantiated perpetrator and the victim.

(c) The following are private data on individuals under section 13.02, subdivision 12, or nonpublic data under section 13.02, subdivision 9: personal and personal financial data on family day care program and family foster care program applicants and licensees and their family members who provide services under the license.

(d) The following are private data on individuals: the identity of persons who have made reports concerning licensees or applicants that appear in inactive investigative data, and the records of clients or employees of the licensee or applicant for licensure whose records are received by the licensing agency for purposes of review or in anticipation of a contested matter. The names of reporters under sections 626.556 and 626.557 may be disclosed only as provided in section 626.556, subdivision 11, or 626.557, subdivision 12b.

(e) Data classified as private, confidential, nonpublic, or protected nonpublic under this subdivision become public data if submitted to a court or administrative law

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judge as part of a disciplinary proceeding in which there is a public hearing concerning a license which has been suspended, immediately suspended, revoked, or denied.

(f) Data generated in the course of licensing investigations that relate to an alleged violation of law are investigative data under subdivision 3.

(g) Data that are not public data collected, maintained, used, or disseminated under this subdivision that relate to or are derived from a report as defined in section 626.556, subdivision 2, or 626.5572, subdivision 18, are subject to the destruction provisions of sections 626.556, subdivision 11c, and 626.557, subdivision 12b.

(h) Upon request, not public data collected, maintained, used, or disseminated under this subdivision that relate to or are derived from a report of substantiated maltreatment as defined in section 626.556 or 626.557 may be exchanged with the Department of Health for purposes of completing background studies pursuant to section 144.057 and with the Department of Corrections for purposes of completing background studies pursuant to section 241.021.

(i) Data on individuals collected according to licensing activities under chapters 245A and 245C, and data on individuals collected by the commissioner of human services according to maltreatment investigations under sections 626.556 and 626.557, may be shared with the Department of Human Rights, the Department of Health, the Department of Corrections, the Ombudsman for Mental Health and Retardation, and the individual's professional regulatory board when there is reason to believe that laws or standards under the jurisdiction of those agencies may have been violated.

(j) In addition to the notice of determinations required under section 626.556, subdivision 10f, if the commissioner or the local social services agency has determined that an individual is a substantiated perpetrator of maltreatment of a child based on sexual abuse, as defined in section 626.556, subdivision 2, and the commissioner or local social services agency knows that the individual is a person responsible for a child's care in another facility, the commissioner or local social services agency shall notify the head of that facility of this determination. The notification must include an explanation of the individual's available appeal rights and the status of any appeal. If a notice is given under this paragraph, the government entity making the notification shall provide a copy of the notice to the individual who is the subject of the notice.

(k) All not public data collected, maintained, used, or disseminated under this subdivision and subdivision 3 may be exchanged between the Department of Human Services, Licensing Division, and the Department of Corrections for purposes of regulating services for which the Department of Human Services and the Department of Corrections have regulatory authority.

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

Sec. 2. Minnesota Statutes 2004, section 243.166, subdivision 4b, as added by Laws 2005, chapter 136, article 3, section 8, is amended to read:

Subd. 4b. **HEALTH CARE FACILITY; NOTICE OF STATUS.** (a) As used in paragraphs (b) and (c), For the purposes of this subdivision, "health care facility"

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means a hospital or other entity licensed under sections 144.50 to 144.58, a nursing home licensed to serve adults under section 144A.02, or a group residential housing facility or an intermediate care facility for the mentally retarded licensed under chapter 245A. As used in paragraph (d), "health care facility" means a nursing home licensed to serve adults under section 144A.02, or a group residential housing facility or an intermediate care facility for the mentally retarded licensed under chapter 245A facility licensed by:

(1) the commissioner of health as a hospital, boarding care home or supervised living facility under sections 144.50 to 144.58, or a nursing home under chapter 144A;
or

(2) the commissioner of human services as a residential facility under chapter 245A to provide adult foster care, adult mental health treatment, chemical dependency treatment to adults, or residential services to persons with developmental disabilities.

(b) Upon admittance to a health care facility, a person required to register under this section shall disclose to:

(1) the health care facility employee processing the admission the person's status as a registered predatory offender under this section; and

(2) the person's corrections agent, or if the person does not have an assigned corrections agent, the law enforcement authority with whom the person is currently required to register, that inpatient admission has occurred.

(c) A law enforcement authority or corrections agent who receives notice under paragraph (b) or who knows that a person required to register under this section has been admitted and is receiving health care at a health care facility shall notify the administrator of the facility.

(d) Except for a hospital licensed under sections 144.50 to 144.58, a health care facility that receives notice under this subdivision that a predatory offender has been admitted to the facility shall notify other patients residents at the facility of this fact. If the facility determines that notice to a patient resident is not appropriate given the patient's resident's medical, emotional, or mental status, the facility shall notify the patient's next of kin or emergency contact.

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

Sec. 3. Minnesota Statutes 2004, section 243.166, subdivision 7, as amended by Laws 2005, chapter 136, article 5, section 1, is amended to read:

Subd. 7. **USE OF DATA.** Except as otherwise provided in subdivision 7a or sections 244.052 and 299C.093, the data provided under this section is private data on individuals under section 13.02, subdivision 12. The data may be used only for law enforcement and corrections purposes. State-operated services, as defined in section 246.014, are also authorized to have access to the data for the purposes described in section 246.13, subdivision 2, paragraph (e) (b).

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

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Sec. 4. Minnesota Statutes 2004, section 245A.02, subdivision 17, is amended to read:

Subd. 17. **SCHOOL AGE CHILD CARE PROGRAM.** "School age child care program" means a program licensed or required to be licensed as a child care center, serving more than ten children with the primary purpose of providing child care for school age children. ~~School age child care program does not include programs such as scouting, boys clubs, girls clubs, nor sports or art programs.~~

Sec. 5. Minnesota Statutes 2004, section 245A.03, subdivision 2, is amended to read:

Subd. 2. **EXCLUSION FROM LICENSURE.** (a) This chapter does not apply to:

(1) residential or nonresidential programs that are provided to a person by an individual who is related unless the residential program is a child foster care placement made by a local social services agency or a licensed child-placing agency, except as provided in subdivision 2a;

(2) nonresidential programs that are provided by an unrelated individual to persons from a single related family;

(3) residential or nonresidential programs that are provided to adults who do not abuse chemicals or who do not have a chemical dependency, a mental illness, mental retardation or a related condition, a functional impairment, or a physical handicap;

(4) sheltered workshops or work activity programs that are certified by the commissioner of economic security;

(5) programs operated by a public school for children 33 months or older;

(6) nonresidential programs primarily for children that provide care or supervision for periods of less than three hours a day while the child's parent or legal guardian is in the same building as the nonresidential program or present within another building that is directly contiguous to the building in which the nonresidential program is located;

(7) nursing homes or hospitals licensed by the commissioner of health except as specified under section 245A.02;

(8) board and lodge facilities licensed by the commissioner of health that provide services for five or more persons whose primary diagnosis is mental illness that do not provide intensive residential treatment;

(9) homes providing programs for persons placed there by a licensed agency for legal adoption, unless the adoption is not completed within two years;

(10) programs licensed by the commissioner of corrections;

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(11) recreation programs for children or adults that are operated or approved by a park and recreation board whose primary purpose is to provide social and recreational activities;

(12) programs operated by a school as defined in section 120A.22, subdivision 4, whose primary purpose is to provide child care to school-age children;

(13) Head Start nonresidential programs which operate for less than ~~31~~ 45 days in each calendar year;

(14) noncertified boarding care homes unless they provide services for five or more persons whose primary diagnosis is mental illness or mental retardation;

(15) programs for children such as scouting, boys clubs, girls clubs, and sports and art programs, and nonresidential programs for children provided for a cumulative total of less than 30 days in any 12-month period;

(16) residential programs for persons with mental illness, that are located in hospitals;

(17) the religious instruction of school-age children; Sabbath or Sunday schools; or the congregate care of children by a church, congregation, or religious society during the period used by the church, congregation, or religious society for its regular worship;

(18) camps licensed by the commissioner of health under Minnesota Rules, chapter 4630;

(19) mental health outpatient services for adults with mental illness or children with emotional disturbance;

(20) residential programs serving school-age children whose sole purpose is cultural or educational exchange, until the commissioner adopts appropriate rules;

(21) unrelated individuals who provide out-of-home respite care services to persons with mental retardation or related conditions from a single related family for no more than 90 days in a 12-month period and the respite care services are for the temporary relief of the person's family or legal representative;

(22) respite care services provided as a home and community-based service to a person with mental retardation or a related condition, in the person's primary residence;

(23) community support services programs as defined in section 245.462, subdivision 6, and family community support services as defined in section 245.4871, subdivision 17;

(24) the placement of a child by a birth parent or legal guardian in a preadoptive home for purposes of adoption as authorized by section 259.47;

(25) settings registered under chapter 144D which provide home care services licensed by the commissioner of health to fewer than seven adults; or

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(26) consumer-directed community support service funded under the Medicaid waiver for persons with mental retardation and related conditions when the individual who provided the service is:

(i) the same individual who is the direct payee of these specific waiver funds or paid by a fiscal agent, fiscal intermediary, or employer of record; and

(ii) not otherwise under the control of a residential or nonresidential program that is required to be licensed under this chapter when providing the service.

(b) For purposes of paragraph (a), clause (6), a building is directly contiguous to a building in which a nonresidential program is located if it shares a common wall with the building in which the nonresidential program is located or is attached to that building by skyway, tunnel, atrium, or common roof.

(c) Nothing in this chapter shall be construed to require licensure for any services provided and funded according to an approved federal waiver plan where licensure is specifically identified as not being a condition for the services and funding.

Sec. 6. Minnesota Statutes 2004, section 245A.03, subdivision 3, is amended to read:

Subd. 3. **UNLICENSED PROGRAMS.** (a) It is a misdemeanor for an individual, corporation, partnership, voluntary association, other organization, or a controlling individual to provide a residential or nonresidential program without a license and in willful disregard of this chapter unless the program is excluded from licensure under subdivision 2.

(b) The commissioner may ask the appropriate county attorney or the attorney general to begin proceedings to secure a court order against the continued operation of the program, if an individual, corporation, partnership, voluntary association, other organization, or controlling individual has:

(1) failed to apply for a license after receiving notice that a license is required or continues to operate without a license after receiving notice that a license is required;

(2) continued to operate without a license after the license has been revoked or suspended under section 245A.07, and the commissioner has issued a final order affirming the revocation or suspension, or the license holder did not timely appeal the sanction; or

(3) continued to operate without a license after the license has been temporarily suspended under section 245A.07.

The county attorney and the attorney general have a duty to cooperate with the commissioner.

Sec. 7. Minnesota Statutes 2004, section 245A.035, subdivision 1, is amended to read:

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Subdivision 1. **GRANT OF EMERGENCY LICENSE.** Notwithstanding section 245A.03, subdivision 2a, or 245C.13, subdivision 2, a county agency may place a child for foster care with a relative who is not licensed to provide foster care, provided the requirements of subdivision 2 are met. As used in this section, the term "relative" has the meaning given it under section 260C.007, subdivision 27.

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

Sec. 8. Minnesota Statutes 2004, section 245A.035, subdivision 5, is amended to read:

Subd. 5. **CHILD FOSTER CARE LICENSE APPLICATION.** (a) The emergency license holder 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 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 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 set aside a licensing disqualifier under section 245C.22, or to grant a variance of licensing requirements under sections 245C.21 to 245C.27.

(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 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.

Sec. 9. Minnesota Statutes 2004, section 245A.04, subdivision 7, is amended to read:

Subd. 7. **ISSUANCE OF A LICENSE; EXTENSION OF A LICENSE.** (a) If the commissioner determines that the program complies with all applicable rules and laws, the commissioner shall issue a license. At minimum, the license shall state:

- (1) the name of the license holder;
- (2) the address of the program;
- (3) the effective date and expiration date of the license;

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(4) the type of license;

(5) the maximum number and ages of persons that may receive services from the program; and

(6) any special conditions of licensure.

(b) The commissioner may issue an initial license for a period not to exceed two years if:

(1) the commissioner is unable to conduct the evaluation or observation required by subdivision 4, paragraph (a), clauses (3) and (4), because the program is not yet operational;

(2) certain records and documents are not available because persons are not yet receiving services from the program; and

(3) the applicant complies with applicable laws and rules in all other respects.

(c) A decision by the commissioner to issue a license does not guarantee that any person or persons will be placed or cared for in the licensed program. A license shall not be transferable to another individual, corporation, partnership, voluntary association, other organization, or controlling or to another location.

(d) A license holder must notify the commissioner and obtain the commissioner's approval before making any changes that would alter the license information listed under paragraph (a).

(e) The commissioner shall not issue a license if the applicant, license holder, or controlling individual has:

(1) been disqualified and the disqualification was not set aside;

(2) has been denied a license within the past two years; or

(3) had a license revoked within the past five years.

(f) The commissioner shall not issue a license if an individual living in the household where the licensed services will be provided as specified under section 245C.03, subdivision 1, has been disqualified and the disqualification has not been set aside.

For purposes of reimbursement for meals only, under the Child and Adult Care Food Program, Code of Federal Regulations, title 7, subtitle B, chapter II, subchapter A, part 226, relocation within the same county by a licensed family day care provider, shall be considered an extension of the license for a period of no more than 30 calendar days or until the new license is issued, whichever occurs first, provided the county agency has determined the family day care provider meets licensure requirements at the new location.

Unless otherwise specified by statute, all licenses expire at 12:01 a.m. on the day after the expiration date stated on the license. A license holder must apply for and be

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granted a new license to operate the program or the program must not be operated after the expiration date.

Sec. 10. Minnesota Statutes 2004, section 245A.04, subdivision 13, is amended to read:

Subd. 13. **RESIDENTIAL PROGRAMS HANDLING RESIDENT FUNDS AND PROPERTY; ADDITIONAL REQUIREMENTS.** (a) A license holder must ensure that residents persons served by the program retain the use and availability of personal funds or property unless restrictions are justified in the resident's person's individual plan. This subdivision does not apply to programs governed by the provisions in section 245B.07, subdivision 10.

(b) The license holder must ensure separation of resident funds of persons served by the program from funds of the license holder, the residential program, or program staff.

(c) Whenever the license holder assists a resident person served by the program with the safekeeping of funds or other property, the license holder must:

(1) immediately document receipt and disbursement of the resident's person's funds or other property at the time of receipt or disbursement, including the person's signature of the resident, or the signature of the conservator, or payee; and

(2) provide a statement, at least quarterly, itemizing receipts and disbursements of resident funds or other property; and

(3) return to the resident person upon the resident's person's request, funds and property in the license holder's possession subject to restrictions in the resident's person's treatment plan, as soon as possible, but no later than three working days after the date of request.

(d) License holders and program staff must not:

(1) borrow money from a resident person served by the program;

(2) purchase personal items from a resident person served by the program;

(3) sell merchandise or personal services to a resident person served by the program;

(4) require a resident person served by the program to purchase items for which the license holder is eligible for reimbursement; or

(5) use resident funds of persons served by the program to purchase items for which the facility is already receiving public or private payments.

Sec. 11. Minnesota Statutes 2004, section 245A.06, is amended by adding a subdivision to read:

Subd. 8. **FAMILY CHILD CARE AND CHILD CARE CENTERS POSTING OF ORDER.** For licensed family child care providers and child care centers, upon

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receipt of any correction order or order of conditional license issued by the commissioner under this section, and notwithstanding a pending request for reconsideration of the correction order or order of conditional license by the license holder, the license holder shall post the correction order or order of conditional license in a place that is conspicuous to the people receiving services and all visitors to the facility for two years. When the correction order or order of conditional license is accompanied by a maltreatment investigation memorandum prepared under section 626.556 or 626.557, the investigation memoranda must be posted with the correction order or order of conditional license.

Sec. 12. Minnesota Statutes 2004, section 245A.07, subdivision 1, is amended to read:

Subdivision 1. **SANCTIONS AVAILABLE; APPEALS; TEMPORARY PROVISIONAL LICENSE.** (a) In addition to making a license conditional under section 245A.06, the commissioner may propose to suspend or revoke the license, impose a fine, or secure an injunction against the continuing operation of the program of a license holder who does not comply with applicable law or rule. When applying sanctions authorized under this section, the commissioner shall consider the nature, chronicity, or severity of the violation of law or rule and the effect of the violation on the health, safety, or rights of persons served by the program.

(b) If a license holder appeals the suspension or revocation of a license and the license holder continues to operate the program pending a final order on the appeal, and the license expires during this time period, the commissioner shall issue the license holder a temporary provisional license. The temporary provisional license is effective on the date issued and expires on the date that a final order is issued. Unless otherwise specified by the commissioner, variances in effect on the date of the license sanction under appeal continue under the temporary provisional license. If a license holder fails to comply with applicable law or rule while operating under a temporary provisional license, the commissioner may impose sanctions under this section and section 245A.06, and may terminate any prior variance. If the license holder prevails on the appeal and the effective period of the previous license has expired, a new license shall be issued to the license holder upon payment of any fee required under section 245A.10. The effective date of the new license shall be retroactive to the date the license would have shown had no sanction been initiated. The expiration date shall be the expiration date of that license had no license sanction been initiated.

(c) If a license holder is under investigation and the license is due to expire before completion of the investigation, the program shall be issued a new license upon completion of the reapplication requirements. Upon completion of the investigation, a licensing sanction may be imposed against the new license under this section, section 245A.06, or 245A.08.

(d) Failure to reapply or closure of a license by the license holder prior to the completion of any investigation shall not preclude the commissioner from issuing a licensing sanction under this section, section 245A.06, or 245A.08 at the conclusion of the investigation.

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Sec. 13. Minnesota Statutes 2004, section 245A.07, subdivision 3, is amended to read:

Subd. 3. **LICENSE SUSPENSION, REVOCATION, OR FINE.** (a) The commissioner may suspend or revoke a license, or impose a fine if a license holder fails to comply fully with applicable laws or rules, if a license holder or an individual living in the household where the licensed services are provided has a disqualification which has not been set aside under section 245C.22, or if a license holder knowingly withholds relevant information from or gives false or misleading information to the commissioner in connection with an application for a license, in connection with the background study status of an individual, or during an investigation. A license holder who has had a license suspended, revoked, or has been ordered to pay a fine must be given notice of the action by certified mail or personal service. If mailed, the notice must be mailed to the address shown on the application or the last known address of the license holder. The notice must state the reasons the license was suspended, revoked, or a fine was ordered.

(a) (b) If the license was suspended or revoked, the notice must inform the license holder of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The license holder may appeal an order suspending or revoking a license. The appeal of an order suspending or revoking a license must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within ten calendar days after the license holder receives notice that the license has been suspended or revoked. If a request is made by personal service, it must be received by the commissioner within ten calendar days after the license holder received the order. Except as provided in subdivision 2a, paragraph (c), a timely appeal of an order suspending or revoking a license shall stay the suspension or revocation until the commissioner issues a final order.

(b)(c)(1) If the license holder was ordered to pay a fine, the notice must inform the license holder of the responsibility for payment of fines and the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The appeal of an order to pay a fine must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within ten calendar days after the license holder receives notice that the fine has been ordered. If a request is made by personal service, it must be received by the commissioner within ten calendar days after the license holder received the order.

(2) The license holder shall pay the fines assessed on or before the payment date specified. If the license holder fails to fully comply with the order, the commissioner may issue a second fine or suspend the license until the license holder complies. If the license holder receives state funds, the state, county, or municipal agencies or departments responsible for administering the funds shall withhold payments and recover any payments made while the license is suspended for failure to pay a fine. A timely appeal shall stay payment of the fine until the commissioner issues a final order.

(3) A license holder shall promptly notify the commissioner of human services, in writing, when a violation specified in the order to forfeit a fine is corrected. If upon

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reinspection the commissioner determines that a violation has not been corrected as indicated by the order to forfeit a fine, the commissioner may issue a second fine. The commissioner shall notify the license holder by certified mail or personal service that a second fine has been assessed. The license holder may appeal the second fine as provided under this subdivision.

(4) Fines shall be assessed as follows: the license holder shall forfeit \$1,000 for each determination of maltreatment of a child under section 626.556 or the maltreatment of a vulnerable adult under section 626.557; the license holder shall forfeit \$200 for each occurrence of a violation of law or rule governing matters of health, safety, or supervision, including but not limited to the provision of adequate staff-to-child or adult ratios, and failure to submit a background study; and the license holder shall forfeit \$100 for each occurrence of a violation of law or rule other than those subject to a \$1,000 or \$200 fine above. For purposes of this section, "occurrence" means each violation identified in the commissioner's fine order.

(5) When a fine has been assessed, the license holder may not avoid payment by closing, selling, or otherwise transferring the licensed program to a third party. In such an event, the license holder will be personally liable for payment. In the case of a corporation, each controlling individual is personally and jointly liable for payment.

Sec. 14. Minnesota Statutes 2004, section 245A.07, is amended by adding a subdivision to read:

Subd. 5. FAMILY CHILD CARE AND CHILD CARE CENTERS POSTING OF ORDER. For licensed family child care providers and child care centers, upon receipt of any order of license suspension, temporary immediate suspension, fine, or revocation issued by the commissioner under this section, and notwithstanding a pending appeal of the order of license suspension, temporary immediate suspension, fine, or revocation by the license holder, the license holder shall post the order of license suspension, temporary immediate suspension, fine, or revocation in a place that is conspicuous to the people receiving services and all visitors to the facility for two years. When the order of license suspension, temporary immediate suspension, fine, or revocation is accompanied by a maltreatment investigation memorandum prepared under section 626.556 or 626.557, the investigation memoranda must be posted with the order of license suspension, temporary immediate suspension, fine, or revocation.

Sec. 15. Minnesota Statutes 2004, section 245A.08, subdivision 2a, is amended to read:

Subd. 2a. CONSOLIDATED CONTESTED CASE HEARINGS FOR SANCTIONS BASED ON MALTREATMENT DETERMINATIONS AND DISQUALIFICATIONS. (a) When a denial of a license under section 245A.05 or a licensing sanction under section 245A.07, subdivision 3, is based on a disqualification for which reconsideration was requested and which was not set aside under section 245C.22, the scope of the contested case hearing shall include the disqualification and the licensing sanction or denial of a license. When the licensing sanction or denial of a license is

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based on a determination of maltreatment under section 626.556 or 626.557, or a disqualification for serious or recurring maltreatment which was not set aside, the scope of the contested case hearing shall include the maltreatment determination, disqualification, and the licensing sanction or denial of a license. In such cases, a fair hearing under section 256.045 shall not be conducted as provided for in sections 626.556, subdivision 10i, and 626.557, subdivision 9d. When a fine is based on a determination that the license holder is responsible for maltreatment and the fine is issued at the same time as the maltreatment determination, if the license holder appeals the maltreatment and fine, the scope of the contested case hearing shall include the maltreatment determination and fine and reconsideration of the maltreatment determination shall not be conducted as provided for in sections 626.556, subdivision 10i, and 626.557, subdivision 9d.

(b) In consolidated contested case hearings regarding sanctions issued in family child care, child foster care, family adult day services, and adult foster care, the county attorney shall defend the commissioner's orders in accordance with section 245A.16, subdivision 4.

(c) The commissioner's final order under subdivision 5 is the final agency action on the issue of maltreatment and disqualification, including for purposes of subsequent background studies under chapter 245C and is the only administrative appeal of the final agency determination, specifically, including a challenge to the accuracy and completeness of data under section 13.04.

(d) When consolidated hearings under this subdivision involve a licensing sanction based on a previous maltreatment determination for which the commissioner has issued a final order in an appeal of that determination under section 256.045, or the individual failed to exercise the right to appeal the previous maltreatment determination under section 626.556, subdivision 10i, or 626.557, subdivision 9d, the commissioner's order is conclusive on the issue of maltreatment. In such cases, the scope of the administrative law judge's review shall be limited to the disqualification and the licensing sanction or denial of a license. In the case of a denial of a license or a licensing sanction issued to a facility based on a maltreatment determination regarding an individual who is not the license holder or a household member, the scope of the administrative law judge's review includes the maltreatment determination.

(e) If a maltreatment determination or disqualification, which was not set aside under section 245C.22, is the basis for a denial of a license under section 245A.05 or a licensing sanction under section 245A.07, and the disqualified subject is an individual other than the license holder and upon whom a background study must be conducted under section 245C.03, the hearings of all parties may be consolidated into a single contested case hearing upon consent of all parties and the administrative law judge.

(f) Notwithstanding section 245C.27, subdivision 1, paragraph (c), when a denial of a license under section 245A.05 or a licensing sanction under section 245A.07 is based on a disqualification for which reconsideration was requested and was not set

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aside under section 245C.22, and the disqualification was based on a conviction or an admission to any crimes listed in section 245C.15, the scope of the administrative law judge's review shall include the denial or sanction and a determination whether the disqualification should be set aside. In determining whether the disqualification should be set aside, the administrative law judge shall consider the factors under section 245C.22, subdivision 4, to determine whether the individual poses a risk of harm to any person receiving services from the license holder.

(g) Notwithstanding section 245C.30, subdivision 5, when a licensing sanction under section 245A.07 is based on the termination of a variance under section 245C.30, subdivision 4, the scope of the administrative law judge's review shall include the sanction and a determination whether the disqualification should be set aside. In determining whether the disqualification should be set aside, the administrative law judge shall consider the factors under section 245C.22, subdivision 4, to determine whether the individual poses a risk of harm to any person receiving services from the license holder.

Sec. 16. Minnesota Statutes 2004, section 245A.08, subdivision 5, is amended to read:

Subd. 5. **NOTICE OF THE COMMISSIONER'S FINAL ORDER.** After considering the findings of fact, conclusions, and recommendations of the administrative law judge, the commissioner shall issue a final order. The commissioner shall consider, but shall not be bound by, the recommendations of the administrative law judge. The appellant must be notified of the commissioner's final order as required by chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The notice must also contain information about the appellant's rights under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The institution of proceedings for judicial review of the commissioner's final order shall not stay the enforcement of the final order except as provided in section 14.65.

Subd. 5a. **EFFECT OF FINAL ORDER ON GRANTING A SUBSEQUENT LICENSE.** (a) A license holder and each controlling individual of a license holder whose license has been revoked because of noncompliance with applicable law or rule must not be granted a license for five years following the revocation. Notwithstanding the five-year restriction, when a license is revoked because a person, other than the license holder, resides in the home where services are provided and that person has a disqualification that is not set aside and no variance has been granted, the former license holder may reapply for a license when:

(1) the person with a disqualification, who is not a minor child, is no longer residing in the home and is prohibited from residing in or returning to the home; or

(2) the person with the disqualification is a minor child, the restriction applies until the minor child becomes an adult and permanently moves away from the home or five years, whichever is less.

(b) An applicant whose application was denied must not be granted a license for two years following a denial, unless the applicant's subsequent application contains

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new information which constitutes a substantial change in the conditions that caused the previous denial.

Sec. 17. Minnesota Statutes 2004, section 245A.14, is amended by adding a subdivision to read:

Subd. 12. **FIRST AID TRAINING REQUIREMENTS FOR STAFF IN CHILD CARE CENTERS AND FAMILY CHILD CARE.** Notwithstanding Minnesota Rules, part 9503.0035, subpart 2, when children are present in a family child care home governed by Minnesota Rules, parts 9502.0315 to 9502.0445, or a child care center governed by Minnesota Rules, parts 9503.0005 to 9503.0170, at least one staff person must be present in the center or home who has been trained in first aid. The first aid training must have been provided by an individual approved to provide first aid instruction. First aid training may be less than eight hours and persons qualified to provide first aid training shall include individuals approved as first aid instructors.

EFFECTIVE DATE. This section is effective January 1, 2006.

Sec. 18. Minnesota Statutes 2004, section 245A.14, is amended by adding a subdivision to read:

Subd. 13. **CARDIOPULMONARY RESUSCITATION (CPR) TRAINING REQUIREMENT.** (a) When children are present in a child care center governed by Minnesota Rules, parts 9503.0005 to 9503.0170, or in a family child care home governed by Minnesota Rules, parts 9502.0315 to 9502.0445, at least one staff person must be present in the center or home who has been trained in cardiopulmonary resuscitation (CPR) and in the treatment of obstructed airways. The CPR training must have been provided by an individual approved to provide CPR instruction, must be repeated at least once every three years, and must be documented in the staff person's records.

(b) Notwithstanding Minnesota Rules, part 9503.0035, subpart 3, item A, cardiopulmonary resuscitation training may be provided for less than four hours.

(c) Notwithstanding Minnesota Rules, part 9503.0035, subpart 3, item C, persons qualified to provide cardiopulmonary resuscitation training shall include individuals approved as cardiopulmonary resuscitation instructors.

EFFECTIVE DATE. This section is effective January 1, 2006.

Sec. 19. Minnesota Statutes 2004, section 245A.144, is amended to read:

245A.144 REDUCTION OF RISK OF SUDDEN INFANT DEATH SYNDROME AND SHAKEN BABY SYNDROME IN CHILD CARE AND CHILD FOSTER CARE PROGRAMS.

(a) License holders must ensure document that before staff persons, caregivers, and helpers assist in the care of infants, they receive training on reducing the risk of sudden infant death syndrome and shaken baby syndrome. The training on reducing the risk of sudden infant death syndrome and shaken baby syndrome may be provided as:

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(1) orientation training to child care center staff under Minnesota Rules, part 9503.0035, subpart 1, as and to child foster care providers, who care for infants, under Minnesota Rules, part 2960.3070, subpart 1;

(2) initial training to family and group family child care providers under Minnesota Rules, part 9502.0385, subpart 2; as;

(3) in-service training to child care center staff under Minnesota Rules, part 9503.0035, subpart 4, and to child foster care providers, who care for infants, under Minnesota Rules, part 2960.3070, subpart 2; or as

(4) ongoing training to family and group family child care providers under Minnesota Rules, part 9502.0385, subpart 3.

(b) Training required under this section must be at least one hour in length and must be completed at least once every five years. At a minimum, the training must address the risk factors related to sudden infant death syndrome and shaken baby syndrome, means of reducing the risk of sudden infant death syndrome and shaken baby syndrome in child care, and license holder communication with parents regarding reducing the risk of sudden infant death syndrome and shaken baby syndrome.

(c) Training for family and group family child care providers must be approved by the county licensing agency according to Minnesota Rules, part 9502.0385.

(d) Training for child foster care providers must be approved by the county licensing agency and fulfills, in part, training required under Minnesota Rules, part 2960.3070.

EFFECTIVE DATE. This section is effective January 1, 2006.

Sec. 20. Minnesota Statutes 2004, section 245A.16, subdivision 1, is amended to read:

Subdivision 1. **DELEGATION OF AUTHORITY TO AGENCIES.** (a) County agencies and private agencies that have been designated or licensed by the commissioner to perform licensing functions and activities under section 245A.04 and chapter 245C, to recommend denial of applicants under section 245A.05, to issue correction orders, to issue variances, and recommend a conditional license under section 245A.06, or to recommend suspending or revoking a license or issuing a fine under section 245A.07, shall comply with rules and directives of the commissioner governing those functions and with this section. The following variances are excluded from the delegation of variance authority and may be issued only by the commissioner:

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

(2) adult foster care maximum capacity;

(3) adult foster care minimum age requirement;

(4) child foster care maximum age requirement;

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(5) variances regarding disqualified individuals except that county agencies may issue variances under section 245C.30 regarding disqualified individuals when the county 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 (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. 21. Minnesota Statutes 2004, section 245A.16, subdivision 4, is amended to read:

Subd. 4. **ENFORCEMENT OF THE COMMISSIONER'S ORDERS.** The county or private agency shall enforce the commissioner's orders under sections 245A.07, 245A.08, subdivision 5, and chapter 245C, according to the instructions of the commissioner. The county attorney shall assist the county agency in the enforcement and defense of the commissioner's orders under sections 245A.07, 245A.08, and chapter 245C, according to the instructions of the commissioner, unless a conflict of interest exists between the county attorney and the commissioner. For purposes of this section, a conflict of interest means that the county attorney has a direct or shared financial interest with the license holder or has a personal relationship or family relationship with a party in the licensing action.

Sec. 22. Minnesota Statutes 2004, section 245A.18, is amended to read:

245A.18 SEAT BELT USE REQUIRED CHILD PASSENGER RESTRAINT SYSTEMS; TRAINING REQUIREMENT.

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(a) When a nonresidential license holder provides or arranges for transportation for children served by the license holder, children four years old and older must be restrained by a properly adjusted and fastened seat belt and children under age four must be properly fastened in a child passenger restraint system meeting federal motor vehicle safety standards. A child passenger restraint system is not required for a child who, in the judgment of a licensed physician, cannot be safely transported in a child passenger restraint system because of a medical condition, body size, or physical disability, if the license holder possesses a written statement from the physician that satisfies the requirements in section 169.685, subdivision 6, paragraph (b).

(b) Paragraph (a) does not apply to transportation of children in a school bus inspected under section 169.451 that has a gross vehicle weight rating of more than 10,000 pounds, is designed for carrying more than ten persons, and was manufactured after 1977.

Subdivision 1. SEAT BELT USE. A license holder must comply with all seat belt and child passenger restraint system requirements under section 169.685.

Subd. 2. CHILD PASSENGER RESTRAINT SYSTEMS; TRAINING REQUIREMENT.

(a) Family and group family child care, child care centers, child foster care, and other programs licensed by the Department of Human Services that serve a child or children under nine years of age must document training that fulfills the requirements in this subdivision.

(b) Before a license holder, staff person, caregiver, or helper transports a child or children under age nine in a motor vehicle, the person transporting the child must satisfactorily complete training on the proper use and installation of child restraint systems in motor vehicles. Training completed under this section may be used to meet initial or ongoing training under the following:

- (1) Minnesota Rules, part 2960.3070, subparts 1 and 2;
- (2) Minnesota Rules, part 9502.0385, subparts 2 and 3; and
- (3) Minnesota Rules, part 9503.0035, subparts 1 and 4.

(c) Training required under this section must be at least one hour in length, completed at orientation or initial training, and repeated at least once every five years. At a minimum, the training must address the proper use of child restraint systems based on the child's size, weight, and age, and the proper installation of a car seat or booster seat in the motor vehicle used by the license holder to transport the child or children.

(d) Training under paragraph (c) must be provided by individuals who are certified and approved by the Department of Public Safety, Office of Traffic Safety. License holders may obtain a list of certified and approved trainers through the Department of Public Safety Web site or by contacting the agency.

EFFECTIVE DATE. This section is effective January 1, 2006.

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Sec. 23. Minnesota Statutes 2004, section 245B.02, subdivision 10, is amended to read:

Subd. 10. **INCIDENT.** "Incident" means any of the following:

- (1) serious injury as determined by section 245.91, subdivision 6;
- (2) a consumer's death;
- (3) any medical emergencies, unexpected serious illnesses, or accidents that require physician treatment or hospitalization;
- (4) a consumer's unauthorized absence;
- (5) any fires or other events that require the relocation of services for more than 24 hours, or circumstances involving a law enforcement agency or fire department related to the health, safety, or supervision of a consumer;
- (6) physical aggression by a consumer against another consumer that causes physical pain, injury, or persistent emotional distress, including, but not limited to, hitting, slapping, kicking, scratching, pinching, biting, pushing, and spitting;
- (7) any sexual activity between consumers involving force or coercion as defined under section 609.341, subdivisions 3 and 14; or
- (8) a report of child or vulnerable adult maltreatment under section 626.556 or 626.557.

Sec. 24. Minnesota Statutes 2004, section 245B.055, subdivision 7, is amended to read:

Subd. 7. **DETERMINING NUMBER OF DIRECT SERVICE STAFF REQUIRED.** The minimum number of direct service staff members required at any one time to meet the combined staff ratio requirements of the persons present at that time can be determined by following the steps in clauses (1) through (4):

(1) assign each person in attendance the three-digit decimal below that corresponds to the staff ratio requirement assigned to that person. A staff ratio requirement of one to four equals 0.250. A staff ratio requirement of one to eight equals 0.125. A staff ratio requirement of one to six equals 0.166. A staff ratio requirement of one to ten equals 0.100;

(2) add all of the three-digit decimals (one three-digit decimal for every person in attendance) assigned in clause (1);

(3) when the sum in clause (2) falls between two whole numbers, round off the sum to the larger of the two whole numbers; and

(4) the larger of the two whole numbers in clause (3) equals the number of direct service staff members needed to meet the staff ratio requirements of the persons in attendance.

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Sec. 25. Minnesota Statutes 2004, section 245B.07, subdivision 8, is amended to read:

Subd. 8. **POLICIES AND PROCEDURES.** The license holder must develop and implement the policies and procedures in paragraphs (1) to (3).

(1) Policies and procedures that promote consumer health and safety by ensuring:

(i) consumer safety in emergency situations as ~~identified in section 245B.05, subdivision 7;~~

(ii) consumer health through sanitary practices;

(iii) safe transportation, when the license holder is responsible for transportation of consumers, with provisions for handling emergency situations;

(iv) a system of record keeping for both individuals and the organization, for review of incidents and emergencies, and corrective action if needed;

(v) a plan for responding to all incidents, as defined in section 245B.02, subdivision 10, ~~fires, severe weather and natural disasters, bomb threats, and other threats~~ and reporting all incidents required to be reported under section 245B.05, subdivision 7;

(vi) safe medication administration as identified in section 245B.05, subdivision 5, incorporating an observed skill assessment to ensure that staff demonstrate the ability to administer medications consistent with the license holder's policy and procedures;

(vii) psychotropic medication monitoring when the consumer is prescribed a psychotropic medication, including the use of the psychotropic medication use checklist. If the responsibility for implementing the psychotropic medication use checklist has not been assigned in the individual service plan and the consumer lives in a licensed site, the residential license holder shall be designated; and

(viii) ~~criteria for admission or service initiation developed by the license holder;~~

(2) Policies and procedures that protect consumer rights and privacy by ensuring:

(i) consumer data privacy, in compliance with the Minnesota Data Practices Act, chapter 13; and

(ii) that complaint procedures provide consumers with a simple process to bring grievances and consumers receive a response to the grievance within a reasonable time period. The license holder must provide a copy of the program's grievance procedure and time lines for addressing grievances. The program's grievance procedure must permit consumers served by the program and the authorized representatives to bring a grievance to the highest level of authority in the program; ~~and.~~

(3) Policies and procedures that promote continuity and quality of consumer supports by ensuring:

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(i) continuity of care and service coordination, including provisions for service termination, temporary service suspension, and efforts made by the license holder to coordinate services with other vendors who also provide support to the consumer. The policy must include the following requirements:

(A) the license holder must notify the consumer or consumer's legal representative and the consumer's case manager in writing of the intended termination or temporary service suspension and the consumer's right to seek a temporary order staying the termination or suspension of service according to the procedures in section 256.045, subdivision 4a or subdivision 6, paragraph (c);

(B) notice of the proposed termination of services, including those situations that began with a temporary service suspension, must be given at least 60 days before the proposed termination is to become effective;

(C) the license holder must provide information requested by the consumer or consumer's legal representative or case manager when services are temporarily suspended or upon notice of termination;

(D) use of temporary service suspension procedures are restricted to situations in which the consumer's behavior causes immediate and serious danger to the health and safety of the individual or others;

(E) prior to giving notice of service termination or temporary service suspension, the license holder must document actions taken to minimize or eliminate the need for service termination or temporary service suspension; and

(F) during the period of temporary service suspension, the license holder will work with the appropriate county agency to develop reasonable alternatives to protect the individual and others; and

(ii) quality services measured through a program evaluation process including regular evaluations of consumer satisfaction and sharing the results of the evaluations with the consumers and legal representatives.

Sec. 26. Minnesota Statutes 2004, section 245C.03, subdivision 1, is amended to read:

Subdivision 1. **LICENSED PROGRAMS.** (a) The commissioner shall conduct a background study on:

- (1) the person or persons applying for a license;
- (2) an individual age 13 and over living in the household where the licensed program will be provided;
- (3) current or prospective employees or contractors of the applicant who will have direct contact with persons served by the facility, agency, or program;
- (4) volunteers or student volunteers who will have direct contact with persons served by the program to provide program services if the contact is not under the

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continuous, direct supervision by an individual listed in clause (1) or (3);

(5) an individual age ten to 12 living in the household where the licensed services will be provided when the commissioner has reasonable cause;

(6) an individual who, without providing direct contact services at a licensed program, may have unsupervised access to children or vulnerable adults receiving services from a program licensed to provide, when the commissioner has reasonable cause; and

(i) family child care for children;

(ii) foster care for children in the provider's own home; or

(iii) foster care or day care services for adults in the provider's own home; and

(7) all managerial officials as defined under section 245A.02, subdivision 5a.

The commissioner must have reasonable cause to study an individual under this subdivision.

(b) For family child foster care settings, a short-term substitute caregiver providing direct contact services for a child for less than 72 hours of continuous care is not required to receive a background study under this chapter.

Sec. 27. Minnesota Statutes 2004, section 245C.07, is amended to read:

245C.07 STUDY SUBJECT AFFILIATED WITH MULTIPLE LICENSED FACILITIES.

(a) When a license holder owns multiple facilities that are licensed by the Department of Human Services, only one background study is required for an individual who provides direct contact services in one or more of the licensed facilities if:

(1) the license holder designates one individual with one address and telephone number as the person to receive sensitive background study information for the multiple licensed programs that depend on the same background study; and

(2) the individual designated to receive the sensitive background study information is capable of determining, upon request of the department, whether a background study subject is providing direct contact services in one or more of the license holder's programs and, if so, at which location or locations.

(b) When a background study is being initiated by a licensed facility or a foster care provider that is also registered under chapter 144D, a study subject affiliated with multiple licensed facilities may attach to the background study form a cover letter indicating the additional facilities' names, addresses, and background study identification numbers.

When the commissioner receives a notice, the commissioner shall notify each facility identified by the background study subject of the study results.

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The background study notice the commissioner sends to the subsequent agencies shall satisfy those facilities' responsibilities for initiating a background study on that individual.

Sec. 28. Minnesota Statutes 2004, section 245C.08, subdivision 1, is amended to read:

Subdivision 1. **BACKGROUND STUDIES CONDUCTED BY COMMISSIONER OF HUMAN SERVICES.** (a) For a background study conducted by the commissioner, the commissioner shall review:

(1) information related to names of substantiated perpetrators of maltreatment of vulnerable adults that has been received by the commissioner as required under section 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.

(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. 29. Minnesota Statutes 2004, section 245C.08, subdivision 2, is amended to read:

Subd. 2. **BACKGROUND STUDIES CONDUCTED BY A COUNTY OR PRIVATE AGENCY; FOSTER CARE AND FAMILY CHILD CARE.** (a) For a background study conducted by a county or private agency for child foster care, adult foster care, and family child care homes, 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.

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(c) Notwithstanding expungement by a court, the county or private agency 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. 30. Minnesota Statutes 2004, section 245C.15, subdivision 1, as amended by Laws 2005, chapter 136, article 6, section 2, is amended to read:

Subdivision 1. **PERMANENT DISQUALIFICATION.** (a) An individual is disqualified under section 245C.14 if: (1) regardless of how much time has passed since the discharge of the sentence imposed, if any, for the offense; and (2) unless otherwise specified, regardless of the level of the ~~conviction~~ offense, the individual is ~~convicted of~~ has committed any of the following offenses: sections 609.185 (murder in the first degree); 609.19 (murder in the second degree); 609.195 (murder in the third degree); 609.20 (manslaughter in the first degree); 609.205 (manslaughter in the second degree); 609.221 or 609.222 (assault in the first or second degree); a felony offense under sections 609.2242 and 609.2243 (domestic assault), spousal abuse, child abuse or neglect, or a crime against children; 609.228 (great bodily harm caused by distribution of drugs); 609.245 (aggravated robbery); 609.25 (kidnapping); 609.2661 (murder of an unborn child in the first degree); 609.2662 (murder of an unborn child in the second degree); 609.2663 (murder of an unborn child in the third degree); 609.322 (solicitation, inducement, and promotion of prostitution); a felony offense under 609.324, subdivision 1 (other prohibited acts); 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); 609.3451 (criminal sexual conduct in the fifth degree); 609.3453 (criminal sexual predatory conduct); 609.352 (solicitation of children to engage in sexual conduct); 609.365 (incest); a felony offense under 609.377 (malicious punishment of a child); a felony offense under 609.378 (neglect or endangerment of a child); 609.561 (arson in the first degree); 609.66, subdivision 1e (drive-by shooting); 609.749, subdivision 3, 4, or 5 (felony-level harassment; stalking); 609.855, subdivision 5 (shooting at or in a public transit vehicle or facility); 617.246 (use of minors in sexual performance prohibited); or 617.247 (possession of pictorial representations of minors). An individual also is disqualified under section 245C.14 regardless of how much time has passed since the involuntary termination of the individual's parental rights under section 260C.301.

(b) An individual's aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraph (a), as each of these offenses is defined in Minnesota Statutes, permanently disqualifies the individual under section 245C.14.

(c) An individual's offense in any other state or country, where the elements of the offense are substantially similar to any of the offenses listed in paragraph (a), permanently disqualifies the individual under section 245C.14.

(d) When a disqualification is based on a judicial determination other than a conviction, the disqualification period begins from the date of the court order. When

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a disqualification is based on an admission, the disqualification period begins from the date of an admission in court. When a disqualification is based on a preponderance of evidence of a disqualifying act, the disqualification date begins from the date of the dismissal, the date of discharge of the sentence imposed for a conviction for a disqualifying crime of similar elements, or the date of the incident, whichever occurs last.

Sec. 31. Minnesota Statutes 2004, section 245C.15, subdivision 2, is amended to read:

Subd. 2. **15-YEAR DISQUALIFICATION.** (a) An individual is disqualified under section 245C.14 if: (1) less than 15 years have passed since the discharge of the sentence imposed, if any, for the offense; and (2) the individual has received a felony conviction for committed a felony-level violation of any of the following offenses: sections 260C.304 (grounds for termination of parental rights) 256.98 (wrongfully obtaining assistance); 268.182 (false representation; concealment of facts); 393.07, subdivision 10, paragraph (c) (federal Food Stamp Program fraud); 609.165 (felon ineligible to possess firearm); 609.21 (criminal vehicular homicide and injury); 609.215 (suicide); 609.223 or 609.2231 (assault in the third or fourth degree); repeat offenses under 609.224 (assault in the fifth degree); 609.2325 (criminal abuse of a vulnerable adult); 609.2335 (financial exploitation of a vulnerable adult); 609.235 (use of drugs to injure or facilitate crime); 609.24 (simple robbery); 609.255 (false imprisonment); 609.2664 (manslaughter of an unborn child in the first degree); 609.2665 (manslaughter of an unborn child in the second degree); 609.267 (assault of an unborn child in the first degree); 609.2671 (assault of an unborn child in the second degree); 609.268 (injury or death of an unborn child in the commission of a crime); 609.27 (coercion); 609.275 (attempt to coerce); repeat offenses under 609.3451 (criminal sexual conduct in the fifth degree); 609.466 (medical assistance fraud); 609.498, subdivision 1 or 1b (aggravated first degree or first degree tampering with a witness); 609.52 (theft); 609.521 (possession of shoplifting gear); 609.525 (bringing stolen goods into Minnesota); 609.527 (identity theft); 609.53 (receiving stolen property); 609.535 (issuance of dishonored checks); 609.562 (arson in the second degree); 609.563 (arson in the third degree); 609.582 (burglary); 609.611 (insurance fraud); 609.625 (aggravated forgery); 609.63 (forgery); 609.631 (check forgery; offering a forged check); 609.635 (obtaining signature by false pretense); 609.66 (dangerous weapons); 609.67 (machine guns and short-barreled shotguns); 609.687 (adulteration); 609.71 (riot); 609.713 (terroristic threats); 609.82 (fraud in obtaining credit); 609.821 (financial transaction card fraud); repeat offenses under 617.23 (indecent exposure; penalties); repeat offenses under 617.241 (obscene materials and performances; distribution and exhibition prohibited; penalty); chapter 152 (drugs; controlled substance); or a felony-level conviction involving alcohol or drug use.

(b) An individual is disqualified under section 245C.14 if less than 15 years has passed since the individual's aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraph (a), as each of these offenses is defined in Minnesota Statutes.

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(c) For foster care and family child care an individual is disqualified under section 245C.14 if less than 15 years has passed since the individual's voluntary termination of the individual's parental rights under section 260C.301, subdivision 1, paragraph (b), or 260C.301, subdivision 3.

(d) An individual is disqualified under section 245C.14 if less than 15 years has passed since the discharge of the sentence imposed for an offense in any other state or country, the elements of which are substantially similar to the elements of the offenses listed in paragraph (a).

(e) If the individual studied is convicted of one of the felonies listed in paragraph (a), but the sentence is a gross misdemeanor or misdemeanor disposition, the individual is disqualified but the disqualification lookback period for the conviction is the period applicable to the gross misdemeanor or misdemeanor disposition.

(f) When a disqualification is based on a judicial determination other than a conviction, the disqualification period begins from the date of the court order. When a disqualification is based on an admission, the disqualification period begins from the date of an admission in court. When a disqualification is based on a preponderance of evidence of a disqualifying act, the disqualification date begins from the date of the dismissal, the date of discharge of the sentence imposed for a conviction for a disqualifying crime of similar elements, or the date of the incident, whichever occurs last.

Sec. 32. Minnesota Statutes 2004, section 245C.15, subdivision 3, is amended to read:

Subd. 3. **TEN-YEAR DISQUALIFICATION.** (a) An individual is disqualified under section 245C.14 if: (1) less than ten years have passed since the discharge of the sentence imposed, if any, for the offense; and (2) the individual has received ~~committed~~ a gross misdemeanor ~~conviction~~ for a misdemeanor-level violation of any of the following offenses: sections 256.98 (wrongfully obtaining assistance); 268.182 (false representation; concealment of facts); 393.07, subdivision 10, paragraph (c) (federal Food Stamp Program fraud); 609.224 (assault in the fifth degree); 609.224, subdivision 2, paragraph (c) (assault in the fifth degree by a caregiver against a vulnerable adult); 609.2242 and 609.2243 (domestic assault); 609.23 (mistreatment of persons confined); 609.231 (mistreatment of residents or patients); 609.2325 (criminal abuse of a vulnerable adult); 609.233 (criminal neglect of a vulnerable adult); 609.2335 (financial exploitation of a vulnerable adult); 609.234 (failure to report maltreatment of a vulnerable adult); 609.265 (abduction); 609.275 (attempt to coerce); 609.324, subdivision 1a (other prohibited acts; minor engaged in prostitution); 609.33 (disorderly house); 609.3451 (criminal sexual conduct in the fifth degree); 609.377 (malicious punishment of a child); 609.378 (neglect or endangerment of a child); 609.446 (medical assistance fraud); 609.52 (theft); 609.525 (bringing stolen goods into Minnesota); 609.527 (identity theft); 609.53 (receiving stolen property); 609.535 (issuance of dishonored checks); 609.582 (burglary); 609.611 (insurance fraud); 609.631 (check forgery; offering a forged check); 609.66 (dangerous weapons); 609.71

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(riot); 609.72, subdivision 3 (disorderly conduct against a vulnerable adult); repeat offenses under 609.746 (interference with privacy); 609.749, subdivision 2 (harassment; stalking); repeat offenses under 617.23 (indecent exposure); 617.241 (obscene materials and performances); 617.243 (indecent literature, distribution); 617.293 (harmful materials; dissemination and display to minors prohibited); or violation of an order for protection under section 518B.01, subdivision 14.

(b) An individual is disqualified under section 245C.14 if less than ten years has passed since the individual's aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraph (a), as each of these offenses is defined in Minnesota Statutes.

(c) An individual is disqualified under section 245C.14 if less than ten years has passed since the discharge of the sentence imposed for an offense in any other state or country, the elements of which are substantially similar to the elements of any of the offenses listed in paragraph (a).

(d) If the defendant is convicted of one of the gross misdemeanors listed in paragraph (a), but the sentence is a misdemeanor disposition, the individual is disqualified but the disqualification lookback period for the conviction is the period applicable to misdemeanors.

(e) When a disqualification is based on a judicial determination other than a conviction, the disqualification period begins from the date of the court order. When a disqualification is based on an admission, the disqualification period begins from the date of an admission in court. When a disqualification is based on a preponderance of evidence of a disqualifying act, the disqualification date begins from the date of the dismissal, the date of discharge of the sentence imposed for a conviction for a disqualifying crime of similar elements, or the date of the incident, whichever occurs last.

Sec. 33. Minnesota Statutes 2004, section 245C.15, subdivision 4, is amended to read:

Subd. 4. **SEVEN-YEAR DISQUALIFICATION.** (a) An individual is disqualified under section 245C.14 if: (1) less than seven years has passed since the discharge of the sentence imposed, if any, for the offense; and (2) the individual has received committed a misdemeanor conviction for a misdemeanor-level violation of any of the following offenses: sections 256.98 (wrongfully obtaining assistance); 268.182 (false representation; concealment of facts); 393.07, subdivision 10, paragraph (c) (federal Food Stamp Program fraud); 609.224 (assault in the fifth degree); 609.2242 (domestic assault); 609.2335 (financial exploitation of a vulnerable adult); 609.234 (failure to report maltreatment of a vulnerable adult); 609.2672 (assault of an unborn child in the third degree); 609.27 (coercion); violation of an order for protection under 609.3232 (protective order authorized; procedures; penalties); 609.466 (medical assistance fraud); 609.52 (theft); 609.525 (bringing stolen goods into Minnesota); 609.527 (identity theft); 609.53 (receiving stolen property); 609.535 (issuance of dishonored

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checks); 609.611 (insurance fraud); 609.66 (dangerous weapons); 609.665 (spring guns); 609.746 (interference with privacy); 609.79 (obscene or harassing phone telephone calls); 609.795 (letter, telegram, or package; opening; harassment); 609.82 (fraud in obtaining credit); 609.821 (financial transaction card fraud); 617.23 (indecent exposure; penalties); 617.293 (harmful materials; dissemination and display to minors prohibited); or violation of an order for protection under section 518B.01 (Domestic Abuse Act).

(b) An individual is disqualified under section 245C.14 if less than seven years has passed since a determination or disposition of the individual's:

(1) failure to make required reports under section 626.556, subdivision 3, or 626.557, subdivision 3, for incidents in which: (i) the final disposition under section 626.556 or 626.557 was substantiated maltreatment, and (ii) the maltreatment was recurring or serious; or

(2) substantiated serious or recurring maltreatment of a minor under section 626.556, a vulnerable adult under section 626.557, or serious or recurring maltreatment in any other state, the elements of which are substantially similar to the elements of maltreatment under section 626.556 or 626.557 for which: (i) there is a preponderance of evidence that the maltreatment occurred, and (ii) the subject was responsible for the maltreatment.

(c) An individual is disqualified under section 245C.14 if less than seven years has passed since the individual's aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraphs (a) and (b), as each of these offenses is defined in Minnesota Statutes.

(d) An individual is disqualified under section 245C.14 if less than seven years has passed since the discharge of the sentence imposed for an offense in any other state or country, the elements of which are substantially similar to the elements of any of the offenses listed in paragraphs (a) and (b).

(e) When a disqualification is based on a judicial determination other than a conviction, the disqualification period begins from the date of the court order. When a disqualification is based on an admission, the disqualification period begins from the date of an admission in court. When a disqualification is based on a preponderance of evidence of a disqualifying act, the disqualification date begins from the date of the dismissal, the date of discharge of the sentence imposed for a conviction for a disqualifying crime of similar elements, or the date of the incident, whichever occurs last.

Sec. 34. Minnesota Statutes 2004, section 245C.21, subdivision 2, is amended to read:

Subd. 2. **TIME FRAME FOR REQUESTING RECONSIDERATION OF A DISQUALIFICATION.** (a) When the commissioner sends an individual a notice of disqualification based on a finding under section 245C.16, subdivision 2, paragraph (a), clause (1) or (2), the disqualified individual must submit the request for a

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reconsideration within 30 calendar days of the individual's receipt of the notice of disqualification. If mailed, the request for reconsideration must be postmarked and sent to the commissioner within 30 calendar days of the individual's receipt of the notice of disqualification. If a request for reconsideration is made by personal service, it must be received by the commissioner within 30 calendar days after the individual's receipt of the notice of disqualification. Upon showing that the information under subdivision 3 cannot be obtained within 30 days, the disqualified individual may request additional time, not to exceed 30 days, to obtain the information.

(b) When the commissioner sends an individual a notice of disqualification based on a finding under section 245C.16, subdivision 2, paragraph (a), clause (3), the disqualified individual must submit the request for reconsideration within 15 calendar days of the individual's receipt of the notice of disqualification. If mailed, the request for reconsideration must be postmarked and sent to the commissioner within 15 calendar days of the individual's receipt of the notice of disqualification. If a request for reconsideration is made by personal service, it must be received by the commissioner within 15 calendar days after the individual's receipt of the notice of disqualification.

(c) An individual who was determined to have maltreated a child under section 626.556 or a vulnerable adult under section 626.557, and who is disqualified on the basis of serious or recurring maltreatment, may request a reconsideration of both the maltreatment and the disqualification determinations. The request must be submitted within 30 calendar days of the individual's receipt of the notice of disqualification. If mailed, the request for reconsideration must be postmarked and sent to the commissioner within 30 calendar days of the individual's receipt of the notice of disqualification. If a request for reconsideration is made by personal service, it must be received by the commissioner within 30 calendar days after the individual's receipt of the notice of disqualification.

Sec. 35. Minnesota Statutes 2004, section 245C.22, subdivision 3, is amended to read:

Subd. 3. PREEMINENT WEIGHT GIVEN TO SAFETY OF PERSONS BEING SERVED. In reviewing a request for reconsideration of a disqualification, the commissioner shall give preeminent weight to the safety of each person served by the license holder, applicant, or other entities as provided in this chapter over the interests of the disqualified individual, license holder, applicant, or other entity as provided in this chapter, and any single factor under subdivision 4, paragraph (b), may be determinative of the commissioner's decision whether to set aside the individual's disqualification.

Sec. 36. Minnesota Statutes 2004, section 245C.22, subdivision 4, is amended to read:

Subd. 4. RISK OF HARM; SET ASIDE. (a) The commissioner may set aside the disqualification if the commissioner finds that the individual has submitted

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sufficient information to demonstrate that the individual does not pose a risk of harm to any person served by the applicant, license holder, or other entities as provided in this chapter.

(b) In determining whether the individual has met the burden of proof by demonstrating the individual does not pose a risk of harm, the commissioner shall consider:

- (1) the nature, severity, and consequences of the event or events that led to the disqualification;
- (2) whether there is more than one disqualifying event;
- (3) the age and vulnerability of the victim at the time of the event;
- (4) the harm suffered by the victim;
- (5) the similarity between the victim and persons served by the program;
- (6) the time elapsed without a repeat of the same or similar event;
- (7) documentation of successful completion by the individual studied of training or rehabilitation pertinent to the event; and
- (8) any other information relevant to reconsideration.

(c) If the individual requested reconsideration on the basis that the information relied upon to disqualify the individual was incorrect or inaccurate and the commissioner determines that the information relied upon to disqualify the individual is correct, the commissioner must also determine if the individual poses a risk of harm to persons receiving services in accordance with paragraph (b).

Sec. 37. Minnesota Statutes 2004, section 245C.22, subdivision 7, as added by Laws 2005, chapter 136, article 6, section 6, is amended to read:

Subd. 7. **CLASSIFICATION OF CERTAIN DATA AS PUBLIC OR PRIVATE.** (a) Notwithstanding section 13.46, upon setting aside a disqualification under this section, the identity of the disqualified individual who received the set aside and the individual's disqualifying characteristics are public data if the set aside was:

(1) for any disqualifying characteristic under section 245C.15, when the set aside relates to a child care center or a family child care provider licensed under chapter 245A; or

(2) for a disqualifying characteristic under section 245C.15, subdivision 2.

(b) Notwithstanding section 13.46, upon granting a variance to a license holder under section 245C.30, the identity of the disqualified individual who is the subject of the variance, the individual's disqualifying characteristics under section 245C.15, and the terms of the variance are public data, when the variance:

(1) is issued to a child care center or a family child care provider licensed under chapter 245A; or

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(2) relates to an individual with a disqualifying characteristic under section 245C.15, subdivision 2.

(c) The identity of a disqualified individual and the reason for disqualification remain private data when:

(1) a disqualification is not set aside and no variance is granted;

(2) the data are not public under paragraph (a) or (b); or

(3) the disqualification is rescinded because the information relied upon to disqualify the individual is incorrect; or

(4) the disqualification relates to a license to provide relative child foster care. As used in this clause, "relative" has the meaning given it under section 260C.007, subdivision 27.

(d) Licensed family day care providers and child care centers must notify parents considering enrollment of a child or parents of a child attending the family day care or child care center if the program employs or has living in the home any individual who is the subject of either a set aside or variance.

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

Sec. 38. Minnesota Statutes 2004, section 245C.23, subdivision 1, is amended to read:

Subdivision 1. **COMMISSIONER'S NOTICE OF DISQUALIFICATION THAT IS RESCINDED OR SET ASIDE.** ~~(a) Except as provided under paragraph (e),~~ If the commissioner rescinds or sets aside a disqualification, the commissioner shall notify the applicant or, license holder, or other entity in writing or by electronic transmission of the decision. In the notice from the commissioner that a disqualification has been rescinded, the commissioner must inform the applicant, license holder, or other entity that the information relied upon to disqualify the individual was incorrect. In the notice from the commissioner that a disqualification has been set aside, the commissioner must inform the applicant, license holder that information about the nature, or other entity of the reason for the individual's disqualification and that information about which factors under section 245C.22, subdivision 4, were the basis of the decision to set aside the disqualification are available to the license holder upon request without the consent of the background study subject.

~~(b) With the written consent of the background study subject, the commissioner may release to the license holder copies of all information related to the background study subject's disqualification and the commissioner's decision to set aside the disqualification as specified in the written consent.~~

~~(e) If the individual studied submits a timely request for reconsideration under section 245C.21 and the license holder was previously sent a notice under section 245C.17, subdivision 3, paragraph (d), and if the commissioner sets aside the disqualification for that license holder under section 245C.22, the commissioner shall~~

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send the license holder the same notification received by license holders in cases where the individual studied has no disqualifying characteristic.

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

Sec. 39. Minnesota Statutes 2004, section 245C.24, subdivision 2, as amended by Laws 2005, chapter 136, article 6, section 7, is amended to read:

Subd. 2. **PERMANENT BAR TO SET ASIDE A DISQUALIFICATION.** The commissioner may not set aside the disqualification of ~~an any individual in connection with a license issued or in application status under chapter 245A~~ disqualified pursuant to this chapter, regardless of how much time has passed, if the provider individual was disqualified for a crime or conduct listed in section 245C.15, subdivision 1.

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

Sec. 40. Minnesota Statutes 2004, section 245C.24, subdivision 3, is amended to read:

Subd. 3. **TEN-YEAR BAR TO SET ASIDE DISQUALIFICATION.** (a) The commissioner may not set aside the disqualification of an individual in connection with a license to provide family child care for children, foster care for children in the provider's home, or foster care or day care services for adults in the provider's home if: (1) less than ten years has passed since the discharge of the sentence imposed, if any, for the offense; and or (2) when disqualified based on a preponderance of evidence determination under section 245A.14, subdivision 1, paragraph (a), clause (2), or an admission under section 245A.14, subdivision 1, paragraph (a), clause (1), and less than ten years has passed since the individual committed the act or admitted to committing the act, whichever is later; and (3) the individual has been convicted of committed a violation of any of the following offenses: sections 609.165 (felon ineligible to possess firearm); criminal vehicular homicide under 609.21 (criminal vehicular homicide and injury); 609.215 (aiding suicide or aiding attempted suicide); felony violations under 609.223 or 609.2231 (assault in the third or fourth degree); 609.713 (terroristic threats); 609.235 (use of drugs to injure or to facilitate crime); 609.24 (simple robbery); 609.255 (false imprisonment); 609.562 (arson in the second degree); 609.71 (riot); 609.498, subdivision 1 or 1b (aggravated first degree or first degree tampering with a witness); burglary in the first or second degree under 609.582 (burglary); 609.66 (dangerous weapon); 609.665 (spring guns); 609.67 (machine guns and short-barreled shotguns); 609.749, subdivision 2 (gross misdemeanor harassment; stalking); 152.021 or 152.022 (controlled substance crime in the first or second degree); 152.023, subdivision 1, clause (3) or (4) or subdivision 2, clause (4) (controlled substance crime in the third degree); 152.024, subdivision 1, clause (2), (3), or (4) (controlled substance crime in the fourth degree); 609.224, subdivision 2, paragraph (c) (fifth-degree assault by a caregiver against a vulnerable adult); 609.23 (mistreatment of persons confined); 609.231 (mistreatment of residents or patients); 609.2325 (criminal abuse of a vulnerable adult); 609.233 (criminal neglect of a vulnerable adult); 609.2335 (financial exploitation of a vulnerable adult); 609.234

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(failure to report); 609.265 (abduction); 609.2664 to 609.2665 (manslaughter of an unborn child in the first or second degree); 609.267 to 609.2672 (assault of an unborn child in the first, second, or third degree); 609.268 (injury or death of an unborn child in the commission of a crime); 617.293 (disseminating or displaying harmful material to minors); a felony-level conviction involving alcohol or drug use, a gross misdemeanor offense under 609.324, subdivision 1 (other prohibited acts); a gross misdemeanor offense under 609.378 (neglect or endangerment of a child); a gross misdemeanor offense under 609.377 (malicious punishment of a child); or 609.72, subdivision 3 (disorderly conduct against a vulnerable adult).

(b) The commissioner may not set aside the disqualification of an individual if less than ten years have passed since the individual's aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraph (a) as each of these offenses is defined in Minnesota Statutes.

(c) The commissioner may not set aside the disqualification of an individual if less than ten years have passed since the discharge of the sentence imposed for an offense in any other state or country, the elements of which are substantially similar to the elements of any of the offenses listed in paragraph (a).

Sec. 41. Minnesota Statutes 2004, section 245C.27, subdivision 1, is amended to read:

Subdivision 1. FAIR HEARING WHEN DISQUALIFICATION IS NOT SET ASIDE. (a) If the commissioner does not set aside or ~~renew~~ a disqualification of an individual under section 245C.22 who is disqualified on the basis of a preponderance of evidence that the individual committed an act or acts that meet the definition of any of the crimes listed in section 245C.15; for a determination under section 626.556 or 626.557 of substantiated maltreatment that was serious or recurring under section 245C.15; or for failure to make required reports under section 626.556, subdivision 3; or 626.557, subdivision 3, pursuant to section 245C.15, subdivision 4, paragraph (b), clause (1), the individual may request a fair hearing under section 256.045, unless the disqualification is deemed conclusive under section 245C.29.

(b) The fair hearing is the only administrative appeal of the final agency determination for purposes of appeal by the disqualified individual. The disqualified individual does not have the right to challenge the accuracy and completeness of data under section 13.04.

(c) If the individual was disqualified based on a conviction or admission to any crimes listed in section 245C.15, subdivisions 1 to 4, the reconsideration decision under section 245C.22 is the final agency determination for purposes of appeal by the disqualified individual and is not subject to a hearing under section 256.045. If the individual was disqualified based on a judicial determination, that determination is treated the same as a conviction for purposes of appeal.

(d) This subdivision does not apply to a public employee's appeal of a disqualification under section 245C.28, subdivision 3.

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(e) Notwithstanding paragraph (c), if the commissioner does not set aside a disqualification of an individual who was disqualified based on both a preponderance of evidence and a conviction or admission, the individual may request a fair hearing under section 256.045, unless the disqualifications are deemed conclusive under section 245C.29. The scope of the hearing conducted under section 256.045 with regard to the disqualification based on a conviction or admission shall be limited solely to whether the individual poses a risk of harm, according to section 256.045, subdivision 3b.

Sec. 42. Minnesota Statutes 2004, section 245C.28, subdivision 3, is amended to read:

Subd. 3. **EMPLOYEES OF PUBLIC EMPLOYER.** (a) If the commissioner does not set aside the disqualification of an individual who is an employee of an employer, as defined in section 179A.03, subdivision 15, the individual may request a contested case hearing under chapter 14. The request for a contested case hearing must be made in writing and must be postmarked and mailed sent within 30 calendar days after the employee receives notice that the disqualification has not been set aside. If the individual was disqualified based on a conviction or admission to any crimes listed in section 245C.15, the scope of the contested case hearing shall be limited solely to whether the individual poses a risk of harm pursuant to section 245C.22.

(b) If the commissioner does not set aside or ~~renew~~ a disqualification that is based on a maltreatment determination, the scope of the contested case hearing must include the maltreatment determination and the disqualification. In such cases, a fair hearing must not be conducted under section 256.045.

(c) Rules adopted under this chapter may not preclude an employee in a contested case hearing for a disqualification from submitting evidence concerning information gathered under this chapter.

(d) When a ~~person~~ an individual has been disqualified from multiple licensed programs and the disqualifications have not been set aside under section 245C.22, if at least one of the disqualifications entitles the person to a contested case hearing under this subdivision, the scope of the contested case hearing shall include all disqualifications from licensed programs which were not set aside.

(e) In determining whether the disqualification should be set aside, the administrative law judge shall consider all of the characteristics that cause the individual to be disqualified, ~~including those characteristics that were not subject to review under paragraph (b)~~, in order to determine whether the individual poses a risk of harm. The administrative law judge's recommendation and the commissioner's order to set aside a disqualification that is the subject of the hearing constitutes a determination that the individual does not pose a risk of harm and that the individual may provide direct contact services in the individual program specified in the set aside.

Sec. 43. Minnesota Statutes 2004, section 245C.30, subdivision 1, is amended to read:

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Subdivision 1. **LICENSE HOLDER VARIANCE.** (a) Except for any disqualification under section 245C.15, subdivision 1, when the commissioner has not set aside a background study subject's disqualification, and there are conditions under which the disqualified individual may provide direct contact services or have access to people receiving services that minimize the risk of harm to people receiving services, the commissioner may grant a time-limited variance to a license holder.

(b) The variance shall state the reason for the disqualification, the services that may be provided by the disqualified individual, and the conditions with which the license holder or applicant must comply for the variance to remain in effect.

(c) Except for programs licensed to provide family child care, foster care for children in the provider's own home, or foster care or day care services for adults in the provider's own home, the variance must be requested by the license holder.

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

Sec. 44. Minnesota Statutes 2004, section 245C.30, subdivision 2, is amended to read:

Subd. 2. **DISCLOSURE OF REASON FOR DISQUALIFICATION.** (a) The commissioner may not grant a variance for a disqualified individual unless the applicant or license holder requests the variance and the disqualified individual provides written consent for the commissioner to disclose to the applicant or license holder the reason for the disqualification.

(b) This subdivision does not apply to programs licensed to provide family child care for children, foster care for children in the provider's own home, or foster care or day care services for adults in the provider's own home. When the commissioner grants a variance for a disqualified individual in connection with a license to provide the services specified in this paragraph, the disqualified individual's consent is not required to disclose the reason for the disqualification to the license holder in the variance issued under subdivision 1.

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

Sec. 45. [245C.301] **NOTIFICATION OF SET-ASIDE OR VARIANCE.**

Licensed family child care providers and child care centers must provide a written notification to parents considering enrollment of a child or parents of a child attending the family child care or child care center if the program employs or has living in the home any individual who is the subject of either a set-aside or variance.

Sec. 46. Minnesota Statutes 2004, section 246.13, as amended by Laws 2005, chapter 136, article 5, section 2, is amended to read:

246.13 RECORDS OF PATIENTS AND RESIDENTS RECEIVING STATE-OPERATED SERVICES.

Subdivision 1. **POWERS, DUTIES, AND AUTHORITY OF COMMISSIONER.** (a) The commissioner of human services' office shall have, accessible only

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by consent of the commissioner or on the order of a judge or court of record, a record showing the residence, sex, age, nativity, occupation, civil condition, and date of entrance or commitment of every person, in the state-operated services facilities as defined under section 246.014 under exclusive control of the commissioner; the date of discharge and whether such discharge was final; the condition of the person when the person left the state-operated services facility; the vulnerable adult abuse prevention associated with the person; and the date and cause of all deaths. The record shall state every transfer from one state-operated services facility to another, naming each state-operated services facility. This information shall be furnished to the commissioner of human services by each public agency, along with other obtainable facts as the commissioner may require. When a patient or resident in a state-operated services facility is discharged, transferred, or dies, the head of the state-operated services facility or designee shall inform the commissioner of human services of these events within ten days on forms furnished by the commissioner.

(b) The commissioner of human services shall cause to be devised, installed, and operated an adequate system of records and statistics which shall consist of all basic record forms, including patient personal records and medical record forms, and the manner of their use shall be precisely uniform throughout all state-operated services facilities.

Subd. 2. DEFINITIONS; RISK ASSESSMENT AND MANAGEMENT. (a) As used in this section:

(1) "appropriate and necessary medical and other records" includes patient medical records and other protected health information as defined by Code of Federal Regulations, title 45, section 164.501, relating to a patient in a state-operated services facility including, but not limited to, the patient's treatment plan and abuse prevention plan that is pertinent to the patient's ongoing care, treatment, or placement in a community-based treatment facility or a health care facility that is not operated by state-operated services, and includes information describing the level of risk posed by a patient when the patient enters such a the facility;

(2) "community-based treatment" means the community support services listed in section 253B.02, subdivision 4b;

(3) "criminal history data" means those data maintained or used by the Departments of Corrections and Public Safety and by the supervisory authorities listed in section 13.84, subdivision 1, that relate to an individual's criminal history or propensity for violence, including data in the Corrections Offender Management System (COMS) and Statewide Supervision System (S3) maintained by the Department of Corrections; the Criminal Justice Information System (CJIS) and the Predatory Offender Registration (POR) system maintained by the Department of Public Safety; and the CrimNet system;

(4) "designated agency" means the agency defined in section 253B.02, subdivision 5;

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(5) "law enforcement agency" means the law enforcement agency having primary jurisdiction over the location where the offender expects to reside upon release;

(6) "predatory offender" and "offender" mean a person who is required to register as a predatory offender under section 243.166; and

(7) "treatment facility" means a facility as defined in section 253B.02, subdivision 19.

(b) To promote public safety and for the purposes and subject to the requirements of this paragraph (e), the commissioner or the commissioner's designee shall have access to, and may review and disclose, medical and criminal history data as provided by this section.

~~(e) The commissioner or the commissioner's designee shall disseminate data to designated treatment facility staff, special review board members, and end-of-confinement review committee members in accordance with Minnesota Rules, part 1205.0400, to, as necessary to comply with Minnesota Rules, part 1205.0400:~~

~~(1) to determine whether a patient is required under state law to register as a predatory offender according to section 243.166;~~

~~(2) to facilitate and expedite the responsibilities of the special review board and end-of-confinement review committees by corrections institutions and state treatment facilities;~~

~~(3) to prepare, amend, or revise the abuse prevention plans required under section 626.557, subdivision 14, and individual patient treatment plans required under section 253B.03, subdivision 7;~~

~~(4) to facilitate changes of the custody and transfers, supervision, and transport of individuals transferred between the Department of Corrections and the Department of Human Services; and or~~

~~(5) facilitate the exchange of data between to effectively monitor and supervise individuals who are under the authority of the Department of Corrections, the Department of Human Services, and any of the supervisory authorities listed in section 13.84, regarding an individual under the authority of one or more of these entities subdivision 1.~~

~~(c) The state-operated services treatment facility must make a good faith effort to obtain written authorization from the patient before releasing information from the patient's medical record.~~

~~(d) If the patient refuses or is unable to give informed consent to authorize the release of information required above, the chief executive officer for state-operated services shall provide the appropriate and necessary medical and other records. The chief executive officer shall comply with the minimum necessary requirements.~~

~~(d) If approved by the United States Department of Justice, (e) The commissioner may have access to national criminal history information the National Crime~~

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Information Center (NCIC) database, through the Department of Public Safety, in support of the law enforcement ~~function~~ functions described in paragraph (e). If approval of the United States Department of Justice is not obtained by the commissioner before July 1, 2007, the authorization in this paragraph sunsets on that date (b).

Subd. 3. COMMUNITY-BASED TREATMENT AND MEDICAL TREATMENT. (a) When a patient under the care and supervision of state-operated services is released to a community-based treatment facility or facility that provides health care services, state-operated services may disclose all appropriate and necessary health and other information relating to the patient.

(b) The information that must be provided to the designated agency, community-based treatment facility, or facility that provides health care services includes, but is not limited to, the patient's abuse prevention plan required under section 626.557, subdivision 14, paragraph (b).

Subd. 4. PREDATORY OFFENDER REGISTRATION NOTIFICATION. (a) When a state-operated facility determines that a patient is required under section 243.166, subdivision 1, to register as a predatory offender or, under section 243.166, subdivision 4a, to provide notice of a change in status, the facility shall provide written notice to the patient of the requirement.

(b) If the patient refuses, is unable, or lacks capacity to comply with the requirement described in paragraph (a) within five days after receiving the notification of the duty to comply, state-operated services staff shall obtain and disclose the necessary data to complete the registration form or change of status notification for the patient. The treatment facility shall also forward the registration or change of status data that it completes to the Bureau of Criminal Apprehension and, as applicable, the patient's corrections agent and the law enforcement agency in the community in which the patient currently resides. If, after providing notification, the patient refuses to comply with the requirements described in paragraph (a), the treatment facility shall also notify the county attorney in the county in which the patient is currently residing of the refusal.

(c) The duties of state-operated services described in this subdivision do not relieve the patient of the ongoing individual duty to comply with the requirements of section 243.166.

Subd. 5. LIMITATIONS ON USE OF PROCEDURE FOR BLOODBORNE PATHOGEN TEST RESULTS PATHOGENS. Sections 246.71, 246.711, 246.712, 246.713, 246.714, 246.715, 246.716, 246.717, 246.718, 246.719, 246.72, 246.721, and to 246.722 apply to state-operated services facilities.

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

Sec. 47. Minnesota Statutes 2004, section 260B.163, subdivision 6, is amended to read:

Subd. 6. GUARDIAN AD LITEM. (a) The court shall appoint a guardian ad litem to protect the interests of the minor when it appears, at any stage of the

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proceedings, that the minor is without a parent or guardian, or that the minor's parent is a minor or incompetent, or that the parent or guardian is indifferent or hostile to the minor's interests. In any other case the court may appoint a guardian ad litem to protect the interests of the minor when the court feels that such an appointment is desirable. The court shall appoint the guardian ad litem on its own motion or in the manner provided for the appointment of a guardian ad litem in the district court. The court may appoint separate counsel for the guardian ad litem if necessary.

(b) A guardian ad litem shall carry out the following responsibilities:

(1) conduct an independent investigation to determine the facts relevant to the situation of the child and the family, which must include, unless specifically excluded by the court, reviewing relevant documents; meeting with and observing the child in the home setting and considering the child's wishes, as appropriate; and interviewing parents, caregivers, and others with knowledge relevant to the case;

(2) advocate for the child's best interests by participating in appropriate aspects of the case and advocating for appropriate community services when necessary;

(3) maintain the confidentiality of information related to a case, with the exception of sharing information as permitted by law to promote cooperative solutions that are in the best interests of the child;

(4) monitor the child's best interests throughout the judicial proceeding; and

(5) present written reports on the child's best interests that include conclusions and recommendations and the facts upon which they are based.

(c) The court may waive the appointment of a guardian ad litem pursuant to paragraph (a), whenever counsel has been appointed pursuant to subdivision 2 or is retained otherwise, and the court is satisfied that the interests of the minor are protected.

(d) In appointing a guardian ad litem pursuant to paragraph (a), the court shall not appoint the party, or any agent or employee thereof, filing a petition pursuant to section 260B.141 and 260C.141.

(e) The following factors shall be considered when appointing a guardian ad litem in a case involving an Indian or minority child:

(1) whether a person is available who is the same racial or ethnic heritage as the child or, if that is not possible;

(2) whether a person is available who knows and appreciates the child's racial or ethnic heritage.

(f) The court shall require a background study for each guardian ad litem as provided under section 518.165. The court shall have access to data collected pursuant to section 245C.32 for purposes of the background study.

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

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Sec. 48. Minnesota Statutes 2004, section 260C.163, subdivision 5, is amended to read:

Subd. 5. **GUARDIAN AD LITEM.** (a) The court shall appoint a guardian ad litem to protect the interests of the minor when it appears, at any stage of the proceedings, that the minor is without a parent or guardian, or that the minor's parent is a minor or incompetent, or that the parent or guardian is indifferent or hostile to the minor's interests, and in every proceeding alleging a child's need for protection or services under section 260C.007, subdivision 6, except proceedings where the sole allegation is that the child is a runaway or habitual truant. In any other case the court may appoint a guardian ad litem to protect the interests of the minor when the court feels that such an appointment is desirable. The court shall appoint the guardian ad litem on its own motion or in the manner provided for the appointment of a guardian ad litem in the district court. The court may appoint separate counsel for the guardian ad litem if necessary.

(b) A guardian ad litem shall carry out the following responsibilities:

(1) conduct an independent investigation to determine the facts relevant to the situation of the child and the family, which must include, unless specifically excluded by the court, reviewing relevant documents; meeting with and observing the child in the home setting and considering the child's wishes, as appropriate; and interviewing parents, caregivers, and others with knowledge relevant to the case;

(2) advocate for the child's best interests by participating in appropriate aspects of the case and advocating for appropriate community services when necessary;

(3) maintain the confidentiality of information related to a case, with the exception of sharing information as permitted by law to promote cooperative solutions that are in the best interests of the child;

(4) monitor the child's best interests throughout the judicial proceeding; and

(5) present written reports on the child's best interests that include conclusions and recommendations and the facts upon which they are based.

(c) Except in cases where the child is alleged to have been abused or neglected, the court may waive the appointment of a guardian ad litem pursuant to clause (a), whenever counsel has been appointed pursuant to subdivision 2 or is retained otherwise, and the court is satisfied that the interests of the minor are protected.

(d) In appointing a guardian ad litem pursuant to clause (a), the court shall not appoint the party, or any agent or employee thereof, filing a petition pursuant to section 260C.141.

(e) The following factors shall be considered when appointing a guardian ad litem in a case involving an Indian or minority child:

(1) whether a person is available who is the same racial or ethnic heritage as the child or, if that is not possible;

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(2) whether a person is available who knows and appreciates the child's racial or ethnic heritage.

(f) The court shall require a background study for each guardian ad litem as provided under section 518.165. The court shall have access to data collected pursuant to section 245C.32 for purposes of the background study.

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

Sec. 49. Minnesota Statutes 2004, section 299C.093, as amended by Laws 2005, chapter 136, article 5, section 4, is amended to read:

299C.093 DATABASE OF REGISTERED PREDATORY OFFENDERS.

The superintendent of the bureau of criminal apprehension shall maintain a computerized data system relating to individuals required to register as predatory offenders under section 243.166. To the degree feasible, the system must include the data required to be provided under section 243.166, subdivisions 4 and 4a, and indicate the time period that the person is required to register. The superintendent shall maintain this data in a manner that ensures that it is readily available to law enforcement agencies. This data is private data on individuals under section 13.02, subdivision 12, but may be used for law enforcement and corrections purposes. State-operated services, as defined in section 246.014, are also authorized to have access to the data for the purposes described in section 246.13, subdivision 2, paragraph (e) (b).

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

Sec. 50. Minnesota Statutes 2004, section 518.165, is amended by adding a subdivision to read:

Subd. 4. BACKGROUND STUDY OF GUARDIAN AD LITEM. (a) The court shall initiate a background study through the commissioner of human services under section 245C.32 on every guardian ad litem appointed under this section if a background study has not been completed on the guardian ad litem within the past three years. The background study must be completed before the court appoints the guardian ad litem, unless the court determines that it is in the best interest of the child to appoint a guardian ad litem before a background study can be completed by the commissioner. The court shall initiate a subsequent background study under this paragraph once every three years after the guardian has been appointed as long as the individual continues to serve as a guardian ad litem.

(b) The background study must include criminal history data from the Bureau of Criminal Apprehension, other criminal history data held by the commissioner of human services, and data regarding whether the person has been a perpetrator of substantiated maltreatment of a minor or a vulnerable adult. When the information from the Bureau of Criminal Apprehension indicates that the subject of a study under paragraph (a) is a multistate offender or that the subject's multistate offender status is undetermined, the court shall require a search of the National Criminal Records

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Repository, and shall provide the commissioner a set of classifiable fingerprints of the subject of the study.

(c) The Minnesota Supreme Court shall pay the commissioner a fee for conducting a background study under section 245C.32.

(d) Nothing precludes the court from initiating background studies using court data on criminal convictions.

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

Sec. 51. Minnesota Statutes 2004, section 518.165, is amended by adding a subdivision to read:

Subd. 5. PROCEDURE, CRIMINAL HISTORY, AND MALTREATMENT RECORDS BACKGROUND STUDY. (a) When the court requests a background study under subdivision 4, paragraph (a), the request shall be submitted to the Department of Human Services through the department's electronic online background study system.

(b) When the court requests a search of the National Criminal Records Repository, the court must provide a set of classifiable fingerprints of the subject of the study on a fingerprint card provided by the commissioner of human services.

(c) The commissioner of human services shall provide the court with information from the Bureau of Criminal Apprehension's Criminal Justice Information System, other criminal history data held by the commissioner of human services, and data regarding substantiated maltreatment of a minor under section 626.556, and substantiated maltreatment of a vulnerable adult under section 626.557, within 15 working days of receipt of a request. If the subject of the study has been determined by the Department of Human Services or the Department of Health to be the perpetrator of substantiated maltreatment of a minor or vulnerable adult in a licensed facility, the response must include a copy of the public portion of the investigation memorandum under section 626.556, subdivision 10f, or the public portion of the investigation memorandum under section 626.557, subdivision 12b. When the background study shows that the subject has been determined by a county adult protection or child protection agency to have been responsible for maltreatment, the court shall be informed of the county, the date of the finding, and the nature of the maltreatment that was substantiated. The commissioner shall provide the court with information from the National Criminal Records Repository within three working days of the commissioner's receipt of the data. When the commissioner finds no criminal history or substantiated maltreatment on a background study subject, the commissioner shall make these results available to the court electronically through the secure online background study system.

(d) Notwithstanding section 626.556, subdivision 10f, or 626.557, subdivision 12b, if the commissioner or county lead agency has information that a person on whom a background study was previously done under this section has been determined to be a perpetrator of maltreatment of a minor or vulnerable adult, the commissioner or the county may provide this information to the court that requested the background study.

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

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Sec. 52. Minnesota Statutes 2004, section 518.165, is amended by adding a subdivision to read:

Subd. 6. RIGHTS. The court shall notify the subject of a background study that the subject has the following rights:

(1) the right to be informed that the court will request a background study on the subject for the purpose of determining whether the person's appointment or continued appointment is in the best interests of the child;

(2) the right to be informed of the results of the study and to obtain from the court a copy of the results; and

(3) the right to challenge the accuracy and completeness of the information contained in the results to the agency responsible for creation of the data except to the extent precluded by section 256.045, subdivision 3.

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

Sec. 53. Minnesota Statutes 2004, section 609A.03, subdivision 7, as amended by Laws 2005, chapter 136, article 12, section 11, is amended to read:

Subd. 7. **LIMITATIONS OF ORDER.** (a) Upon issuance of an expungement order related to a charge supported by probable cause, the DNA samples and DNA records held by the Bureau of Criminal Apprehension and collected under authority other than section 299C.105, shall not be sealed, returned to the subject of the record, or destroyed.

(b) Notwithstanding the issuance of an expungement order:

(1) an expunged record may be opened for purposes of a criminal investigation, prosecution, or sentencing, upon an ex parte court order; ~~and~~

(2) an expunged record of a conviction may be opened for purposes of evaluating a prospective employee in a criminal justice agency without a court order; ~~and~~

(3) an expunged record of a conviction may be opened for purposes of a background study under section 245C.08 unless the court order for expungement is directed specifically to the commissioner of human services.

Upon request by law enforcement, prosecution, or corrections authorities, an agency or jurisdiction subject to an expungement order shall inform the requester of the existence of a sealed record and of the right to obtain access to it as provided by this paragraph. For purposes of this section, a "criminal justice agency" means courts or a government agency that performs the administration of criminal justice under statutory authority.

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Sec. 54. Minnesota Statutes 2004, section 626.556, subdivision 10i, as amended by Laws 2005, chapter 159, article 1, section 9, is amended to read:

Subd. 10i. **ADMINISTRATIVE RECONSIDERATION OF FINAL DETERMINATION OF MALTREATMENT AND DISQUALIFICATION BASED ON SERIOUS OR RECURRING MALTREATMENT; REVIEW PANEL.** (a) Administrative reconsideration is not applicable in family assessments since no determination concerning maltreatment is made. For investigations, except as provided under paragraph (e), an individual or facility that the commissioner of human services, a local social service agency, or the commissioner of education determines has maltreated a child, an interested person acting on behalf of the child, regardless of the determination, who contests the investigating agency's final determination regarding maltreatment, may request the investigating agency to reconsider its final determination regarding maltreatment. The request for reconsideration must be submitted in writing to the investigating agency within 15 calendar days after receipt of notice of the final determination regarding maltreatment or, if the request is made by an interested person who is not entitled to notice, within 15 days after receipt of the notice by the parent or guardian of the child. If mailed, the request for reconsideration must be postmarked and sent to the investigating agency within 15 calendar days of the individual's or facility's receipt of the final determination. If the request for reconsideration is made by personal service, it must be received by the investigating agency within 15 calendar days after the individual's or facility's receipt of the final determination. Effective January 1, 2002, an individual who was determined to have maltreated a child under this section and who was disqualified on the basis of serious or recurring maltreatment under sections 245C.14 and 245C.15, may request reconsideration of the maltreatment determination and the disqualification. The request for reconsideration of the maltreatment determination and the disqualification must be submitted within 30 calendar days of the individual's receipt of the notice of disqualification under sections 245C.16 and 245C.17. If mailed, the request for reconsideration of the maltreatment determination and the disqualification must be postmarked and sent to the investigating agency within 30 calendar days of the individual's receipt of the maltreatment determination and notice of disqualification. If the request for reconsideration is made by personal service, it must be received by the investigating agency within 30 calendar days after the individual's receipt of the notice of disqualification.

(b) Except as provided under paragraphs (e) and (f), if the investigating agency denies the request or fails to act upon the request within 15 calendar working days after receiving the request for reconsideration, the person or facility entitled to a fair hearing under section 256.045 may submit to the commissioner of human services or the commissioner of education a written request for a hearing under that section. Section 256.045 also governs hearings requested to contest a final determination of the commissioner of education. For reports involving maltreatment of a child in a facility, an interested person acting on behalf of the child may request a review by the Child Maltreatment Review Panel under section 256.022 if the investigating agency denies the request or fails to act upon the request or if the interested person contests a reconsidered determination. The investigating agency shall notify persons who request

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reconsideration of their rights under this paragraph. The request must be submitted in writing to the review panel and a copy sent to the investigating agency within 30 calendar days of receipt of notice of a denial of a request for reconsideration or of a reconsidered determination. The request must specifically identify the aspects of the agency determination with which the person is dissatisfied.

(c) If, as a result of a reconsideration or review, the investigating agency changes the final determination of maltreatment, that agency shall notify the parties specified in subdivisions 10b, 10d, and 10f.

(d) Except as provided under paragraph (f), if an individual or facility contests the investigating agency's final determination regarding maltreatment by requesting a fair hearing under section 256.045, the commissioner of human services shall assure that the hearing is conducted and a decision is reached within 90 days of receipt of the request for a hearing. The time for action on the decision may be extended for as many days as the hearing is postponed or the record is held open for the benefit of either party.

(e) Effective January 1, 2002, if an individual was disqualified under sections 245C.14 and 245C.15, on the basis of a determination of maltreatment, which was serious or recurring, and the individual has requested reconsideration of the maltreatment determination under paragraph (a) and requested reconsideration of the disqualification under sections 245C.21 to 245C.27, reconsideration of the maltreatment determination and reconsideration of the disqualification shall be consolidated into a single reconsideration. If reconsideration of the maltreatment determination is denied or the disqualification is not set aside under sections 245C.21 to 245C.27, the individual may request a fair hearing under section 256.045. If an individual requests a fair hearing on the maltreatment determination and the disqualification, the scope of the fair hearing shall include both the maltreatment determination and the disqualification.

(f) Effective January 1, 2002, if a maltreatment determination or a disqualification based on serious or recurring maltreatment is the basis for a denial of a license under section 245A.05 or a licensing sanction under section 245A.07, the license holder has the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. As provided for under section 245A.08, subdivision 2a, the scope of the contested case hearing shall include the maltreatment determination, disqualification, and licensing sanction or denial of a license. In such cases, a fair hearing regarding the maltreatment determination shall not be conducted under paragraph (b). When a fine is based on a determination that the license holder is responsible for maltreatment and the fine is issued at the same time as the maltreatment determination, if the license holder appeals the maltreatment and fine, reconsideration of the maltreatment determination shall not be conducted under this section. If the disqualified subject is an individual other than the license holder and upon whom a background study must be conducted under chapter 245C, the hearings of all parties may be consolidated into a single contested case hearing upon consent of all parties and the administrative law judge.

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(g) For purposes of this subdivision, "interested person acting on behalf of the child" means a parent or legal guardian; stepparent; grandparent; guardian ad litem; adult stepbrother, stepsister, or sibling; or adult aunt or uncle; unless the person has been determined to be the perpetrator of the maltreatment.

Sec. 55. Minnesota Statutes 2004, section 626.557, subdivision 9d, is amended to read:

Subd. 9d. **ADMINISTRATIVE RECONSIDERATION OF FINAL DISPOSITION OF MALTREATMENT AND DISQUALIFICATION BASED ON SERIOUS OR RECURRING MALTREATMENT; REVIEW PANEL.** (a) Except as provided under paragraph (e), any individual or facility which a lead agency determines has maltreated a vulnerable adult, or the vulnerable adult or an interested person acting on behalf of the vulnerable adult, regardless of the lead agency's determination, who contests the lead agency's final disposition of an allegation of maltreatment, may request the lead agency to reconsider its final disposition. The request for reconsideration must be submitted in writing to the lead agency within 15 calendar days after receipt of notice of final disposition or, if the request is made by an interested person who is not entitled to notice, within 15 days after receipt of the notice by the vulnerable adult or the vulnerable adult's legal guardian. If mailed, the request for reconsideration must be postmarked and sent to the lead agency within 15 calendar days of the individual's or facility's receipt of the final disposition. If the request for reconsideration is made by personal service, it must be received by the lead agency within 15 calendar days of the individual's or facility's receipt of the final disposition. An individual who was determined to have maltreated a vulnerable adult under this section and who was disqualified on the basis of serious or recurring maltreatment under sections 245C.14 and 245C.15, may request reconsideration of the maltreatment determination and the disqualification. The request for reconsideration of the maltreatment determination and the disqualification must be submitted in writing within 30 calendar days of the individual's receipt of the notice of disqualification under sections 245C.16 and 245C.17. If mailed, the request for reconsideration of the maltreatment determination and the disqualification must be postmarked and sent to the lead agency within 30 calendar days of the individual's receipt of the notice of disqualification. If the request for reconsideration is made by personal service, it must be received by the lead agency within 30 calendar days after the individual's receipt of the notice of disqualification.

(b) Except as provided under paragraphs (e) and (f), if the lead agency denies the request or fails to act upon the request within 15 calendar working days after receiving the request for reconsideration, the person or facility entitled to a fair hearing under section 256.045, may submit to the commissioner of human services a written request for a hearing under that statute. The vulnerable adult, or an interested person acting on behalf of the vulnerable adult, may request a review by the Vulnerable Adult Maltreatment Review Panel under section 256.021 if the lead agency denies the request or fails to act upon the request, or if the vulnerable adult or interested person contests a reconsidered disposition. The lead agency shall notify persons who request

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reconsideration of their rights under this paragraph. The request must be submitted in writing to the review panel and a copy sent to the lead agency within 30 calendar days of receipt of notice of a denial of a request for reconsideration or of a reconsidered disposition. The request must specifically identify the aspects of the agency determination with which the person is dissatisfied.

(c) If, as a result of a reconsideration or review, the lead agency changes the final disposition, it shall notify the parties specified in subdivision 9c, paragraph (d).

(d) For purposes of this subdivision, "interested person acting on behalf of the vulnerable adult" means a person designated in writing by the vulnerable adult to act on behalf of the vulnerable adult, or a legal guardian or conservator or other legal representative, a proxy or health care agent appointed under chapter 145B or 145C, or an individual who is related to the vulnerable adult, as defined in section 245A.02, subdivision 13.

(e) If an individual was disqualified under sections 245C.14 and 245C.15, on the basis of a determination of maltreatment, which was serious or recurring, and the individual has requested reconsideration of the maltreatment determination under paragraph (a) and reconsideration of the disqualification under sections 245C.21 to 245C.27, reconsideration of the maltreatment determination and requested reconsideration of the disqualification shall be consolidated into a single reconsideration. If reconsideration of the maltreatment determination is denied or if the disqualification is not set aside under sections 245C.21 to 245C.27, the individual may request a fair hearing under section 256.045. If an individual requests a fair hearing on the maltreatment determination and the disqualification, the scope of the fair hearing shall include both the maltreatment determination and the disqualification.

(f) If a maltreatment determination or a disqualification based on serious or recurring maltreatment is the basis for a denial of a license under section 245A.05 or a licensing sanction under section 245A.07, the license holder has the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. As provided for under section 245A.08, the scope of the contested case hearing shall include the maltreatment determination, disqualification, and licensing sanction or denial of a license. In such cases, a fair hearing shall not be conducted under paragraph (b). When a fine is based on a determination that the license holder is responsible for maltreatment and the fine is issued at the same time as the maltreatment determination, if the license holder appeals the maltreatment and fine, reconsideration of the maltreatment determination shall not be conducted under this section. If the disqualified subject is an individual other than the license holder and upon whom a background study must be conducted under chapter 245C, the hearings of all parties may be consolidated into a single contested case hearing upon consent of all parties and the administrative law judge.

(g) Until August 1, 2002, an individual or facility that was determined by the commissioner of human services or the commissioner of health to be responsible for neglect under section 626.5572, subdivision 17, after October 1, 1995, and before

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August 1, 2001, that believes that the finding of neglect does not meet an amended definition of neglect may request a reconsideration of the determination of neglect. The commissioner of human services or the commissioner of health shall mail a notice to the last known address of individuals who are eligible to seek this reconsideration. The request for reconsideration must state how the established findings no longer meet the elements of the definition of neglect. The commissioner shall review the request for reconsideration and make a determination within 15 calendar days. The commissioner's decision on this reconsideration is the final agency action.

(1) For purposes of compliance with the data destruction schedule under subdivision 12b, paragraph (d), when a finding of substantiated maltreatment has been changed as a result of a reconsideration under this paragraph, the date of the original finding of a substantiated maltreatment must be used to calculate the destruction date.

(2) For purposes of any background studies under chapter 245C, when a determination of substantiated maltreatment has been changed as a result of a reconsideration under this paragraph, any prior disqualification of the individual under chapter 245C that was based on this determination of maltreatment shall be rescinded, and for future background studies under chapter 245C the commissioner must not use the previous determination of substantiated maltreatment as a basis for disqualification or as a basis for referring the individual's maltreatment history to a health-related licensing board under section 245C.31.

Sec. 56. Minnesota Statutes 2004, section 626.557, subdivision 14, as amended by Laws 2005, chapter 136, article 5, section 5, is amended to read:

Subd. 14. **ABUSE PREVENTION PLANS.** (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency.

(b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse.

(c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might

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reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult.

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 57. **EFFECTIVE DATE.**

This article is effective August 1, 2005, unless specified otherwise.

ARTICLE 2

MENTAL AND CHEMICAL HEALTH

Section 1. Minnesota Statutes 2004, section 62J.692, subdivision 3, as amended by Laws 2005, chapter 84, section 1, is amended to read:

Subd. 3. **APPLICATION PROCESS.** (a) A clinical medical education program conducted in Minnesota by a teaching institution to train physicians, doctor of pharmacy practitioners, dentists, chiropractors, or physician assistants is eligible for funds under subdivision 4 if the program:

- (1) is funded, in part, by patient care revenues;
- (2) occurs in patient care settings that face increased financial pressure as a result of competition with nonteaching patient care entities; and
- (3) emphasizes primary care or specialties that are in undersupply in Minnesota.

A clinical medical education program that trains pediatricians is requested to include in its program curriculum training in case management and medication management for children suffering from mental illness to be eligible for funds under subdivision 4.

(b) A clinical medical education program for advanced practice nursing is eligible for funds under subdivision 4 if the program meets the eligibility requirements in paragraph (a), clauses (1) to (3), and is sponsored by the University of Minnesota Academic Health Center, the Mayo Foundation, or institutions that are part of the Minnesota State Colleges and Universities system or members of the Minnesota Private College Council.

(c) Applications must be submitted to the commissioner by a sponsoring institution on behalf of an eligible clinical medical education program and must be received by October 31 of each year for distribution in the following year. An

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application for funds must contain the following information:

(1) the official name and address of the sponsoring institution and the official name and site address of the clinical medical education programs on whose behalf the sponsoring institution is applying;

(2) the name, title, and business address of those persons responsible for administering the funds;

(3) for each clinical medical education program for which funds are being sought; the type and specialty orientation of trainees in the program; the name, site address, and medical assistance provider number of each training site used in the program; the total number of trainees at each training site; and the total number of eligible trainee FTEs at each site; and

(4) other supporting information the commissioner deems necessary to determine program eligibility based on the criteria in paragraphs (a) and (b) and to ensure the equitable distribution of funds.

(d) An application must include the information specified in clauses (1) to (3) for each clinical medical education program on an annual basis for three consecutive years. After that time, an application must include the information specified in clauses (1) to (3) when requested, at the discretion of the commissioner:

(1) audited clinical training costs per trainee for each clinical medical education program when available or estimates of clinical training costs based on audited financial data;

(2) a description of current sources of funding for clinical medical education costs, including a description and dollar amount of all state and federal financial support, including Medicare direct and indirect payments; and

(3) other revenue received for the purposes of clinical training.

(e) An applicant that does not provide information requested by the commissioner shall not be eligible for funds for the current funding cycle.

Sec. 2. Minnesota Statutes 2004, section 245.4661, is amended by adding a subdivision to read:

Subd. 8. BUDGET FLEXIBILITY. The commissioner may make budget transfers that do not increase the state share of costs to effectively implement the restructuring of adult mental health services.

Sec. 3. Minnesota Statutes 2004, section 245.4874, as amended by Laws 2005, chapter 98, article 3, section 11, is amended to read:

245.4874 DUTIES OF COUNTY BOARD.

(a) The county board must:

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(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 improve the availability of mental health services to children and the cost-effectiveness of their delivery;

(6) assure that mental health services delivered according to sections 245.487 to 245.4887 are delivered expeditiously and are appropriate to the child's diagnostic assessment and individual treatment plan;

(7) provide the community with information about predictors and symptoms of emotional disturbances and how to access children's mental health services according to sections 245.4877 and 245.4878;

(8) provide for case management services to each child with severe emotional disturbance according to sections 245.486; 245.4871, subdivisions 3 and 4; and 245.4881, subdivisions 1, 3, and 5;

(9) provide for screening of each child under section 245.4885 upon admission to a residential treatment facility, acute care hospital inpatient treatment, or informal admission to a regional treatment center;

(10) prudently administer grants and purchase-of-service contracts that the county board determines are necessary to fulfill its responsibilities under sections 245.487 to 245.4887;

(11) assure that mental health professionals, mental health practitioners, and case managers employed by or under contract to the county to provide mental health services are qualified under section 245.4871;

(12) assure that children's mental health services are coordinated with adult mental health services specified in sections 245.461 to 245.486 so that a continuum of mental health services is available to serve persons with mental illness, regardless of the person's age;

(13) assure that culturally informed mental health consultants are used as necessary to assist the county board in assessing and providing appropriate treatment

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for children of cultural or racial minority heritage; and

(14) consistent with section 245.486, arrange for or provide a children's mental health screening to a child receiving child protective services or a child in out-of-home placement, a child for whom parental rights have been terminated, a child found to be delinquent, and a child found to have committed a juvenile petty offense for the third or subsequent time, unless a screening has been performed within the previous 180 days, or the child is currently under the care of a mental health professional. The court or county agency must notify a parent or guardian whose parental rights have not been terminated of the potential mental health screening and the option to prevent the screening by notifying the court or county agency in writing. The screening shall be conducted with a screening instrument approved by the commissioner of human services according to criteria that are updated and issued annually to ensure that approved screening instruments are valid and useful for child welfare and juvenile justice populations, and shall be conducted by a mental health practitioner as defined in section 245.4871, subdivision 26, or a probation officer or local social services agency staff person who is trained in the use of the screening instrument. Training in the use of the instrument shall include training in the administration of the instrument, the interpretation of its validity given the child's current circumstances, the state and federal data practices laws and confidentiality standards, the parental consent requirement, and providing respect for families and cultural values. If the screen indicates a need for assessment, the child's family, or if the family lacks mental health insurance, the local social services agency, in consultation with the child's family, shall have conducted a diagnostic assessment, including a functional assessment, as defined in section 245.4871. The administration of the screening shall safeguard the privacy of children receiving the screening and their families and shall comply with the Minnesota Government Data Practices Act, chapter 13, and the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191. Screening results shall be considered private data and the commissioner shall not collect individual screening results.

(b) When the county board refers clients to providers of children's therapeutic services and supports under section 256B.0943, the county board must clearly identify the desired services components not covered under section 256B.0943 and identify the reimbursement source for those requested services, the method of payment, and the payment rate to the provider.

Sec. 4. Minnesota Statutes 2004, section 245.4885, subdivision 1, is amended to read:

Subdivision 1. **SCREENING REQUIRED ADMISSION CRITERIA.** The county board shall, prior to admission, except in the case of emergency admission, screen determine the needed level of care for all children referred for treatment of severe emotional disturbance to in a treatment foster care setting, residential treatment facility, or informally admitted to a regional treatment center if public funds are used to pay for the services. The county board shall also screen determine the needed level of care for all children admitted to an acute care hospital for treatment of severe

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emotional disturbance if public funds other than reimbursement under chapters 256B and 256D are used to pay for the services. If a child is admitted to a residential treatment facility or acute care hospital for emergency treatment or held for emergency care by a regional treatment center under section 253B.05, subdivision 1, screening must occur within three working days of admission. Screening The level of care determination shall determine whether the proposed treatment:

- (1) is necessary;
- (2) is appropriate to the child's individual treatment needs;
- (3) cannot be effectively provided in the child's home; and
- (4) provides a length of stay as short as possible consistent with the individual child's need.

When a screening level of care determination is conducted, the county board may not determine that referral or admission to a treatment foster care setting, residential treatment facility, or acute care hospital is not appropriate solely because services were not first provided to the child in a less restrictive setting and the child failed to make progress toward or meet treatment goals in the less restrictive setting. Screening shall include both The level of care determination must be based on a diagnostic assessment and that includes a functional assessment which evaluates family, school, and community living situations; and an assessment of the child's need for care out of the home using a validated tool which assesses a child's functional status and assigns an appropriate level of care. The validated tool must be approved by the commissioner of human services. If a diagnostic assessment or including a functional assessment has been completed by a mental health professional within the past 180 days, a new diagnostic or functional assessment need not be completed unless in the opinion of the current treating mental health professional the child's mental health status has changed markedly since the assessment was completed. The child's parent shall be notified if an assessment will not be completed and of the reasons. A copy of the notice shall be placed in the child's file. Recommendations developed as part of the screening level of care determination process shall include specific community services needed by the child and, if appropriate, the child's family, and shall indicate whether or not these services are available and accessible to the child and family.

During the screening level of care determination process, the child, child's family, or child's legal representative, as appropriate, must be informed of the child's eligibility for case management services and family community support services and that an individual family community support plan is being developed by the case manager, if assigned.

Screening The level of care determination shall be in compliance comply with section 260C.212. Wherever possible, the parent shall be consulted in the screening process, unless clinically inappropriate.

The screening process level of care determination, and placement decision, and recommendations for mental health services must be documented in the child's record.

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An alternate review process may be approved by the commissioner if the county board demonstrates that an alternate review process has been established by the county board and the times of review, persons responsible for the review, and review criteria are comparable to the standards in clauses (1) to (4).

EFFECTIVE DATE. This section is effective July 1, 2006.

Sec. 5. Minnesota Statutes 2004, section 245.4885, is amended by adding a subdivision to read:

Subd. 1a. EMERGENCY ADMISSION. Effective July 1, 2006, if a child is admitted to a treatment foster care setting, residential treatment facility, or acute care hospital for emergency treatment or held for emergency care by a regional treatment center under section 253B.05, subdivision 1, the level of care determination must occur within three working days of admission.

Sec. 6. Minnesota Statutes 2004, section 245.4885, subdivision 2, is amended to read:

Subd. 2. QUALIFICATIONS. No later than July 1, 1991, Screening Level of care determination of children for treatment foster care, residential, and inpatient services must be conducted by a mental health professional. Where appropriate and available, culturally informed mental health consultants must participate in the screening level of care determination. Mental health professionals providing screening level of care determination for treatment foster care, inpatient, and residential services must not be financially affiliated with any acute care inpatient hospital, residential treatment facility, or regional treatment center nongovernment entity which may be providing those services. The commissioner may waive this requirement for mental health professional participation after July 1, 1991, if the county documents that:

- (1) mental health professionals or mental health practitioners are unavailable to provide this service; and
- (2) services are provided by a designated person with training in human services who receives clinical supervision from a mental health professional.

EFFECTIVE DATE. This section is effective July 1, 2006.

Sec. 7. Minnesota Statutes 2004, section 256B.0622, subdivision 2, is amended to read:

Subd. 2. **DEFINITIONS.** For purposes of this section, the following terms have the meanings given them.

(a) "Intensive nonresidential rehabilitative mental health services" means adult rehabilitative mental health services as defined in section 256B.0623, subdivision 2, paragraph (a), except that these services are provided by a multidisciplinary staff using a total team approach consistent with assertive community treatment, the Fairweather Lodge treatment model, as defined by the standards established by the National Coalition for Community Living, and other evidence-based practices, and directed to

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recipients with a serious mental illness who require intensive services.

(b) "Intensive residential rehabilitative mental health services" means short-term, time-limited services provided in a residential setting to recipients who are in need of more restrictive settings and are at risk of significant functional deterioration if they do not receive these services. Services are designed to develop and enhance psychiatric stability, personal and emotional adjustment, self-sufficiency, and skills to live in a more independent setting. Services must be directed toward a targeted discharge date with specified client outcomes and must be consistent with the Fairweather Lodge treatment model as defined in paragraph (a), and other evidence-based practices.

(c) "Evidence-based practices" are nationally recognized mental health services that are proven by substantial research to be effective in helping individuals with serious mental illness obtain specific treatment goals.

(d) "Overnight staff" means a member of the intensive residential rehabilitative mental health treatment team who is responsible during hours when recipients are typically asleep.

(e) "Treatment team" means all staff who provide services under this section to recipients. At a minimum, this includes the clinical supervisor, mental health professionals, mental health practitioners, and mental health rehabilitation workers.

Sec. 8. Minnesota Statutes 2004, section 256B.0625, is amended by adding a subdivision to read:

Subd. 46. **MENTAL HEALTH TELMEDICINE.** Effective January 1, 2006, and subject to federal approval, mental health services that are otherwise covered by medical assistance as direct face-to-face services may be provided via two-way interactive video. Use of two-way interactive video must be medically appropriate to the condition and needs of the person being served. Reimbursement is at the same rates and under the same conditions that would otherwise apply to the service. The interactive video equipment and connection must comply with Medicare standards in effect at the time the service is provided.

Sec. 9. Minnesota Statutes 2004, section 256B.0625, is amended by adding a subdivision to read:

Subd. 47. **TREATMENT FOSTER CARE SERVICES.** Effective July 1, 2006, and subject to federal approval, medical assistance covers treatment foster care services according to section 256B.0946.

Sec. 10. Minnesota Statutes 2004, section 256B.0625, is amended by adding a subdivision to read:

Subd. 48. **PSYCHIATRIC CONSULTATION TO PRIMARY CARE PRACTITIONERS.** Effective January 1, 2006, medical assistance covers consultation provided by a psychiatrist via telephone, e-mail, facsimile, or other means of communication to primary care practitioners, including pediatricians. The need for consultation and the receipt of the consultation must be documented in the patient

record maintained by the primary care practitioner. If the patient consents, and subject to federal limitations and data privacy provisions, the consultation may be provided without the patient present.

Sec. 11. Minnesota Statutes 2004, section 256B.0943, subdivision 3, is amended to read:

Subd. 3. **DETERMINATION OF CLIENT ELIGIBILITY.** A client's eligibility to receive children's therapeutic services and supports under this section shall be determined based on a diagnostic assessment by a mental health professional that is performed within 180 days of the initial start of service. The diagnostic assessment must:

(1) include current diagnoses on all five axes of the client's current mental health status;

(2) determine whether a child under age 18 has a diagnosis of emotional disturbance or, if the person is between the ages of 18 and 21, whether the person has a mental illness;

(3) document children's therapeutic services and supports as medically necessary to address an identified disability, functional impairment, and the individual client's needs and goals;

(4) be used in the development of the individualized treatment plan; and

(5) be completed annually until age 18. A client with autism spectrum disorder or pervasive developmental disorder may receive a diagnostic assessment once every three years, at the request of the parent or guardian, if a mental health professional agrees there has been little change in the condition and that an annual assessment is not needed. For individuals between age 18 and 21, unless a client's mental health condition has changed markedly since the client's most recent diagnostic assessment, annual updating is necessary. For the purpose of this section, "updating" means a written summary, including current diagnoses on all five axes, by a mental health professional of the client's current mental health status and service needs.

Sec. 12. **[256B.0946] TREATMENT FOSTER CARE.**

Subdivision 1. **COVERED SERVICE.** (a) Effective July 1, 2006, and subject to federal approval, medical assistance covers medically necessary services described under paragraph (b) that are provided by a provider entity eligible under subdivision 3 to a client eligible under subdivision 2 who is placed in a treatment foster home licensed under Minnesota Rules, parts 2960.3000 to 2960.3340.

(b) Services to children with severe emotional disturbance residing in treatment foster care settings must meet the relevant standards for mental health services under sections 245.487 to 245.4887. In addition, specific service components reimbursed by medical assistance must meet the following standards:

(1) case management service component must meet the standards in Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10;

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(2) psychotherapy and skills training components must meet the standards for children's therapeutic services and supports in section 256B.0943; and

(3) family psychoeducation services under supervision of a mental health professional.

Subd. 2. DETERMINATION OF CLIENT ELIGIBILITY. A client's eligibility to receive treatment foster care under this section shall be determined by a diagnostic assessment, an evaluation of level of care needed, and development of an individual treatment plan, as defined in paragraphs (a) to (c).

(a) The diagnostic assessment must:

(1) be conducted by a psychiatrist, licensed psychologist, or licensed independent clinical social worker that is performed within 180 days prior to the start of service;

(2) include current diagnoses on all five axes of the client's current mental health status;

(3) determine whether or not a child meets the criteria for severe emotional disturbance in section 245.4871, subdivision 6, or for serious and persistent mental illness in section 245.462, subdivision 20; and

(4) be completed annually until age 18. For individuals between age 18 and 21, unless a client's mental health condition has changed markedly since the client's most recent diagnostic assessment, annual updating is necessary. For the purpose of this section, "updating" means a written summary, including current diagnoses on all five axes, by a mental health professional of the client's current mental status and service needs.

(b) The evaluation of level of care must be conducted by the placing county with an instrument approved by the commissioner of human services. The commissioner shall update the list of approved level of care instruments annually.

(c) The individual treatment plan must be:

(1) based on the information in the client's diagnostic assessment;

(2) developed through a child-centered, family driven planning process that identifies service needs and individualized, planned, and culturally appropriate interventions that contain specific measurable treatment goals and objectives for the client and treatment strategies for the client's family and foster family;

(3) reviewed at least once every 90 days and revised; and

(4) signed by the client or, if appropriate, by the client's parent or other person authorized by statute to consent to mental health services for the client.

Subd. 3. ELIGIBLE PROVIDERS. For purposes of this section, a provider agency must have an individual placement agreement for each recipient and must be a licensed child placing agency, under Minnesota Rules, parts 9543.0010 to 9543.0150, and either:

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(1) a county;

(2) an Indian Health Services facility operated by a tribe or tribal organization under funding authorized by United States Code, title 25, sections 450f to 450n, or title 3 of the Indian Self-Determination Act, Public Law 93-638, section 638 (facilities or providers); or

(3) a noncounty entity under contract with a county board.

Subd. 4. ELIGIBLE PROVIDER RESPONSIBILITIES. (a) To be an eligible provider under this section, a provider must develop written policies and procedures for treatment foster care services consistent with subdivision 1, paragraph (b), clauses (1), (2), and (3).

(b) In delivering services under this section, a treatment foster care provider must ensure that staff caseload size reasonably enables the provider to play an active role in service planning, monitoring, delivering, and reviewing for discharge planning to meet the needs of the client, the client's foster family, and the birth family, as specified in each client's individual treatment plan.

Subd. 5. SERVICE AUTHORIZATION. The commissioner will administer authorizations for services under this section in compliance with section 256B.0625, subdivision 25.

Subd. 6. EXCLUDED SERVICES. (a) Services in clauses (1) to (4) are not eligible as components of treatment foster care services:

(1) treatment foster care services provided in violation of medical assistance policy in Minnesota Rules, part 9505.0220;

(2) service components of children's therapeutic services and supports simultaneously provided by more than one treatment foster care provider;

(3) home and community-based waiver services; and

(4) treatment foster care services provided to a child without a level of care determination according to section 245.4885, subdivision 1.

(b) Children receiving treatment foster care services are not eligible for medical assistance reimbursement for the following services while receiving treatment foster care:

(1) mental health case management services under section 256B.0625, subdivision 20; and

(2) psychotherapy and skill training components of children's therapeutic services and supports under section 256B.0625, subdivision 35b.

Sec. 13. [256B.0947] TRANSITIONAL YOUTH INTENSIVE REHABILITATIVE MENTAL HEALTH SERVICES.

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Subdivision 1. SCOPE. Subject to federal approval, medical assistance covers medically necessary, intensive nonresidential rehabilitative mental health services as defined in subdivision 2, for recipients as defined in subdivision 3, when the services are provided by an entity meeting the standards in this section.

Subd. 2. DEFINITIONS. For purposes of this section, the following terms have the meanings given them.

(a) "Intensive nonresidential rehabilitative mental health services" means child rehabilitative mental health services as defined in section 256B.0943, except that these services are provided by a multidisciplinary staff using a total team approach consistent with assertive community treatment, or other evidence-based practices, and directed to recipients with a serious mental illness who require intensive services.

(b) "Evidence-based practices" are nationally recognized mental health services that are proven by substantial research to be effective in helping individuals with serious mental illness obtain specific treatment goals.

(c) "Treatment team" means all staff who provide services to recipients under this section. At a minimum, this includes the clinical supervisor, mental health professionals, mental health practitioners, mental health behavioral aides, and a school representative familiar with the recipient's individual education plan (IEP) if applicable.

Subd. 3. ELIGIBILITY FOR TRANSITIONAL YOUTH. An eligible recipient under the age of 18 is an individual who:

(1) is age 16 or 17;

(2) is diagnosed with a medical condition, such as an emotional disturbance or traumatic brain injury, for which intensive nonresidential rehabilitative mental health services are needed;

(3) has substantial disability and functional impairment in three or more of the areas listed in section 245.462, subdivision 11a, so that self-sufficiency upon adulthood or emancipation is unlikely; and

(4) has had a recent diagnostic assessment by a qualified professional that documents that intensive nonresidential rehabilitative mental health services are medically necessary to address identified disability and functional impairments and individual recipient goals.

Subd. 4. PROVIDER CERTIFICATION AND CONTRACT REQUIREMENTS. (a) The intensive nonresidential rehabilitative mental health services provider must:

(1) have a contract with the host county to provide intensive transition youth rehabilitative mental health services; and

(2) be certified by the commissioner as being in compliance with this section and section 256B.0943.

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(b) The commissioner shall develop procedures for counties and providers to submit contracts and other documentation as needed to allow the commissioner to determine whether the standards in this section are met.

Subd. 5. STANDARDS APPLICABLE TO NONRESIDENTIAL PROVIDERS. (a) Services must be provided by a certified provider entity as defined in section 256B.0943, subdivision 4 that meets the requirements in section 245B.0943, subdivisions 5 and 6.

(b) The clinical supervisor must be an active member of the treatment team. The treatment team must meet with the clinical supervisor at least weekly to discuss recipients' progress and make rapid adjustments to meet recipients' needs. The team meeting shall include recipient-specific case reviews and general treatment discussions among team members. Recipient-specific case reviews and planning must be documented in the individual recipient's treatment record.

(c) Treatment staff must have prompt access in person or by telephone to a mental health practitioner or mental health professional. The provider must have the capacity to promptly and appropriately respond to emergent needs and make any necessary staffing adjustments to assure the health and safety of recipients.

(d) The initial functional assessment must be completed within ten days of intake and updated at least every three months or prior to discharge from the service, whichever comes first.

(e) The initial individual treatment plan must be completed within ten days of intake and reviewed and updated at least monthly with the recipient.

Subd. 6. ADDITIONAL STANDARDS FOR NONRESIDENTIAL SERVICES. The standards in this subdivision apply to intensive nonresidential rehabilitative mental health services.

(1) The treatment team must use team treatment, not an individual treatment model.

(2) The clinical supervisor must function as a practicing clinician at least on a part-time basis.

(3) The staffing ratio must not exceed ten recipients to one full-time equivalent treatment team position.

(4) Services must be available at times that meet client needs.

(5) The treatment team must actively and assertively engage and reach out to the recipient's family members and significant others, after obtaining the recipient's permission.

(6) The treatment team must establish ongoing communication and collaboration between the team, family, and significant others and educate the family and significant others about mental illness, symptom management, and the family's role in treatment.

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(7) The treatment team must provide interventions to promote positive interpersonal relationships.

Subd. 7. MEDICAL ASSISTANCE PAYMENT FOR INTENSIVE REHABILITATIVE MENTAL HEALTH SERVICES. (a) Payment for nonresidential services in this section shall be based on one daily rate per provider inclusive of the following services received by an eligible recipient in a given calendar day: all rehabilitative services under this section, staff travel time to provide rehabilitative services under this section, and nonresidential crisis stabilization services under section 256B.0944.

(b) Except as indicated in paragraph (c), payment will not be made to more than one entity for each recipient for services provided under this section on a given day. If services under this section are provided by a team that includes staff from more than one entity, the team must determine how to distribute the payment among the members.

(c) The host county shall recommend to the commissioner one rate for each entity that will bill medical assistance for nonresidential intensive rehabilitative mental health services. In developing these rates, the host county shall consider and document:

- (1) the cost for similar services in the local trade area;
- (2) actual costs incurred by entities providing the services;
- (3) the intensity and frequency of services to be provided to each recipient;
- (4) the degree to which recipients will receive services other than services under this section; and
- (5) the costs of other services that will be separately reimbursed.

(d) The rate for intensive rehabilitative mental health services must exclude medical assistance room and board rate, as defined in section 256I.03, subdivision 6, and services not covered under this section, such as partial hospitalization and inpatient services. Physician services are not a component of the treatment team and may be billed separately. The county's recommendation shall specify the period for which the rate will be applicable, not to exceed two years.

(e) When services under this section are provided by an assertive community team, case management functions must be an integral part of the team.

(f) The rate for a provider must not exceed the rate charged by that provider for the same service to other payors.

(g) The commissioner shall approve or reject the county's rate recommendation, based on the commissioner's own analysis of the criteria in paragraph (c).

Subd. 8. PROVIDER ENROLLMENT; RATE SETTING FOR COUNTY-OPERATED ENTITIES. Counties that employ their own staff to provide services under this section shall apply directly to the commissioner for enrollment and rate setting. In this case, a county contract is not required and the commissioner shall

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perform the program review and rate setting duties which would otherwise be required of counties under this section.

EFFECTIVE DATE. This section is effective July 1, 2006.

Sec. 14. Minnesota Statutes 2004, section 256B.19, subdivision 1, is amended to read:

Subdivision 1. **DIVISION OF COST.** The state and county share of medical assistance costs not paid by federal funds shall be as follows:

(1) beginning January 1, 1992, 50 percent state funds and 50 percent county funds for the cost of placement of severely emotionally disturbed children in regional treatment centers;

(2) beginning January 1, 2003, 80 percent state funds and 20 percent county funds for the costs of nursing facility placements of persons with disabilities under the age of 65 that have exceeded 90 days. This clause shall be subject to chapter 256G and shall not apply to placements in facilities not certified to participate in medical assistance;

(3) beginning July 1, 2004, ~~80~~ 90 percent state funds and ~~20~~ ten percent county funds for the costs of placements that have exceeded 90 days in intermediate care facilities for persons with mental retardation or a related condition that have seven or more beds. This provision includes pass-through payments made under section 256B.5015; and

(4) beginning July 1, 2004, when state funds are used to pay for a nursing facility placement due to the facility's status as an institution for mental diseases (IMD), the county shall pay 20 percent of the nonfederal share of costs that have exceeded 90 days. This clause is subject to chapter 256G.

For counties that participate in a Medicaid demonstration project under sections 256B.69 and 256B.71, the division of the nonfederal share of medical assistance expenses for payments made to prepaid health plans or for payments made to health maintenance organizations in the form of prepaid capitation payments, this division of medical assistance expenses shall be 95 percent by the state and five percent by the county of financial responsibility.

In counties where prepaid health plans are under contract to the commissioner to provide services to medical assistance recipients, the cost of court ordered treatment ordered without consulting the prepaid health plan that does not include diagnostic evaluation, recommendation, and referral for treatment by the prepaid health plan is the responsibility of the county of financial responsibility.

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

Sec. 15. Minnesota Statutes 2004, section 256D.03, subdivision 4, is amended to read:

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Subd. 4. **GENERAL ASSISTANCE MEDICAL CARE; SERVICES.** (a)(i) For a person who is eligible under subdivision 3, paragraph (a), clause (2), item (i), general assistance medical care covers, except as provided in paragraph (c):

- (1) inpatient hospital services;
- (2) outpatient hospital services;
- (3) services provided by Medicare certified rehabilitation agencies;
- (4) prescription drugs and other products recommended through the process established in section 256B.0625, subdivision 13;
- (5) equipment necessary to administer insulin and diagnostic supplies and equipment for diabetics to monitor blood sugar level;
- (6) eyeglasses and eye examinations provided by a physician or optometrist;
- (7) hearing aids;
- (8) prosthetic devices;
- (9) laboratory and X-ray services;
- (10) physician's services;
- (11) medical transportation except special transportation;
- (12) chiropractic services as covered under the medical assistance program;
- (13) podiatric services;
- (14) dental services and dentures, subject to the limitations specified in section 256B.0625, subdivision 9;
- (15) outpatient services provided by a mental health center or clinic that is under contract with the county board and is established under section 245.62;
- (16) day treatment services for mental illness provided under contract with the county board;
- (17) prescribed medications for persons who have been diagnosed as mentally ill as necessary to prevent more restrictive institutionalization;
- (18) psychological services, medical supplies and equipment, and Medicare premiums, coinsurance and deductible payments;
- (19) medical equipment not specifically listed in this paragraph when the use of the equipment will prevent the need for costlier services that are reimbursable under this subdivision;
- (20) services performed by a certified pediatric nurse practitioner, a certified family nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological nurse practitioner, a certified neonatal nurse practitioner, or a certified geriatric nurse practitioner in independent practice, if (1) the service is

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otherwise covered under this chapter as a physician service, (2) the service provided on an inpatient basis is not included as part of the cost for inpatient services included in the operating payment rate, and (3) the service is within the scope of practice of the nurse practitioner's license as a registered nurse, as defined in section 148.171;

(21) services of a certified public health nurse or a registered nurse practicing in a public health nursing clinic that is a department of, or that operates under the direct authority of, a unit of government, if the service is within the scope of practice of the public health nurse's license as a registered nurse, as defined in section 148.171; ~~and~~

(22) telemedicine consultations, to the extent they are covered under section 256B.0625, subdivision 3b; and

(23) mental health telemedicine and psychiatric consultation as covered under section 256B.0625, subdivisions 46 and 48.

(ii) Effective October 1, 2003, for a person who is eligible under subdivision 3, paragraph (a), clause (2), item (ii), general assistance medical care coverage is limited to inpatient hospital services, including physician services provided during the inpatient hospital stay. A \$1,000 deductible is required for each inpatient hospitalization.

(b) Gender reassignment surgery and related services are not covered services under this subdivision unless the individual began receiving gender reassignment services prior to July 1, 1995.

(c) In order to contain costs, the commissioner of human services shall select vendors of medical care who can provide the most economical care consistent with high medical standards and shall where possible contract with organizations on a prepaid capitation basis to provide these services. The commissioner shall consider proposals by counties and vendors for prepaid health plans, competitive bidding programs, block grants, or other vendor payment mechanisms designed to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are provided. Before implementing prepaid programs in counties with a county operated or affiliated public teaching hospital or a hospital or clinic operated by the University of Minnesota, the commissioner shall consider the risks the prepaid program creates for the hospital and allow the county or hospital the opportunity to participate in the program in a manner that reflects the risk of adverse selection and the nature of the patients served by the hospital, provided the terms of participation in the program are competitive with the terms of other participants considering the nature of the population served. Payment for services provided pursuant to this subdivision shall be as provided to medical assistance vendors of these services under sections 256B.02, subdivision 8, and 256B.0625. For payments made during fiscal year 1990 and later years, the commissioner shall consult with an independent actuary in establishing prepayment rates, but shall retain final control over the rate methodology.

(d) Recipients eligible under subdivision 3, paragraph (a), clause (2), item (i), shall pay the following co-payments for services provided on or after October 1, 2003:

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(1) \$3 per nonpreventive visit. For purposes of this subdivision, a visit means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;

(2) \$25 for eyeglasses;

(3) \$25 for nonemergency visits to a hospital-based emergency room;

(4) \$3 per brand-name drug prescription and \$1 per generic drug prescription, subject to a \$20 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness; and

(5) 50 percent coinsurance on restorative dental services.

(e) Co-payments shall be limited to one per day per provider for nonpreventive visits, eyeglasses, and nonemergency visits to a hospital-based emergency room. Recipients of general assistance medical care are responsible for all co-payments in this subdivision. The general assistance medical care reimbursement to the provider 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 (f).

(f) 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.

(g) Any county may, from its own resources, provide medical payments for which state payments are not made.

(h) Chemical dependency services that are reimbursed under chapter 254B must not be reimbursed under general assistance medical care.

(i) The maximum payment for new vendors enrolled in the general assistance medical care program after the base year shall be determined from the average usual and customary charge of the same vendor type enrolled in the base year.

(j) The conditions of payment for services under this subdivision are the same as the conditions specified in rules adopted under chapter 256B governing the medical assistance program, unless otherwise provided by statute or rule.

(k) Inpatient and outpatient payments shall be reduced by five percent, effective July 1, 2003. This reduction is in addition to the five percent reduction effective July 1, 2003, and incorporated by reference in paragraph (i).

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(l) Payments for all other health services except inpatient, outpatient, and pharmacy services shall be reduced by five percent, effective July 1, 2003.

(m) Payments to managed care plans shall be reduced by five percent for services provided on or after October 1, 2003.

(n) A hospital receiving a reduced payment as a result of this section may apply the unpaid balance toward satisfaction of the hospital's bad debts.

EFFECTIVE DATE. This section is effective January 1, 2006.

Sec. 16. Minnesota Statutes 2004, section 256D.44, subdivision 5, is amended to read:

Subd. 5. **SPECIAL NEEDS.** In addition to the state standards of assistance established in subdivisions 1 to 4, payments are allowed for the following special needs of recipients of Minnesota supplemental aid who are not residents of a nursing home, a regional treatment center, or a group residential housing facility.

(a) The county agency shall pay a monthly allowance for medically prescribed diets if the cost of those additional dietary needs cannot be met through some other maintenance benefit. The need for special diets or dietary items must be prescribed by a licensed physician. Costs for special diets shall be determined as percentages of the allotment for a one-person household under the thrifty food plan as defined by the United States Department of Agriculture. The types of diets and the percentages of the thrifty food plan that are covered are as follows:

(1) high protein diet, at least 80 grams daily, 25 percent of thrifty food plan;

(2) controlled protein diet, 40 to 60 grams and requires special products, 100 percent of thrifty food plan;

(3) controlled protein diet, less than 40 grams and requires special products, 125 percent of thrifty food plan;

(4) low cholesterol diet, 25 percent of thrifty food plan;

(5) high residue diet, 20 percent of thrifty food plan;

(6) pregnancy and lactation diet, 35 percent of thrifty food plan;

(7) gluten-free diet, 25 percent of thrifty food plan;

(8) lactose-free diet, 25 percent of thrifty food plan;

(9) antidumping diet, 15 percent of thrifty food plan;

(10) hypoglycemic diet, 15 percent of thrifty food plan; or

(11) ketogenic diet, 25 percent of thrifty food plan.

(b) Payment for nonrecurring special needs must be allowed for necessary home repairs or necessary repairs or replacement of household furniture and appliances using the payment standard of the AFDC program in effect on July 16, 1996, for these

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expenses, as long as other funding sources are not available.

(c) A fee for guardian or conservator service is allowed at a reasonable rate negotiated by the county or approved by the court. This rate shall not exceed five percent of the assistance unit's gross monthly income up to a maximum of \$100 per month. If the guardian or conservator is a member of the county agency staff, no fee is allowed.

(d) The county agency shall continue to pay a monthly allowance of \$68 for restaurant meals for a person who was receiving a restaurant meal allowance on June 1, 1990, and who eats two or more meals in a restaurant daily. The allowance must continue until the person has not received Minnesota supplemental aid for one full calendar month or until the person's living arrangement changes and the person no longer meets the criteria for the restaurant meal allowance, whichever occurs first.

(e) A fee of ten percent of the recipient's gross income or \$25, whichever is less, is allowed for representative payee services provided by an agency that meets the requirements under SSI regulations to charge a fee for representative payee services. This special need is available to all recipients of Minnesota supplemental aid regardless of their living arrangement.

(f) Notwithstanding the language in this subdivision, an amount equal to the maximum allotment authorized by the federal Food Stamp Program for a single individual which is in effect on the first day of January of the previous year will be added to the standards of assistance established in subdivisions 1 to 4 for individuals under the age of 65 who are relocating from an institution, or an adult mental health residential treatment program under section 256B.0622, and who are shelter needy. An eligible individual who receives this benefit prior to age 65 may continue to receive the benefit after the age of 65.

"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, 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.

EFFECTIVE DATE. This section is effective January 1, 2006.

Sec. 17. Minnesota Statutes 2004, section 256L.03, subdivision 1, is amended to read:

Subdivision 1. **COVERED HEALTH SERVICES.** For individuals under section 256L.04, subdivision 7, with income no greater than 75 percent of the federal poverty guidelines or for families with children under section 256L.04, subdivision 1, all subdivisions of this section apply. "Covered health services" means the health services reimbursed under chapter 256B, with the exception of inpatient hospital services, special education services, private duty nursing services, adult dental care services

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other than services covered under section 256B.0625, subdivision 9, paragraph (b), orthodontic services, nonemergency medical transportation services, personal care assistant and case management services, nursing home or intermediate care facilities services, inpatient mental health services, and chemical dependency services. Outpatient mental health services covered under the MinnesotaCare program are limited to diagnostic assessments, psychological testing, explanation of findings, mental health telemedicine, psychiatric consultation, medication management by a physician, day treatment, partial hospitalization, and individual, family, and group psychotherapy.

No public funds shall be used for coverage of abortion under MinnesotaCare except where the life of the female would be endangered or substantial and irreversible impairment of a major bodily function would result if the fetus were carried to term; or where the pregnancy is the result of rape or incest.

Covered health services shall be expanded as provided in this section.

EFFECTIVE DATE. This section is effective January 1, 2006.

Sec. 18. [641.155] DISCHARGE PLANS; OFFENDERS WITH SERIOUS AND PERSISTENT MENTAL ILLNESS.

The commissioner of corrections shall develop a model discharge planning process for every offender with a serious and persistent mental illness, as defined in section 245.462, subdivision 20, paragraph (c), who has been convicted and sentenced to serve three or more months and is being released from a county jail or county regional jail.

An offender with a serious and persistent mental illness, as defined in section 245.462, subdivision 20, paragraph (c), who has been convicted and sentenced to serve three or more months and is being released from a county jail or county regional jail shall be referred to the appropriate staff in the county human services department at least 60 days before being released. The county human services department may carry out provisions of the model discharge planning process such as:

- (1) providing assistance in filling out an application for medical assistance, general assistance medical care, or MinnesotaCare;
- (2) making a referral for case management as outlined under section 245.467, subdivision 4;
- (3) providing assistance in obtaining a state photo identification;
- (4) securing a timely appointment with a psychiatrist or other appropriate community mental health providers; and
- (5) providing prescriptions for a 30-day supply of all necessary medications.

Sec. 19. PRIORITY IN JANITORIAL CONTRACTS.

When awarding contracts to provide the janitorial services for the new Department of Human Services and Department of Health buildings, the commissioner of

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administration shall give priority to supported work vendors, provided those vendors submit a bid that is equal to or less than bids submitted by other vendors.

Sec. 20. ENHANCED SEPARATION.

A state employee covered by a collective bargaining agreement negotiated by the exclusive representatives of the American Federation of State, County and Municipal Employees Council 5, who separates from employment at the Willmar Regional Treatment Center after the center ceases to be a state facility, is governed by the enhanced separation package agreed to by the state of Minnesota and the American Federation of State, County and Municipal Employees Council 5 that is scheduled to take effect August 1, 2005, even if the center ceases to be a state facility before August 1, 2005. This section is repealed on August 1, 2005, or on the date the memorandum of understanding that includes the enhanced separation package is ratified, whichever occurs later.

Sec. 21. PENSION COVERAGE.

(a) This section applies to an employee of the Willmar Regional Treatment Center whose position at the treatment center changes from state employment to Kandiyohi County employment during the biennium ending June 30, 2007. Notwithstanding any law to the contrary, an employee to whom this section applies remains a member of the Minnesota State Retirement System while employed by Kandiyohi County unless the member elects to become a member of the Public Employees Retirement Association.

(b) An election to become a member of the Public Employees Retirement Association under this section must be made within six months from the date the position changes from state employment to Kandiyohi County employment, is irrevocable, and must be made in a manner specified by the executive directors of the Minnesota State Retirement System and the Public Employees Retirement Association.

Sec. 22. EFFECTIVE DATE.

(a) Sections 20 and 21 are effective the day following final enactment.

(b) The sections in this article are effective August 1, 2005, unless otherwise specified.

ARTICLE 3

FAMILY SUPPORT

Section 1. Minnesota Statutes 2004, section 119B.13, subdivision 1, is amended to read:

Subdivision 1. **SUBSIDY RESTRICTIONS.** The maximum rate paid for child care assistance under the child care fund may not exceed the 75th percentile rate for

like-care arrangements in the county as surveyed by the commissioner. (a)(i) Effective July 1, 2005, the commissioner of human services shall modify the rate tables for child care centers published in Department of Human Services Bulletin No. 03-68-07 so that in counties with regional or statewide cells, the higher of the 100th percentile of the 2002 market rate survey data or the rate currently identified in the bulletin will be the maximum rate. The rates established in this clause will be considered as the previous year's rates for purposes of the increase in item (iii), and shall be compared to the 100th percentile of current market rates.

(ii) For the period between July 1, 2005, and through the full implementation of the new rates under item (iii), the rates published in Department of Human Services Bulletin No. 03-68-07 as adjusted by item (i) shall remain in effect.

(iii) Beginning January 1, 2006, the maximum rate paid for child care assistance in any county or multicounty region under the child care fund shall be the lesser of the 75th percentile rate for like-care arrangements in the county or multicounty region as surveyed by the commissioner or the previous year's rate for like-care arrangements in the county increased by 1.75 percent.

(iv) Rate changes shall be implemented for services provided in March 2006 unless a participant eligibility redetermination or a new provider agreement is completed between January 1, 2006, and February 28, 2006.

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

New cases approved on or after January 1, 2006, shall have the maximum rates under item (iii) implemented immediately.

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

(c) A rate which includes a special needs rate paid under subdivision 3 may be in excess of the maximum rate allowed under this subdivision.

(d) 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 handicapped care. Not less than once every two years, the commissioner shall evaluate market practices for payment of absences and shall establish policies for payment of absent days that reflect current market practice.

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(e) 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.

Sec. 2. Minnesota Statutes 2004, section 119B.13, is amended by adding a subdivision to read:

Subd. 7. ABSENT DAYS. Child care providers may not be reimbursed for more than 25 absent days per child, excluding holidays, in a fiscal year, or for more than ten consecutive absent days, unless the child has a documented medical condition that causes more frequent absences. Documentation of medical conditions must be on the forms and submitted according to the timelines established by the commissioner.

EFFECTIVE DATE. This section is effective October 1, 2005.

Sec. 3. [245A.1445] CHILD CARE PROVIDER TRAINING; DANGERS OF SHAKING INFANTS AND YOUNG CHILDREN.

The commissioner shall make available for viewing by all licensed and legal nonlicensed child care providers a video presentation on the dangers associated with shaking infants and young children. The video presentation shall be part of the initial and annual training of licensed child care providers. Legal nonlicensed child care providers may participate at their option in a video presentation session offered under this section. The commissioner shall provide to child care providers and interested individuals, at cost, copies of a video approved by the commissioner of health under section 144.574 on the dangers associated with shaking infants and young children.

Sec. 4. Minnesota Statutes 2004, section 245A.10, subdivision 4, is amended to read:

Subd. 4. ANNUAL LICENSE OR CERTIFICATION FEE FOR PROGRAMS WITH LICENSED CAPACITY. (a) Child care centers and programs with a licensed capacity shall pay an annual nonrefundable license or certification fee based on the following schedule:

Licensed Capacity	Child Care Center License Fee	Other Program License Fee	
1 to 24 persons	\$300	\$225	\$400
25 to 49 persons	\$450	\$340	\$600
50 to 74 persons	\$600	\$450	\$800
75 to 99 persons	\$750	\$565	\$1,000
100 to 124 persons	\$900	\$675	\$1,200
125 to 149 persons	\$1,200	\$900	\$1,400
150 to 174 persons	\$1,400	\$1,050	\$1,600
175 to 199 persons	\$1,600	\$1,200	\$1,800
200 to 224 persons	\$1,800	\$1,350	\$2,000
225 or more persons	\$2,000	\$1,500	\$2,500

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(b) A day training and habilitation program serving persons with developmental disabilities or related conditions shall be assessed a license fee based on the schedule in paragraph (a) unless the license holder serves more than 50 percent of the same persons at two or more locations in the community. When a day training and habilitation program serves more than 50 percent of the same persons in two or more locations in a community, the day training and habilitation program shall pay a license fee based on the licensed capacity of the largest facility and the other facility or facilities shall be charged a license fee based on a licensed capacity of a residential program serving one to 24 persons.

Sec. 5. Minnesota Statutes 2004, 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.

(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 ~~375~~ 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 ~~375~~ 545 percent of federal poverty guidelines;

(3) if the adjusted gross income is greater than ~~375~~ 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

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(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 is reduced by \$2,400 prior to calculating the parental contribution. 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

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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.

EFFECTIVE DATE. This section is effective retroactively from July 1, 2005.

Sec. 6. Minnesota Statutes 2004, section 254A.035, subdivision 2, is amended to read:

Subd. 2. **MEMBERSHIP TERMS, COMPENSATION, REMOVAL AND EXPIRATION.** The membership of this council shall be composed of 17 persons who are American Indians and who are appointed by the commissioner. The commissioner shall appoint one representative from each of the following groups: Red Lake Band of Chippewa Indians; Fond du Lac Band, Minnesota Chippewa Tribe; Grand Portage Band, Minnesota Chippewa Tribe; Leech Lake Band, Minnesota Chippewa Tribe; Mille Lacs Band, Minnesota Chippewa Tribe; Bois Forte Band, Minnesota Chippewa Tribe; White Earth Band, Minnesota Chippewa Tribe; Lower Sioux Indian Reservation; Prairie Island Sioux Indian Reservation; Shakopee Mdewakanton Sioux Indian Reservation; Upper Sioux Indian Reservation; International Falls Northern Range;

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Duluth Urban Indian Community; and two representatives from the Minneapolis Urban Indian Community and two from the St. Paul Urban Indian Community. The terms, compensation, and removal of American Indian Advisory Council members shall be as provided in section 15.059. The council expires June 30, 2004 2008.

EFFECTIVE DATE. This section is effective retroactively from June 30, 2001. Sec. 7. Minnesota Statutes 2004, section 254A.04, is amended to read:

254A.04 CITIZENS ADVISORY COUNCIL.

There is hereby created an Alcohol and Other Drug Abuse Advisory Council to advise the Department of Human Services concerning the problems of alcohol and other drug dependency and abuse, composed of ten members. Five members shall be individuals whose interests or training are in the field of alcohol dependency and abuse; and five members whose interests or training are in the field of dependency and abuse of drugs other than alcohol. The terms, compensation and removal of members shall be as provided in section 15.059. The council expires June 30, 2004 2008. The commissioner of human services shall appoint members whose terms end in even-numbered years. The commissioner of health shall appoint members whose terms end in odd-numbered years.

EFFECTIVE DATE. This section is effective retroactively from June 30, 2001. Sec. 8. Minnesota Statutes 2004, section 256.01, is amended by adding a subdivision to read:

Subd. 14b. **AMERICAN INDIAN CHILD WELFARE PROJECTS.** (a) The commissioner of human services may authorize projects to test tribal delivery of child welfare services to American Indian children and their parents and custodians living on the reservation. The commissioner has authority to solicit and determine which tribes may participate in a project. Grants may be issued to Minnesota Indian tribes to support the projects. The commissioner may waive existing state rules as needed to accomplish the projects. Notwithstanding section 626.556, the commissioner may authorize projects to use alternative methods of investigating and assessing reports of child maltreatment, provided that the projects comply with the provisions of section 626.556 dealing with the rights of individuals who are subjects of reports or investigations, including notice and appeal rights and data practices requirements. The commissioner may seek any federal approvals necessary to carry out the projects as well as seek and use any funds available to the commissioner, including use of federal funds, foundation funds, existing grant funds, and other funds. The commissioner is authorized to advance state funds as necessary to operate the projects. Federal reimbursement applicable to the projects is appropriated to the commissioner for the purposes of the projects. The projects must be required to address responsibility for safety, permanency, and well-being of children.

(b) For the purposes of this section, "American Indian child" means a person under 18 years of age who is a tribal member or eligible for membership in one of the

tribes chosen for a project under this subdivision and who is residing on the reservation of that tribe.

(c) In order to qualify for an American Indian child welfare project, a tribe must:

(1) be one of the existing tribes with reservation land in Minnesota;

(2) have a tribal court with jurisdiction over child custody proceedings;

(3) have a substantial number of children for whom determinations of maltreatment have occurred;

(4) have capacity to respond to reports of abuse and neglect under section 626.556;

(5) provide a wide range of services to families in need of child welfare services;
and

(6) have a tribal-state title IV-E agreement in effect.

(d) Grants awarded under this section may be used for the nonfederal costs of providing child welfare services to American Indian children on the tribe's reservation, including costs associated with:

(1) assessment and prevention of child abuse and neglect;

(2) family preservation;

(3) facilitative, supportive, and reunification services;

(4) out-of-home placement for children removed from the home for child protective purposes; and

(5) other activities and services approved by the commissioner that further the goals of providing safety, permanency, and well-being of American Indian children.

(e) When a tribe has initiated a project and has been approved by the commissioner to assume child welfare responsibilities for American Indian children of that tribe under this section, the affected county social service agency is relieved of responsibility for responding to reports of abuse and neglect under section 626.556 for those children during the time within which the tribal project is in effect and funded. The commissioner shall work with tribes and affected counties to develop procedures for data collection, evaluation, and clarification of ongoing role and financial responsibilities of the county and tribe for child welfare services prior to initiation of the project. Children who have not been identified by the tribe as participating in the project shall remain the responsibility of the county. Nothing in this section shall alter responsibilities of the county for law enforcement or court services.

(f) The commissioner shall collect information on outcomes relating to child safety, permanency, and well-being of American Indian children who are served in the projects. Participating tribes must provide information to the state in a format and

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completeness deemed acceptable by the state to meet state and federal reporting requirements.

Sec. 9. Minnesota Statutes 2004, section 256B.0924, subdivision 3, is amended to read:

Subd. 3. **ELIGIBILITY.** Persons are eligible to receive targeted case management services under this section if the requirements in paragraphs (a) and (b) are met.

(a) The person must be assessed and determined by the local county agency to:

(1) be age 18 or older;

(2) be receiving medical assistance;

(3) have significant functional limitations; and

(4) be in need of service coordination to attain or maintain living in an integrated community setting.

(b) The person must be a vulnerable adult in need of adult protection as defined in section 626.5572, or is an adult with mental retardation as defined in section 252A.02, subdivision 2, or a related condition as defined in section 252.27, subdivision 1a, and is not receiving home and community-based waiver services, or is an adult who lacks a permanent residence and who has been without a permanent residence for at least one year or on at least four occasions in the last three years.

Sec. 10. Minnesota Statutes 2004, section 256B.093, subdivision 1, is amended to read:

Subdivision 1. **STATE TRAUMATIC BRAIN INJURY PROGRAM.** The commissioner of human services shall:

(1) maintain a statewide traumatic brain injury program;

(2) supervise and coordinate services and policies for persons with traumatic brain injuries;

(3) contract with qualified agencies or employ staff to provide statewide administrative case management and consultation;

(4) maintain an advisory committee to provide recommendations in reports to the commissioner regarding program and service needs of persons with traumatic brain injuries;

(5) investigate the need for the development of rules or statutes for the traumatic brain injury home and community-based services waiver;

(6) investigate present and potential models of service coordination which can be delivered at the local level; and

(7) the advisory committee required by clause (4) must consist of no fewer than ten members and no more than 30 members. The commissioner shall appoint all

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advisory committee members to one- or two-year terms and appoint one member as chair. Notwithstanding section 15.059, subdivision 5, the advisory committee does not terminate until June 30, ~~2005~~ 2008.

Sec. 11. Minnesota Statutes 2004, section 256D.06, subdivision 5, is amended to read:

Subd. 5. **ELIGIBILITY; REQUIREMENTS.** (a) Any applicant, otherwise eligible for general assistance and possibly eligible for maintenance benefits from any other source shall (a) (1) make application for those benefits within 30 days of the general assistance application; and (b) (2) execute an interim assistance ~~authorization~~ agreement on a form as directed by the commissioner.

(b) The commissioner shall review a denial of an application for other maintenance benefits and may require a recipient of general assistance to file an appeal of the denial if appropriate. If found eligible for benefits from other sources, and a payment received from another source relates to the period during which general assistance was also being received, the recipient shall be required to reimburse the county agency for the interim assistance paid. Reimbursement shall not exceed the amount of general assistance paid during the time period to which the other maintenance benefits apply and shall not exceed the state standard applicable to that time period.

(c) ~~The commissioner shall adopt rules authorizing county agencies or other client representatives to retain from the amount recovered under an interim assistance agreement 25 percent plus actual reasonable fees, costs, and disbursements of appeals and litigation, of providing special assistance to the recipient in processing the recipient's claim for maintenance benefits from another source. The may contract with the county agencies, qualified agencies, organizations, or persons to provide advocacy and support services to process claims for federal disability benefits for applicants or recipients of services or benefits supervised by the commissioner using money retained under this section shall be from the state share of the recovery. The commissioner or the county agency may contract with qualified persons to provide the special assistance.~~

(d) ~~The rules adopted by the commissioner shall include the may provide methods by which county agencies shall identify, refer, and assist recipients who may be eligible for benefits under federal programs for the disabled. This subdivision does not require repayment of per diem payments made to shelters for battered women pursuant to section 256D.05, subdivision 3.~~

(e) ~~The total amount of interim assistance recoveries retained under this section for advocacy, support, and claim processing services shall not exceed 35 percent of the interim assistance recoveries in the prior fiscal year.~~

Sec. 12. Minnesota Statutes 2004, section 256D.06, subdivision 7, is amended to read:

Subd. 7. **SSI CONVERSIONS AND BACK CLAIMS.** (a) **SSI CONVERSIONS.** The commissioner of human services shall contract with agencies or

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organizations capable of ensuring that clients who are presently receiving assistance under sections 256D.01 to 256D.21, and who may be eligible for benefits under the federal Supplemental Security Income program, apply and, when eligible, are converted to the federal income assistance program and made eligible for health care benefits under the medical assistance program. The commissioner shall ensure that money owing to the state under interim assistance agreements is collected.

(b) **BACK CLAIMS FOR FEDERAL HEALTH CARE BENEFITS.** The commissioner shall also directly or through contract implement procedures for collecting federal Medicare and medical assistance funds for which clients converted to SSI are retroactively eligible.

(c) **ADDITIONAL REQUIREMENTS.** The commissioner shall ~~begin contract-~~ing contract with agencies to ensure implementation of this section ~~within 14 days after April 29, 1992.~~ County contracts with providers for residential services shall include the requirement that providers screen residents who may be eligible for federal benefits and provide that information to the local agency. The commissioner shall modify the MAXIS computer system to provide information on clients who have been on general assistance for two years or longer. The list of clients shall be provided to local services for screening under this section.

(d) **REPORT.** The commissioner shall report to the legislature by January 15, 1993, on the implementation of this section. The report shall contain information on the following:

- (1) the number of clients converted from general assistance to SSI, by county;
- (2) information on the organizations involved;
- (3) the amount of money collected through interim assistance agreements;
- (4) the amount of money collected in federal Medicare or Medicaid funds;
- (5) problems encountered in processing conversions and back claims; and
- (6) recommended changes to enhance recoveries and maximize the receipt of federal money in the most efficient way possible.

Sec. 13. Minnesota Statutes 2004, section 256I.05, subdivision 1e, is amended to read:

Subd. 1e. **SUPPLEMENTARY RATE FOR CERTAIN FACILITIES.** Notwithstanding the provisions of subdivisions 1a and 1c, beginning July 1, ~~2004~~ 2005, a county agency shall negotiate a supplementary rate in addition to the rate specified in subdivision 1, equal to 46 percent of the amount specified in ~~subdivision 1a~~ not to exceed \$700 per month, including any legislatively authorized inflationary adjustments, for a group residential housing provider that:

- (1) is located in Hennepin County and has had a group residential housing contract with the county since June 1996;

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(2) operates in three separate locations a ~~71-bed~~ 75-bed facility, a 50-bed facility, and ~~two 40-bed facilities~~ a 26-bed facility; and

(3) serves a chemically dependent clientele, providing 24 hours per day supervision and limiting a resident's maximum length of stay to 13 months out of a consecutive 24-month period.

Sec. 14. Minnesota Statutes 2004, section 256J.37, subdivision 3b, is amended to read:

Subd. 3b. **TREATMENT OF SUPPLEMENTAL SECURITY INCOME.** Effective July 1, 2003, The county shall reduce the cash portion of the MFIP grant by up to \$125 per for an MFIP assistance unit that includes one or more SSI recipient recipients who resides reside in the household, and who would otherwise be included in the MFIP assistance unit under section 256J.24, subdivision 2, but is are excluded solely due to the SSI recipient status under section 256J.24, subdivision 3, paragraph (a), clause (1). If the SSI recipient receives or recipients receive less than \$125 of SSI, only the amount received shall be used in calculating the MFIP cash assistance payment. This provision does not apply to relative caregivers who could elect to be included in the MFIP assistance unit under section 256J.24, subdivision 4, unless the caregiver's children or stepchildren are included in the MFIP assistance unit.

EFFECTIVE DATE. This section is effective the first day of the second month after the date of approval by the United States Department of Agriculture.

Sec. 15. Minnesota Statutes 2004, section 256J.515, is amended to read:

256J.515 OVERVIEW OF EMPLOYMENT AND TRAINING SERVICES.

During the first meeting with participants, job counselors must ensure that an overview of employment and training services is provided that:

- (1) stresses the necessity and opportunity of immediate employment;
- (2) outlines the job search resources offered;
- (3) outlines education or training opportunities available;
- (4) describes the range of work activities, including activities under section 256J.49, subdivision 13, clause (18), that are allowable under MFIP to meet the individual needs of participants;
- (5) explains the requirements to comply with an employment plan;
- (6) explains the consequences for failing to comply;
- (7) explains the services that are available to support job search and work and education; and
- (8) provides referral information about shelters and programs for victims of family violence and the time limit exemption for family violence victims; and

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(9) explains the probationary employment periods new employees may serve after being hired and any assistance with job retention services that may be available.

Failure to attend the overview of employment and training services without good cause results in the imposition of a sanction under section 256J.46.

An applicant who requests and qualifies for a family violence waiver is exempt from attending a group overview. Information usually presented in an overview must be covered during the development of an employment plan under section 256J.521, subdivision 3.

Sec. 16. [256K.26] LONG-TERM HOMELESS SUPPORTIVE SERVICES.

Subdivision 1. ESTABLISHMENT AND PURPOSE. The commissioner shall establish the long-term homeless supportive services fund to provide integrated services needed to stabilize individuals, families, and youth living in supportive housing developed to further the goals set forth in Laws 2003, chapter 128, article 15, section 9.

Subd. 2. IMPLEMENTATION. The commissioner, in consultation with the commissioners of the Department of Corrections and the Minnesota Housing Finance Agency, counties, providers and funders of supportive housing and services, shall develop application requirements and make funds available according to this section, with the goal of providing maximum flexibility in program design.

Subd. 3. DEFINITIONS. For purposes of this section, the following terms have the meanings given:

(1) "long-term homelessness" means lacking a permanent place to live continuously for one year or more or at least four times in the past three years; and

(2) "household" means an individual, family, or unaccompanied minor experiencing long-term homelessness.

Subd. 4. COUNTY ELIGIBILITY. Counties are eligible for funding under this section. Priority will be given to proposals submitted on behalf of multicounty partnerships.

Subd. 5. CONTENT OF PROPOSALS. Proposals will be evaluated on the extent to which they:

(1) include partnerships with providers of services or other partners;

(2) develop strategies to enhance housing stability for people experiencing long-term homelessness by integrating services and establishing consistent services and procedures across jurisdictions as appropriate;

(3) evidence a commitment to working with the commissioners of human services, corrections, and the Housing Finance Agency to identify appropriate households to be served under this section and serve households as defined in subdivision 3. The commissioner may also set criteria for serving people at significant

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risk of experiencing long-term homelessness, with a priority on serving families with minor children;

(4) ensure that projects make maximum use of mainstream resources, including employment, social, and health services, and leverage additional public and private resources in order to serve the maximum number of households;

(5) demonstrate cost-effectiveness by identifying and prioritizing those services most necessary for housing stability; and

(6) evaluate and report on outcomes of the projects according to protocols developed by the commissioner of human services in cooperation with the commissioners of corrections and the Housing Finance Agency. Evaluation would include methods for determining the quality of the integrated service approach, improvement in outcomes, cost savings, or reduction in service disparities that may result.

Subd. 6. OUTCOMES. Projects will be selected to further the following outcomes:

(1) reduce the number of Minnesota individuals and families that experience long-term homelessness;

(2) increase the number of housing opportunities with supportive services;

(3) develop integrated, cost-effective service models that address the multiple barriers to obtaining housing stability faced by people experiencing long-term homelessness, including abuse, neglect, chemical dependency, disability, chronic health problems, or other factors including ethnicity and race that may result in poor outcomes or service disparities;

(4) encourage partnerships among counties, community agencies, schools, and other providers so that the service delivery system is seamless for people experiencing long-term homelessness;

(5) increase employability, self-sufficiency, and other social outcomes for individuals and families experiencing long-term homelessness; and

(6) reduce inappropriate use of emergency health care, shelter, chemical dependency, foster care, child protection, corrections, and similar services used by people experiencing long-term homelessness.

Subd. 7. ELIGIBLE SERVICES. Services eligible for funding under this section are all services needed to maintain households in permanent supportive housing, as determined by the county or counties administering the project or projects.

Subd. 8. FAMILIES EXPERIENCING LONG-TERM HOMELESSNESS. The commissioner, in consultation with the commissioners of housing finance and corrections, shall assess whether the definition of long-term homelessness impacts the ability of families with minor children experiencing homelessness to obtain services necessary to support housing stability.

EFFECTIVE DATE. This section is effective retroactively from July 1, 2005.

New language is indicated by underline, deletions by ~~strikeout~~.

Sec. 17. Minnesota Statutes 2004, section 260.835, is amended to read:

260.835 AMERICAN INDIAN CHILD WELFARE ADVISORY COUNCIL.

Subdivision 1. CREATION. The commissioner shall appoint an American Indian Advisory Council to help formulate policies and procedures relating to Indian child welfare services and to make recommendations regarding approval of grants provided under section 260.785, subdivisions 1, 2, and 3. The council shall consist of 17 members appointed by the commissioner and must include representatives of each of the 11 Minnesota reservations who are authorized by tribal resolution, one representative from the Duluth Urban Indian Community, three representatives from the Minneapolis Urban Indian Community, and two representatives from the St. Paul Urban Indian Community. Representatives from the urban Indian communities must be selected through an open appointments process under section 15.0597. The terms, compensation, and removal of American Indian Child Welfare Advisory Council members shall be as provided in section 15.059.

Subd. 2. EXPIRATION. Notwithstanding section 15.059, subdivision 5, the American Indian Child Welfare Advisory Council expires June 30, 2008.

EFFECTIVE DATE. This section is effective retroactively from June 30, 2003.

Sec. 18. RECOMMENDATIONS ON STANDARD STATEWIDE CHILD CARE LICENSE FEE; REPORT.

The commissioner of human services in conjunction with the Minnesota Association of County Social Service Administrators and the Minnesota Licensed Family Child Care Association, shall examine the feasibility of a statewide standard for setting license fees and background study fees for licensed family child care providers, and shall make recommendations on the feasibility of a statewide standard for setting license fees and background study fees in a report to the chairs of the senate and house of representatives committees having jurisdiction over child care issues. The report is due January 15, 2006.

Sec. 19. PARENT FEE SCHEDULE.

(a) Notwithstanding Minnesota Rules, part 3400.0100, subpart 4, 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>3.23%</u>
<u>105.00-109.99%</u>	<u>3.23%</u>
<u>110.00-114.99%</u>	<u>3.23%</u>

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<u>115.00-119.99%</u>	<u>3.23%</u>
<u>120.00-124.99%</u>	<u>3.60%</u>
<u>125.00-129.99%</u>	<u>3.60%</u>
<u>130.00-134.99%</u>	<u>3.60%</u>
<u>135.00-139.99%</u>	<u>3.60%</u>
<u>140.00-144.99%</u>	<u>3.97%</u>
<u>145.00-149.99%</u>	<u>3.97%</u>
<u>150.00-154.99%</u>	<u>3.97%</u>
<u>155.00-159.99%</u>	<u>4.75%</u>
<u>160.00-164.99%</u>	<u>4.75%</u>
<u>165.00-169.99%</u>	<u>5.51%</u>
<u>170.00-174.99%</u>	<u>5.88%</u>
<u>175.00-179.99%</u>	<u>6.25%</u>
<u>180.00-184.99%</u>	<u>6.98%</u>
<u>185.00-189.99%</u>	<u>7.35%</u>
<u>190.00-194.99%</u>	<u>7.72%</u>
<u>195.00-199.99%</u>	<u>8.45%</u>
<u>200.00-204.99%</u>	<u>9.92%</u>
<u>205.00-209.99%</u>	<u>12.22%</u>
<u>210.00-214.99%</u>	<u>12.65%</u>
<u>215.00-219.99%</u>	<u>13.09%</u>
<u>220.00-224.99%</u>	<u>13.52%</u>
<u>225.00-229.99%</u>	<u>14.35%</u>
<u>230.00-234.99%</u>	<u>15.71%</u>
<u>235.00-239.99%</u>	<u>16.28%</u>
<u>240.00-244.99%</u>	<u>17.37%</u>
<u>245.00-249.99%</u>	<u>18.00%</u>
<u>250%</u>	<u>ineligible</u>

(b) This schedule is effective January 1, 2006, and shall be implemented at or before the participant's next eligibility redetermination. The parent fee schedule in Laws 2003, First Special Session chapter 14, article 9, section 36, shall remain in effect until the schedule in this section is fully implemented.

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

Sec. 20. **REPEALER.**

(a) Laws 2003, First Special Session chapter 14, article 9, section 34, is repealed.

(b) Minnesota Statutes 2004, sections 119B.074, 256D.54, subdivision 3, and 256M.40, subdivision 2, are repealed.

Sec. 21. **EFFECTIVE DATE.**

The sections in this article are effective August 1, 2005, unless otherwise specified.

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ARTICLE 4

HEALTH IMPACT FEE

Section 1. [16A.725] HEALTH IMPACT FUND AND FUND REIMBURSEMENTS.

Subdivision 1. HEALTH IMPACT FUND. There is created in the state treasury a health impact fund to which must be credited all revenue from the health impact fee under section 256.9658 and any floor stocks fee enacted into law.

Subd. 2. CERTIFIED TOBACCO EXPENDITURES. By April 30 of each year, the commissioner of human services shall certify to the commissioner of finance the state share, by fund, of tobacco use attributable costs for the previous fiscal year in Minnesota health care programs, including medical assistance, general assistance medical care, and MinnesotaCare, or other applicable expenditures.

Subd. 3. FUND REIMBURSEMENTS. (a) Each fiscal year, the commissioner of finance shall first transfer from the health impact fund to the general fund an amount sufficient to offset the general fund cost of the certified expenditures under subdivision 2 or the balance of the fund, whichever is less.

(b) If any balance remains in the health impact fund after the transfer in paragraph (a), the commissioner of finance shall transfer to the health care access fund the amount sufficient to offset the health care access fund cost of the certified expenditures in subdivision 2, or the balance of the fund, whichever is less.

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 2. [256.9658] TOBACCO HEALTH IMPACT FEE.

Subdivision 1. PURPOSE. A tobacco use health impact fee is imposed on and collected from cigarette distributors and tobacco products distributors to recover for the state health costs related to or caused by tobacco use and to reduce tobacco use, particularly by youths.

Subd. 2. DEFINITIONS. The definitions under section 297F.01 apply to this section.

Subd. 3. FEE IMPOSED. (a) A fee is imposed upon the sale of cigarettes in this state, upon having cigarettes in possession in this state with intent to sell, upon any person engaged in business as a distributor, and upon the use or storage by consumers of cigarettes. The fee is imposed at the following rates:

(1) on cigarettes weighing not more than three pounds per thousand, 37.5 mills on each cigarette; and

(2) on cigarettes weighing more than three pounds per thousand, 75 mills on each cigarette.

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(b) A fee is imposed upon all tobacco products in this state and upon any person engaged in business as a distributor in an amount equal to the liability for tax under section 297F.05, subdivision 3, or on a consumer of tobacco products equal to the tax under section 297F.05, subdivision 4. Liability for the fee is in addition to the tax under section 297F.05, subdivision 3 or 4.

Subd. 4. PAYMENT. A distributor must pay the fee at the same time and in the same manner as provided for payment of tax under chapter 297F.

Subd. 5. FEE ON USE OF UNSTAMPED CIGARETTES. Any person, other than a distributor, that purchases or possesses cigarettes that have not been stamped and on which the fee imposed under this section has not been paid is liable for the fee under this section on the possession or use of those cigarettes.

Subd. 6. ADMINISTRATION. The audit, assessment, interest, appeal, refund, penalty, enforcement, administrative, and collection provisions of chapters 270C and 297F apply to the fee imposed under this section.

Subd. 7. CIGARETTE STAMP. (a) The stamp in section 297F.08 must be affixed to each package and is prima facie evidence that the fee imposed by this section has been paid.

(b) Notwithstanding any other provisions of this section, the fee due on the return is based upon actual stamps purchased during the reporting period.

Subd. 8. LICENSE REVOCATION. The commissioner of revenue may revoke or suspend the license of a distributor for failure to pay the fee or otherwise comply with the requirements under this section. The provisions and procedures under section 297F.04 apply to a suspension or revocation under this subdivision.

Subd. 9. DEPOSIT OF REVENUES. The commissioner of revenue shall deposit the revenues from the fee under this section in the state treasury and credit them to the health impact fund.

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 3. Minnesota Statutes 2004, section 297F.185, is amended to read:

297F.185 REVOCATION OF SALES AND USE TAX PERMITS.

(a) If a retailer purchases for resale from an unlicensed seller more than 20,000 cigarettes or \$500 or more worth of tobacco products, the commissioner may revoke the person's sales and use tax permit as provided in section 297A.86.

(b) The commissioner may revoke a retailer's sales or use permit as provided in section 297A.86 if the retailer, directly or indirectly, purchases for resale cigarettes without the proper stamp affixed.

EFFECTIVE DATE. This section is effective for violations occurring on or after August 1, 2005.

New language is indicated by underline, deletions by strikeout.

Sec. 4. Minnesota Statutes 2004, section 325D.32, subdivision 9, is amended to read:

Subd. 9. **BASIC COST OF CIGARETTES.** "Basic cost of cigarettes" means the gross invoice cost of cigarettes to the wholesaler or retailer plus the full face value of any stamps which may be required by any cigarette tax or fee act of this state, unless included by the manufacturer in the list price.

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 5. **FLOOR STOCKS FEE.**

Subdivision 1. **CIGARETTES.** A floor stocks cigarette fee is imposed on every person engaged in the business in this state as a distributor, retailer, subjobber, vendor, manufacturer, or manufacturer's representative of cigarettes, on the stamped cigarettes and unaffixed stamps in the person's possession or under the person's control at 12:01 a.m. on August 1, 2005. The fee is imposed at the following rates:

(1) on cigarettes weighing not more than three pounds per thousand, 37.5 mills on each cigarette; and

(2) on cigarettes weighing more than three pounds per thousand, 75 mills on each cigarette.

Each distributor, on or before August 10, 2005, shall file a return with the commissioner of revenue, in the form the commissioner prescribes, showing the stamped cigarettes and unaffixed stamps on hand at 12:01 a.m. on August 1, 2005, and the amount of fee due on the cigarettes and unaffixed stamps. Each retailer, subjobber, vendor, manufacturer, or manufacturer's representative, on or before August 10, 2005, shall file a return with the commissioner of revenue, in the form the commissioner prescribes, showing the cigarettes on hand at 12:01 a.m. on August 1, 2005, and the amount of fee due on the cigarettes. The fee imposed by this section is due and payable on or before September 7, 2005, and after that date bears interest at the rate of one percent per month.

Subd. 2. **AUDIT AND ENFORCEMENT.** The fee imposed by this section is subject to the audit, assessment, interest, appeal, refund, penalty, enforcement, administrative, and collection provisions of Minnesota Statutes, chapters 270C and 297F. The commissioner of revenue may require a distributor to receive and maintain copies of floor stocks fee returns filed by all persons requesting a credit for returned cigarettes.

Subd. 3. **DEPOSIT OF PROCEEDS.** The commissioner of revenue shall deposit the revenues from the fee under this section in the state treasury and credit them to the health impact fund.

EFFECTIVE DATE. This section is effective August 1, 2005.

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Sec. 6. TOBACCO PRODUCTS FLOOR STOCKS FEE.

A floor stocks fee is imposed upon every person engaged in business in this state as a distributor of tobacco products, at the rate of 35 percent of the wholesale sales price of each tobacco product in the distributor's possession or under the distributor's control at 12:01 a.m. on August 1, 2005. Each distributor, by August 10, 2005, shall file a return with the commissioner, in the form the commissioner prescribes, showing the tobacco products on hand at 12:01 a.m. on August 1, 2005, and the amount of fees due on them. The fee imposed by this section is due and payable by September 7, 2005, and after that bears interest at the rate of one percent a month.

EFFECTIVE DATE. This section is effective August 1, 2005.

ARTICLE 5**MISCELLANEOUS**

Section 1. Minnesota Statutes 2004, section 148D.220, subdivision 8, as added by Laws 2005, chapter 147, article 1, section 49, is amended to read:

Subd. 8. **SEXUAL CONDUCT WITH A FORMER CLIENT.** (a) A social worker who has engaged in diagnosing, counseling, or treating a client with mental, emotional, or behavioral disorders must not engage in or suggest sexual conduct with the former client under any circumstances for a period of two years following the termination of the professional relationship. After two years following the termination of the professional relationship, a social worker who has engaged in diagnosing, counseling, or treating a client with mental, emotional, or behavioral disorder must not engage in or suggest sexual conduct with the former client under any circumstances unless:

(1) the social worker did not intentionally or unintentionally coerce, exploit, deceive, or manipulate the former client at any time;

(2) the social worker did not represent to the former client that sexual conduct with the social worker is consistent with or part of the client's treatment;

(3) the social worker's sexual conduct was not detrimental to the former client at any time;

(4) the former client is not emotionally dependent on the social worker and does not continue to relate to the social worker as a client; and

(5) the social worker is not emotionally dependent on the client and does not continue to relate to the former client as a social worker.

(b) If there is an alleged violation of paragraph (a), the social worker assumes the full burden of demonstrating to the board that the social worker did not intentionally

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or unintentionally coerce, exploit, deceive, or manipulate the client, and the social worker's sexual conduct was not detrimental to the client at any time. Upon request, a social worker must provide information to the board addressing:

- (1) the amount of time that has passed since termination of services;
- (2) the duration, intensity, and nature of services;
- (3) the circumstances of termination of services;
- (4) the former client's emotional, mental, and behavioral history;
- (5) the former client's current emotional, mental, and behavioral status;
- (6) the likelihood of adverse impact on the former client; and

(7) the existence of actions, conduct, or statements made by the social worker during the course of services suggesting or inviting the possibility of a sexual relationship with the client following termination of services.

(c) A social worker who has provided social work services other than those described in paragraph (a) to a client must not engage in or suggest sexual conduct with the former client if a reasonable and prudent social worker would conclude after appropriate assessment that engaging in such behavior with the former client would create an unacceptable risk of harm to the former client.

Sec. 2. [151.55] CANCER DRUG REPOSITORY PROGRAM.

Subdivision 1. DEFINITIONS. (a) For the purposes of this section, the terms defined in this subdivision have the meanings given.

(b) "Board" means the Board of Pharmacy.

(c) "Cancer drug" means a prescription drug that is used to treat:

(1) cancer or the side effects of cancer; or

(2) the side effects of any prescription drug that is used to treat cancer or the side effects of cancer.

(d) "Cancer drug repository" means a medical facility or pharmacy that has notified the board of its election to participate in the cancer drug repository program.

(e) "Cancer supply" or "supplies" means prescription and nonprescription cancer supplies needed to administer a cancer drug.

(f) "Dispense" has the meaning given in section 151.01, subdivision 30.

(g) "Distribute" means to deliver, other than by administering or dispensing.

(h) "Donor" means an individual and not a drug manufacturer or wholesale drug distributor who donates a cancer drug or supply according to the requirements of the cancer drug repository program.

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(i) "Medical facility" means an institution defined in section 144.50, subdivision 2.

(j) "Medical supplies" means any prescription and nonprescription medical supply needed to administer a cancer drug.

(k) "Pharmacist" has the meaning given in section 151.01, subdivision 3.

(l) "Pharmacy" means any pharmacy registered with the Board of Pharmacy according to section 151.19, subdivision 1.

(m) "Practitioner" has the meaning given in section 151.01, subdivision 23.

(n) "Prescription drug" means a legend drug as defined in section 151.01, subdivision 17.

(o) "Side effects of cancer" means symptoms of cancer.

(p) "Single-unit-dose packaging" means a single-unit container for articles intended for administration as a single dose, direct from the container.

(q) "Tamper-evident unit dose packaging" means a container within which a drug is sealed so that the contents cannot be opened without obvious destruction of the seal.

Subd. 2. ESTABLISHMENT. The Board of Pharmacy shall establish and maintain a cancer drug repository program, under which any person may donate a cancer drug or supply for use by an individual who meets the eligibility criteria specified under subdivision 4. Under the program, donations may be made on the premises of a medical facility or pharmacy that elects to participate in the program and meets the requirements specified under subdivision 3.

Subd. 3. REQUIREMENTS FOR PARTICIPATION BY PHARMACIES AND MEDICAL FACILITIES. (a) To be eligible for participation in the cancer drug repository program, a pharmacy or medical facility must be licensed and in compliance with all applicable federal and state laws and administrative rules.

(b) Participation in the cancer drug repository program is voluntary. A pharmacy or medical facility may elect to participate in the cancer drug repository program by submitting the following information to the board, in a form provided by the board:

(1) the name, street address, and telephone number of the pharmacy or medical facility;

(2) the name and telephone number of a pharmacist who is employed by or under contract with the pharmacy or medical facility, or other contact person who is familiar with the pharmacy's or medical facility's participation in the cancer drug repository program; and

(3) a statement indicating that the pharmacy or medical facility meets the eligibility requirements under paragraph (a) and the chosen level of participation under paragraph (c).

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(c) A pharmacy or medical facility may fully participate in the cancer drug repository program by accepting, storing, and dispensing or administering donated drugs and supplies, or may limit its participation to only accepting and storing donated drugs and supplies. If a pharmacy or facility chooses to limit its participation, the pharmacy or facility shall distribute any donated drugs to a fully participating cancer drug repository according to subdivision 8.

(d) A pharmacy or medical facility may withdraw from participation in the cancer drug repository program at any time upon notification to the board. A notice to withdraw from participation may be given by telephone or regular mail.

Subd. 4. INDIVIDUAL ELIGIBILITY REQUIREMENTS. Any Minnesota resident who is diagnosed with cancer is eligible to receive drugs or supplies under the cancer drug repository program. Drugs and supplies shall be dispensed or administered according to the priority given under subdivision 6, paragraph (d).

Subd. 5. DONATIONS OF CANCER DRUGS AND SUPPLIES. (a) Any one of the following persons may donate legally obtained cancer drugs or supplies to a cancer drug repository, if the drugs or supplies meet the requirements under paragraph (b) or (c) as determined by a pharmacist who is employed by or under contract with a cancer drug repository:

(1) an individual who is 18 years old or older; or

(2) a pharmacy, medical facility, drug manufacturer, or wholesale drug distributor, if the donated drugs have not been previously dispensed.

(b) A cancer drug is eligible for donation under the cancer drug repository program only if the following requirements are met:

(1) the donation is accompanied by a cancer drug repository donor form described under paragraph (d) that is signed by the person making the donation or that person's authorized representative;

(2) the drug's expiration date is at least six months later than the date that the drug was donated;

(3) the drug is in its original, unopened, tamper-evident unit dose packaging that includes the drug's lot number and expiration date. Single-unit dose drugs may be accepted if the single-unit-dose packaging is unopened; and

(4) the drug is not adulterated or misbranded.

(c) Cancer supplies are eligible for donation under the cancer drug repository program only if the following requirements are met:

(1) the supplies are not adulterated or misbranded;

(2) the supplies are in their original, unopened, sealed packaging; and

(3) the donation is accompanied by a cancer drug repository donor form described under paragraph (d) that is signed by the person making the donation or that person's authorized representative.

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(d) The cancer drug repository donor form must be provided by the board and shall state that to the best of the donor's knowledge the donated drug or supply has been properly stored and that the drug or supply has never been opened, used, tampered with, adulterated, or misbranded. The board shall make the cancer drug repository donor form available on the Board of Pharmacy's Web site.

(e) Controlled substances and drugs and supplies that do not meet the criteria under this subdivision are not eligible for donation or acceptance under the cancer drug repository program.

(f) Drugs and supplies may be donated on the premises of a cancer drug repository to a pharmacist designated by the repository. A drop box may not be used to deliver or accept donations.

(g) Cancer drugs and supplies donated under the cancer drug repository program must be stored in a secure storage area under environmental conditions appropriate for the drugs or supplies being stored. Donated drugs and supplies may not be stored with nondonated inventory.

Subd. 6. DISPENSING REQUIREMENTS. (a) Drugs and supplies must be dispensed by a licensed pharmacist pursuant to a prescription by a practitioner or may be dispensed or administered by a practitioner according to the requirements of chapter 151 and within the practitioner's scope of practice.

(b) Cancer drugs and supplies shall be visually inspected by the pharmacist or practitioner before being dispensed or administered for adulteration, misbranding, and date of expiration. Drugs or supplies that have expired or appear upon visual inspection to be adulterated, misbranded, or tampered with in any way may not be dispensed or administered.

(c) Before a cancer drug or supply may be dispensed or administered to an individual, the individual must sign a cancer drug repository recipient form provided by the board acknowledging that the individual understands the information stated on the form. The form shall include the following information:

(1) that the drug or supply being dispensed or administered has been donated and may have been previously dispensed;

(2) that a visual inspection has been conducted by the pharmacist or practitioner to ensure that the drug has not expired, has not been adulterated or misbranded, and is in its original, unopened packaging; and

(3) that the dispensing pharmacist, the dispensing or administering practitioner, the cancer drug repository, the Board of Pharmacy, and any other participant of the cancer drug repository program cannot guarantee the safety of the drug or supply being dispensed or administered and that the pharmacist or practitioner has determined that the drug or supply is safe to dispense or administer based on the accuracy of the donor's form submitted with the donated drug or supply and the visual inspection

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required to be performed by the pharmacist or practitioner before dispensing or administering.

The board shall make the cancer drug repository form available on the Board of Pharmacy's Web site.

(d) Drugs and supplies shall only be dispensed or administered to individuals who meet the eligibility requirements in subdivision 4 and in the following order of priority:

(1) individuals who are uninsured;

(2) individuals who are enrolled in medical assistance, general assistance medical care, MinnesotaCare, Medicare, or other public assistance health care; and

(3) all other individuals who are otherwise eligible under subdivision 4 to receive drugs or supplies from a cancer drug repository.

Subd. 7. HANDLING FEES. A cancer drug repository may charge the individual receiving a drug or supply a handling fee of no more than 250 percent of the medical assistance program dispensing fee for each cancer drug or supply dispensed or administered.

Subd. 8. DISTRIBUTION OF DONATED CANCER DRUGS AND SUPPLIES. (a) Cancer drug repositories may distribute drugs and supplies donated under the cancer drug repository program to other repositories if requested by a participating repository.

(b) A cancer drug repository that has elected not to dispense donated drugs or supplies shall distribute any donated drugs and supplies to a participating repository upon request of the repository.

(c) If a cancer drug repository distributes drugs or supplies under paragraph (a) or (b), the repository shall complete a cancer drug repository donor form provided by the board. The completed form and a copy of the donor form that was completed by the original donor under subdivision 5 shall be provided to the fully participating cancer drug repository at the time of distribution.

Subd. 9. RESALE OF DONATED DRUGS OR SUPPLIES. Donated drugs and supplies may not be resold.

Subd. 10. RECORD-KEEPING REQUIREMENTS. (a) Cancer drug repository donor and recipient forms shall be maintained for at least five years.

(b) A record of destruction of donated drugs and supplies that are not dispensed under subdivision 6 shall be maintained by the dispensing repository for at least five years. For each drug or supply destroyed, the record shall include the following information:

(1) the date of destruction;

(2) the name, strength, and quantity of the cancer drug destroyed;

(3) the name of the person or firm that destroyed the drug; and

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(4) the source of the drugs or supplies destroyed.

Subd. 11. LIABILITY. (a) The manufacturer of a drug or supply is not subject to criminal or civil liability for injury, death, or loss to a person or to property for causes of action described in clauses (1) and (2). A manufacturer is not liable for:

(1) the intentional or unintentional alteration of the drug or supply by a party not under the control of the manufacturer; or

(2) the failure of a party not under the control of the manufacturer to transfer or communicate product or consumer information or the expiration date of the donated drug or supply.

(b) A medical facility or pharmacy participating in the program, a pharmacist dispensing a drug or supply pursuant to the program, a practitioner dispensing or administering a drug or supply pursuant to the program, or a donor of a cancer drug or supply as defined in subdivision 1 is immune from civil liability for an act or omission that causes injury to or the death of an individual to whom the cancer drug or supply is dispensed and no disciplinary action shall be taken against a pharmacist or practitioner so long as the drug or supply is donated, accepted, distributed, and dispensed according to the requirements of this section. This immunity does not apply if the act or omission involves reckless, wanton, or intentional misconduct, or malpractice unrelated to the quality of the cancer drug or supply.

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 3. Minnesota Statutes 2004, section 241.01, is amended by adding a subdivision to read:

Subd. 10. PURCHASING FOR PRESCRIPTION DRUGS. In accordance with section 241.021, subdivision 4, the commissioner may contract with a separate entity to purchase prescription drugs for persons confined in institutions under the control of the commissioner. Local governments may participate in this purchasing pool in order to purchase prescription drugs for those persons confined in local correctional facilities in which the local government has responsibility for providing health care. If any county participates, the commissioner shall appoint a county representative to any committee convened by the commissioner for the purpose of establishing a drug formulary to be used for state and local correctional facilities.

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

Sec. 4. Minnesota Statutes 2004, section 245.4661, subdivision 2, is amended to read:

Subd. 2. PROGRAM DESIGN AND IMPLEMENTATION. (a) The pilot projects shall be established to design, plan, and improve the mental health service delivery system for adults with serious and persistent mental illness that would:

(1) provide an expanded array of services from which clients can choose services appropriate to their needs;

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(2) be based on purchasing strategies that improve access and coordinate services without cost shifting;

(3) incorporate existing state facilities and resources into the community mental health infrastructure through creative partnerships with local vendors; and

(4) utilize existing categorical funding streams and reimbursement sources in combined and creative ways, except appropriations to regional treatment centers and all funds that are attributable to the operation of state-operated services are excluded unless appropriated specifically by the legislature for a purpose consistent with this section or section 246.0136, subdivision 1.

(b) All projects funded by January 1, 1997, must complete the planning phase and be operational by June 30, 1997; all projects funded by January 1, 1998, must be operational by June 30, 1998.

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

Sec. 5. Minnesota Statutes 2004, section 245.4661, subdivision 6, is amended to read:

Subd. 6. DUTIES OF COMMISSIONER. (a) For purposes of the pilot projects, the commissioner shall facilitate integration of funds or other resources as needed and requested by each project. These resources may include:

(1) residential services funds administered under Minnesota Rules, parts 9535.2000 to 9535.3000, in an amount to be determined by mutual agreement between the project's managing entity and the commissioner of human services after an examination of the county's historical utilization of facilities located both within and outside of the county and licensed under Minnesota Rules, parts 9520.0500 to 9520.0690;

(2) community support services funds administered under Minnesota Rules, parts 9535.1700 to 9535.1760;

(3) other mental health special project funds;

(4) medical assistance, general assistance medical care, MinnesotaCare and group residential housing if requested by the project's managing entity, and if the commissioner determines this would be consistent with the state's overall health care reform efforts; and

(5) regional treatment center ~~nonfiscal~~ resources to the extent agreed to by the ~~project's managing entity and the regional treatment center~~ consistent with section 246.0136, subdivision 1.

(b) The commissioner shall consider the following criteria in awarding start-up and implementation grants for the pilot projects:

(1) the ability of the proposed projects to accomplish the objectives described in subdivision 2;

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(2) the size of the target population to be served; and

(3) geographical distribution.

(c) The commissioner shall review overall status of the projects initiatives at least every two years and recommend any legislative changes needed by January 15 of each odd-numbered year.

(d) The commissioner may waive administrative rule requirements which are incompatible with the implementation of the pilot project.

(e) The commissioner may exempt the participating counties from fiscal sanctions for noncompliance with requirements in laws and rules which are incompatible with the implementation of the pilot project.

(f) The commissioner may award grants to an entity designated by a county board or group of county boards to pay for start-up and implementation costs of the pilot project.

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

Sec. 6. Minnesota Statutes 2004, section 245A.10, subdivision 5, is amended to read:

Subd. 5. **ANNUAL LICENSE OR CERTIFICATION FEE FOR PROGRAMS WITHOUT A LICENSED CAPACITY.** (a) Except as provided in ~~paragraph~~ paragraphs (b) and (c), a program without a stated licensed capacity shall pay a license or certification fee of \$400.

(b) A mental health center or mental health clinic requesting certification for purposes of insurance and subscriber contract reimbursement under Minnesota Rules, parts 9520.0750 to 9520.0870, shall pay a certification fee of \$1,000 per year. If the mental health center or mental health clinic provides services at a primary location with satellite facilities, the satellite facilities shall be certified with the primary location without an additional charge.

(c) A program licensed to provide residential-based habilitation services under the home and community-based waiver for persons with developmental disabilities shall pay an annual license fee that includes a base rate of \$250 plus \$38 times the number of clients served on the first day of August of the current license year. State-operated programs are exempt from the license fee under this paragraph.

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 7. Minnesota Statutes 2004, section 245C.10, subdivision 2, is amended to read:

Subd. 2. **SUPPLEMENTAL NURSING SERVICES AGENCIES.** The commissioner shall recover the cost of the background studies initiated by supplemental nursing services agencies registered under section 144A.71, subdivision 1, through a fee of no more than ~~\$8~~ \$20 per study charged to the agency. The fees collected under

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this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 8. Minnesota Statutes 2004, section 245C.10, subdivision 3, is amended to read:

Subd. 3. **PERSONAL CARE PROVIDER ORGANIZATIONS.** The commissioner shall recover the cost of background studies initiated by a personal care provider organization under section 256B.0627 through a fee of no more than ~~\$12~~ \$20 per study charged to the organization responsible for submitting the background study form. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 9. Minnesota Statutes 2004, section 245C.32, subdivision 2, is amended to read:

Subd. 2. **USE.** (a) The commissioner may also use these systems and records to obtain and provide criminal history data from the Bureau of Criminal Apprehension, criminal history data held by the commissioner, and data about substantiated maltreatment under section 626.556 or 626.557, for other purposes, provided that:

(1) the background study is specifically authorized in statute; or

(2) the request is made with the informed consent of the subject of the study as provided in section 13.05, subdivision 4.

(b) An individual making a request under paragraph (a), clause (2), must agree in writing not to disclose the data to any other individual without the consent of the subject of the data.

(c) The commissioner may recover the cost of obtaining and providing background study data by charging the individual or entity requesting the study a fee of no more than ~~\$12~~ \$20 per study. The fees collected under this paragraph are appropriated to the commissioner for the purpose of conducting background studies.

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 10. Minnesota Statutes 2004, section 246.0136, subdivision 1, is amended to read:

Subdivision 1. **PLANNING FOR ENTERPRISE ACTIVITIES.** The commissioner of human services is directed to study and make recommendations to the legislature on establishing enterprise activities within state-operated services. Before implementing an enterprise activity, the commissioner must obtain statutory authorization for its implementation, except that the commissioner has authority to implement enterprise activities for adult mental health, adolescent services, and to establish a public group practice without statutory authorization. Enterprise activities are defined

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as the range of services, which are delivered by state employees, needed by people with disabilities and are fully funded by public or private third-party health insurance or other revenue sources available to clients that provide reimbursement for the services provided. Enterprise activities within state-operated services shall specialize in caring for vulnerable people for whom no other providers are available or for whom state-operated services may be the provider selected by the payer. In subsequent biennia after an enterprise activity is established within a state-operated service, the base state appropriation for that state-operated service shall be reduced proportionate to the size of the enterprise activity.

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

Sec. 11. Minnesota Statutes 2004, section 253.20, is amended to read:

253.20 MINNESOTA SECURITY HOSPITAL.

The commissioner of human services shall erect, equip, and maintain in St. Peter a and other geographic locations under the control of the commissioner of human services suitable building buildings to be known as the Minnesota Security Hospital, for the purpose of providing a secure treatment facility as defined in section 253B.02, subdivision 18a, for persons who may be committed there by courts, or otherwise, or transferred there by the commissioner of human services, and for persons who are found to be mentally ill while confined in any correctional facility, or who may be found to be mentally ill and dangerous, and the commissioner shall supervise and manage the same as in the case of other state hospitals.

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

Sec. 12. Minnesota Statutes 2004, section 256.01, subdivision 2, is amended to read:

Subd. 2. **SPECIFIC POWERS.** Subject to the provisions of section 241.021, subdivision 2, the commissioner of human services shall carry out the specific duties in paragraphs (a) through ~~(aa)~~ (bb):

(a) Administer and supervise all forms of public assistance provided for by state law and other welfare activities or services as are vested in the commissioner. Administration and supervision of human services activities or services includes, but is not limited to, assuring timely and accurate distribution of benefits, completeness of service, and quality program management. In addition to administering and supervising human services activities vested by law in the department, the commissioner shall have the authority to:

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

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

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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 handicapped, dependent, neglected and delinquent children, and children born to mothers who were not married to the children's fathers at the times of the conception nor at the births of the children; license and supervise child-caring and child-placing agencies and institutions; supervise the care of children in boarding and foster homes or in private institutions; and generally perform all functions relating to the field of child welfare now vested in the State Board of Control.

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

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

(f) Act as the agent of and cooperate with the federal government in matters of mutual concern relative to and in conformity with the provisions of Laws 1939, chapter 431, including the administration of any federal funds granted to the state to aid in the

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performance of any functions of the commissioner as specified in Laws 1939, chapter 431, and including the promulgation of rules making uniformly available medical care benefits to all recipients of public assistance, at such times as the federal government increases its participation in assistance expenditures for medical care to recipients of public assistance, the cost thereof to be borne in the same proportion as are grants of aid to said recipients.

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

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

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

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

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

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

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effective until the following conditions have been met:

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

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

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

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

(1) one-half of the total amount of the disallowance shall be borne by the county boards responsible for administering the programs. For the medical assistance and the AFDC program formerly codified in sections 256.72 to 256.87, disallowances shall be shared by each county board in the same proportion as that county's expenditures for the sanctioned program are to the total of all counties' expenditures for the AFDC program formerly codified in sections 256.72 to 256.87, and medical assistance programs. For the 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

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

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

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

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

(5) the final deadline for fiscal reports or amendments to fiscal reports is one year after the date the report was originally due. If the commissioner does not receive a report by the final deadline, the county board forfeits the funding associated with the

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report for that reporting period and the county board must repay any funds associated with the report received for that reporting period;

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

(7) counties subject to withholding of funds under clause (3) or forfeiture or 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

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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

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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.

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 13. Minnesota Statutes 2004, section 256.741, subdivision 4, is amended to read:

Subd. 4. **EFFECT OF ASSIGNMENT.** Assignments in this section take effect upon a determination that the applicant is eligible for public assistance. The amount of support assigned under this subdivision may not exceed the total amount of public assistance issued or the total support obligation, whichever is less. Child care support collections made according to an assignment under subdivision 2, paragraph (c), must be deposited, subject to any limitations of federal law, by the commissioner of human services in the child support collection account in the special revenue fund and appropriated to the commissioner of education for child care assistance under section 119B.03. ~~These collections are in addition to state and federal funds appropriated to the child care in the general fund.~~

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 14. Minnesota Statutes 2004, section 256M.40, subdivision 2, is amended to read:

Subd. 2. **PROJECT OF REGIONAL SIGNIFICANCE; STUDY.** The commissioner shall study whether and how to dedicate a portion of the allocated funds for projects of regional significance. The study shall include an analysis of the amount of annual funding to be dedicated for projects of regional significance and what efforts these projects must support. The commissioner shall submit a report to the chairs of the house and senate committees with jurisdiction over children and community services grants by January 15, 2005. ~~The commissioner of finance, in preparing the proposed biennial budget for fiscal years 2006 and 2007, is instructed to include \$25 million each year in funding for projects of regional significance under this chapter.~~

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

Sec. 15. Minnesota Statutes 2004, section 295.582, as amended by Laws 2005, chapter 77, section 7, is amended to read:

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295.582 AUTHORITY.

Subdivision 1. WHOLESALE DRUG DISTRIBUTOR TAX. (a) A hospital, surgical center, or health care provider that is subject to a tax under section 295.52, or a pharmacy that has paid additional expense transferred under this section by a wholesale drug distributor, may transfer additional expense generated by section 295.52 obligations on to all third-party contracts for the purchase of health care services on behalf of a patient or consumer. Nothing shall prohibit a pharmacy from transferring the additional expense generated under section 295.52 to a pharmacy benefits manager. The additional expense transferred to the third-party purchaser or a pharmacy benefits manager must not exceed the tax percentage specified in section 295.52 multiplied against the gross revenues received under the third-party contract, and the tax percentage specified in section 295.52 multiplied against co-payments and deductibles paid by the individual patient or consumer. The expense must not be generated on revenues derived from payments that are excluded from the tax under section 295.53. All third-party purchasers of health care services including, but not limited to, third-party purchasers regulated under chapter 60A, 62A, 62C, 62D, 62H, 62N, 64B, 65A, 65B, 79, or 79A, or under section 471.61 or 471.617, and pharmacy benefits managers must pay the transferred expense in addition to any payments due under existing contracts with the hospital, surgical center, pharmacy, or health care provider, to the extent allowed under federal law. A third-party purchaser of health care services includes, but is not limited to, a health carrier or community integrated service network that pays for health care services on behalf of patients or that reimburses, indemnifies, compensates, or otherwise insures patients for health care services. For purposes of this section, a pharmacy benefits manager means an entity that performs pharmacy benefits management. A third-party purchaser or pharmacy benefits manager shall comply with this section regardless of whether the third-party purchaser or pharmacy benefits manager is a for-profit, not-for-profit, or nonprofit entity. A wholesale drug distributor may transfer additional expense generated by section 295.52 obligations to entities that purchase from the wholesaler, and the entities must pay the additional expense. Nothing in this section limits the ability of a hospital, surgical center, pharmacy, wholesale drug distributor, or health care provider to recover all or part of the section 295.52 obligation by other methods, including increasing fees or charges.

(b) Any hospital, surgical center, or health care provider subject to a tax under section 295.52 or a pharmacy that has paid additional expense transferred under this section by a wholesale drug distributor may file a complaint with the commissioner responsible for regulating the third-party purchaser if at any time the third-party purchaser fails to comply with paragraph (a).

(c) If the commissioner responsible for regulating the third-party purchaser finds at any time that the third-party purchaser has not complied with paragraph (a), the commissioner may take enforcement action against a third-party purchaser which is subject to the commissioner's regulatory jurisdiction and which does not allow a hospital, surgical center, pharmacy, or provider to pass-through the tax. The commis-

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stioner may by order fine or censure the third-party purchaser or revoke or suspend the certificate of authority or license of the third-party purchaser to do business in this state if the commissioner finds that the third-party purchaser has not complied with this section. The third-party purchaser may appeal the commissioner's order through a contested case hearing in accordance with chapter 14.

Subd. 2. AGREEMENT. A contracting agreement between a third-party purchaser or a pharmacy benefits manager and a resident or nonresident pharmacy registered under chapter 151, may not prohibit:

(1) a pharmacy that has paid additional expense transferred under this section by a wholesale drug distributor from exercising its option under this section to transfer such additional expenses generated by the section 295.52 obligations on to the third-party purchaser or pharmacy benefits manager; or

(2) a pharmacy that is subject to tax under section 295.52, subdivision 4, from exercising its option under this section to recover all or part of the section 295.52 obligations from the third-party purchaser or a pharmacy benefits manager.

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

Sec. 16. Minnesota Statutes 2004, section 471.61, is amended by adding a subdivision to read:

Subd. 5. PROVISION OF LONG-TERM CARE INSURANCE. Any political subdivision, or any two or more political subdivisions acting jointly, may contract with an insurance company licensed to do business in this state for the voluntary purchase of long-term care insurance by the employees and their dependents of the political subdivision or subdivisions. The coverage may be through a group policy or through individual coverage.

Sec. 17. Minnesota Statutes 2004, section 641.15, subdivision 2, is amended to read:

Subd. 2. MEDICAL AID. Except as provided in section 466.101, the county board shall pay the costs of medical services provided to prisoners. The amount paid by the Anoka county board for a medical service shall not exceed the maximum allowed medical assistance payment rate for the service, as determined by the commissioner of human services. For all other counties, medical providers shall charge no higher than the rate negotiated between the county and the provider. In the absence of an agreement between the county and the provider, the provider may charge no more than the discounted rate the provider has negotiated with the nongovernmental third-party payer that provided the most revenue to the provider during the previous calendar year. The county is entitled to reimbursement from the prisoner for payment of medical bills to the extent that the prisoner to whom the medical aid was provided has the ability to pay the bills. The prisoner shall, at a minimum, incur co-payment obligations for health care services provided by a county correctional facility. The county board shall determine the co-payment amount. Notwithstanding any law to the contrary, the co-payment shall be deducted from any of the prisoner's funds held by the

county, to the extent possible. If there is a disagreement between the county and a prisoner concerning the prisoner's ability to pay, the court with jurisdiction over the defendant shall determine the extent, if any, of the prisoner's ability to pay for the medical services. If a prisoner is covered by health or medical insurance or other health plan when medical services are provided, the county providing the medical services has a right of subrogation to be reimbursed by the insurance carrier for all sums spent by it for medical services to the prisoner that are covered by the policy of insurance or health plan, in accordance with the benefits, limitations, exclusions, provider restrictions, and other provisions of the policy or health plan. The county may maintain an action to enforce this subrogation right. The county does not have a right of subrogation against the medical assistance program or the general assistance medical care program.

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 18. Laws 2003, First Special Session chapter 14, article 13C, section 2, subdivision 6, is amended to read:

Subd. 6. Basic Health Care Grants

Summary by Fund

General	1,499,941,000	1,533,016,000
Health Care Access	268,151,000	282,605,000

UPDATING FEDERAL POVERTY GUIDELINES. Annual updates to the federal poverty guidelines are effective each July 1, following publication by the United States Department of Health and Human Services for health care programs under Minnesota Statutes, chapters 256, 256B, 256D, and 256L.

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) MinnesotaCare Grants

Health Care Access	267,401,000	281,855,000
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MINNESOTACARE FEDERAL RECEIPTS. Receipts received as a result of federal participation pertaining to administrative costs of the Minnesota health care reform waiver shall be deposited as non-dedicated revenue in the health care access fund. Receipts received as a result of fed-

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eral participation pertaining to grants shall be deposited in the federal fund and shall offset health care access funds for payments to providers.

MINNESOTACARE FUNDING. The commissioner may expend money appropriated from the health care access fund for MinnesotaCare in either fiscal year of the biennium.

(b) MA Basic Health Care Grants -
Families and Children

General	568,254,000	582,161,000
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SERVICES TO PREGNANT WOMEN.

The commissioner shall use available federal money for the State-Children's Health Insurance Program for medical assistance services provided to pregnant women who are not otherwise eligible for federal financial participation beginning in fiscal year 2003. This federal money shall be deposited in the federal fund and shall offset general funds for payments to providers. Notwithstanding section 14, this paragraph shall not expire.

MANAGED CARE RATE INCREASE.

(a) Effective January 1, 2004, the commissioner of human services shall increase the total payments to managed care plans under Minnesota Statutes, section 256B.69, by an amount equal to the cost increases to the managed care plans from by the elimination of: (1) the exemption from the taxes imposed under Minnesota Statutes, section 297I.05, subdivision 5, for premiums paid by the state for medical assistance, general assistance medical care, and the MinnesotaCare program; and (2) the exemption of gross revenues subject to the taxes imposed under Minnesota Statutes, sections 295.50 to 295.57, for payments paid by the state for services provided under medical assis-

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tance, general assistance medical care, and the MinnesotaCare program. Any increase based on clause (2) must be reflected in provider rates paid by the managed care plan unless the managed care plan is a staff model health plan company.

(b) The commissioner of human services shall increase by ~~two percent~~ the applicable tax rate in effect under Minnesota Statutes, section 295.52, the fee-for-service payments under medical assistance, general assistance medical care, and the MinnesotaCare program for services subject to the hospital, surgical center, or health care provider taxes under Minnesota Statutes, sections 295.50 to 295.57, effective for services rendered on or after January 1, 2004.

(c) The commissioner of finance shall transfer from the health care access fund to the general fund the following amounts in the fiscal years indicated: 2004, \$16,587,000; 2005, \$46,322,000; 2006, \$49,413,000; and 2007, \$52,659,000.

(d) For fiscal years after 2007, the commissioner of finance shall transfer from the health care access fund to the general fund an amount equal to the revenue collected by the commissioner of revenue on the following:

(1) gross revenues received by hospitals, surgical centers, and health care providers as payments for services provided under medical assistance, general assistance medical care, and the MinnesotaCare program, including payments received directly from the state or from a prepaid plan, under Minnesota Statutes, sections 295.50 to 295.57; and

(2) premiums paid by the state under medical assistance, general assistance medical

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care, and the MinnesotaCare program under Minnesota Statutes, section 297I.05, subdivision 5.

The commissioner of finance shall monitor and adjust if necessary the amount transferred each fiscal year from the health care access fund to the general fund to ensure that the amount transferred equals the tax revenue collected for the items described in clauses (1) and (2) for that fiscal year.

(e) Notwithstanding section 14, these provisions shall not expire.

(c) MA Basic Health Care Grants -
Elderly and Disabled

General	695,421,000	741,605,000
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DELAY MEDICAL ASSISTANCE FEE-FOR-SERVICE - ACUTE CARE. The following payments in fiscal year 2005 from the Medicaid Management Information System that would otherwise have been made to providers for medical assistance and general assistance medical care services shall be delayed and included in the first payment in fiscal year 2006:

(1) for hospitals, the last two payments; and

(2) for nonhospital providers, the last payment.

This payment delay shall not include payments to skilled nursing facilities, intermediate care facilities for mental retardation, prepaid health plans, home health agencies, personal care nursing providers, and providers of only waiver services. The provisions of Minnesota Statutes, section 16A.124, shall not apply to these delayed payments. Notwithstanding section 14, this provision shall not expire.

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DEAF AND HARD-OF-HEARING SERVICES. If, after making reasonable efforts, the service provider for mental health services to persons who are deaf or hearing impaired is not able to earn \$227,000 through participation in medical assistance intensive rehabilitation services in fiscal year 2005, the commissioner shall transfer \$227,000 minus medical assistance earnings achieved by the grantee to deaf and hard-of-hearing grants to enable the provider to continue providing services to eligible persons.

(d) General Assistance Medical Care Grants

General	223,960,000	196,617,000
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(e) Health Care Grants - Other Assistance

General	3,067,000	3,407,000
Health Care Access	750,000	750,000

MINNESOTA PRESCRIPTION DRUG DEDICATED FUND. Of the general fund appropriation, \$284,000 in fiscal year 2005 is appropriated to the commissioner for the prescription drug dedicated fund established under the prescription drug discount program.

DENTAL ACCESS GRANTS CARRY-OVER AUTHORITY. Any unspent portion of the appropriation from the health care access fund in fiscal years 2002 and 2003 for dental access grants under Minnesota Statutes, section 256B.53, shall not cancel but shall be allowed to carry forward to be spent in the biennium beginning July 1, 2003, for these purposes.

STOP-LOSS FUND ACCOUNT. The appropriation to the purchasing alliance stop-loss fund account established under Minnesota Statutes, section 256.956, subdivision 2, for fiscal years 2004 and

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2005 shall only be available for claim reimbursements for qualifying enrollees who are members of purchasing alliances that meet the requirements described under Minnesota Statutes, section 256.956, subdivision 1, paragraph (f), clauses (1), (2), and (3).

(f) Prescription Drug Program

General	9,239,000	9,226,000
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PRESCRIPTION DRUG ASSISTANCE PROGRAM. Of the general fund appropriation, \$702,000 in fiscal year 2004 and \$887,000 in fiscal year 2005 are for the commissioner to establish and administer the prescription drug assistance program through the Minnesota board on aging.

REBATE REVENUE RECAPTURE.

Any funds received by the state from a drug manufacturer due to errors in the pharmaceutical pricing used by the manufacturer in determining the prescription drug rebate are appropriated to the commissioner to augment funding of the prescription drug program established in Minnesota Statutes, section 256.955.

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

Sec. 19. **REPEALER.**

Minnesota Statutes 2004, section 119B.074, as amended by Laws 2005, chapter 98, article 1, section 5, is repealed effective August 1, 2005. House File No. 138, article 11, section 6, if enacted in the 2005 First Special Session, is repealed effective upon final enactment.

ARTICLE 6

HEALTH DEPARTMENT

Section 1. [62J.495] **HEALTH INFORMATION TECHNOLOGY AND INFRASTRUCTURE ADVISORY COMMITTEE.**

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Subdivision 1. ESTABLISHMENT; MEMBERS; DUTIES. (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) 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. 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. Notwithstanding section 15.059, this section expires June 30, 2009.

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

Sec. 2. Minnesota Statutes 2004, section 103I.101, subdivision 6, is amended to read:

Subd. 6. **FEEES FOR VARIANCES.** The commissioner shall charge a non-refundable application fee of \$150 ~~\$175~~ 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, 2006.

Sec. 3. Minnesota Statutes 2004, section 103I.208, subdivision 1, as amended by Laws 2005, chapter 106, section 24, is amended to read:

New language is indicated by underline, deletions by ~~strikeout~~.

Subdivision 1. **WELL NOTIFICATION FEE.** The well notification fee to be paid by a property owner is:

(1) for a new water supply well, ~~\$150~~ \$175, which includes the state core function fee;

(2) for a well sealing, ~~\$30~~ \$35 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 ~~\$30~~ \$35; and

(3) for construction of a dewatering well, ~~\$150~~ \$175, 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 ~~\$750~~ \$875 for the dewatering wells recorded on the notification.

EFFECTIVE DATE. This section is effective July 1, 2006.

Sec. 4. Minnesota Statutes 2004, section 1031.208, subdivision 2, as amended by Laws 2005, chapter 106, section 25, 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, ~~\$125~~ \$150 annually;

(2) for construction of a monitoring well, ~~\$150~~ \$175, which includes the state core function fee;

(3) for a monitoring well that is unsealed under a maintenance permit, ~~\$125~~ \$150 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 ~~\$150~~ \$175, 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 ~~\$125~~ \$150 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, ~~\$150~~ \$175, which includes the state core function fee;

(6) for a vertical heat exchanger, ~~\$150~~ \$175;

(7) for a dewatering well that is unsealed under a maintenance permit, ~~\$125~~ \$150 annually for each dewatering well, except a dewatering project comprising more than five dewatering wells shall be issued a single permit for ~~\$625~~ \$750 annually for dewatering wells recorded on the permit; and

(8) for an elevator boring, ~~\$150~~ \$175 for each boring.

EFFECTIVE DATE. This section is effective July 1, 2006.

New language is indicated by underline, deletions by ~~strikeout~~.

Sec. 5. Minnesota Statutes 2004, 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.

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(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 must not accept a certificate unless it contains all the required information. The county recorder or registrar of titles shall note on each deed or other instrument of conveyance accompanied by a well disclosure certificate that the well disclosure certificate was received. The notation must include the statement "No wells on property" if the disclosure certificate states there are no wells on the property. The well disclosure certificate shall not be filed or recorded in the records maintained by the county recorder or registrar of titles. After noting "No wells on property" on the deed or other instrument of conveyance, the county recorder or registrar of titles shall destroy or return to the buyer the well disclosure certificate. The county recorder or registrar of titles shall collect from the buyer or the person seeking to record a deed or other instrument of conveyance, a fee of ~~\$30~~ \$40 for receipt of a completed well disclosure certificate. By the tenth day of each month, the county recorder or registrar of titles shall transmit the well disclosure certificates to the commissioner of health. By the tenth day after the end of each calendar quarter, the county recorder or registrar of titles shall transmit to the commissioner of health ~~\$27.50~~ \$32.50 of the fee for each well disclosure certificate received during the quarter. The commissioner shall maintain the well disclosure certificate for at least six years. The commissioner may store the certificate as an electronic image. A copy of that image shall be as valid as the original.

(j) No new well disclosure certificate is required under this subdivision if the buyer or seller, or a person authorized to act on behalf of the buyer or seller, certifies on the deed or other instrument of conveyance that the status and number of wells on the property have not changed since the last previously filed well disclosure certificate. The following statement, if followed by the signature of the person making the statement, is sufficient to comply with the certification requirement of this paragraph: "I am familiar with the property described in this instrument and I certify that the status and number of wells on the described real property have not changed since the last previously filed well disclosure certificate." The certification and signature may be on the front or back of the deed or on an attached sheet and an acknowledgment of the statement is not required for the deed or other instrument of conveyance to be recordable.

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(k) The commissioner in consultation with county recorders shall prescribe the form for a well disclosure certificate and provide well disclosure certificate forms to county recorders and registrars of titles and other interested persons.

(l) Failure to comply with a requirement of this subdivision does not impair:

(1) the validity of a deed or other instrument of conveyance as between the parties to the deed or instrument or as to any other person who otherwise would be bound by the deed or instrument; or

(2) the record, as notice, of any deed or other instrument of conveyance accepted for filing or recording contrary to the provisions of this subdivision.

EFFECTIVE DATE. This section is effective July 1, 2006.

Sec. 6. Minnesota Statutes 2004, section 103I.601, subdivision 2, is amended to read:

Subd. 2. **LICENSE REQUIRED TO MAKE BORINGS.** (a) Except as provided in paragraph (b) ~~(d)~~, a person ~~may~~ must not make an exploratory boring without an exploratory ~~borer's~~ explorer's license. The fee for an explorer's license is \$75. The explorer's license is valid until the date prescribed in the license by the commissioner.

(b) A person must file an application and renewal application fee to renew the explorer's license by the date stated in the license. The renewal application fee is \$75.

(c) If the licensee submits an application fee after the required renewal date, the licensee:

(1) must include a late fee of \$75; and

(2) may not conduct activities authorized by an explorer's license until the renewal application, renewal application fee, late fee, and sealing reports required in subdivision 9 are submitted.

(d) An explorer may must designate a responsible individual to supervise and oversee the making of exploratory borings. Before an individual supervises or oversees an exploratory boring, the individual must file an application and application fee of \$75 to qualify as a responsible individual. The individual must take and pass an examination relating to construction, location, and sealing of exploratory borings. A professional engineer registered or geoscientist licensed under sections 326.02 to 326.15 or a certified professional geologist certified by the American Institute of Professional Geologists is not required to take the examination required in this subdivision, but must be licensed certified as a responsible individual to make supervise an exploratory boring.

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

Sec. 7. Minnesota Statutes 2004, section 144.122, as amended by Laws 2005, chapter 85, section 1, is amended to read:

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144.122 LICENSE, PERMIT, AND SURVEY FEES.

(a) The state commissioner of health, by rule, may prescribe reasonable procedures and fees for filing with the commissioner as prescribed by statute and for the issuance of original and renewal permits, licenses, registrations, and certifications issued under authority of the commissioner. The expiration dates of the various licenses, permits, registrations, and certifications as prescribed by the rules shall be plainly marked thereon. Fees may include application and examination fees and a penalty fee for renewal applications submitted after the expiration date of the previously issued permit, license, registration, and certification. The commissioner may also prescribe, by rule, reduced fees for permits, licenses, registrations, and certifications when the application therefor is submitted during the last three months of the permit, license, registration, or certification period. Fees proposed to be prescribed in the rules shall be first approved by the Department of Finance. All fees proposed to be prescribed in rules shall be reasonable. The fees shall be in an amount so that the total fees collected by the commissioner will, where practical, approximate the cost to the commissioner in administering the program. All fees collected shall be deposited in the state treasury and credited to the state government special revenue fund unless otherwise specifically appropriated by law for specific purposes.

(b) The commissioner may charge a fee for voluntary certification of medical laboratories and environmental laboratories, and for environmental and medical laboratory services provided by the department, without complying with paragraph (a) or chapter 14. Fees charged for environment and medical laboratory services provided by the department must be approximately equal to the costs of providing the services.

(c) The commissioner may develop a schedule of fees for diagnostic evaluations conducted at clinics held by the services for children with handicaps program. All receipts generated by the program are annually appropriated to the commissioner for use in the maternal and child health program.

(d) The commissioner shall set license fees for hospitals and nursing homes that are not boarding care homes at the following levels:

Joint Commission on Accreditation of Healthcare

**Organizations (JCAHO)
and American Osteopathic**

Association (AOA) hospitals	\$7,055 <u>\$7,555</u> plus <u>\$13</u> per bed
Non-JCAHO and non-AOA hospitals	\$4,680 <u>\$5,180</u> plus \$234 <u>\$247</u> per bed
Nursing home	\$183 plus <u>\$91</u> per bed

The commissioner shall set license fees for outpatient surgical centers, boarding care homes, and supervised living facilities at the following levels:

Outpatient surgical centers	\$1,512 <u>\$3,349</u>
Boarding care homes	\$183 plus <u>\$91</u> per bed
Supervised living facilities	\$183 plus <u>\$91</u> per bed.

New language is indicated by underline, deletions by strikeout.

(e) Unless prohibited by federal law, the commissioner of health shall charge applicants the following fees to cover the cost of any initial certification surveys required to determine a provider's eligibility to participate in the Medicare or Medicaid program:

Prospective payment surveys for hospitals	\$ 900
Swing bed surveys for nursing homes	\$1,200
Psychiatric hospitals	\$1,400
Rural health facilities	\$1,100
Portable x-ray providers	\$ 500
Home health agencies	\$1,800
Outpatient therapy agencies	\$ 800
End stage renal dialysis providers	\$2,100
Independent therapists	\$ 800
Comprehensive rehabilitation outpatient facilities	\$1,200
Hospice providers	\$1,700
Ambulatory surgical providers	\$1,800
Hospitals	\$4,200
Other provider categories or additional resurveys required to complete initial certification	Actual surveyor costs: average surveyor cost x number of hours for the survey process.

These fees shall be submitted at the time of the application for federal certification and shall not be refunded. All fees collected after the date that the imposition of fees is not prohibited by federal law shall be deposited in the state treasury and credited to the state government special revenue fund.

(f) The commissioner shall charge the following fees for examinations, registrations, licenses, and inspections:

<u>Plumbing examination</u>	<u>\$ 50</u>
<u>Water conditioning examination</u>	<u>\$ 50</u>
<u>Plumbing bond registration fee</u>	<u>\$ 40</u>
<u>Water conditioning bond registration fee</u>	<u>\$ 40</u>
<u>Master plumber's license</u>	<u>\$120</u>
<u>Journeyman plumber's license</u>	<u>\$ 55</u>
<u>Apprentice registration</u>	<u>\$ 25</u>
<u>Water conditioning contractor license</u>	<u>\$ 70</u>
<u>Water conditioning installer license</u>	<u>\$ 35</u>
<u>Residential inspection fee (each visit)</u>	<u>\$ 50</u>
<u>Public, commercial, and industrial inspections</u>	<u>Inspection fee</u>
<u>25 or fewer drainage</u>	

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<u>fixture units</u>	<u>\$ 300</u>
<u>26 to 50 drainage</u>	
<u>fixture units</u>	<u>\$ 900</u>
<u>51 to 150 drainage</u>	
<u>fixture units</u>	<u>\$1,200</u>
<u>151 to 249 drainage</u>	
<u>fixture units</u>	<u>\$1,500</u>
<u>250 or more drainage</u>	
<u>fixture units</u>	<u>\$1,800</u>
<u>Callback fee (each visit)</u>	<u>\$ 100</u>

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 8. Minnesota Statutes 2004, section 144.147, subdivision 1, is amended to read:

Subdivision 1. **DEFINITION.** "Eligible rural hospital" means any nonfederal, general acute care hospital that:

(1) is either located in a rural area, as defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 405.1041, or located in a community with a population of less than ~~40,000~~ 15,000, according to United States Census Bureau statistics, outside the seven-county metropolitan area;

(2) has 50 or fewer beds; and

(3) is not for profit.

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

Sec. 9. Minnesota Statutes 2004, section 144.147, subdivision 2, is amended to read:

Subd. 2. **GRANTS AUTHORIZED.** The commissioner shall establish a program of grants to assist eligible rural hospitals. The commissioner shall award grants to hospitals and communities for the purposes set forth in paragraphs (a) and (b).

(a) Grants may be used by hospitals and their communities to develop strategic plans for preserving or enhancing access to health services. At a minimum, a strategic plan must consist of:

(1) a needs assessment to determine what health services are needed and desired by the community. The assessment must include interviews with or surveys of area health professionals, local community leaders, and public hearings;

(2) an assessment of the feasibility of providing needed health services that identifies priorities and timeliness for potential changes; and

(3) an implementation plan.

The strategic plan must be developed by a committee that includes representatives from the hospital, local public health agencies, other health providers, and consumers from the community.

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(b) The grants may also be used by eligible rural hospitals that have developed strategic plans to implement transition projects to modify the type and extent of services provided, in order to reflect the needs of that plan. Grants may be used by hospitals under this paragraph to develop hospital-based physician practices that integrate hospital and existing medical practice facilities that agree to transfer their practices, equipment, staffing, and administration to the hospital. The grants may also be used by the hospital to establish a health provider cooperative, a telemedicine system, an electronic health records system, or a rural health care system or to cover expenses associated with being designated as a critical access hospital for the Medicare rural hospital flexibility program. Not more than one-third of any grant shall be used to offset losses incurred by physicians agreeing to transfer their practices to hospitals.

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

Sec. 10. [144.1476] RURAL PHARMACY PLANNING AND TRANSITION GRANT PROGRAM.

Subdivision 1. DEFINITIONS. (a) For the purposes of this section, the following definitions apply.

(b) "Eligible rural community" means:

(1) a Minnesota community that is located in a rural area, as defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 405.1041; or

(2) a Minnesota community that has a population of less than 10,000, according to the United States Bureau of Statistics, and that is outside the seven-county metropolitan area, excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud.

(c) "Health care provider" means a hospital, clinic, pharmacy, long-term care institution, or other health care facility that is licensed, certified, or otherwise authorized by the laws of this state to provide health care.

(d) "Pharmacist" means an individual with a valid license issued under chapter 151 to practice pharmacy.

(e) "Pharmacy" has the meaning given under section 151.01, subdivision 2.

Subd. 2. GRANTS AUTHORIZED; ELIGIBILITY. (a) The commissioner of health shall establish a program to award grants to eligible rural communities or health care providers in eligible rural communities for planning, establishing, keeping in operation, or providing health care services that preserve access to prescription medications and the skills of a pharmacist according to sections 151.01 to 151.40.

(b) To be eligible for a grant, an applicant must develop a strategic plan for preserving or enhancing access to prescription medications and the skills of a pharmacist. At a minimum, a strategic plan must consist of:

(1) a needs assessment to determine what pharmacy services are needed and desired by the community. The assessment must include interviews with or surveys of

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area and local health professionals, local community leaders, and public officials;

(2) an assessment of the feasibility of providing needed pharmacy services that identifies priorities and timelines for potential changes; and

(3) an implementation plan.

(c) A grant may be used by a recipient that has developed a strategic plan to implement transition projects to modify the type and extent of pharmacy services provided, in order to reflect the needs of the community. Grants may also be used by recipients:

(1) to develop pharmacy practices that integrate pharmacy and existing health care provider facilities; or

(2) to establish a pharmacy provider cooperative or initiatives that maintain local access to prescription medications and the skills of a pharmacist.

Subd. 3. CONSIDERATION OF GRANTS. In determining which applicants shall receive grants under this section, the commissioner of health shall appoint a committee comprised of members with experience and knowledge about rural pharmacy issues including, but not limited to, two rural pharmacists with a community pharmacy background, two health care providers from rural communities, one representative from a statewide pharmacist organization, and one representative of the Board of Pharmacy. A representative of the commissioner may serve on the committee in an ex officio status. In determining who shall receive a grant, the committee shall take into account:

(1) improving or maintaining access to prescription medications and the skills of a pharmacist;

(2) changes in service populations;

(3) the extent community pharmacy needs are not currently met by other providers in the area;

(4) the financial condition of the applicant;

(5) the integration of pharmacy services into existing health care services; and

(6) community support.

The commissioner may also take into account other relevant factors.

Subd. 4. ALLOCATION OF GRANTS. (a) The commissioner shall establish a deadline for receiving applications and must make a final decision on the funding of each application within 60 days of the deadline. An applicant must apply no later than March 1 of each fiscal year for grants awarded for that fiscal year.

(b) Any grant awarded must not exceed \$50,000 a year and may not exceed a one-year term.

(c) Applicants may apply to the program each year they are eligible.

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(d) Project grants may not be used to retire debt incurred with respect to any capital expenditure made prior to the date on which the project is initiated.

Subd. 5. EVALUATION. The commissioner shall evaluate the overall effectiveness of the grant program and may collect progress reports and other information from grantees needed for program evaluation. An academic institution that has the expertise in evaluating rural pharmacy outcomes may participate in the program evaluation if asked by a grantee or the commissioner. The commissioner shall compile summaries of successful grant projects and other model community efforts to preserve access to prescription medications and the skills of a pharmacist, and make this information available to Minnesota communities seeking to address local pharmacy issues.

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 11. Minnesota Statutes 2004, section 144.148, subdivision 1, is amended to read:

Subdivision 1. **DEFINITION.** (a) For purposes of this section, the following definitions apply.

(b) "Eligible rural hospital" means any nonfederal, general acute care hospital that:

(1) is either located in a rural area, as defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 405.1041, or located in a community with a population of less than ~~10,000~~ 15,000, according to United States Census Bureau statistics, outside the seven-county metropolitan area;

(2) has 50 or fewer beds; and

(3) is not for profit.

(c) "Eligible project" means a modernization project to update, remodel, or replace aging hospital facilities and equipment necessary to maintain the operations of a hospital, including establishing an electronic health records system.

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

Sec. 12. Minnesota Statutes 2004, section 144.1483, is amended to read:

144.1483 RURAL HEALTH INITIATIVES.

The commissioner of health, through the Office of Rural Health, and consulting as necessary with the commissioner of human services, the commissioner of commerce, the Higher Education Services Office, and other state agencies, shall:

(1) develop a detailed plan regarding the feasibility of coordinating rural health care services by organizing individual medical providers and smaller hospitals and clinics into referral networks with larger rural hospitals and clinics that provide a broader array of services;

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~~(2) develop and implement a program to assist rural communities in establishing community health centers, as required by section 144.1486;~~

(3) develop recommendations regarding health education and training programs in rural areas, including but not limited to a physician assistants' training program, continuing education programs for rural health care providers, and rural outreach programs for nurse practitioners within existing training programs;

(4) (3) develop a statewide, coordinated recruitment strategy for health care personnel and maintain a database on health care personnel as required under section 144.1485;

(5) (4) develop and administer technical assistance programs to assist rural communities in: (i) planning and coordinating the delivery of local health care services; and (ii) hiring physicians, nurse practitioners, public health nurses, physician assistants, and other health personnel;

(6) (5) study and recommend changes in the regulation of health care personnel, such as nurse practitioners and physician assistants, related to scope of practice, the amount of on-site physician supervision, and dispensing of medication, to address rural health personnel shortages;

(7) (6) support efforts to ensure continued funding for medical and nursing education programs that will increase the number of health professionals serving in rural areas;

(8) (7) support efforts to secure higher reimbursement for rural health care providers from the Medicare and medical assistance programs;

(9) (8) coordinate the development of a statewide plan for emergency medical services, in cooperation with the Emergency Medical Services Advisory Council;

(10) (9) establish a Medicare rural hospital flexibility program pursuant to section 1820 of the federal Social Security Act, United States Code, title 42, section 1395i-4, by developing a state rural health plan and designating, consistent with the rural health plan, rural nonprofit or public hospitals in the state as critical access hospitals. Critical access hospitals shall include facilities that are certified by the state as necessary providers of health care services to residents in the area. Necessary providers of health care services are designated as critical access hospitals on the basis of being more than 20 miles, defined as official mileage as reported by the Minnesota Department of Transportation, from the next nearest hospital, being the sole hospital in the county, being a hospital located in a county with a designated medically underserved area or health professional shortage area, or being a hospital located in a county contiguous to a county with a medically underserved area or health professional shortage area. A critical access hospital located in a county with a designated medically underserved area or a health professional shortage area or in a county contiguous to a county with a medically underserved area or health professional shortage area shall continue to be recognized as a critical access hospital in the event the medically underserved area or health professional shortage area designation is subsequently withdrawn; and

(11) (10) carry out other activities necessary to address rural health problems.

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

New language is indicated by underline, deletions by ~~strikeout~~.

Sec. 13. Minnesota Statutes 2004, section 144.1501, subdivision 1, is amended to read:

Subdivision 1. **DEFINITIONS.** (a) For purposes of this section, the following definitions apply.

(b) "Dentist" means an individual who is licensed to practice dentistry.

(c) "Designated rural area" means:

(1) an area in Minnesota outside the counties of Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington, excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud; or

(2) a municipal corporation, as defined under section 471.634, that is physically located, in whole or in part, in an area defined as a designated rural area under clause (1).

(e) (d) "Emergency circumstances" means those conditions that make it impossible for the participant to fulfill the service commitment, including death, total and permanent disability, or temporary disability lasting more than two years.

(d) (e) "Medical resident" means an individual participating in a medical residency in family practice, internal medicine, obstetrics and gynecology, pediatrics, or psychiatry.

(e) (f) "Midlevel practitioner" means a nurse practitioner, nurse-midwife, nurse anesthetist, advanced clinical nurse specialist, or physician assistant.

(f) (g) "Nurse" means an individual who has completed training and received all licensing or certification necessary to perform duties as a licensed practical nurse or registered nurse.

(g) (h) "Nurse-midwife" means a registered nurse who has graduated from a program of study designed to prepare registered nurses for advanced practice as nurse-midwives.

(h) (i) "Nurse practitioner" means a registered nurse who has graduated from a program of study designed to prepare registered nurses for advanced practice as nurse practitioners.

(i) (j) "Pharmacist" means an individual with a valid license issued under chapter 151.

(k) "Physician" means an individual who is licensed to practice medicine in the areas of family practice, internal medicine, obstetrics and gynecology, pediatrics, or psychiatry.

(j) (l) "Physician assistant" means a person registered under chapter 147A.

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~~(k)~~ (m) "Qualified educational loan" means a government, commercial, or foundation loan for actual costs paid for tuition, reasonable education expenses, and reasonable living expenses related to the graduate or undergraduate education of a health care professional.

(4) (n) "Underserved urban community" means a Minnesota urban area or population included in the list of designated primary medical care health professional shortage areas (HPSAs), medically underserved areas (MUAs), or medically underserved populations (MUPs) maintained and updated by the United States Department of Health and Human Services.

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 14. Minnesota Statutes 2004, section 144.1501, subdivision 2, is amended to read:

Subd. 2. **CREATION OF ACCOUNT.** (a) A health professional education loan forgiveness program account is established. The commissioner of health shall use money from the account to establish a loan forgiveness program:

(1) for medical residents agreeing to practice in designated rural areas or underserved urban communities, or specializing in the area of pediatric psychiatry;

(2) for midlevel practitioners agreeing to practice in designated rural areas, and or to teach for at least 20 hours per week in the nursing field in a postsecondary program;

(3) for nurses who agree to practice in a Minnesota nursing home or intermediate care facility for persons with mental retardation or related conditions or to teach for at least 20 hours per week in the nursing field in a postsecondary program;

(4) for other health care technicians agreeing to teach for at least 20 hours per week in their designated field in a postsecondary program. The commissioner, in consultation with the Healthcare Education-Industry Partnership, shall determine the health care fields where the need is the greatest, including, but not limited to, respiratory therapy, clinical laboratory technology, radiologic technology, and surgical technology;

(5) for pharmacists who agree to practice in designated rural areas; and

(6) for dentists agreeing to deliver at least 25 percent of the dentist's yearly patient encounters to state public program enrollees or patients receiving sliding fee schedule discounts through a formal sliding fee schedule meeting the standards established by the United States Department of Health and Human Services under Code of Federal Regulations, title 42, section 51, chapter 303.

(b) Appropriations made to the account do not cancel and are available until expended, except that at the end of each biennium, any remaining balance in the account that is not committed by contract and not needed to fulfill existing commitments shall cancel to the fund.

EFFECTIVE DATE. This section is effective August 1, 2005.

New language is indicated by underline, deletions by ~~strikeout~~.

Sec. 15. Minnesota Statutes 2004, section 144.1501, subdivision 3, is amended to read:

Subd. 3. **ELIGIBILITY.** (a) To be eligible to participate in the loan forgiveness program, an individual must:

(1) be a medical or dental resident, a licensed pharmacist or be enrolled in a dentist, midlevel practitioner, registered nurse, or a licensed practical nurse training program; and

(2) submit an application to the commissioner of health. If fewer applications are submitted by dental students or residents than there are dentist participant slots available, the commissioner may consider applications submitted by dental program graduates who are licensed dentists.

(b) An applicant selected to participate must sign a contract to agree to serve a minimum three-year full-time service obligation according to subdivision 2, which shall begin no later than March 31 following completion of required training.

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 16. Minnesota Statutes 2004, section 144.1501, subdivision 4, is amended to read:

Subd. 4. **LOAN FORGIVENESS.** The commissioner of health may select applicants each year for participation in the loan forgiveness program, within the limits of available funding. The commissioner shall distribute available funds for loan forgiveness proportionally among the eligible professions according to the vacancy rate for each profession in the required geographic area ~~or~~ facility type, teaching area, patient group, or specialty type specified in subdivision 2. The commissioner shall allocate funds for physician loan forgiveness so that 75 percent of the funds available are used for rural physician loan forgiveness and 25 percent of the funds available are used for underserved urban communities and pediatric psychiatry loan forgiveness. If the commissioner does not receive enough qualified applicants each year to use the entire allocation of funds for ~~urban underserved communities~~ any eligible profession, the remaining funds may be allocated ~~for rural physician loan forgiveness~~ proportionally among the other eligible professions according to the vacancy rate for each profession in the required geographic area, patient group, or facility type specified in subdivision 2. Applicants are responsible for securing their own qualified educational loans. The commissioner shall select participants based on their suitability for practice serving the required geographic area or facility type specified in subdivision 2, as indicated by experience or training. The commissioner shall give preference to applicants closest to completing their training. For each year that a participant meets the service obligation required under subdivision 3, up to a maximum of four years, the commissioner shall make annual disbursements directly to the participant equivalent to 15 percent of the average educational debt for indebted graduates in their profession in the year closest to the applicant's selection for which information is available, not to exceed the balance of the participant's qualifying educational loans. Before receiving

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loan repayment disbursements and as requested, the participant must complete and return to the commissioner an affidavit of practice form provided by the commissioner verifying that the participant is practicing as required under subdivisions 2 and 3. The participant must provide the commissioner with verification that the full amount of loan repayment disbursement received by the participant has been applied toward the designated loans. After each disbursement, verification must be received by the commissioner and approved before the next loan repayment disbursement is made. Participants who move their practice remain eligible for loan repayment as long as they practice as required under subdivision 2.

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 17. Minnesota Statutes 2004, section 144.226, subdivision 1, as amended by Laws 2005, chapter 60, section 4, is amended to read:

Subdivision 1. **WHICH SERVICES ARE FOR FEE.** The fees for the following services shall be the following or an amount prescribed by rule of the commissioner:

(a) The fee for the issuance of a certified vital record or a certification that the vital record cannot be found is ~~\$\$~~ \$9. No fee shall be charged for a certified birth, stillbirth, or death record that is reissued within one year of the original issue, if an amendment is made to the vital record and if the previously issued vital record is surrendered. The fee is nonrefundable.

(b) The fee for processing a request for the replacement of a birth record for all events, except when filing a recognition of parentage pursuant to section 257.73, subdivision 1, is \$20 ~~\$40~~. The fee is payable at the time of application and is nonrefundable.

(c) The fee for processing a request for the filing of a delayed registration of birth, stillbirth, or death is \$20 ~~\$40~~. The fee is payable at the time of application and is nonrefundable. This fee includes one subsequent review of the request if the request is not acceptable upon the initial receipt.

(d) The fee for processing a request for the amendment of any vital record when requested more than 45 days after the filing of the vital record is \$20 ~~\$40~~. No fee shall be charged for an amendment requested within 45 days after the filing of the vital record. The fee is payable at the time of application and is nonrefundable. This fee includes one subsequent review of the request if the request is not acceptable upon the initial receipt.

(e) The fee for processing a request for the verification of information from vital records is \$8 ~~\$9~~ when the applicant furnishes the specific information to locate the vital record. When the applicant does not furnish specific information, the fee is \$20 per hour for staff time expended. Specific information includes the correct date of the event and the correct name of the registrant. Fees charged shall approximate the costs incurred in searching and copying the vital records. The fee ~~shall be~~ is payable at the time of application and is nonrefundable.

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(f) The fee for processing a request for the issuance of a copy of any document on file pertaining to a vital record or statement that a related document cannot be found is \$8 \$9. The fee is payable at the time of application and is nonrefundable.

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 18. Minnesota Statutes 2004, section 144.226, subdivision 4, as amended by Laws 2005, chapter 60, section 6, is amended to read:

Subd. 4. **VITAL RECORDS SURCHARGE.** (a) In addition to any fee prescribed under subdivision 1, there is a nonrefundable surcharge of \$2 for each certified and noncertified birth, stillbirth, or death record, and for a certification that the record cannot be found. The local or state registrar shall forward this amount to the commissioner of finance to be deposited into the state government special revenue fund. This surcharge shall not be charged under those circumstances in which no fee for a birth, stillbirth, or death record is permitted under subdivision 1, paragraph (a).

(b) Effective August 1, 2005, to June 30, 2009, the surcharge in paragraph (a) shall be \$4.

Sec. 19. Minnesota Statutes 2004, section 144.226, is amended by adding a subdivision to read:

Subd. 5. **ELECTRONIC VERIFICATION.** A fee for the electronic verification of a vital event, when the information being verified is obtained from a certified birth or death record, shall be established through contractual or interagency agreements with interested local, state, or federal government agencies.

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 20. Minnesota Statutes 2004, section 144.226, is amended by adding a subdivision to read:

Subd. 6. **ALTERNATIVE PAYMENT METHODS.** Notwithstanding subdivision 1, alternative payment methods may be approved and implemented by the state registrar or a local registrar.

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 21. Minnesota Statutes 2004, section 144.3831, subdivision 1, is amended to read:

Subdivision 1. **FEE SETTING.** The commissioner of health may assess an annual fee of ~~\$5.21~~ \$6.36 for every service connection to a public water supply that is owned or operated by a home rule charter city, a statutory city, a city of the first class, or a town. The commissioner of health may also assess an annual fee for every service connection served by a water user district defined in section 110A.02.

EFFECTIVE DATE. This section is effective July 1, 2006.

Sec. 22. Minnesota Statutes 2004, section 144.551, subdivision 1, is amended to read:

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Subdivision 1. **RESTRICTED CONSTRUCTION OR MODIFICATION.** (a) The following construction or modification may not be commenced:

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

(2) the establishment of a new hospital.

(b) This section does not apply to:

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

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

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

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

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

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

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

(8) relocation or redistribution of hospital beds within a hospital corporate system that involves the transfer of beds from a closed facility site or complex to an existing site or complex provided that: (i) no more than 50 percent of the capacity of the closed facility is transferred; (ii) the capacity of the site or complex to which the beds are transferred does not increase by more than 50 percent; (iii) the beds are not transferred

New language is indicated by underline, deletions by ~~strikeout~~.

outside of a federal health systems agency boundary in place on July 1, 1983; and (iv) the relocation or redistribution does not involve the construction of a new hospital building;

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

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

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

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

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

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

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

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

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

(18) a project to add 20 licensed beds in existing space at a hospital in Hennepin County that closed 20 rehabilitation beds in 2002, provided that the beds are used only for rehabilitation in the hospital's current rehabilitation building. If the beds are used

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for another purpose or moved to another location, the hospital's licensed capacity is reduced by 20 beds; or

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

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

Sec. 23. Minnesota Statutes 2004, section 144.562, subdivision 2, is amended to read:

Subd. 2. **ELIGIBILITY FOR LICENSE CONDITION.** (a) A hospital is not eligible to receive a license condition for swing beds unless (1) it either has a licensed bed capacity of less than 50 beds defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 482.66, or it has a licensed bed capacity of 50 beds or more and has swing beds that were approved for Medicare reimbursement before May 1, 1985, or it has a licensed bed capacity of less than 65 beds and the available nursing homes within 50 miles have had, in the aggregate, an average occupancy rate of 96 percent or higher in the most recent two years as documented on the statistical reports to the Department of Health; and (2) it is located in a rural area as defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 482.66.

(b) Except for those critical access hospitals established under section 144.1483, clause (9), and section 1820 of the federal Social Security Act, United States Code, title 42, section 1395i-4, that have an attached nursing home or that owned a nursing home located in the same municipality as of May 1, 2005, eligible hospitals are allowed a total of ~~1,460~~ 2,000 days of swing bed use per year; provided that no more than ~~ten~~ hospital beds are used as swing beds at any one time. Critical access hospitals that have an attached nursing home or that owned a nursing home located in the same municipality as of May 1, 2005, are allowed swing bed use as provided in federal law.

(c) Except for critical access hospitals that have an attached nursing home or that owned a nursing home located in the same municipality as of May 1, 2005, the commissioner of health ~~must~~ may approve swing bed use beyond ~~1,460~~ 2,000 days as long as there are no Medicare certified skilled nursing facility beds available within 25 miles of that hospital that are willing to admit the patient. Critical access hospitals exceeding 2,000 swing bed days must maintain documentation that they have contacted skilled nursing facilities within 25 miles to determine if any skilled nursing facility beds are available that are willing to admit the patient.

(d) After reaching 2,000 days of swing bed use in a year, an eligible hospital to which this limit applies may admit six additional patients to swing beds each year without seeking approval from the commissioner or being in violation of this subdivision. These six swing bed admissions are exempt from the limit of 2,000 annual

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swing bed days for hospitals subject to this limit.

(e) A health care system that is in full compliance with this subdivision may allocate its total limit of swing bed days among the hospitals within the system, provided that no hospital in the system without an attached nursing home may exceed 2,000 swing bed days per year.

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

Sec. 24. [144.574] EDUCATION ABOUT THE DANGERS OF SHAKING INFANTS AND YOUNG CHILDREN.

Subdivision 1. EDUCATION BY HOSPITALS. (a) A hospital licensed under sections 144.50 to 144.56 shall make available for viewing by the parents of each newborn baby delivered in the hospital a video presentation on the dangers associated with shaking infants and young children.

(b) A hospital shall use a video obtained from the commissioner or approved by the commissioner. The commissioner shall provide to a hospital and any interested individuals, at cost, copies of an approved video. The commissioner shall review other video presentations for possible approval upon the request of a hospital. The commissioner shall not require a hospital to use videos that would require the hospital to pay royalties for use of the video, restrict viewing in order to comply with public viewing or other restrictions, or be subject to other costs or restrictions associated with copyrights.

(c) A hospital shall, whenever possible, request both parents to view the video.

(d) The showing or distribution of the video shall not subject any person or facility to any action for damages or other relief provided the person or facility acted in good faith.

Subd. 2. EDUCATION BY HEALTH CARE PROVIDERS. The commissioner shall establish a protocol for health care providers to educate parents and primary caregivers about the dangers associated with shaking infants and young children. The commissioner shall request family practice physicians, pediatricians, and other pediatric health care providers to review these dangers with the parents and primary caregivers of infants and young children up to the age of three at each well-baby visit.

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 25. [144.602] DEFINITIONS.

Subdivision 1. APPLICABILITY. For purposes of sections 144.601 to 144.608, the terms defined in this section have the meanings given them.

Subd. 2. COMMISSIONER. “Commissioner” means the commissioner of health.

Subd. 3. MAJOR TRAUMA. “Major trauma” means a sudden severe injury or damage to the body caused by an external force that results in potentially life-

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threatening injuries or that could result in the following disabilities:

- (1) impairment of cognitive or mental abilities;
- (2) impairment of physical functioning; or
- (3) disturbance of behavioral or emotional functioning.

Subd. 4. TRAUMA HOSPITAL. "Trauma hospital" means a hospital that voluntarily meets the commissioner's criteria under section 144.603 and that has been designated as a trauma hospital under section 144.605.

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

Sec. 26. [144.603] STATEWIDE TRAUMA SYSTEM CRITERIA.

Subdivision 1. CRITERIA ESTABLISHED. The commissioner shall adopt criteria to ensure that severely injured people are promptly transported and treated at trauma hospitals appropriate to the severity of injury. Minimum criteria shall address emergency medical service trauma triage and transportation guidelines as approved under section 144E.101, subdivision 14, designation of hospitals as trauma hospitals, interhospital transfers, a trauma registry, and a trauma system governance structure.

Subd. 2. BASIS; VERIFICATION. The commissioner shall base the establishment, implementation, and modifications to the criteria under subdivision 1 on the department-published Minnesota comprehensive statewide trauma system plan. The commissioner shall seek the advice of the Trauma Advisory Council in implementing and updating the criteria, using accepted and prevailing trauma transport, treatment, and referral standards of the American College of Surgeons, the American College of Emergency Physicians, the Minnesota Emergency Medical Services Regulatory Board, the national Trauma Resources Network, and other widely recognized trauma experts. The commissioner shall adapt and modify the standards as appropriate to accommodate Minnesota's unique geography and the state's hospital and health professional distribution and shall verify that the criteria are met by each hospital voluntarily participating in the statewide trauma system.

Subd. 3. RULE EXEMPTION AND REPORT TO THE LEGISLATURE. In developing and adopting the criteria under this section, the commissioner of health is exempt from chapter 14, including section 14.386. By September 1, 2009, the commissioner must report to the legislature on implementation of the voluntary trauma system, including recommendations on the need for including the trauma system criteria in rule.

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

Sec. 27. [144.604] TRAUMA TRIAGE AND TRANSPORTATION.

Subdivision 1. TRANSPORT REQUIREMENT. Unless the Emergency Medical Services Regulatory Board has approved a licensed ambulance service's deviation from the guidelines under section 144E.101, subdivision 14, the ambulance service must transport major trauma patients from the scene to the highest state-designated trauma hospital within 30 minutes' transport time.

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Subd. 2. **GROUND AMBULANCE EXCEPTIONS.** Notwithstanding subdivision 1, ground ambulances must comply with the following:

(1) patients with compromised airways must be transported immediately to the nearest designated trauma hospital; and

(2) level II trauma hospitals capable of providing definitive trauma care must not be bypassed to reach a level I trauma hospital.

Subd. 3. **UNDESIGNATED HOSPITALS.** No major trauma patient shall be transported to a hospital not participating in the statewide trauma system unless no trauma hospital is available within 30 minutes' transport time.

EFFECTIVE DATE. This section is effective July 1, 2009.

Sec. 28. [144.605] DESIGNATING TRAUMA HOSPITALS.

Subdivision 1. **NAMING PRIVILEGES.** Unless it has been designated a trauma hospital by the commissioner, no hospital shall use the term trauma center or trauma hospital in its name or its advertising or shall otherwise indicate it has trauma treatment capabilities.

Subd. 2. **DESIGNATION; REVERIFICATION.** The commissioner shall designate four levels of trauma hospitals. A hospital that voluntarily meets the criteria for a particular level of trauma hospital shall apply to the commissioner for designation and, upon the commissioner's verifying the hospital meets the criteria, be designated a trauma hospital at the appropriate level for a three-year period. Prior to the expiration of the three-year designation, a hospital seeking to remain part of the voluntary system must apply for and successfully complete a reverification process, be awaiting the site visit for the reverification, or be awaiting the results of the site visit. The commissioner may extend a hospital's existing designation for up to 18 months on a provisional basis if the hospital has applied for reverification in a timely manner but has not yet completed the reverification process within the expiration of the three-year designation and the extension is in the best interest of trauma system patient safety. To be granted a provisional extension, the hospital must be:

(1) scheduled and awaiting the site visit for reverification;

(2) awaiting the results of the site visit; or

(3) responding to and correcting identified deficiencies identified in the site visit.

Subd. 3. **ACS VERIFICATION.** The commissioner shall grant the appropriate level I, II, or III trauma hospital designation to a hospital that successfully completes and passes the American College of Surgeons (ACS) verification standards at the hospital's cost, submits verification documentation to the Trauma Advisory Council, and formally notifies the Trauma Advisory Council of ACS verification.

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Subd. 4. LEVEL III DESIGNATION; NOT ACS VERIFIED. (a) The commissioner shall grant the appropriate level III trauma hospital designation to a hospital that is not ACS verified but that successfully completes the designation process under paragraph (b).

(b) The hospital must complete and submit a self-reported survey and application to the Trauma Advisory Council for review, verifying that the hospital meets the criteria as a level III trauma hospital. When the Trauma Advisory Council is satisfied the application is complete, the commissioner shall arrange a site review visit. Upon successful completion of the site review, the review team shall make written recommendations to the Trauma Advisory Council. If approved by the Trauma Advisory Council, a letter of recommendation shall be sent to the commissioner for final approval and designation.

Subd. 5. LEVEL IV DESIGNATION. (a) The commissioner shall grant the appropriate level IV trauma hospital designation to a hospital that successfully completes the designation process under paragraph (b).

(b) The hospital must complete and submit a self-reported survey and application to the Trauma Advisory Council for review, verifying that the hospital meets the criteria as a level IV trauma hospital. When the Trauma Advisory Council is satisfied the application is complete, the council shall review the application and, if the council approves the application, send a letter of recommendation to the commissioner for final approval and designation. The commissioner shall grant a level IV designation and shall arrange a site review visit within three years of the designation and every three years thereafter, to coincide with the three-year reverification process.

Subd. 6. CHANGES IN DESIGNATION. Changes in a trauma hospital's ability to meet the criteria for the hospital's level of designation must be self-reported to the Trauma Advisory Council and to other regional hospitals and local emergency medical services providers and authorities. If the hospital cannot correct its ability to meet the criteria for its level within six months, the hospital may apply for redesignation at a different level.

Subd. 7. HIGHER DESIGNATION. A trauma hospital may apply for a higher trauma hospital designation one time during the hospital's three-year designation by completing the designation process for that level of trauma hospital.

Subd. 8. LOSS OF DESIGNATION. The commissioner may refuse to designate or redesignate or may revoke a previously issued trauma hospital designation if a hospital does not meet the criteria of the statewide trauma plan, in the interests of patient safety, or if a hospital denies or refuses a reasonable request by the commissioner or the commissioner's designee to verify information by correspondence or an on-site visit.

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

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Sec. 29. [144.606] INTERHOSPITAL TRANSFERS.

Subdivision 1. WRITTEN PROCEDURES REQUIRED. A level III or IV trauma hospital must have predetermined, written procedures that direct the internal process for rapidly and efficiently transferring a major trauma patient to definitive care, including:

(1) clearly identified anatomic and physiologic criteria that, if met, will immediately initiate transfer to definitive care;

(2) a listing of appropriate ground and air transport services, including primary and secondary telephone contact numbers; and

(3) immediately available supplies, records, or other necessary resources that will accompany a patient.

Subd. 2. TRANSFER AGREEMENTS. (a) A level III or IV trauma hospital may transfer patients to a hospital with which the trauma hospital has a written transfer agreement.

(b) Each agreement must be current and with a trauma hospital or trauma hospitals capable of caring for major trauma injuries.

(c) A level III or IV trauma hospital must have a current transfer agreement with a hospital that has special capabilities in the treatment of burn injuries and a transfer agreement with a second hospital that has special capabilities in the treatment of burn injuries, should the primary transfer hospital be unable to accept a burn patient.

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

Sec. 30. [144.607] TRAUMA REGISTRY.

Subdivision 1. REGISTRY PARTICIPATION REQUIRED. A trauma hospital must participate in the statewide trauma registry.

Subd. 2. TRAUMA REPORTING. A trauma hospital must report major trauma injuries as part of the reporting for the traumatic brain injury and spinal cord injury registry required in sections 144.661 to 144.665.

Subd. 3. APPLICATION OF OTHER LAW. Sections 144.661 to 144.665 apply to a major trauma reported to the statewide trauma registry, with the exception of sections 144.662, clause (2), and 144.664, subdivision 3.

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

Sec. 31. [144.608] TRAUMA ADVISORY COUNCIL.

Subdivision 1. TRAUMA ADVISORY COUNCIL ESTABLISHED. (a) A Trauma Advisory Council is established to advise, consult with, and make recommendations to the commissioner on the development, maintenance, and improvement of a statewide trauma system.

(b) The council shall consist of the following members:

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(1) a trauma surgeon certified by the American College of Surgeons who practices in a level I or II trauma hospital;

(2) a general surgeon certified by the American College of Surgeons whose practice includes trauma and who practices in a designated rural area as defined under section 144.1501, subdivision 1, paragraph (b);

(3) a neurosurgeon certified by the American Board of Neurological Surgery who practices in a level I or II trauma hospital;

(4) a trauma program nurse manager or coordinator practicing in a level I or II trauma hospital;

(5) an emergency physician certified by the American College of Emergency Physicians whose practice includes emergency room care in a level I, II, III, or IV trauma hospital;

(6) an emergency room nurse manager who practices in a level III or IV trauma hospital;

(7) a family practice physician whose practice includes emergency room care in a level III or IV trauma hospital located in a designated rural area as defined under section 144.1501, subdivision 1, paragraph (b);

(8) a nurse practitioner, as defined under section 144.1501, subdivision 1, paragraph (h), or a physician assistant, as defined under section 144.1501, subdivision 1, paragraph (j), whose practice includes emergency room care in a level IV trauma hospital located in a designated rural area as defined under section 144.1501, subdivision 1, paragraph (b);

(9) a pediatrician certified by the American Academy of Pediatrics whose practice includes emergency room care in a level I, II, III, or IV trauma hospital;

(10) an orthopedic surgeon certified by the American Board of Orthopaedic Surgery whose practice includes trauma and who practices in a level I, II, or III trauma hospital;

(11) the state emergency medical services medical director appointed by the Emergency Medical Services Regulatory Board;

(12) a hospital administrator of a level III or IV trauma hospital located in a designated rural area as defined under section 144.1501, subdivision 1, paragraph (b);

(13) a rehabilitation specialist whose practice includes rehabilitation of patients with major trauma injuries or traumatic brain injuries and spinal cord injuries as defined under section 144.661;

(14) an attendant or ambulance director who is an EMT, EMT-I, or EMT-P within the meaning of section 144E.001 and who actively practices with a licensed ambulance service in a primary service area located in a designated rural area as defined under section 144.1501, subdivision 1, paragraph (b); and

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(15) the commissioner of public safety or the commissioner's designee.

(c) Council members whose appointment is dependent on practice in a level III or IV trauma hospital may be appointed to an initial term based upon their statements that the hospital intends to become a level III or IV facility by July 1, 2009.

Subd. 2. COUNCIL ADMINISTRATION. (a) The council must meet at least twice a year but may meet more frequently at the call of the chair, a majority of the council members, or the commissioner.

(b) The terms, compensation, and removal of members of the council are governed by section 15.059, except that the council expires June 30, 2015.

(c) The council may appoint subcommittees and workgroups. Subcommittees shall consist of council members. Workgroups may include noncouncil members. Noncouncil members shall be compensated for workgroup activities under section 15.059, subdivision 3, but shall receive expenses only.

Subd. 3. REGIONAL TRAUMA ADVISORY COUNCILS. (a) Up to eight regional trauma advisory councils may be formed as needed.

(b) Regional trauma advisory councils shall advise, consult with, and make recommendation to the state Trauma Advisory Council on suggested regional modifications to the statewide trauma criteria that will improve patient care and accommodate specific regional needs.

(c) Each regional advisory council must have no more than 15 members. The commissioner, in consultation with the Emergency Medical Services Regulatory Board, shall name the council members.

(d) Regional council members may receive expenses in the same manner and amount as authorized by the plan adopted under section 43A.18, subdivision 2.

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

Sec. 32. Minnesota Statutes 2004, section 144.9504, subdivision 2, is amended to read:

Subd. 2. LEAD RISK ASSESSMENT. (a) An assessing agency shall conduct a lead risk assessment of a residence according to the venous blood lead level and time frame set forth in clauses (1) to ~~(5)~~ (4) for purposes of secondary prevention:

(1) within 48 hours of a child or pregnant female in the residence being identified to the agency as having a venous blood lead level equal to or greater than ~~70~~ 60 micrograms of lead per deciliter of whole blood;

(2) within five working days of a child or pregnant female in the residence being identified to the agency as having a venous blood lead level equal to or greater than 45 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 ~~20~~ 15 micrograms of lead per deciliter of whole blood; or

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(4) within ten working days of a child in the residence being identified to the agency as having a venous blood lead level that persists in the range of 15 to 19 micrograms of lead per deciliter of whole blood for 90 days after initial identification; or

(5) 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 ~~20~~ 15 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

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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.

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 33. Minnesota Statutes 2004, section 144.98, subdivision 3, is amended to read:

Subd. 3. **FEES.** (a) An application for certification under subdivision 1 must be accompanied by the biennial fee specified in this subdivision. The fees are for:

- (1) nonrefundable base certification fee, \$1,200 \$1,600; and
- (2) sample preparation techniques fees, \$100 per technique; and
- (3) test category certification fees:

Test Category	Certification Fee
Clean water program bacteriology	\$600 <u>\$800</u>
Safe drinking water program bacteriology	\$600 <u>\$800</u>
Clean water program inorganic chemistry	\$600 <u>\$800</u>
Safe drinking water program inorganic chemistry	\$600 <u>\$800</u>
Clean water program chemistry metals	\$800 <u>\$1,200</u>
Safe drinking water program chemistry metals	\$800 <u>\$1,200</u>
Resource conservation and recovery program chemistry metals	\$800 <u>\$1,200</u>
Clean water program volatile organic compounds	\$1,200 <u>\$1,500</u>
Safe drinking water program volatile organic compounds	\$1,200 <u>\$1,500</u>
Resource conservation and recovery program volatile organic compounds	\$1,200 <u>\$1,500</u>
Underground storage tank program volatile organic compounds	\$1,200 <u>\$1,500</u>
Clean water program other organic compounds	\$1,200 <u>\$1,500</u>
Safe drinking water program other organic compounds	\$1,200 <u>\$1,500</u>

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Resource conservation and recovery program	
other organic compounds	\$1,200 \$1,500
<u>Clean water program radiochemistry</u>	<u>\$2,500</u>
<u>Safe drinking water program radiochemistry</u>	<u>\$2,500</u>
<u>Resource conservation and recovery program</u>	
<u>agricultural contaminants</u>	<u>\$2,500</u>
<u>Resource conservation and recovery program</u>	
<u>emerging contaminants</u>	<u>\$2,500</u>

(b) ~~The total biennial certification fee is the base fee plus the applicable test category fees.~~

(e) ~~Laboratories located outside of this state that require an on-site survey will inspection shall be assessed an additional \$2,500 \$3,750 fee.~~

(c) The total biennial certification fee includes the base fee, the sample preparation techniques fees, the test category fees, and, when applicable, the on-site inspection fee.

(d) Fees must be set so that the total fees support the laboratory certification program. Direct costs of the certification service include program administration, inspections, the agency's general support costs, and attorney general costs attributable to the fee function.

(e) A change fee shall be assessed if a laboratory requests additional analytes or methods at any time other than when applying for or renewing its certification. The change fee is equal to the test category certification fee for the analyte.

(f) A variance fee shall be assessed if a laboratory requests and is granted a variance from a rule adopted under this section. The variance fee is \$500 per variance.

(g) Refunds or credits shall not be made for analytes or methods requested but not approved.

(h) Certification of a laboratory shall not be awarded until all fees are paid.

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 34. Minnesota Statutes 2004, section 144E.101, is amended by adding a subdivision to read:

Subd. 14. TRAUMA TRIAGE AND TRANSPORT GUIDELINES. By July 1, 2009, a licensee shall have written age appropriate trauma triage and transport guidelines consistent with the criteria issued by the Trauma Advisory Council established under section 144.608 and approved by the board. The board may approve a licensee's requested deviations to the guidelines due to the availability of local or regional trauma resources if the changes are in the best interest of the patient's health.

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

New language is indicated by underline, deletions by ~~strikeout~~.

Sec. 35. Minnesota Statutes 2004, section 145.4242, is amended to read:

145.4242 **INFORMED CONSENT.**

(a) No abortion shall be performed in this state except with the voluntary and informed consent of the female upon whom the abortion is to be performed. Except in the case of a medical emergency, consent to an abortion is voluntary and informed only if:

(1) the female is told the following, by telephone or in person, by the physician who is to perform the abortion or by a referring physician, at least 24 hours before the abortion:

(i) the particular medical risks associated with the particular abortion procedure to be employed including, when medically accurate, the risks of infection, hemorrhage, breast cancer, danger to subsequent pregnancies, and infertility;

(ii) the probable gestational age of the unborn child at the time the abortion is to be performed; and

(iii) the medical risks associated with carrying her child to term; and

(iv) for abortions after 20 weeks gestational, whether or not an anesthetic or analgesic would eliminate or alleviate organic pain to the unborn child caused by the particular method of abortion to be employed and the particular medical benefits and risks associated with the particular anesthetic or analgesic.

The information required by this clause may be provided by telephone without conducting a physical examination or tests of the patient, in which case the information required to be provided may be based on facts supplied to the physician by the female and whatever other relevant information is reasonably available to the physician. It may not be provided by a tape recording, but must be provided during a consultation in which the physician is able to ask questions of the female and the female is able to ask questions of the physician. If a physical examination, tests, or the availability of other information to the physician subsequently indicate, in the medical judgment of the physician, a revision of the information previously supplied to the patient, that revised information may be communicated to the patient at any time prior to the performance of the abortion. Nothing in this section may be construed to preclude provision of required information in a language understood by the patient through a translator;

(2) the female is informed, by telephone or in person, by the physician who is to perform the abortion, by a referring physician, or by an agent of either physician at least 24 hours before the abortion:

(i) that medical assistance benefits may be available for prenatal care, childbirth, and neonatal care;

(ii) that the father is liable to assist in the support of her child, even in instances when the father has offered to pay for the abortion; and

(iii) that she has the right to review the printed materials described in section 145.4243, that these materials are available on a state-sponsored Web site, and what the

New language is indicated by underline, deletions by ~~strikeout~~.

Web site address is. The physician or the physician's agent shall orally inform the female that the materials have been provided by the state of Minnesota and that they describe the unborn child, list agencies that offer alternatives to abortion, and contain information on fetal pain. If the female chooses to view the materials other than on the Web site, they shall either be given to her at least 24 hours before the abortion or mailed to her at least 72 hours before the abortion by certified mail, restricted delivery to addressee, which means the postal employee can only deliver the mail to the addressee.

The information required by this clause may be provided by a tape recording if provision is made to record or otherwise register specifically whether the female does or does not choose to have the printed materials given or mailed to her;

(3) the female certifies in writing, prior to the abortion, that the information described in clauses (1) and (2) has been furnished to her and that she has been informed of her opportunity to review the information referred to in clause (2), subclause (iii); and

(4) prior to the performance of the abortion, the physician who is to perform the abortion or the physician's agent obtains a copy of the written certification prescribed by clause (3) and retains it on file with the female's medical record for at least three years following the date of receipt.

(b) Prior to administering the anesthetic or analgesic as described in paragraph (a), clause (1), item (iv), the physician must disclose to the woman any additional cost of the procedure for the administration of the anesthetic or analgesic. If the woman consents to the administration of the anesthetic or analgesic, the physician shall administer the anesthetic or analgesic or arrange to have the anesthetic or analgesic administered.

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 36. Minnesota Statutes 2004, section 145.56, subdivision 2, is amended to read:

Subd. 2. **COMMUNITY-BASED PROGRAMS.** (a) To the extent funds are appropriated for the purposes of this subdivision, the commissioner shall establish a grant program to fund:

(1) community-based programs to provide education, outreach, and advocacy services to populations who may be at risk for suicide;

(2) community-based programs that educate community helpers and gatekeepers, such as family members, spiritual leaders, coaches, and business owners, employers, and coworkers on how to prevent suicide by encouraging help-seeking behaviors;

(3) community-based programs that educate populations at risk for suicide and community helpers and gatekeepers that must include information on the symptoms of depression and other psychiatric illnesses, the warning signs of suicide, skills for

New language is indicated by underline, deletions by ~~strikeout~~.

preventing suicides, and making or seeking effective referrals to intervention and community resources; and

(4) community-based programs to provide evidence-based suicide prevention and intervention education to school staff, parents, and students in grades kindergarten through 12.

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

Sec. 37. Minnesota Statutes 2004, section 145.56, subdivision 5, is amended to read:

Subd. 5. **PERIODIC EVALUATIONS; BIENNIAL REPORTS.** To the extent funds are appropriated for the purposes of this subdivision, the commissioner shall conduct periodic evaluations of the impact of and outcomes from implementation of the state's suicide prevention plan and each of the activities specified in this section. By July 1, 2002, and July 1 of each even-numbered year thereafter, the commissioner shall report the results of these evaluations to the chairs of the policy and finance committees in the house and senate with jurisdiction over health and human services issues.

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

Sec. 38. **[145.906] POSTPARTUM DEPRESSION EDUCATION AND INFORMATION.**

(a) The commissioner of health shall work with health care facilities, licensed health and mental health care professionals, mental health advocates, consumers, and families in the state to develop materials and information about postpartum depression, including treatment resources, and develop policies and procedures to comply with this section.

(b) Physicians, traditional midwives, and other licensed health care professionals providing prenatal care to women must have available to women and their families information about postpartum depression.

(c) Hospitals and other health care facilities in the state must provide departing new mothers and fathers and other family members, as appropriate, with written information about postpartum depression, including its symptoms, methods of coping with the illness, and treatment resources.

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 39. Minnesota Statutes 2004, section 145.9268, is amended to read:

145.9268 **COMMUNITY CLINIC GRANTS.**

Subdivision 1. **DEFINITION.** For purposes of this section, "eligible community clinic" means:

(1) a nonprofit clinic that provides is established to provide health services under conditions as defined in Minnesota Rules, part 9505.0255, to low income or rural

New language is indicated by underline, deletions by ~~strikeout~~.

population groups; provides medical, preventive, dental, or mental health primary care services; and utilizes a sliding fee scale or other procedure to determine eligibility for charity care or to ensure that no person will be denied services because of inability to pay;

(2) a governmental entity or an Indian tribal government or Indian health service unit that provides services and utilizes a sliding fee scale or other procedure as described under clause (1); or

(3) a consortium of clinics comprised of entities under clause (1) or (2); or

(4) a nonprofit, tribal, or governmental entity proposing the establishment of a clinic that will provide services and utilize a sliding fee scale or other procedure as described under clause (1).

Subd. 2. **GRANTS AUTHORIZED.** The commissioner of health shall award grants to eligible community clinics to plan, establish, or operate services to improve the ongoing viability of Minnesota's clinic-based safety net providers. Grants shall be awarded to support the capacity of eligible community clinics to serve low-income populations, reduce current or future uncompensated care burdens, or provide for improved care delivery infrastructure. The commissioner shall award grants to community clinics in metropolitan and rural areas of the state, and shall ensure geographic representation in grant awards among all regions of the state.

Subd. 3. **ALLOCATION OF GRANTS.** (a) To receive a grant under this section, an eligible community clinic 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. Community clinics may apply for and the commissioner may award grants for one-year or two-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; and

(3) a description of achievable objectives, a workplan, and a timeline for implementation and completion of processes or projects enabled by the grant; and

(4) a process for documenting and evaluating results of the grant.

(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 according to paragraph (d), the commissioner shall establish criteria including, but not limited to: the priority level eligibility of the project; the applicant's thoroughness and clarity in describing the problem grant funds are intended to address; a description of the applicant's proposed project; a description of the population demographics and service area of the proposed project; the manner

New language is indicated by underline, deletions by ~~strikeout~~.

in which the applicant will demonstrate the effectiveness of any projects undertaken; and evidence of efficiencies and effectiveness gained through collaborative efforts. The commissioner may also take into account other relevant factors, including, but not limited to, the percentage for which uninsured patients represent the applicant's patient base and the degree to which grant funds will be used to support services increasing or maintaining access to health care services. During application review, the commissioner may request additional information about a proposed project, including information on project cost. Failure to provide the information requested disqualifies an applicant. The commissioner has discretion over the number of grants awarded.

(d) In determining which eligible community clinics will receive grants under this section, the commissioner shall give preference to those grant applications that show evidence of collaboration with other eligible community clinics, hospitals, health care providers, or community organizations. ~~In addition, the commissioner shall give priority, in declining order, to grant applications for projects that:~~

Subd. 3a. AWARDING GRANTS. (a) The commissioner may award grants for activities to:

(1) provide a direct offset to expenses incurred for services provided to the clinic's target population;

(2) establish, update, or improve information, data collection, or billing systems, including electronic health records systems;

(3) procure, modernize, remodel, or replace equipment used in the delivery of direct patient care at a clinic;

(4) provide improvements for care delivery, such as increased translation and interpretation services; or

(5) build a new clinic or expand an existing facility; or

(6) other projects determined by the commissioner to improve the ability of applicants to provide care to the vulnerable populations they serve.

(e) (b) A grant awarded to an eligible community clinic may not exceed \$300,000 per eligible community clinic. For an applicant applying as a consortium of clinics, a grant may not exceed \$300,000 per clinic included in the consortium. The commissioner has discretion over the 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 reports to evaluate the grant program from the eligible community clinics receiving grants. Every two years, as part of this evaluation, the commissioner shall report to the legislature on priority areas for grants set under subdivision 3 the needs of community clinics and provide any recommendations for adding or changing priority areas eligible activities.

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

New language is indicated by underline, deletions by strikeout.

Sec. 40. Minnesota Statutes 2004, section 147A.08, is amended to read:

147A.08 EXEMPTIONS.

(a) This chapter does not apply to, control, prevent, or restrict the practice, service, or activities of persons listed in section 147.09, clauses (1) to (6) and (8) to (13), persons regulated under section 214.01, subdivision 2, or persons defined in section 144.1501, subdivision 1, paragraphs ~~(e)~~ (f), ~~(g)~~ (h), and ~~(h)~~ (i).

(b) Nothing in this chapter shall be construed to require registration of:

(1) a physician assistant student enrolled in a physician assistant or surgeon assistant educational program accredited by the Committee on Allied Health Education and Accreditation or by its successor agency approved by the board;

(2) a physician assistant employed in the service of the federal government while performing duties incident to that employment; or

(3) technicians, other assistants, or employees of physicians who perform delegated tasks in the office of a physician but who do not identify themselves as a physician assistant.

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 41. Minnesota Statutes 2004, section 150A.22, is amended to read:

150A.22 DONATED DENTAL SERVICES.

(a) The ~~Board of Dentistry~~ commissioner of health shall contract with the Minnesota Dental Association, or another appropriate and qualified organization to develop and operate a donated dental services program to provide dental care to public program recipients and the uninsured through dentists who volunteer their services without compensation. As part of the contract, the ~~board~~ commissioner shall include specific performance and outcome measures that the contracting organization must meet. The donated dental services program shall:

(1) establish a network of volunteer dentists, including dental specialties, to donate dental services to eligible individuals;

(2) establish a system to refer eligible individuals to the appropriate volunteer dentists; and

(3) develop and implement a public awareness campaign to educate eligible individuals about the availability of the program.

(b) Funding for the program may be used for administrative or technical support. The organization contracting with the ~~board~~ commissioner shall provide an annual report that accounts for funding appropriated to the program by the state, documents the number of individuals served by the program and the number of dentists participating as program providers, and provides data on meeting the specific performance and outcome measures identified by the ~~board~~ commissioner.

EFFECTIVE DATE. This section is effective retroactively from July 1, 2005.

New language is indicated by underline, deletions by ~~strikeout~~.

Sec. 42, Minnesota Statutes 2004, section 157.011, is amended by adding a subdivision to read:

Subd. 3. RULE EXEMPTION. Notwithstanding any rule to the contrary, no food establishment shall be required to acquire equipment or change construction solely because ownership of the food establishment has been transferred.

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

Sec. 43, Minnesota Statutes 2004, section 157.15, is amended by adding a subdivision to read:

Subd. 19. STATEWIDE HOSPITALITY FEE. "Statewide hospitality fee" means a fee to fund statewide food, beverage, and lodging program development activities, including training for inspection staff, technical assistance, maintenance of a statewide integrated food safety and security information system, and other related statewide activities that support the food, beverage, and lodging program activities.

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 44, Minnesota Statutes 2004, section 157.16, subdivision 2, is amended to read:

Subd. 2. LICENSE RENEWAL. Initial and renewal licenses for all food and beverage service establishments, hotels, motels, lodging establishments, and resorts shall be issued for the calendar year for which application is made and shall expire on December 31 of such year. Any person who operates a place of business after the expiration date of a license or without having submitted an application and paid the fee shall be deemed to have violated the provisions of this chapter and shall be subject to enforcement action, as provided in the Health Enforcement Consolidation Act, sections 144.989 to 144.993. In addition, a penalty of \$25 \$50 shall be added to the total of the license fee for any food and beverage service establishment operating without a license as a mobile food unit, a seasonal temporary or seasonal permanent food stand, or a special event food stand, and a penalty of \$50 \$100 shall be added to the total of the license fee for all restaurants, food carts, hotels, motels, lodging establishments, and resorts operating without a license for a period of up to 30 days. A late fee of \$300 shall be added to the license fee for establishments operating more than 30 days without a license.

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 45, Minnesota Statutes 2004, section 157.16, is amended by adding a subdivision to read:

Subd. 2a. FOOD MANAGER CERTIFICATION. An applicant for certification or certification renewal as a food manager must submit to the commissioner a \$28 nonrefundable certification fee payable to the Department of Health.

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 46. Minnesota Statutes 2004, section 157.16, subdivision 3, is amended to read:

Subd. 3. **ESTABLISHMENT FEES; DEFINITIONS.** (a) The following fees are required for food and beverage service establishments, hotels, motels, lodging establishments, and resorts licensed under this chapter. Food and beverage service establishments must pay the highest applicable fee under paragraph (e) (d), clause (1), (2), (3), or (4), and establishments serving alcohol must pay the highest applicable fee under paragraph (e) (d), clause (6) or (7). The license fee for new operators previously licensed under this chapter for the same calendar year is one-half of the appropriate annual license fee, plus any penalty that may be required. The license fee for operators opening on or after October 1 is one-half of the appropriate annual license fee, plus any penalty that may be required.

(b) All food and beverage service establishments, except special event food stands, and all hotels, motels, lodging establishments, and resorts shall pay an annual base fee of ~~\$145~~ \$150.

(c) A special event food stand shall pay a flat fee of ~~\$35~~ \$40 annually. "Special event food stand" means a fee category where food is prepared or served in conjunction with celebrations, county fairs, or special events from a special event food stand as defined in section 157.15.

(d) In addition to the base fee in paragraph (b), each food and beverage service establishment, other than a special event food stand, and each hotel, motel, lodging establishment, and resort shall pay an additional annual fee for each fee category as additional food service, or required additional inspection specified in this paragraph:

(1) Limited food menu selection, ~~\$40~~ \$50. "Limited food menu selection" means a fee category that provides one or more of the following:

- (i) prepackaged food that receives heat treatment and is served in the package;
- (ii) frozen pizza that is heated and served;
- (iii) a continental breakfast such as rolls, coffee, juice, milk, and cold cereal;
- (iv) soft drinks, coffee, or nonalcoholic beverages; or

(v) cleaning for eating, drinking, or cooking utensils, when the only food served is prepared off site.

(2) Small establishment, including boarding establishments, ~~\$75~~ \$100. "Small establishment" means a fee category that has no salad bar and meets one or more of the following:

- (i) possesses food service equipment that consists of no more than a deep fat fryer, a grill, two hot holding containers, and one or more microwave ovens;
- (ii) serves dipped ice cream or soft serve frozen desserts;
- (iii) serves breakfast in an owner-occupied bed and breakfast establishment;

New language is indicated by underline, deletions by ~~strikeout~~.

(iv) is a boarding establishment; or

(v) meets the equipment criteria in clause (3), item (i) or (ii), and has a maximum patron seating capacity of not more than 50.

(3) Medium establishment, ~~\$210~~ \$260. "Medium establishment" means a fee category that meets one or more of the following:

(i) possesses food service equipment that includes a range, oven, steam table, salad bar, or salad preparation area;

(ii) possesses food service equipment that includes more than one deep fat fryer, one grill, or two hot holding containers; or

(iii) is an establishment where food is prepared at one location and served at one or more separate locations.

Establishments meeting criteria in clause (2), item (v), are not included in this fee category.

(4) Large establishment, ~~\$350~~ \$460. "Large establishment" means either:

(i) a fee category that (A) meets the criteria in clause (3), items (i) or (ii), for a medium establishment, (B) seats more than 175 people, and (C) offers the full menu selection an average of five or more days a week during the weeks of operation; or

(ii) a fee category that (A) meets the criteria in clause (3), item (iii), for a medium establishment, and (B) prepares and serves 500 or more meals per day.

(5) Other food and beverage service, including food carts, mobile food units, seasonal temporary food stands, and seasonal permanent food stands, ~~\$40~~ \$50.

(6) Beer or wine table service, ~~\$40~~ \$50. "Beer or wine table service" means a fee category where the only alcoholic beverage service is beer or wine, served to customers seated at tables.

(7) Alcoholic beverage service, other than beer or wine table service, ~~\$105~~ \$135.

"Alcohol beverage service, other than beer or wine table service" means a fee category where alcoholic mixed drinks are served or where beer or wine are served from a bar.

(8) Lodging per sleeping accommodation unit, ~~\$6~~ \$8, including hotels, motels, lodging establishments, and resorts, up to a maximum of ~~\$600~~ \$800. "Lodging per sleeping accommodation unit" means a fee category including the number of guest rooms, cottages, or other rental units of a hotel, motel, lodging establishment, or resort; or the number of beds in a dormitory.

(9) First public swimming pool, ~~\$140~~ \$180; each additional public swimming pool, ~~\$80~~ \$100. "Public swimming pool" means a fee category that has the meaning given in Minnesota Rules, part 4717.0250, subpart 8.

New language is indicated by underline, deletions by ~~strikeout~~.

(10) First spa, \$80 \$110; each additional spa, \$40 \$50. "Spa pool" means a fee category that has the meaning given in Minnesota Rules, part 4717.0250, subpart 9.

(11) Private sewer or water, \$40 \$50. "Individual private water" means a fee category with a water supply other than a community public water supply as defined in Minnesota Rules, chapter 4720. "Individual private sewer" means a fee category with an individual sewage treatment system which uses subsurface treatment and disposal.

(12) Additional food service, \$130. "Additional food service" means a location at a food service establishment, other than the primary food preparation and service area, used to prepare or serve food to the public.

(13) Additional inspection fee, \$300. "Additional inspection fee" means a fee to conduct the second inspection each year for elementary and secondary education facility school lunch programs when required by the Richard B. Russell National School Lunch Act.

(e) A fee of ~~\$150~~ \$350 for review of the construction plans must accompany the initial license application for ~~food and beverage service establishments~~ restaurants, hotels, motels, lodging establishments, or resorts with five or more sleeping units.

(f) When existing food and beverage service establishments, hotels, motels, lodging establishments, or resorts are extensively remodeled, a fee of ~~\$150~~ \$250 must be submitted with the remodeling plans. A fee of \$250 must be submitted for new construction or remodeling for a restaurant with a limited food menu selection, a seasonal permanent food stand, a mobile food unit, or a food cart, or for a hotel, motel, resort, or lodging establishment addition of less than five sleeping units.

(g) Seasonal temporary food stands and special event food stands are not required to submit construction or remodeling plans for review.

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 47. Minnesota Statutes 2004, section 157.16, is amended by adding a subdivision to read:

Subd. 3a. STATEWIDE HOSPITALITY FEE. Every person, firm, or corporation that operates a licensed boarding establishment, food and beverage service establishment, seasonal temporary or permanent food stand, special event food stand, mobile food unit, food cart, resort, hotel, motel, or lodging establishment in Minnesota must submit to the commissioner a \$35 annual statewide hospitality fee for each licensed activity. The fee for establishments licensed by the Department of Health is required at the same time the licensure fee is due. For establishments licensed by local governments, the fee is due by July 1 of each year.

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 48. Minnesota Statutes 2004, section 157.20, subdivision 2, is amended to read:

New language is indicated by underline, deletions by ~~strikeout~~.

Subd. 2. **INSPECTION FREQUENCY.** The frequency of inspections of the establishments shall be based on the degree of health risk.

(a) High-risk establishments must be inspected at least once a year every 12 months.

(b) Medium-risk establishments must be inspected at least once every 18 months.

(c) Low-risk establishments must be inspected at least once every ~~two years~~ 24 months.

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 49. Minnesota Statutes 2004, section 157.20, subdivision 2a, is amended to read:

Subd. 2a. **RISK CATEGORIES.** (a) **HIGH-RISK ESTABLISHMENT.** "High-risk establishment" means any food and beverage service establishment, hotel, motel, lodging establishment, or resort that:

(1) serves potentially hazardous foods that require extensive processing on the premises, including manual handling, cooling, reheating, or holding for service;

(2) prepares foods several hours or days before service;

(3) serves menu items that epidemiologic experience has demonstrated to be common vehicles of food-borne illness;

(4) has a public swimming pool; or

(5) draws its drinking water from a surface water supply.

(b) **MEDIUM-RISK ESTABLISHMENT.** "Medium-risk establishment" means a food and beverage service establishment, hotel, motel, lodging establishment, or resort that:

(1) serves potentially hazardous foods but with minimal holding between preparation and service; or

(2) serves foods, such as pizza, that require extensive handling followed by heat treatment.

(c) **LOW-RISK ESTABLISHMENT.** "Low-risk establishment" means a food and beverage service establishment, hotel, motel, lodging establishment, or resort that is not a high-risk or medium-risk establishment.

(d) **RISK EXCEPTIONS.** Mobile food units, seasonal permanent and seasonal temporary food stands, food carts, and special event food stands are not inspected on an established schedule and therefore are not defined as high-risk, medium-risk, or low-risk establishments.

(e) **SCHOOL INSPECTION FREQUENCY.** Elementary and secondary school food service establishments must be inspected according to the assigned risk category

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or by the frequency required in the Richard B. Russell National School Lunch Act, whichever frequency is more restrictive.

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 50. Minnesota Statutes 2004, section 326.42, subdivision 2, is amended to read:

Subd. 2. **FEES.** Plumbing system plans and specifications that are submitted to the commissioner for review shall be accompanied by the appropriate plan examination fees. If the commissioner determines, upon review of the plans, that inadequate fees were paid, the necessary additional fees shall be paid prior to plan approval. The commissioner shall charge the following fees for plan reviews and audits of plumbing installations for public, commercial, and industrial buildings:

(1) systems with both water distribution and drain, waste, and vent systems and having:

(i) 25 or fewer drainage fixture units, \$150;

(ii) 26 to 50 drainage fixture units, \$250;

(iii) 51 to 150 drainage fixture units, \$350;

(iv) 151 to 249 drainage fixture units, \$500;

(v) 250 or more drainage fixture units, \$3 per drainage fixture unit to a maximum of \$4,000; and

(vi) interceptors, separators, or catch basins, \$70 per interceptor, separator, or catch basin design;

(2) building sewer service only, \$150;

(3) building water service only, \$150;

(4) building water distribution system only, no drainage system, \$5 per supply fixture unit or \$150, whichever is greater;

(5) storm drainage system, a minimum fee of \$150 or:

(i) \$50 per drain opening, up to a maximum of \$500; and

(ii) \$70 per interceptor, separator, or catch basin design;

(6) manufactured home park or campground, one to 25 sites, \$300;

(7) manufactured home park or campground, 26 to 50 sites, \$350;

(8) manufactured home park or campground, 51 to 125 sites, \$400;

(9) manufactured home park or campground, more than 125 sites, \$500;

(10) accelerated review, double the regular fee, one-half to be refunded if no response from the commissioner within 15 business days; and

New language is indicated by underline, deletions by ~~strikeout~~.

(11) revision to previously reviewed or incomplete plans:

(i) review of plans for which commissioner has issued two or more requests for additional information, per review, \$100 or ten percent of the original fee, whichever is greater;

(ii) proposer-requested revision with no increase in project scope, \$50 or ten percent of original fee, whichever is greater; and

(iii) proposer-requested revision with an increase in project scope, \$50 plus the difference between the original project fee and the revised project fee.

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

Sec. 51. Laws 2005, chapter 107, article 1, section 6, is amended to read:

Sec. 6. COMMISSIONER OF HEALTH 95,000 155,000

To the commissioner of health to implement new Minnesota Statutes, section 144.1498 144.1501.

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

Sec. 52. **CERVICAL CANCER ELIMINATION STUDY.**

(a) The commissioner of health shall develop a statewide integrated and comprehensive cervical cancer prevention plan, including strategies for promoting and implementing the plan. The plan must include activities that identify and implement methods to improve the cervical cancer screening rates in Minnesota, including, but not limited to:

(1) identifying and disseminating appropriate evidence-based cervical cancer screening guidelines to be used in Minnesota;

(2) increasing the use of appropriate screening based on these guidelines for patients seen by medical groups in Minnesota and monitoring results of these medical groups; and

(3) reducing the number of women who should but have not been screened.

(b) In developing the plan, the commissioner shall also identify and examine limitations and barriers in providing cervical cancer screening, diagnosis tools, and treatment, including, but not limited to, medical care reimbursement, treatment costs, and the availability of insurance coverage.

(c) The commissioner may work with one or more nonprofit quality improvement organizations in Minnesota to identify evidence-based guidelines for cervical cancer screening and to identify methods to improve the cervical cancer screening rates among medical groups; and may work with one or more nonprofit health care result reporting organizations to monitor results by medical groups in Minnesota.

New language is indicated by underline, deletions by ~~strikeout~~.

(d) The commissioner may convene an advisory committee that includes representatives of health care providers, the American Cancer Society, health plan companies, the University of Minnesota Academic Health Center, community health boards, and the general public.

(e) The commissioner shall submit a report to the legislature by January 15, 2006, on:

(1) the statewide cervical cancer prevention plan, including a description of the plan activities and strategies developed for promoting and implementing the plan;

(2) methods for monitoring the results by medical groups and by the entire state of cervical cancer screening improvement activities; and

(3) recommended changes to existing laws, programs, or services in terms of reducing the occurrence of cervical cancer by improving insurance coverage for the prevention, diagnosis, and treatment for cervical cancer.

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 53. PUBLIC HEALTH INFORMATION NETWORK.

(a) The commissioner of health shall work with local public health departments to develop a public health information network. The development of the network must be consistent with the recommendations, goals, and strategies of the Minnesota public health information network report to the 2005 legislature and the e-health initiative.

(b) The commissioner of health shall work with the commissioner of human services to determine how data from care systems can be utilized to assist with population health needs assessments and targeted prevention efforts.

(c) Before the next biennium, the commissioner of health shall submit to the legislature a status report on the progress of the information network and the e-health initiative.

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

Sec. 54. REPORT TO LEGISLATURE ON SWING BED USAGE.

The commissioner of health shall review swing bed and related data reported under Minnesota Statutes, sections 144.562, subdivision 3, paragraph (f); 144.564; and 144.698. The commissioner shall report and make any appropriate recommendations to the legislature by January 31, 2007, on:

(1) the use of swing bed days by all hospitals and by critical access hospitals;

(2) occupancy rates in skilled nursing facilities within 25 miles of hospitals with swing beds; and

(3) information provided by rural providers on the use of swing beds and the adequacy of rural services across the continuum of care.

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

New language is indicated by underline, deletions by ~~strikeout~~.

Sec. 55. IMPLEMENTATION OF AN ELECTRONIC HEALTH RECORDS SYSTEM.

The commissioner of health, in consultation with the electronic health record planning work group established in Laws 2004, chapter 288, article 7, section 7, shall develop a statewide plan for all hospitals and physician group practices to have in place an interoperable electronic health records system by January 1, 2015. In developing the plan, the commissioner shall consider:

(1) creating financial assistance to hospitals and providers for implementing or updating an electronic health records system, including, but not limited to, the establishment of grants, financial incentives, or low-interest loans;

(2) addressing specific needs and concerns of safety-net hospitals, community health clinics, and other health care providers who serve low-income patients in implementing an electronic records system within the hospital or practice; and

(3) providing assistance in the development of possible alliances or collaborations among providers.

The commissioner shall provide preliminary reports to the chairs of the senate and house committees with jurisdiction over health care policy and finance biennially beginning January 15, 2007, on the status of reaching the goal for all hospitals and physician group practices to have an interoperable electronic health records system in place by January 1, 2015. The reports shall include recommendations on statutory language necessary to implement the plan, including possible financing options.

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

Sec. 56. RULE AMENDMENT.

The commissioner of health shall amend Minnesota Rules, part 4626.2015, subparts 3, item C; and 6, item B, to conform with Minnesota Statutes, section 157.16, subdivision 2a. The commissioner may use the good cause exemption under Minnesota Statutes, section 14.388, subdivision 1, clause (3). Minnesota Statutes, section 14.386, does not apply, except to the extent provided under Minnesota Statutes, section 14.388.

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 57. DIRECTION TO COMMISSIONER; DENTAL REVIEW.

The commissioner of health, in consultation with the relevant dental associations, licensed dental and public health professionals, and others, shall review the leadership and advisory role of the Department of Health relative to dental health including the usefulness of utilizing a dental director.

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

Sec. 58. REPEALER.

(a) Minnesota Statutes 2004, sections 144.1486; 144.1502; and 157.215, are repealed effective the day following final enactment.

New language is indicated by underline, deletions by strikeout.

(b) Laws 2005, chapter 107, article 2, section 51, is repealed effective the day following final enactment.

ARTICLE 7

LONG-TERM CARE AND CONTINUING CARE

Section 1. Minnesota Statutes 2004, section 144A.073, is amended by adding a subdivision to read:

Subd. 3d. PROJECT AMENDMENT AUTHORIZED. Notwithstanding the provisions of subdivision 3b:

(1) the commissioner may approve a request by a nursing facility located in the city of Duluth with 48 licensed beds as of January 1, 2005, that received approval under this section in 2002 for a moratorium exception project for amendment of the project design that:

(i) reduces the total amount of common space devoted to resident and family uses by more than five percent if the total amount of common space in the facility, including that added by the project, is at least 175 percent of the state requirement for common space; and

(ii) reduces the space for no more than two residents' living areas by increasing the size of a majority of the single-bed rooms from the size in the project design as originally approved and converting two single-bed rooms in the project design as originally approved to one semi-private room; and

(2) the commissioner may approve a request by a nursing facility located in the city of Duluth with 129 licensed beds as of January 1, 2005, that received approval under this section in 2002 for a moratorium exception project for amendment of the project design that:

(i) reduces the total amount of common space devoted to resident and family uses by more than five percent if the total amount of common space in the facility, including that added by the project, is at least 175 percent of the state requirement for common space; and

(ii) reduces the space for no more than four residents' living areas by increasing the size of a majority of the single-bed rooms from the size in the project design as originally approved and converting four single-bed rooms in the project design as originally approved to two semi-private rooms; and

(3) the amended project designs in clauses (1) and (2) must provide solutions to all of the problems addressed by the original application that are at least as effective as the original solutions.

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Sec. 2. Minnesota Statutes 2004, section 144A.073, subdivision 10, is amended to read:

Subd. 10. **EXTENSION OF APPROVAL OF MORATORIUM EXCEPTION.** Notwithstanding subdivision 3, the commissioner of health shall extend project approval for an additional ~~18~~ 36 months for any proposed exception to the nursing home licensure and certification moratorium if the proposal was approved under this section between July 1, 2001, and June 30, 2003.

Sec. 3. **[256B.0185] REQUIRED REPORT.**

Subdivision 1. **PENDING APPLICATION.** By December 15 of both 2005 and 2006, the commissioner must deliver to the legislature a report that identifies:

(1) each county in which an application for medical assistance from a person identified as residing in a long-term care facility is or was pending, at any time between January 1 and December 1 of the calendar year to which the report relates, for more than 60 days in the case of a person who is disabled, or for more than 45 days in the case of a person who is age 65 or older; and

(2) for each of the identified counties: the number of applications described in clause (1), the average number of days the applications were pending, the distribution of days for applications that were pending, and what percentage of the applications, respectively, the county approved and denied.

Subd. 2. **TIME TO PROCESS APPLICATION.** The report must include specific recommendations for how counties, as a group, could shorten the time it takes to act on the applications described in subdivision 1, clause (1).

Sec. 4. Minnesota Statutes 2004, section 256B.057, subdivision 9, is amended to read:

Subd. 9. **EMPLOYED PERSONS WITH DISABILITIES.** (a) Medical assistance may be paid for a person who is employed and who:

(1) meets the definition of disabled under the supplemental security income program;

(2) is at least 16 but less than 65 years of age;

(3) meets the asset limits in paragraph (b); and

(4) effective November 1, 2003, pays a premium and other obligations under paragraph (d).

Any spousal income or assets shall be disregarded for purposes of eligibility and premium determinations.

After the month of enrollment, a person enrolled in medical assistance under this subdivision who:

New language is indicated by underline, deletions by ~~strikeout~~.

(1) is temporarily unable to work and without receipt of earned income due to a medical condition, as verified by a physician, may retain eligibility for up to four calendar months; or

(2) effective January 1, 2004, loses employment for reasons not attributable to the enrollee, may retain eligibility for up to four consecutive months after the month of job loss. To receive a four-month extension, enrollees must verify the medical condition or provide notification of job loss. All other eligibility requirements must be met and the enrollee must pay all calculated premium costs for continued eligibility.

(b) For purposes of determining eligibility under this subdivision, a person's assets must not exceed \$20,000, excluding:

(1) all assets excluded under section 256B.056;

(2) retirement accounts, including individual accounts, 401(k) plans, 403(b) plans, Keogh plans, and pension plans; and

(3) medical expense accounts set up through the person's employer.

(c)(1) Effective January 1, 2004, for purposes of eligibility, there will be a \$65 earned income disregard. To be eligible, a person applying for medical assistance under this subdivision must have earned income above the disregard level.

(2) Effective January 1, 2004, to be considered earned income, Medicare, Social Security, and applicable state and federal income taxes must be withheld. To be eligible, a person must document earned income tax withholding.

(d)(1) A person whose earned and unearned income is equal to or greater than 100 percent of federal poverty guidelines for the applicable family size must pay a premium to be eligible for medical assistance under this subdivision. The premium shall be based on the person's gross earned and unearned income and the applicable family size using a sliding fee scale established by the commissioner, which begins at one percent of income at 100 percent of the federal poverty guidelines and increases to 7.5 percent of income for those with incomes at or above 300 percent of the federal poverty guidelines. Annual adjustments in the premium schedule based upon changes in the federal poverty guidelines shall be effective for premiums due in July of each year.

(2) Effective January 1, 2004, all enrollees must pay a premium to be eligible for medical assistance under this subdivision. An enrollee shall pay the greater of a \$35 premium or the premium calculated in clause (1).

(3) Effective November 1, 2003, all enrollees who receive unearned income must pay one-half of one percent of unearned income in addition to the premium amount.

(4) Effective November 1, 2003, for enrollees whose income does not exceed 200 percent of the federal poverty guidelines and who are also enrolled in Medicare, the commissioner must reimburse the enrollee for Medicare Part B premiums under section 256B.0625, subdivision 15, paragraph (a).

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(5) 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.

(e) A person's eligibility and premium shall be determined by the local county agency. Premiums must be paid to the commissioner. All premiums are dedicated to the commissioner.

(f) Any required premium shall be determined at application and redetermined at the enrollee's six-month income review or when a change in income or household size is reported. Enrollees must report any change in income or household size within ten days of when the change occurs. A decreased premium resulting from a reported change in income or household size shall be effective the first day of the next available billing month after the change is reported. Except for changes occurring from annual cost-of-living increases, a change resulting in an increased premium shall not affect the premium amount until the next six-month review.

(g) Premium payment is due upon notification from the commissioner of the premium amount required. Premiums may be paid in installments at the discretion of the commissioner.

(h) Nonpayment of the premium shall result in denial or termination of medical assistance unless the person demonstrates good cause for nonpayment. Good cause exists if the requirements specified in Minnesota Rules, part 9506.0040, subpart 7, items B to D, are met. Except when an installment agreement is accepted by the commissioner, all persons disenrolled for nonpayment of a premium must pay any past due premiums as well as current premiums due prior to being reenrolled. Nonpayment shall include payment with a returned, refused, or dishonored instrument. The commissioner may require a guaranteed form of payment as the only means to replace a returned, refused, or dishonored instrument.

Sec. 5. **[256B.0571] LONG-TERM CARE PARTNERSHIP.**

Subdivision 1. DEFINITIONS. For purposes of this section, the following terms have the meanings given them.

Subd. 2. HOME CARE SERVICE. "Home care service" means care described in section 144A.43.

Subd. 3. LONG-TERM CARE INSURANCE. "Long-term care insurance" means a policy described in section 62S.01.

Subd. 4. MEDICAL ASSISTANCE. "Medical assistance" means the program of medical assistance established under section 256B.01.

Subd. 5. NURSING HOME. "Nursing home" means a nursing home as described in section 144A.01.

Subd. 6. PARTNERSHIP POLICY. "Partnership policy" means a long-term care insurance policy that meets the requirements under subdivision 10 or 11, regardless of when the policy was first issued.

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Subd. 7. PARTNERSHIP PROGRAM. "Partnership program" means the Minnesota partnership for long-term care program established under this section.

Subd. 8. PROGRAM ESTABLISHED. (a) The commissioner, in cooperation with the commissioner of commerce, shall establish the Minnesota partnership for long-term care program to provide for the financing of long-term care through a combination of private insurance and medical assistance.

(b) An individual who meets the requirements in this paragraph is eligible to participate in the partnership program. The individual must:

(1) be a Minnesota resident;

(2) purchase a partnership policy that is delivered, issued for delivery, or renewed on or after the effective date of this section, and maintain the partnership policy in effect throughout the period of participation in the partnership program; and

(3) exhaust the minimum benefits under the partnership policy as described in this section. Benefits received under a long-term care insurance policy before the effective date of this section do not count toward the exhaustion of benefits required in this subdivision.

Subd. 9. MEDICAL ASSISTANCE ELIGIBILITY. (a) Upon application of an individual who meets the requirements described in subdivision 8, the commissioner shall determine the individual's eligibility for medical assistance according to paragraphs (b) and (c).

(b) After disregarding financial assets exempted under medical assistance eligibility requirements, the commissioner shall disregard an additional amount of financial assets equal to the dollar amount of coverage utilized under the partnership policy.

(c) The commissioner shall consider the individual's income according to medical assistance eligibility requirements.

Subd. 10. DOLLAR-FOR-DOLLAR ASSET PROTECTION POLICIES. (a) A dollar-for-dollar asset protection policy must meet all of the requirements in paragraphs (b) to (e).

(b) The policy must satisfy the requirements of chapter 62S.

(c) The policy must offer an elimination period of not more than 180 days for an adjusted premium.

(d) The policy must satisfy the requirements established by the commissioner of human services under subdivision 14.

(e) Minimum daily benefits shall be \$130 for nursing home care or \$65 for home care, with inflation protection provided in the policy as described in section 62S.23, subdivision 1, clause (1). These minimum daily benefit amounts shall be adjusted by the commissioner on October 1 of each year by a percentage equal to the inflation

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protection feature described in section 62S.23, subdivision 1, clause (1), for purposes of setting minimum requirements that a policy must meet in future years in order to initially qualify as an approved policy under this subdivision. Adjusted minimum daily benefit amounts shall be rounded to the nearest whole dollar.

Subd. 11. TOTAL ASSET PROTECTION POLICIES. (a) A total asset protection policy must meet all of the requirements in subdivision 10, paragraphs (b) to (d), and this subdivision.

(b) Minimum coverage shall be for a period of not less than three years and for a dollar amount equal to 36 months of nursing home care at the minimum daily benefit rate determined and adjusted under paragraph (c).

(c) Minimum daily benefits shall be \$150 for nursing home care or \$75 for home care, with inflation protection provided in the policy as described in section 62S.23, subdivision 1, clause (1). These minimum daily benefit amounts shall also be adjusted by the commissioner on October 1 of each year by a percentage equal to the inflation protection feature described in section 62S.23, subdivision 1, clause (1), for purposes of setting minimum requirements that a policy must meet in future years in order to initially qualify as an approved policy under this subdivision. Adjusted minimum daily benefit amounts shall be rounded to the nearest whole dollar.

(d) The policy must cover all of the following services:

(1) nursing home stay;

(2) home care service; and

(3) care management.

Subd. 12. COMPLIANCE WITH FEDERAL LAW. An issuer of a partnership policy must comply with any federal law authorizing partnership policies in Minnesota, including any federal regulations, as amended, adopted under that law. This paragraph does not require compliance with any provision of this federal law until the date upon which the law requires compliance with the provision. The commissioner has authority to enforce this paragraph.

Subd. 13. LIMITATIONS ON ESTATE RECOVERY. (a) For an individual who exhausts the minimum benefits of a dollar-for-dollar asset protection policy under subdivision 10, and is determined eligible for medical assistance under subdivision 9, the state shall limit recovery under the provisions of section 256B.15 against the estate of the individual or individual's spouse for medical assistance benefits received by that individual to an amount that exceeds the dollar amount of coverage utilized under the partnership policy.

(b) For an individual who exhausts the minimum benefits of a total asset protection policy under subdivision 11, and is determined eligible for medical assistance under subdivision 9, the state shall not seek recovery under the provisions of section 256B.15 against the estate of the individual or individual's spouse for medical assistance benefits received by that individual.

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Subd. 14. **IMPLEMENTATION.** (a) If federal law is amended or a federal waiver is granted to permit implementation of this section, the commissioner, in consultation with the commissioner of commerce, may alter the requirements of subdivisions 10 and 11, and may establish additional requirements for approved policies in order to conform with federal law or waiver authority. In establishing these requirements, the commissioner shall seek to maximize purchase of qualifying policies by Minnesota residents while controlling medical assistance costs.

(b) The commissioner is authorized to suspend implementation of this section until the next session of the legislature if the commissioner, in consultation with the commissioner of commerce, determines that the federal legislation or federal waiver authorizing a partnership program in Minnesota is likely to impose substantial unforeseen costs on the state budget.

(c) The commissioner must take action under paragraph (a) or (b) within 45 days of final federal action authorizing a partnership policy in Minnesota.

(d) The commissioner must notify the appropriate legislative committees of action taken under this subdivision within 50 days of final federal action authorizing a partnership policy in Minnesota.

(e) The commissioner must publish a notice in the State Register of implementation decisions made under this subdivision as soon as practicable.

EFFECTIVE DATE. (a) If any provision of this section is prohibited by federal law, no provision shall become effective until federal law is changed to permit its full implementation. The commissioner of human services shall notify the revisor of statutes when federal law is enacted or other federal approval is received and publish a notice in the State Register. The commissioner must include the notice in the first State Register published after the effective date of the federal changes.

(b) If federal law is changed to permit a waiver of any provisions prohibited by federal law, the commissioner of human services shall apply to the federal government for a waiver of those prohibitions or other federal authority, and that provision shall become effective upon receipt of a federal waiver or other federal approval, notification to the revisor of statutes, and publication of a notice in the State Register to that effect.

Sec. 6. Minnesota Statutes 2004, section 256B.0621, subdivision 2, is amended to read:

Subd. 2. **TARGETED CASE MANAGEMENT; DEFINITIONS.** For purposes of subdivisions 3 to 10, the following terms have the meanings given them:

(1) "home care service recipients" means those individuals receiving the following services under section 256B.0627: skilled nursing visits, home health aide visits, private duty nursing, personal care assistants, or therapies provided through a home health agency;

New language is indicated by underline, deletions by ~~strikeout~~.

(2) "home care targeted case management" means the provision of targeted case management services for the purpose of assisting home care service recipients to gain access to needed services and supports so that they may remain in the community;

(3) "institutions" means hospitals, consistent with Code of Federal Regulations, title 42, section 440.10; regional treatment center inpatient services, consistent with section 245.474; nursing facilities; and intermediate care facilities for persons with mental retardation;

(4) "relocation targeted case management" means includes the provision of both county targeted case management and public or private vendor service coordination services for the purpose of assisting recipients to gain access to needed services and supports if they choose to move from an institution to the community. Relocation targeted case management may be provided during the last 180 consecutive days of an eligible recipient's institutional stay; and

(5) "targeted case management" means case management services provided to help recipients gain access to needed medical, social, educational, and other services and supports.

Sec. 7. Minnesota Statutes 2004, section 256B.0621, subdivision 3, is amended to read:

Subd. 3. **ELIGIBILITY.** The following persons are eligible for relocation targeted case management or ~~home care-targeted care targeted case management~~:

(1) medical assistance eligible persons residing in institutions who choose to move into the community are eligible for relocation targeted case management services; and

(2) medical assistance eligible persons receiving home care services, who are not eligible for any other medical assistance reimbursable case management service, are eligible for ~~home care-targeted care~~ targeted case management services beginning January 1, 2003 July 1, 2005.

Sec. 8. Minnesota Statutes 2004, section 256B.0621, subdivision 4, is amended to read:

Subd. 4. **RELOCATION TARGETED COUNTY CASE MANAGEMENT PROVIDER QUALIFICATIONS.** (a) A relocation targeted county case management provider is an enrolled medical assistance provider who is determined by the commissioner to have all of the following characteristics:

(1) the legal authority to provide public welfare under sections 393.01, subdivision 7; and 393.07; or a federally recognized Indian tribe;

(2) the demonstrated capacity and experience to provide the components of case management to coordinate and link community resources needed by the eligible population;

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(3) the administrative capacity and experience to serve the target population for whom it will provide services and ensure quality of services under state and federal requirements;

(4) the legal authority to provide complete investigative and protective services under section 626.556, subdivision 10; and child welfare and foster care services under section 393.07, subdivisions 1 and 2; or a federally recognized Indian tribe;

(5) a financial management system that provides accurate documentation of services and costs under state and federal requirements; and

(6) the capacity to document and maintain individual case records under state and federal requirements.

(b) A provider of targeted case management under section 256B.0625, subdivision 20, may be deemed a certified provider of relocation targeted case management.

(c) A relocation targeted county case management provider may subcontract with another provider to deliver relocation targeted case management services. Subcontracted providers must demonstrate the ability to provide the services outlined in subdivision 6, and have a procedure in place that notifies the recipient and the recipient's legal representative of any conflict of interest if the contracted targeted case management provider also provides, or will provide, the recipient's services and supports. Counties must require that contracted providers must provide information on all conflicts of interest and obtain the recipient's informed consent or provide the recipient with alternatives.

Sec. 9. Minnesota Statutes 2004, section 256B.0621, subdivision 5, is amended to read:

Subd. 5. HOME CARE TARGETED CASE MANAGEMENT AND RELOCATION SERVICE COORDINATION PROVIDER QUALIFICATIONS. The following qualifications and certification standards must be met by Providers of home care targeted case management and relocation service coordination must meet the qualifications under subdivision 4 for county vendors or the qualifications and certification standards under paragraphs (a) and (b) for private vendors.

(a) The commissioner must certify each provider of home care targeted case management and relocation service coordination before enrollment. The certification process shall examine the provider's ability to meet the requirements in this subdivision and other state and federal requirements of this service.

(b) A Both home care targeted case management provider is an providers and relocation service coordination providers are enrolled medical assistance provider providers who has have a minimum of a bachelor's degree or a license in a health or human services field, comparable training and two years of experience in human services, or who have been credentialed by an American Indian tribe under section 256B.02, subdivision 7, and is have been determined by the commissioner to have all of the following characteristics:

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(1) the demonstrated capacity and experience to provide the components of case management to coordinate and link community resources needed by the eligible population;

(2) the administrative capacity and experience to serve the target population for whom it will provide services and ensure quality of services under state and federal requirements;

(3) a financial management system that provides accurate documentation of services and costs under state and federal requirements;

(4) the capacity to document and maintain individual case records under state and federal requirements; and

(5) the capacity to coordinate with county administrative functions;

(6) have no financial interest in the provision of out-of-home residential services to persons for whom home care targeted case management or relocation service coordination is provided; and

(7) if a provider has a financial interest in services other than out-of-home residential services provided to persons for whom home care targeted case management or relocation service coordination is also provided, the county must determine each year that:

(i) any possible conflict of interest is explained annually at a face-to-face meeting and in writing and the person provides written informed consent consistent with section 256B.77, subdivision 2, paragraph (p); and

(ii) information on a range of other feasible service provider options has been provided.

(c) The state of Minnesota, a county board, or agency acting on behalf of a county board shall not be liable for damages, injuries, or liabilities sustained because of services provided to a client by a private service coordination vendor.

Sec. 10. Minnesota Statutes 2004, section 256B.0621, subdivision 6, is amended to read:

Subd. 6. **ELIGIBLE SERVICES.** (a) Services eligible for medical assistance reimbursement as targeted case management include:

(1) assessment of the recipient's need for targeted case management services and for persons choosing to relocate, the county must provide service coordination provider options at the first contact and upon request;

(2) development, completion, and regular review of a written individual service plan, which is based upon the assessment of the recipient's needs and choices, and which will ensure access to medical, social, educational, and other related services and supports;

New language is indicated by underline, deletions by ~~strikeout~~.

(3) routine contact or communication with the recipient, recipient's family, primary caregiver, legal representative, substitute care provider, service providers, or other relevant persons identified as necessary to the development or implementation of the goals of the individual service plan;

(4) coordinating referrals for, and the provision of, case management services for the recipient with appropriate service providers, consistent with section 1902(a)(23) of the Social Security Act;

(5) coordinating and monitoring the overall service delivery and engaging in advocacy as needed to ensure quality of services, appropriateness, and continued need;

(6) completing and maintaining necessary documentation that supports and verifies the activities in this subdivision;

(7) traveling assisting individuals in order to access needed services, including travel to conduct a visit with the recipient or other relevant person necessary to develop or implement the goals of the individual service plan; and

(8) coordinating with the institution discharge planner in the 180-day period before the recipient's discharge.

(b) Relocation targeted county case management includes services under paragraph (a), clauses (1), (2), and (4). Relocation service coordination includes services under paragraph (a), clauses (3) and (5) to (8). Home care targeted case management includes services under paragraph (a), clauses (1) to (8).

Sec. 11. Minnesota Statutes 2004, section 256B.0621, subdivision 7, is amended to read:

Subd. 7. **TIME LINES.** The following time lines must be met for assigning a case manager:

(a) For relocation targeted case management, an eligible recipient must be assigned a county case manager who visits the person within 20 working days of requesting a case manager from their county of financial responsibility as determined under chapter 256G.

(1) If a county agency, its contractor, or federally recognized tribe does not provide case management services as required, the recipient may obtain targeted relocation case management services relocation service coordination from an alternative a provider of targeted case management services enrolled by the commissioner qualified under subdivision 5.

(2) The commissioner may waive the provider requirements in subdivision 4, paragraph (a), clauses (1) and (4), to ensure recipient access to the assistance necessary to move from an institution to the community. The recipient or the recipient's legal guardian shall provide written notice to the county or tribe of the decision to obtain services from an alternative provider.

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(3) Providers of relocation targeted case management enrolled under this subdivision shall:

(i) meet the provider requirements under subdivision 4 that are not waived by the commissioner;

(ii) be qualified to provide the services specified in subdivision 6;

(iii) coordinate efforts with local social service agencies and tribes; and

(iv) comply with the conflict of interest provisions established under subdivision 4, paragraph (c).

(4) Local social service agencies and federally recognized tribes shall cooperate with providers certified by the commissioner under this subdivision to facilitate the recipient's successful relocation from an institution to the community.

(b) For home care targeted case management, an eligible recipient must be assigned a case manager within 20 working days of requesting a case manager from a home care targeted case management provider, as defined in subdivision 5.

Sec. 12. Minnesota Statutes 2004, section 256B.0621, is amended by adding a subdivision to read:

Subd. 11. DATA USE AGREEMENT AND NOTICE OF RELOCATION TARGETED CASE MANAGEMENT AVAILABILITY. The commissioner shall execute a data use agreement with the Centers for Medicare and Medicaid Services to obtain the long-term care minimum data set data to assist residents of nursing facilities who have indicated a desire to live in the community. The commissioner shall in turn enter into agreements with the Centers for Independent Living to provide information about assistance for persons who want to move to the community. The commissioner shall work with the Centers for Independent Living on both the content of the information to be provided and privacy protections for the individual residents.

Sec. 13. Minnesota Statutes 2004, section 256B.0625, subdivision 2, is amended to read:

Subd. 2. SKILLED AND INTERMEDIATE NURSING CARE. Medical assistance covers skilled nursing home services and services of intermediate care facilities, including training and habilitation services, as defined in section 252.41, subdivision 3, for persons with mental retardation or related conditions who are residing in intermediate care facilities for persons with mental retardation or related conditions. Medical assistance must not be used to pay the costs of nursing care provided to a patient in a swing bed as defined in section 144.562, unless (a) the facility in which the swing bed is located is eligible as a sole community provider, as defined in Code of Federal Regulations, title 42, section 412.92, or the facility is a public hospital owned by a governmental entity with 15 or fewer licensed acute care beds; (b) the Centers for Medicare and Medicaid Services approves the necessary state plan amendments; (c) the patient was screened as provided by law; (d) the patient no longer requires acute care services; and (e) no nursing home beds are available within 25

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miles of the facility. The commissioner shall exempt a facility from compliance with the sole community provider requirement in clause (a) if, as of January 1, 2004, the facility had an agreement with the commissioner to provide medical assistance swing bed services. Medical assistance also covers up to ten days of nursing care provided to a patient in a swing bed if: (1) the patient's physician certifies that the patient has a terminal illness or condition that is likely to result in death within 30 days and that moving the patient would not be in the best interests of the patient and patient's family; (2) no open nursing home beds are available within 25 miles of the facility; and (3) no open beds are available in any Medicare hospice program within 50 miles of the facility. The daily medical assistance payment for nursing care for the patient in the swing bed is the statewide average medical assistance skilled nursing care per diem as computed annually by the commissioner on July 1 of each year.

EFFECTIVE DATE. This section is effective the day following final enactment and applies to medical assistance payments for swing bed services provided on or after July 1, 2005.

Sec. 14. Minnesota Statutes 2004, section 256B.0625, subdivision 19c, is amended to read:

Subd. 19c. **PERSONAL CARE.** Medical assistance covers personal care assistant services provided by an individual who is qualified to provide the services according to subdivision 19a and section 256B.0627, where the services are ~~prescribed~~ have a statement of need by a physician, provided in accordance with a plan of treatment, and are supervised by the recipient or a qualified professional. The physician's statement of need for personal care assistant services shall be documented on a form approved by the commissioner and include the diagnosis or condition of the person that results in a need for personal care assistant services and be updated when the person's medical condition requires a change, but at least annually if the need for personal care assistant services is ongoing.

"Qualified professional" means a mental health professional as defined in section 245.462, subdivision 18, or 245.4871, subdivision 27; or a registered nurse as defined in sections 148.171 to 148.285, or a licensed social worker as defined in section 148B.21. As part of the assessment, the county public health nurse will assist the recipient or responsible party to identify the most appropriate person to provide supervision of the personal care assistant. The qualified professional shall perform the duties described in Minnesota Rules, part 9505.0335, subpart 4.

Sec. 15. Minnesota Statutes 2004, section 256B.0627, subdivision 1, as amended by Laws 2005, chapter 10, article 1, section 49, is amended to read:

Subdivision 1. **DEFINITION.** (a) "Activities of daily living" includes eating, toileting, grooming, dressing, bathing, transferring, mobility, and positioning.

(b) "Assessment" means a review and evaluation of a recipient's need for home care services conducted in person. Assessments for private duty nursing shall be conducted by a registered private duty nurse. Assessments for home health agency

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services shall be conducted by a home health agency nurse. Assessments for personal care assistant services shall be conducted by the county public health nurse or a certified public health nurse under contract with the county. A face-to-face assessment must include: documentation of health status, determination of need, evaluation of service effectiveness, identification of appropriate services, service plan development or modification, coordination of services, referrals and follow-up to appropriate payers and community resources, completion of required reports, recommendation of service authorization, and consumer education. Once the need for personal care assistant services is determined under this section, the county public health nurse or certified public health nurse under contract with the county is responsible for communicating this recommendation to the commissioner and the recipient. A face-to-face assessment for personal care assistant services is conducted on those recipients who have never had a county public health nurse assessment. A face-to-face assessment must occur at least annually or when there is a significant change in the recipient's condition or when there is a change in the need for personal care assistant services. A service update may substitute for the annual face-to-face assessment when there is not a significant change in recipient condition or a change in the need for personal care assistant service. A service update or review for temporary increase includes a review of initial baseline data, evaluation of service effectiveness, redetermination of service need, modification of service plan and appropriate referrals, update of initial forms, obtaining service authorization, and on going consumer education. Assessments for medical assistance home care services for mental retardation or related conditions and alternative care services for developmentally disabled home and community-based waived recipients may be conducted by the county public health nurse to ensure coordination and avoid duplication. Assessments must be completed on forms provided by the commissioner within 30 days of a request for home care services by a recipient or responsible party.

(c) "Care plan" means a written description of personal care assistant services developed by the qualified professional or the recipient's physician with the recipient or responsible party to be used by the personal care assistant with a copy provided to the recipient or responsible party.

(d) "Complex and regular private duty nursing care" means:

(1) complex care is private duty nursing provided to recipients who are ventilator dependent or for whom a physician has certified that were it not for private duty nursing the recipient would meet the criteria for inpatient hospital intensive care unit (ICU) level of care; and

(2) regular care is private duty nursing provided to all other recipients.

(e) "Health-related functions" means functions that can be delegated or assigned by a licensed health care professional under state law to be performed by a personal care assistant.

(f) "Home care services" means a health service, determined by the commissioner as medically necessary, that is ordered by a physician and documented in a service plan

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that is reviewed by the physician at least once every 60 days for the provision of home health services, or private duty nursing, or at least once every 365 days for personal care. Home care services are provided to the recipient at the recipient's residence that is a place other than a hospital or long-term care facility or as specified in section 256B.0625.

(g) "Instrumental activities of daily living" includes meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communication by telephone and other media, and getting around and participating in the community.

(h) "Medically necessary" has the meaning given in Minnesota Rules, parts 9505.0170 to 9505.0475.

(i) "Personal care assistant" means a person who:

(1) is at least 18 years old, except for persons 16 to 18 years of age who participated in a related school-based job training program or have completed a certified home health aide competency evaluation;

(2) is able to effectively communicate with the recipient and personal care provider organization;

(3) effective July 1, 1996, has completed one of the training requirements as specified in Minnesota Rules, part 9505.0335, subpart 3, items A to D;

(4) has the ability to, and provides covered personal care assistant services according to the recipient's care plan, responds appropriately to recipient needs, and reports changes in the recipient's condition to the supervising qualified professional or physician;

(5) is not a consumer of personal care assistant services; and

(6) maintains daily written records detailing:

(i) the actual services provided to the recipient; and

(ii) the amount of time spent providing the services; and

(7) is subject to criminal background checks and procedures specified in chapter 245C.

(j) "Personal care provider organization" means an organization enrolled to provide personal care assistant services under the medical assistance program that complies with the following:

(1) owners who have a five percent interest or more, and managerial officials are subject to a background study as provided in chapter 245C. This applies to currently enrolled personal care provider organizations and those agencies seeking enrollment as a personal care provider organization. An organization will be barred from enrollment if an owner or managerial official of the organization has been convicted of a crime specified in chapter 245C, or a comparable crime in another jurisdiction, unless the

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owner or managerial official meets the reconsideration criteria specified in chapter 245C;

(2) the organization must maintain a surety bond and liability insurance throughout the duration of enrollment and provides proof thereof. The insurer must notify the Department of Human Services of the cancellation or lapse of policy; and (3) the organization must maintain documentation of services as specified in Minnesota Rules, part 9505.2175, subpart 7, as well as evidence of compliance with personal care assistant training requirements;

(3) the organization must maintain documentation and a recipient file and satisfy communication requirements in subdivision 4, paragraph (f); and

(4) the organization must comply with all laws and rules governing the provision of personal care assistant services.

(k) "Responsible party" means an individual who is capable of providing the support necessary to assist the recipient to live in the community, is at least 18 years old, actively participates in planning and directing of personal care assistant services, and is not the personal care assistant. The responsible party must be accessible to the recipient and the personal care assistant when personal care services are being provided and monitor the services at least weekly according to the plan of care. The responsible party must be identified at the time of assessment and listed on the recipient's service agreement and care plan. Responsible parties who are parents of minors or guardians of minors or incapacitated persons may delegate the responsibility to another adult who is not the personal care assistant during a temporary absence of at least 24 hours but not more than six months. The person delegated as a responsible party must be able to meet the definition of responsible party, except that the delegated responsible party is required to reside with the recipient only while serving as the responsible party. The delegated responsible party is not required to reside with the recipient while serving as the responsible party if competent supervision to ensure the health and safety of the recipient and monitoring of services provided are stated as part of the person's individual service plan under a home care service or home and community-based waiver program or in conjunction with a home care targeted case management service provider or other case manager. The responsible party must assure that the delegate performs the functions of the responsible party, is identified at the time of the assessment, and is listed on the service agreement and the care plan. Foster care license holders may be designated the responsible party for residents of the foster care home if case management is provided as required in section 256B.0625, subdivision 19a. For persons who, as of April 1, 1992, are sharing personal care assistant services in order to obtain the availability of 24-hour coverage, an employee of the personal care provider organization may be designated as the responsible party if case management is provided as required in section 256B.0625, subdivision 19a.

(l) "Service plan" means a written description of the services needed based on the assessment developed by the nurse who conducts the assessment together with the recipient or responsible party. The service plan shall include a description of the

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covered home care services, frequency and duration of services, and expected outcomes and goals. The recipient and the provider chosen by the recipient or responsible party must be given a copy of the completed service plan within 30 calendar days of the request for home care services by the recipient or responsible party.

(m) "Skilled nurse visits" are provided in a recipient's residence under a plan of care or service plan that specifies a level of care which the nurse is qualified to provide. These services are:

(1) nursing services according to the written plan of care or service plan and accepted standards of medical and nursing practice in accordance with chapter 148;

(2) services which due to the recipient's medical condition may only be safely and effectively provided by a registered nurse or a licensed practical nurse;

(3) assessments performed only by a registered nurse; and

(4) teaching and training the recipient, the recipient's family, or other caregivers requiring the skills of a registered nurse or licensed practical nurse.

(n) "Telehomecare" means the use of telecommunications technology by a home health care professional to deliver home health care services, within the professional's scope of practice, to a patient located at a site other than the site where the practitioner is located.

Sec. 16. Minnesota Statutes 2004, section 256B.0627, subdivision 4, is amended to read:

Subd. 4. **PERSONAL CARE ASSISTANT SERVICES.** (a) The personal care assistant services that are eligible for payment are services and supports furnished to an individual, as needed, to assist in accomplishing activities of daily living; instrumental activities of daily living; health-related functions through hands-on assistance, supervision, and cuing; and redirection and intervention for behavior including observation and monitoring.

(b) Payment for services will be made within the limits approved using the prior authorized process established in subdivision 5.

(c) The amount and type of services authorized shall be based on an assessment of the recipient's needs in these areas:

(1) bowel and bladder care;

(2) skin care to maintain the health of the skin;

(3) repetitive maintenance range of motion, muscle strengthening exercises, and other tasks specific to maintaining a recipient's optimal level of function;

(4) respiratory assistance;

(5) transfers and ambulation;

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- (6) bathing, grooming, and hairwashing necessary for personal hygiene;
- (7) turning and positioning;
- (8) assistance with furnishing medication that is self-administered;
- (9) application and maintenance of prosthetics and orthotics;
- (10) cleaning medical equipment;
- (11) dressing or undressing;
- (12) assistance with eating and meal preparation and necessary grocery shopping;
- (13) accompanying a recipient to obtain medical diagnosis or treatment;
- (14) assisting, monitoring, or prompting the recipient to complete the services in clauses (1) to (13);
- (15) redirection, monitoring, and observation that are medically necessary and an integral part of completing the personal care assistant services described in clauses (1) to (14);
- (16) redirection and intervention for behavior, including observation and monitoring;
- (17) interventions for seizure disorders, including monitoring and observation if the recipient has had a seizure that requires intervention within the past three months;
- (18) tracheostomy suctioning using a clean procedure if the procedure is properly delegated by a registered nurse. Before this procedure can be delegated to a personal care assistant, a registered nurse must determine that the tracheostomy suctioning can be accomplished utilizing a clean rather than a sterile procedure and must ensure that the personal care assistant has been taught the proper procedure; and
- (19) incidental household services that are an integral part of a personal care service described in clauses (1) to (18).

For purposes of this subdivision, monitoring and observation means watching for outward visible signs that are likely to occur and for which there is a covered personal care service or an appropriate personal care intervention. For purposes of this subdivision, a clean procedure refers to a procedure that reduces the numbers of microorganisms or prevents or reduces the transmission of microorganisms from one person or place to another. A clean procedure may be used beginning 14 days after insertion.

(d) The personal care assistant services that are not eligible for payment are the following:

- (1) services not ordered by the physician provided without a physician's statement of need as required by section 256B.0625, subdivision 19c, and included in the personal care provider agency's file for the recipient;

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(2) assessments by personal care assistant provider organizations or by independently enrolled registered nurses;

(3) services that are not in the service plan;

(4) services provided by the recipient's spouse, legal guardian for an adult or child recipient, or parent of a recipient under age 18;

(5) services provided by a foster care provider of a recipient who cannot direct the recipient's own care, unless monitored by a county or state case manager under section 256B.0625, subdivision 19a;

(6) services provided by the residential or program license holder in a residence for more than four persons;

(7) services that are the responsibility of a residential or program license holder under the terms of a service agreement and administrative rules;

(8) sterile procedures;

(9) injections of fluids into veins, muscles, or skin;

(10) homemaker services that are not an integral part of a personal care assistant services;

(11) home maintenance or chore services;

(12) services not specified under paragraph (a); and

(13) services not authorized by the commissioner or the commissioner's designee.

(e) The recipient or responsible party may choose to supervise the personal care assistant or to have a qualified professional, as defined in section 256B.0625, subdivision 19c, provide the supervision. As required under section 256B.0625, subdivision 19c, the county public health nurse, as a part of the assessment, will assist the recipient or responsible party to identify the most appropriate person to provide supervision of the personal care assistant. Health-related delegated tasks performed by the personal care assistant will be under the supervision of a qualified professional or the direction of the recipient's physician. If the recipient has a qualified professional, Minnesota Rules, part 9505.0335, subpart 4, applies.

(f) In order to be paid for personal care assistant services, personal care provider organizations, and personal care assistant choice providers are required:

(1) to maintain a recipient file for each recipient for whom services are being billed that contains:

(i) the current physician's statement of need as required by section 256B.0625, subdivision 19c;

(ii) the service plan, including the monthly authorized hours, or flexible use plan;

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(iii) the care plan, signed by the recipient and the qualified professional, if required or designated, detailing the personal care assistant services to be provided;

(iv) documentation, on a form approved by the commissioner and signed by the personal care assistant, specifying the day, month, year, arrival, and departure times, with AM and PM notation, for all services provided to the recipient. The form must include a notice that it is a federal crime to provide false information on personal care service billings for medical assistance payment; and

(v) all notices to the recipient regarding personal care service use exceeding authorized hours; and

(2) to communicate, by telephone if available, and in writing, with the recipient or the responsible party about the schedule for use of authorized hours and to notify the recipient and the county public health nurse in advance and as soon as possible, on a form approved by the commissioner, if the monthly number of hours authorized is likely to be exceeded for the month.

(g) The commissioner shall establish an ongoing audit process for potential fraud and abuse for personal care assistant services. The audit process must include, at a minimum, a requirement that the documentation of hours of care provided be on a form approved by the commissioner and include the personal care assistant's signature attesting that the hours shown on each bill were provided by the personal care assistant on the dates and the times specified.

Sec. 17. Minnesota Statutes 2004, section 256B.0627, subdivision 5, as amended by Laws 2005, chapter 10, article 1, section 50, is amended to read:

Subd. 5. **LIMITATION ON PAYMENTS.** Medical assistance payments for home care services shall be limited according to this subdivision.

(a) **LIMITS ON SERVICES WITHOUT PRIOR AUTHORIZATION.** A recipient may receive the following home care services during a calendar year:

(1) up to two face-to-face assessments to determine a recipient's need for personal care assistant services;

(2) one service update done to determine a recipient's need for personal care assistant services; and

(3) up to nine skilled nurse visits.

(b) **PRIOR AUTHORIZATION; EXCEPTIONS.** All home care services above the limits in paragraph (a) must receive the commissioner's prior authorization, except when:

(1) the home care services were required to treat an emergency medical condition that if not immediately treated could cause a recipient serious physical or mental disability, continuation of severe pain, or death. The provider must request retroactive authorization no later than five working days after giving the initial service. The provider must be able to substantiate the emergency by documentation such as reports,

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notes, and admission or discharge histories;

(2) the home care services were provided on or after the date on which the recipient's eligibility began, but before the date on which the recipient was notified that the case was opened. Authorization will be considered if the request is submitted by the provider within 20 working days of the date the recipient was notified that the case was opened;

(3) a third-party payor for home care services has denied or adjusted a payment. Authorization requests must be submitted by the provider within 20 working days of the notice of denial or adjustment. A copy of the notice must be included with the request;

(4) the commissioner has determined that a county or state human services agency has made an error; or

(5) the professional nurse determines an immediate need for up to 40 skilled nursing or home health aide visits per calendar year and submits a request for authorization within 20 working days of the initial service date, and medical assistance is determined to be the appropriate payer.

(c) **RETROACTIVE AUTHORIZATION.** A request for retroactive authorization will be evaluated according to the same criteria applied to prior authorization requests.

(d) **ASSESSMENT AND SERVICE PLAN.** Assessments under section 256B.0627, subdivision 1, paragraph (b), shall be conducted initially, and at least annually thereafter, in person with the recipient and result in a completed service plan using forms specified by the commissioner. Within 30 days of recipient or responsible party request for home care services, the assessment, the service plan, and other information necessary to determine medical necessity such as diagnostic or testing information, social or medical histories, and hospital or facility discharge summaries shall be submitted to the commissioner. Notwithstanding the provisions of section 256B.0627, subdivision 12, the commissioner shall maximize federal financial participation to pay for public health nurse assessments for personal care services. For personal care assistant services:

(1) The amount and type of service authorized based upon the assessment and service plan will follow the recipient if the recipient chooses to change providers.

(2) If the recipient's medical need changes, the recipient's provider may assess the need for a change in service authorization and request the change from the county public health nurse. Within 30 days of the request, the public health nurse will determine whether to request the change in services based upon the provider assessment, or conduct a home visit to assess the need and determine whether the change is appropriate. If the change in service need is due to a change in medical condition, a new physician's statement of need required by section 256B.0625, subdivision 19c, must be obtained.

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(3) To continue to receive personal care assistant services after the first year, the recipient or the responsible party, in conjunction with the public health nurse, may complete a service update on forms developed by the commissioner according to criteria and procedures in subdivision 1.

(e) **PRIOR AUTHORIZATION.** The commissioner, or the commissioner's designee, shall review the assessment, service update, request for temporary services, request for flexible use option, service plan, and any additional information that is submitted. The commissioner shall, within 30 days after receiving a complete request, assessment, and service plan, authorize home care services as follows:

(1) **HOME HEALTH SERVICES.** All home health services provided by a home health aide must be prior authorized by the commissioner or the commissioner's designee. Prior authorization must be based on medical necessity and cost-effectiveness when compared with other care options. When home health services are used in combination with personal care and private duty nursing, the cost of all home care services shall be considered for cost-effectiveness. The commissioner shall limit home health aide visits to no more than one visit each per day. The commissioner, or the commissioner's designee, may authorize up to two skilled nurse visits per day.

(2) **PERSONAL CARE ASSISTANT SERVICES.** (i) All personal care assistant services and supervision by a qualified professional, if requested by the recipient, must be prior authorized by the commissioner or the commissioner's designee except for the assessments established in paragraph (a). The amount of personal care assistant services authorized must be based on the recipient's home care rating. A child may not be found to be dependent in an activity of daily living if because of the child's age an adult would either perform the activity for the child or assist the child with the activity and the amount of assistance needed is similar to the assistance appropriate for a typical child of the same age. Based on medical necessity, the commissioner may authorize:

(A) up to two times the average number of direct care hours provided in nursing facilities for the recipient's comparable case mix level; or

(B) up to three times the average number of direct care hours provided in nursing facilities for recipients who have complex medical needs or are dependent in at least seven activities of daily living and need physical assistance with eating or have a neurological diagnosis; or

(C) up to 60 percent of the average reimbursement rate, as of July 1, 1991, for care provided in a regional treatment center for recipients who have Level I behavior, plus any inflation adjustment as provided by the legislature for personal care service; or

(D) up to the amount the commissioner would pay, as of July 1, 1991, plus any inflation adjustment provided for home care services, for care provided in a regional treatment center for recipients referred to the commissioner by a regional treatment center preadmission evaluation team. For purposes of this clause, home care services means all services provided in the home or community that would be included in the payment to a regional treatment center; or

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(E) up to the amount medical assistance would reimburse for facility care for recipients referred to the commissioner by a preadmission screening team established under section 256B.0911 or 256B.092; and

(F) a reasonable amount of time for the provision of supervision by a qualified professional of personal care assistant services, if a qualified professional is requested by the recipient or responsible party.

(ii) The number of direct care hours shall be determined according to the annual cost report submitted to the department by nursing facilities. The average number of direct care hours, as established by May 1, 1992, shall be calculated and incorporated into the home care limits on July 1, 1992. These limits shall be calculated to the nearest quarter hour.

(iii) The home care rating shall be determined by the commissioner or the commissioner's designee based on information submitted to the commissioner by the county public health nurse on forms specified by the commissioner. The home care rating shall be a combination of current assessment tools developed under sections 256B.0911 and 256B.501 with an addition for seizure activity that will assess the frequency and severity of seizure activity and with adjustments, additions, and clarifications that are necessary to reflect the needs and conditions of recipients who need home care including children and adults under 65 years of age. The commissioner shall establish these forms and protocols under this section and shall use an advisory group, including representatives of recipients, providers, and counties, for consultation in establishing and revising the forms and protocols.

(iv) A recipient shall qualify as having complex medical needs if the care required is difficult to perform and because of recipient's medical condition requires more time than community-based standards allow or requires more skill than would ordinarily be required and the recipient needs or has one or more of the following:

(A) daily tube feedings;

(B) daily parenteral therapy;

(C) wound or decubiti care;

(D) postural drainage, percussion, nebulizer treatments, suctioning, tracheotomy care, oxygen, mechanical ventilation;

(E) catheterization;

(F) ostomy care;

(G) quadriplegia; or

(H) other comparable medical conditions or treatments the commissioner determines would otherwise require institutional care.

(v) A recipient shall qualify as having Level I behavior if there is reasonable supporting evidence that the recipient exhibits, or that without supervision, observa-

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tion, or redirection would exhibit, one or more of the following behaviors that cause, or have the potential to cause:

- (A) injury to the recipient's own body;
- (B) physical injury to other people; or
- (C) destruction of property.

(vi) Time authorized for personal care relating to Level I behavior in subclause (v), items (A) to (C), shall be based on the predictability, frequency, and amount of intervention required.

(vii) A recipient shall qualify as having Level II behavior if the recipient exhibits on a daily basis one or more of the following behaviors that interfere with the completion of personal care assistant services under subdivision 4, paragraph (a):

- (A) unusual or repetitive habits;
- (B) withdrawn behavior; or
- (C) offensive behavior.

(viii) A recipient with a home care rating of Level II behavior in subclause (vii), items (A) to (C), shall be rated as comparable to a recipient with complex medical needs under subclause (iv). If a recipient has both complex medical needs and Level II behavior, the home care rating shall be the next complex category up to the maximum rating under subclause (i), item (B).

(3) PRIVATE DUTY NURSING SERVICES. All private duty nursing services shall be prior authorized by the commissioner or the commissioner's designee. Prior authorization for private duty nursing services shall be based on medical necessity and cost-effectiveness when compared with alternative care options. The commissioner may authorize medically necessary private duty nursing services in quarter-hour units when:

- (i) the recipient requires more individual and continuous care than can be provided during a nurse visit; or
- (ii) the cares are outside of the scope of services that can be provided by a home health aide or personal care assistant.

The commissioner may authorize:

(A) up to two times the average amount of direct care hours provided in nursing facilities statewide for case mix classification "K" as established by the annual cost report submitted to the department by nursing facilities in May 1992;

(B) private duty nursing in combination with other home care services up to the total cost allowed under clause (2);

(C) up to 16 hours per day if the recipient requires more nursing than the maximum number of direct care hours as established in item (A) and the recipient

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meets the hospital admission criteria established under Minnesota Rules, parts 9505.0501 to 9505.0540.

The commissioner may authorize up to 16 hours per day of medically necessary private duty nursing services or up to 24 hours per day of medically necessary private duty nursing services until such time as the commissioner is able to make a determination of eligibility for recipients who are cooperatively applying for home care services under the community alternative care program developed under section 256B.49, or until it is determined by the appropriate regulatory agency that a health benefit plan is or is not required to pay for appropriate medically necessary health care services. Recipients or their representatives must cooperatively assist the commissioner in obtaining this determination. Recipients who are eligible for the community alternative care program may not receive more hours of nursing under this section than would otherwise be authorized under section 256B.49.

(4) **VENTILATOR-DEPENDENT RECIPIENTS.** If the recipient is ventilator-dependent, the monthly medical assistance authorization for home care services shall not exceed what the commissioner would pay for care at the highest cost hospital designated as a long-term hospital under the Medicare program. For purposes of this clause, home care services means all services provided in the home that would be included in the payment for care at the long-term hospital. "Ventilator-dependent" means an individual who receives mechanical ventilation for life support at least six hours per day and is expected to be or has been dependent for at least 30 consecutive days.

(f) **PRIOR AUTHORIZATION; TIME LIMITS.** The commissioner or the commissioner's designee shall determine the time period for which a prior authorization shall be effective and, if flexible use has been requested, whether to allow the flexible use option. If the recipient continues to require home care services beyond the duration of the prior authorization, the home care provider must request a new prior authorization. Under no circumstances, other than the exceptions in paragraph (b), shall a prior authorization be valid prior to the date the commissioner receives the request or for more than 12 months. A recipient who appeals a reduction in previously authorized home care services may continue previously authorized services, other than temporary services under paragraph (h), pending an appeal under section 256.045. The commissioner must provide a detailed explanation of why the authorized services are reduced in amount from those requested by the home care provider.

(g) **APPROVAL OF HOME CARE SERVICES.** The commissioner or the commissioner's designee shall determine the medical necessity of home care services, the level of caregiver according to subdivision 2, and the institutional comparison according to this subdivision, the cost-effectiveness of services, and the amount, scope, and duration of home care services reimbursable by medical assistance, based on the assessment, primary payer coverage determination information as required, the service plan, the recipient's age, the cost of services, the recipient's medical condition, and diagnosis or disability. The commissioner may publish additional criteria for determining medical necessity according to section 256B.04.

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(h) PRIOR AUTHORIZATION REQUESTS; TEMPORARY SERVICES.

The agency nurse, the independently enrolled private duty nurse, or county public health nurse may request a temporary authorization for home care services by telephone. The commissioner may approve a temporary level of home care services based on the assessment, and service or care plan information, and primary payer coverage determination information as required. Authorization for a temporary level of home care services including nurse supervision is limited to the time specified by the commissioner, but shall not exceed 45 days, unless extended because the county public health nurse has not completed the required assessment and service plan, or the commissioner's determination has not been made. The level of services authorized under this provision shall have no bearing on a future prior authorization.

(i) PRIOR AUTHORIZATION REQUIRED IN FOSTER CARE SETTING.

Home care services provided in an adult or child foster care setting must receive prior authorization by the department according to the limits established in paragraph (a).

The commissioner may not authorize:

(1) home care services that are the responsibility of the foster care provider under the terms of the foster care placement agreement and administrative rules;

(2) personal care assistant services when the foster care license holder is also the personal care provider or personal care assistant unless the recipient can direct the recipient's own care, or case management is provided as required in section 256B.0625, subdivision 19a;

(3) personal care assistant services when the responsible party is an employee of, or under contract with, or has any direct or indirect financial relationship with the personal care provider or personal care assistant, unless case management is provided as required in section 256B.0625, subdivision 19a; or

(4) personal care assistant and private duty nursing services when the number of foster care residents is greater than four unless the county responsible for the recipient's foster placement made the placement prior to April 1, 1992, requests that personal care assistant and private duty nursing services be provided, and case management is provided as required in section 256B.0625, subdivision 19a.

Sec. 18. Minnesota Statutes 2004, section 256B.0627, subdivision 9, is amended to read:

Subd. 9. **OPTION FOR FLEXIBLE USE OF PERSONAL CARE ASSISTANT HOURS.** (a) "Flexible use option" means the scheduled use of authorized hours of personal care assistant services, which vary within the length of the a service authorization period covering no more than six months, in order to more effectively meet the needs and schedule of the recipient. Authorized hours not used within the six-month period may not be carried over to another time period. The flexible use of personal care assistant hours for a six-month period must be prior authorized by the commissioner, based on a request submitted on a form approved by the commissioner.

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The request must include the assessment and the annual service plan prepared by the county public health nurse.

(b) The recipient or responsible party, together with the case manager, if the recipient has case management services, and the county public health nurse, shall determine whether flexible use is an appropriate option based on the needs, abilities, preferences, and history of service use of the recipient or responsible party, and if appropriate, must ensure that the allocation of hours covers the ongoing needs of the recipient over an entire year divided into two six-month periods of flexible use. A recipient who has terminated personal care assistant services before the end of the 12-month authorization period shall not receive additional hours upon reapplying during the same 12-month authorization period, except if a change in condition is documented. Services shall be prorated for the remainder of the 12-month authorization period based on earlier assessment.

(c) If prior authorized, recipients may use their approved hours flexibly within the service authorization period for medically necessary covered services specified in the assessment required in subdivision 1. The flexible use of authorized hours does not increase the total amount of authorized hours available to a recipient as determined under subdivision 5. The commissioner shall not authorize additional personal care assistant services to supplement a service authorization that is exhausted before the end date under a flexible service use plan, unless the county public health nurse determines a change in condition and a need for increased services is established.

(b) (d) The personal care provider organization and the recipient or responsible party, together with the provider, or the personal care assistant choice provider must work to monitor and document the use of authorized hours and ensure that a recipient is able to manage services effectively throughout the authorized period. Upon request of the recipient or responsible party, the provider must furnish regular updates to the recipient or responsible party on the amount of personal care assistant services used develop a written month-to-month plan of the projected use of personal care assistant services that is part of the care plan and ensures:

(1) that the health and safety needs of the recipient will be met;

(2) that the total annual authorization will not be used before the end of the authorization period; and

(3) monthly monitoring will be conducted of hours used as a percentage of the authorized amount.

(e) The provider shall notify the recipient or responsible party, any case manager for the recipient, and the county public health nurse in advance and as soon as possible, on a form approved by the commissioner, if the monthly amount of hours authorized is likely to be exceeded for the month.

(f) The commissioner shall provide written notice to the provider, the recipient or responsible party, any case manager for the recipient, and the county public health nurse, when a flexible use recipient exceeds the personal care assistant service

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authorization for the month by an amount determined by the commissioner. If the use of hours exceeds the monthly service authorization by the amount determined by the commissioner for two months during any three-month period, the commissioner shall notify the recipient and the county public health nurse that the flexible use authorization will be revoked beginning the following month. The revocation will not become effective if, within ten working days of the commissioner's notice of flexible use revocation, the county public health nurse requests prior authorization for an increase in the service authorization or continuation of the flexible use option, or the recipient appeals and assistance pending appeal is ordered. The commissioner shall determine whether to approve the increase and continued flexible use.

(g) The recipient or responsible party may stop the flexible use of hours by notifying the personal care provider organization or the personal care assistance choice provider and county public health nurse in writing.

(h) The recipient or responsible party may appeal the commissioner's action according to section 256.045. The denial or revocation of the flexible use option shall not affect the recipient's authorized level of personal care assistant services as determined under subdivision 5.

Sec. 19. Minnesota Statutes 2004, section 256B.0627, is amended by adding a subdivision to read:

Subd. 18. OVERSIGHT OF ENROLLED PERSONAL CARE ASSISTANT SERVICES PROVIDERS. The commissioner may request from providers documentation of compliance with laws, rules, and policies governing the provision of personal care assistant services. A personal care assistant service provider must provide the requested documentation to the commissioner within ten business days of the request. Failure to provide information to demonstrate substantial compliance with laws, rules, or policies may result in suspension, denial, or termination of the provider agreement.

Sec. 20. Minnesota Statutes 2004, section 256B.0913, subdivision 2, is amended to read:

Subd. 2. ELIGIBILITY FOR SERVICES. Alternative care services are available to Minnesotans age 65 or older who would be eligible for medical assistance within 180 135 days of admission to a nursing facility and subject to subdivisions 4 to 13.

Sec. 21. Minnesota Statutes 2004, 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;

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(2) the person is age 65 or older;

(3) the person would be eligible for medical assistance within ~~180~~ 135 days of admission to a nursing facility;

(4) the person is not ineligible for the medical assistance program due to an asset transfer penalty;

(5) the person needs 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 supplies and equipment or environmental modifications 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 event, the annual cost of alternative care services shall not exceed 12 times the monthly limit described in this paragraph; and

(7) the person is making timely payments of the assessed monthly fee.

A person is ineligible if payment of the fee is over 60 days past due, unless the person agrees to:

(i) the appointment of a representative payee;

(ii) automatic payment from a financial account;

(iii) the establishment of greater family involvement in the financial management of payments; or

(iv) another method acceptable to the county to ensure prompt fee payments.

The county shall extend the client's eligibility as necessary while making arrangements to facilitate payment of past-due amounts and future premium payments. Following disenrollment due to nonpayment of a monthly fee, eligibility shall not be reinstated for a period of 30 days.

(b) Alternative care funding under this subdivision is not available for a person who is a medical assistance recipient or who would be eligible for medical assistance without a spenddown or waiver obligation. A person whose initial application for medical assistance and the elderly waiver program is being processed may be served under the alternative care program for a period up to 60 days. If the individual is found to be eligible for medical assistance, medical assistance must be billed for services

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payable under the federally approved elderly waiver plan and delivered from the date the individual was found eligible for the federally approved elderly waiver plan. Notwithstanding this provision, alternative care funds may not be used to pay for any service the cost of which: (i) is payable by medical assistance; (ii) is used by a recipient to meet a waiver obligation; or (iii) is used to pay a medical assistance income spenddown for a person who is eligible to participate in the federally approved elderly waiver program under the special income standard provision.

(c) Alternative care funding is not available for a person who resides in a licensed nursing home, certified boarding care home, hospital, or intermediate care facility, except for case management services which are provided in support of the discharge planning process for a nursing home resident or certified boarding care home resident to assist with a relocation process to a community-based setting.

(d) Alternative care funding is not available for a person whose income is greater than the maintenance needs allowance under section 256B.0915, subdivision 1d, but equal to or less than 120 percent of the federal poverty guideline effective July 1 in the year for which alternative care eligibility is determined, who would be eligible for the elderly waiver with a waiver obligation.

Sec. 22. Minnesota Statutes 2004, section 256B.0913, subdivision 5, is amended to read:

Subd. 5. **SERVICES COVERED UNDER ALTERNATIVE CARE.** Alternative care funding may be used for payment of costs of:

- (1) ~~adult foster care~~;
- (2) ~~adult day care~~;
- (3) (2) home health aide;
- (4) (3) homemaker services;
- (5) (4) personal care;
- (6) (5) case management;
- (7) (6) respite care;
- (8) ~~assisted living~~;
- (9) ~~residential care services~~;
- (10) (7) care-related supplies and equipment;
- (11) (8) meals delivered to the home;
- (12) (9) transportation;
- (13) (10) nursing services;
- (14) (11) chore services;
- (15) (12) companion services;

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- (16) (13) nutrition services;
- (17) (14) training for direct informal caregivers;
- (18) (15) telehome care to provide services in their own homes in conjunction with in-home visits;
- (19) (16) discretionary services, for which counties may make payment from their alternative care program allocation or services not otherwise defined in this section or section 256B.0625, following approval by the commissioner;
- (20) (17) environmental modifications; and
- (21) (18) direct cash payments for which counties may make payment from their alternative care program allocation to clients for the purpose of purchasing services, following approval by the commissioner, and subject to the provisions of subdivision 5h, until approval and implementation of consumer-directed services through the federally approved elderly waiver plan. Upon implementation, consumer-directed services under the alternative care program are available statewide and limited to the average monthly expenditures representative of all alternative care program participants for the same case mix resident class assigned in the most recent fiscal year for which complete expenditure data is available.

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 not exceed 25 percent of that county'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. 23. Minnesota Statutes 2004, 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 transitional support services, assisted living services, adult foster care services, and residential care services.

(b) The county agency must ensure that the funds are not used to supplant services available through other public assistance or services programs. 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 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 agency may contract with a client's

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relative who meets the relative hardship waiver requirements or a relative who meets the criteria and is also the responsible party under an individual service plan that ensures the client's health and safety and supervision of the personal care services by a qualified professional as defined in section 256B.0625, subdivision 19c. Relative hardship is established by the county when the client's care causes a relative caregiver to do any of the following: resign from a paying job, reduce work hours resulting in lost wages, obtain a leave of absence resulting in lost wages, incur substantial client-related expenses, provide services to address authorized, unstaffed direct care time, or meet special needs of the client unmet in the formal service plan.

Sec. 24. Minnesota Statutes 2004, section 256B.095, is amended to read:

256B.095 QUALITY ASSURANCE SYSTEM ESTABLISHED.

(a) Effective July 1, 1998, a quality assurance system for persons with developmental disabilities, which includes an alternative quality assurance licensing system for programs, is established in Dodge, Fillmore, Freeborn, Goodhue, Houston, Mower, Olmsted, Rice, Steele, Wabasha, and Winona Counties for the purpose of improving the quality of services provided to persons with developmental disabilities. A county, at its option, may choose to have all programs for persons with developmental disabilities located within the county licensed under chapter 245A using standards determined under the alternative quality assurance licensing system or may continue regulation of these programs under the licensing system operated by the commissioner. The project expires on June 30, 2007 2009.

(b) Effective July 1, 2003, a county not listed in paragraph (a) may apply to participate in the quality assurance system established under paragraph (a). The commission established under section 256B.0951 may, at its option, allow additional counties to participate in the system.

(c) Effective July 1, 2003, any county or group of counties not listed in paragraph (a) may establish a quality assurance system under this section. A new system established under this section shall have the same rights and duties as the system established under paragraph (a). A new system shall be governed by a commission under section 256B.0951. The commissioner shall appoint the initial commission members based on recommendations from advocates, families, service providers, and counties in the geographic area included in the new system. Counties that choose to participate in a new system shall have the duties assigned under section 256B.0952. The new system shall establish a quality assurance process under section 256B.0953. The provisions of section 256B.0954 shall apply to a new system established under this paragraph. The commissioner shall delegate authority to a new system established under this paragraph according to section 256B.0955.

EFFECTIVE DATE. This section is effective retroactively from July 1, 2005.

Sec. 25. Minnesota Statutes 2004, section 256B.0951, subdivision 1, is amended to read:

Subdivision 1. **MEMBERSHIP.** The Quality Assurance Commission is established. The commission consists of at least 14 but not more than 21 members as

follows: at least three but not more than five members representing advocacy organizations; at least three but not more than five members representing consumers, families, and their legal representatives; at least three but not more than five members representing service providers; at least three but not more than five members representing counties; and the commissioner of human services or the commissioner's designee. The first commission shall establish membership guidelines for the transition and recruitment of membership for the commission's ongoing existence. Members of the commission who do not receive a salary or wages from an employer for time spent on commission duties may receive a per diem payment when performing commission duties and functions. All members may be reimbursed for expenses related to commission activities. Notwithstanding the provisions of section 15.059, subdivision 5, the commission expires on June 30, ~~2007~~ 2009.

EFFECTIVE DATE. This section is effective retroactively from July 1, 2005.

Sec. 26. Minnesota Statutes 2004, section 256B.0952, subdivision 5, is amended to read:

Subd. 5. **QUALITY ASSURANCE TEAMS.** Quality assurance teams shall be comprised of county staff; providers; consumers, families, and their legal representatives; members of advocacy organizations; and other involved community members. Team members must satisfactorily complete the training program approved by the commission and must demonstrate performance-based competency. Team members are not considered to be county employees for purposes of workers' compensation, unemployment insurance, or state retirement laws solely on the basis of participation on a quality assurance team. The county may pay a per diem to team members ~~who do not receive a salary or wages from an employer~~ for time spent on alternative quality assurance process matters. All team members may be reimbursed for expenses related to their participation in the alternative process.

EFFECTIVE DATE. This section is effective retroactively from July 1, 2005.

Sec. 27. Minnesota Statutes 2004, section 256B.0953, subdivision 1, is amended to read:

Subdivision 1. **PROCESS COMPONENTS.** (a) The quality assurance licensing process consists of an evaluation by a quality assurance team of the facility, program, or service according to outcome-based measurements. The process must include an evaluation of a random sample of program consumers. The sample must be representative of each service provided. The sample size must be at least five percent of consumers but not less than three ~~two~~ consumers.

(b) All consumers must be given the opportunity to be included in the quality assurance process in addition to those chosen for the random sample.

EFFECTIVE DATE. This section is effective retroactively from July 1, 2005.

Sec. 28. Minnesota Statutes 2004, section 256B.15, subdivision 1, is amended to read:

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Subdivision 1. **POLICY, APPLICABILITY, PURPOSE, AND CONSTRUCTION; DEFINITION.** (a) It is the policy of this state that individuals or couples, either or both of whom participate in the medical assistance program, use their own assets to pay their share of the total cost of their care during or after their enrollment in the program according to applicable federal law and the laws of this state. The following provisions apply:

(1) subdivisions 1c to 1k shall not apply to claims arising under this section which are presented under section 525.313;

(2) the provisions of subdivisions 1c to 1k expanding the interests included in an estate for purposes of recovery under this section give effect to the provisions of United States Code, title 42, section 1396p, governing recoveries, but do not give rise to any express or implied liens in favor of any other parties not named in these provisions;

(3) the continuation of a recipient's life estate or joint tenancy interest in real property after the recipient's death for the purpose of recovering medical assistance under this section modifies common law principles holding that these interests terminate on the death of the holder;

(4) all laws, rules, and regulations governing or involved with a recovery of medical assistance shall be liberally construed to accomplish their intended purposes;

(5) a deceased recipient's life estate and joint tenancy interests continued under this section shall be owned by the remaindermen or surviving joint tenants as their interests may appear on the date of the recipient's death. They shall not be merged into the remainder interest or the interests of the surviving joint tenants by reason of ownership. They shall be subject to the provisions of this section. Any conveyance, transfer, sale, assignment, or encumbrance by a remainderman, a surviving joint tenant, or their heirs, successors, and assigns shall be deemed to include all of their interest in the deceased recipient's life estate or joint tenancy interest continued under this section; and

(6) the provisions of subdivisions 1c to 1k continuing a recipient's joint tenancy interests in real property after the recipient's death do not apply to a homestead owned of record, on the date the recipient dies, by the recipient and the recipient's spouse as joint tenants with a right of survivorship. Homestead means the real property occupied by the surviving joint tenant spouse as their sole residence on the date the recipient dies and classified and taxed to the recipient and surviving joint tenant spouse as homestead property for property tax purposes in the calendar year in which the recipient dies. For purposes of this exemption, real property the recipient and their surviving joint tenant spouse purchase solely with the proceeds from the sale of their prior homestead, own of record as joint tenants, and qualify as homestead property under section 273.124 in the calendar year in which the recipient dies and prior to the recipient's death shall be deemed to be real property classified and taxed to the recipient and their surviving joint tenant spouse as homestead property in the calendar year in which the recipient dies. The surviving spouse, or any person with personal knowledge of the facts, may provide

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an affidavit describing the homestead property affected by this clause and stating facts showing compliance with this clause. The affidavit shall be prima facie evidence of the facts it states.

(b) For purposes of this section, "medical assistance" includes the medical assistance program under this chapter and the general assistance medical care program under chapter 256D and alternative care for nonmedical assistance recipients under section 256B.0913.

(c) All provisions in this subdivision, and subdivisions 1d, 1f, 1g, 1h, 1i, and 1j, related to the continuation of a recipient's life estate or joint tenancy interests in real property after the recipient's death for the purpose of recovering medical assistance, are effective only for life estates and joint tenancy interests established on or after August 1, 2003. For purposes of this paragraph, medical assistance does not include alternative care.

EFFECTIVE DATE. This section is effective retroactively from August 1, 2003.

Sec. 29. Minnesota Statutes 2004, section 256B.15, subdivision 4, is amended to read:

Subd. 4. **OTHER SURVIVORS.** If the decedent who was single or the surviving spouse of a married couple is survived by one of the following persons, a claim exists against the estate ~~in an amount not to exceed~~ payable first from the value of the nonhomestead property included in the estate and the personal representative shall make, execute, and deliver to the county agency a lien against the homestead property in the estate for any unpaid balance of the claim to the claimant as provided under this section:

(a) a sibling who resided in the decedent medical assistance recipient's home at least one year before the decedent's institutionalization and continuously since the date of institutionalization; or

(b) a son or daughter or a grandchild who resided in the decedent medical assistance recipient's home for at least two years immediately before the parent's or grandparent's institutionalization and continuously since the date of institutionalization, and who establishes by a preponderance of the evidence having provided care to the parent or grandparent who received medical assistance, that the care was provided before institutionalization, and that the care permitted the parent or grandparent to reside at home rather than in an institution.

EFFECTIVE DATE. This section is effective August 1, 2005, and applies to persons dying on and after that date and to probates commenced on and after that date.

Sec. 30. Minnesota Statutes 2004, section 256B.15, is amended by adding a subdivision to read:

Subd. 6. **ESTABLISHMENT OF LIFE ESTATE OR JOINT TENANCY INTEREST.** For purposes of subdivision 1 and section 514.981, subdivision 6, a life estate or joint tenancy interest is established upon the earlier of:

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(1) the date the instrument creating the interest is recorded or filed in the office of the county recorder or registrar of titles where the real estate interest it describes is located;

(2) the date of delivery by the grantor to the grantee of the signed instrument as stated in an affidavit made by a person with knowledge of the facts;

(3) the date on which the judicial order creating the interest was issued by the court; or

(4) the date upon which the interest devolves under section 524.3-101.

EFFECTIVE DATE. This section is effective retroactively from August 1, 2003.

Sec. 31. Minnesota Statutes 2004, section 256B.15, is amended by adding a subdivision to read:

Subd. 7. LIEN NOTICES. Medical assistance liens and liens under notices of potential claims that are of record against life estate or joint tenancy interests established prior to August 1, 2003, shall end, become unenforceable, and cease to be liens on those interests upon the death of the person named in the lien or notice of potential claim, shall be disregarded by examiners of title after the death of the life tenant or joint tenant, and shall not be carried forward to a subsequent certificate of title. This subdivision shall not apply to life estates that continue to exist after the death of the person named in the lien or notice of potential claim under the terms of the instrument creating or reserving the life estate until the life estate ends as provided for in the instrument.

EFFECTIVE DATE. This section is effective retroactively from August 1, 2003.

Sec. 32. Minnesota Statutes 2004, section 256B.15, is amended by adding a subdivision to read:

Subd. 8. IMMUNITY. The commissioner of human services, county agencies, and elected officials and their employees are immune from all liability for any action taken implementing Laws 2003, First Special Session chapter 14, article 12, sections 40 to 52 and 90, as those laws existed at the time the action was taken, and section 514.981, subdivision 6.

EFFECTIVE DATE. This section is effective retroactively from August 1, 2003.

Sec. 33. Minnesota Statutes 2004, section 256B.431, is amended by adding a subdivision to read:

Subd. 41. NURSING FACILITY RATE INCREASES FOR OCTOBER 1, 2005, AND OCTOBER 1, 2006. (a) For the rate period beginning October 1, 2005, the commissioner shall make available to each nursing facility reimbursed under this section or section 256B.434 an adjustment equal to 2.2553 percent of the total operating payment rate, and for the rate year beginning October 1, 2006, the commissioner shall make available to each nursing facility reimbursed under this

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section or section 256B.434 an adjustment equal to 1.2553 percent of the total operating payment rate.

(b) 75 percent of the money resulting from the rate adjustment under paragraph (a) must be used to increase wages and benefits and pay associated costs for all employees, except management fees, the administrator, and central office staff. Except as provided in paragraph (c), 75 percent of the money received by a facility as a result of the rate adjustment provided in paragraph (a) must be used only for wage, benefit, and staff increases implemented on or after the effective date of the rate increase each year, and must not be used for increases implemented prior to that date.

(c) With respect only to the October 1, 2005, rate increase, a nursing facility that incurred costs for salary and employee benefit increases first provided after July 1, 2003, may count those costs towards the amount required to be spent on salaries and benefits under paragraph (b). These costs must be reported to the commissioner in the form and manner specified by the commissioner.

(d) Nursing facilities may apply for the portion of the rate adjustment under paragraph (a) for employee wages and benefits and associated costs. The application must be made to the commissioner and contain a plan by which the nursing facility will distribute the funds according to paragraph (b). For nursing facilities in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative constitutes the plan. A negotiated agreement may constitute the plan only if the agreement is finalized after the date of enactment of all increases for the rate year and signed by both parties prior to submission to the commissioner. The commissioner shall review the plan to ensure that the rate adjustments are used as provided in paragraph (b). To be eligible, a facility must submit its distribution plan by March 31, 2006, and March 31, 2007, respectively. The commissioner may approve distribution plans on or before June 30, 2006, and June 30, 2007, respectively. If a facility's distribution plan is effective after the first day of the applicable rate period that the funds are available, the rate adjustments are effective the same date as the facility's plan.

(e) A copy of the approved distribution plan must be made available to all employees by giving each employee a copy or by posting a copy in an area of the nursing facility to which all employees have access. If an employee does not receive the wage and benefit adjustment described in the facility's approved plan and is unable to resolve the problem with the facility's management or through the employee's union representative, the employee may contact the commissioner at an address or telephone number provided by the commissioner and included in the approved plan.

Sec. 34. Minnesota Statutes 2004, section 256B.431, is amended by adding a subdivision to read:

Subd. 42. INCENTIVE TO ESTABLISH SINGLE-BED ROOMS. (a) Beginning July 1, 2005, the operating payment rate for nursing facilities reimbursed under

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this section, section 256B.434, or 256B.441 shall be increased by 20 percent multiplied by the ratio of the number of new single-bed rooms created divided by the number of active beds on July 1, 2005, for each bed closure that results in the creation of a single-bed room after July 1, 2005. The commissioner may implement rate adjustments for up to 3,000 new single-bed rooms each year. For eligible bed closures for which the commissioner receives a notice from a facility during a calendar quarter that a bed has been delicensed and a new single-bed room has been established, the rate adjustment in this paragraph shall be effective on the first day of the second month following that calendar quarter.

(b) A nursing facility is prohibited from discharging residents for purposes of establishing single-bed rooms. A nursing facility must submit documentation to the commissioner in a form prescribed by the commissioner, certifying the occupancy status of beds closed to create single-bed rooms. In the event that the commissioner determines that a facility has discharged a resident for purposes of establishing a single-bed room, the commissioner shall not provide a rate adjustment under paragraph (a).

(c) If after the date of enactment of this section and before December 31, 2007, more than 4,000 nursing home beds are removed from service, a portion of the appropriation for nursing homes shall be transferred to the alternative care program. The amount of this transfer shall equal the number of beds removed from service less 4,000, multiplied by the average monthly per-person cost for alternative care, multiplied by 12, and further multiplied by 0.3.

Sec. 35. Minnesota Statutes 2004, section 256B.432, subdivision 1, is amended to read:

Subdivision 1. **DEFINITIONS.** For purposes of this section, the following terms have the meanings given them.

(a) "Management agreement" means an agreement in which one or more of the following criteria exist:

(1) the central, affiliated, or corporate office has or is authorized to assume day-to-day operational control of the nursing facility for any six-month period within a 24-month period. "Day-to-day operational control" means that the central, affiliated, or corporate office has the authority to require, mandate, direct, or compel the employees of the nursing facility to perform or refrain from performing certain acts, or to supplant or take the place of the top management of the nursing facility. "Day-to-day operational control" includes the authority to hire or terminate employees or to provide an employee of the central, affiliated, or corporate office to serve as administrator of the nursing facility;

(2) the central, affiliated, or corporate office performs or is authorized to perform two or more of the following: the execution of contracts; authorization of purchase orders; signature authority for checks, notes, or other financial instruments; requiring the nursing facility to use the group or volume purchasing services of the central,

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affiliated, or corporate office; or the authority to make annual capital expenditures for the nursing facility exceeding \$50,000, or \$500 per licensed bed, whichever is less, without first securing the approval of the nursing facility board of directors;

(3) the central, affiliated, or corporate office becomes or is required to become the licensee under applicable state law;

(4) the agreement provides that the compensation for services provided under the agreement is directly related to any profits made by the nursing facility; or

(5) the nursing facility entering into the agreement is governed by a governing body that meets fewer than four times a year, that does not publish notice of its meetings, or that does not keep formal records of its proceedings.

(b) "Consulting agreement" means any agreement the purpose of which is for a central, affiliated, or corporate office to advise, counsel, recommend, or suggest to the owner or operator of the nonrelated nursing facility measures and methods for improving the operations of the nursing facility.

(c) "Nursing facility" means a nursing facility whose medical assistance rates are determined according to section 256B.431 with a medical assistance provider agreement that is licensed as a nursing home under chapter 144A or as a boarding care home under sections 144.50 to 144.56.

Sec. 36. Minnesota Statutes 2004, section 256B.432, subdivision 2, is amended to read:

Subd. 2. **EFFECTIVE DATE.** For rate years beginning on or after July 1, 1990, the central, affiliated, or corporate office cost allocations in subdivisions 3 to 6 must be used when determining medical assistance rates under section 256B.431, 256B.434, or 256B.441.

Sec. 37. Minnesota Statutes 2004, section 256B.432, is amended by adding a subdivision to read:

Subd. 4a. **ALLOCATION; COSTS ALLOCABLE ON A FUNCTIONAL BASIS.** (a) Costs that have not been directly identified must be allocated to nursing facilities on a basis designed to equitably allocate the costs to the nursing facilities or activities receiving the benefits of the costs. This allocation must be made in a manner reasonably related to the services received by the nursing facilities. Where practical and the amounts are material, these costs must be allocated on a functional basis. The functions, or cost centers used to allocate central office costs, and the unit bases used to allocate the costs, including those central office costs allocated according to subdivision 5, must be used consistently from one central office accounting period to another.

(b) If the central office wishes to change its allocation bases and believes the change will result in more appropriate and more accurate allocations, the central office must make a written request, with its justification, to the commissioner for approval of the change no later than 120 days after the beginning of the central office accounting

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period to which the change is to apply. The commissioner's approval of a central office request will be furnished to the central office in writing. Where the commissioner approves the central office request, the change must be applied to the accounting period for which the request was made, and to all subsequent central office accounting periods unless the commissioner approves a subsequent request for change by the central office. The effective date of the change will be the beginning of the accounting period for which the request was made.

Sec. 38. Minnesota Statutes 2004, section 256B.432, subdivision 5, is amended to read:

Subd. 5. ALLOCATION OF REMAINING COSTS; ALLOCATION RATIO.

(a) After the costs that can be directly identified according to subdivisions 3 and 4 have been allocated, the remaining central, affiliated, or corporate office costs must be allocated between the nursing facility operations and the other activities or facilities unrelated to the nursing facility operations based on the ratio of total operating costs. However, in the event that these remaining costs are partially attributable to the start-up of home and community-based services intended to fill a gap identified by the local agency, the facility may assign these remaining costs to the appropriate cost category of the facility for a period not to exceed two years.

(b) For purposes of allocating these remaining central, affiliated, or corporate office costs, the numerator for the allocation ratio shall be determined as follows:

(1) for nursing facilities that are related organizations or are controlled by a central, affiliated, or corporate office under a management agreement, the numerator of the allocation ratio shall be equal to the sum of the total operating costs incurred by each related organization or controlled nursing facility;

(2) for a central, affiliated, or corporate office providing goods or services to related organizations that are not nursing facilities, the numerator of the allocation ratio shall be equal to the sum of the total operating costs incurred by the nonnursing facility related organizations;

(3) for a central, affiliated, or corporate office providing goods or services to unrelated nursing facilities under a consulting agreement, the numerator of the allocation ratio shall be equal to the greater of directly identified central, affiliated, or corporate costs or the contracted amount; or

(4) for business activities that involve the providing of goods or services to unrelated parties which are not nursing facilities, the numerator of the allocation ratio shall be equal to the greater of directly identified costs or revenues generated by the activity or function.

(c) The denominator for the allocation ratio is the sum of the numerators in paragraph (b), clauses (1) to (4).

Sec. 39. Minnesota Statutes 2004, section 256B.432, is amended by adding a subdivision to read:

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Subd. 6a. RELATED ORGANIZATION COSTS. (a) Costs applicable to services, capital assets, and supplies directly or indirectly furnished to the nursing facility by any related organization are includable in the allowable cost of the nursing facility at the purchase price paid by the related organization for capital assets or supplies and at the cost incurred by the related organization for the provision of services to the nursing facility if these prices or costs do not exceed the price of comparable services, capital assets, or supplies that could be purchased elsewhere. For this purpose, the related organization's costs must not include an amount for markup or profit.

(b) If the related organization in the normal course of business sells services, capital assets, or supplies to nonrelated organizations, the cost to the nursing facility shall be the nonrelated organization's price provided that sales to nonrelated organizations constitute at least 50 percent of total annual sales of similar services, capital assets, or supplies.

Sec. 40. Minnesota Statutes 2004, section 256B.434, subdivision 3, is amended to read:

Subd. 3. DURATION AND TERMINATION OF CONTRACTS. (a) Subject to available resources, the commissioner may begin to execute contracts with nursing facilities November 1, 1995.

(b) All contracts entered into under this section are for a term of one year not to exceed four years. Either party may terminate a contract at any time without cause by providing 90 calendar days advance written notice to the other party. The decision to terminate a contract is not appealable. Notwithstanding section 16C.05, subdivision 2, paragraph (a), clause (5), the contract shall be renegotiated for additional one-year terms of up to four years, unless either party provides written notice of termination. The provisions of the contract shall be renegotiated annually at a minimum of every four years by the parties prior to the expiration date of the contract. The parties may voluntarily renegotiate the terms of the contract at any time by mutual agreement.

(c) If a nursing facility fails to comply with the terms of a contract, the commissioner shall provide reasonable notice regarding the breach of contract and a reasonable opportunity for the facility to come into compliance. If the facility fails to come into compliance or to remain in compliance, the commissioner may terminate the contract. If a contract is terminated, the contract payment remains in effect for the remainder of the rate year in which the contract was terminated, but in all other respects the provisions of this section do not apply to that facility effective the date the contract is terminated. The contract shall contain a provision governing the transition back to the cost-based reimbursement system established under section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080. A contract entered into under this section may be amended by mutual agreement of the parties.

Sec. 41. Minnesota Statutes 2004, section 256B.434, subdivision 4, is amended to read:

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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, ~~and 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. Beginning October 1, 2006, facilities reimbursed under this section shall be allowed to receive a property rate adjustment for building projects under section 144A.071, subdivision 2.

(d) ~~The commissioner shall develop additional incentive-based payments of up to five percent above the standard contract rate for achieving outcomes specified in each contract. The specified facility-specific outcomes must be measurable and approved by the commissioner. The commissioner may establish, for each contract, various levels of achievement within an outcome. After the outcomes have been specified the commissioner shall assign various levels of payment associated with achieving the outcome. Any incentive-based payment cancels if there is a termination of the contract. In establishing the specified outcomes and related criteria the commissioner shall consider the following state policy objectives:~~

- (1) ~~improved cost effectiveness and quality of life as measured by improved clinical outcomes;~~
- (2) ~~successful diversion or discharge to community alternatives;~~
- (3) ~~decreased acute care costs;~~

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(4) improved consumer satisfaction;

(5) the achievement of quality; or

(6) any additional outcomes proposed by a nursing facility that the commissioner finds desirable.

EFFECTIVE DATE. This section is effective retroactively from July 1, 2005.

Sec. 42. Minnesota Statutes 2004, section 256B.434, is amended by adding a subdivision to read:

Subd. 18. FACILITIES WITHOUT APS CONTRACTS AS OF OCTOBER 1, 2006. Effective October 1, 2006, payment rates for property shall no longer be determined under section 256B.431. A facility that does not have a contract with the commissioner under this section shall not be eligible for a rate increase.

Sec. 43. [256B.441] NURSING FACILITY REIMBURSEMENT SYSTEM EFFECTIVE OCTOBER 1, 2007.

Subdivision 1. IN GENERAL. (a) The commissioner shall establish a value-based nursing facility reimbursement system which will provide facility-specific, prospective rates for nursing facilities participating in the medical assistance program. The rates shall be determined using an annual statistical and cost report filed by each nursing facility. The total payment rate shall be composed of four rate components: direct care services, support services, external fixed, and property-related rate components. The payment rate shall be derived from statistical measures of actual costs incurred in facility operation of nursing facilities. From this cost basis, the components of the total payment rate shall be adjusted for quality of services provided, recognition of staffing levels, geographic variation in labor costs, and resident acuity.

(b) Rates shall be rebased annually. Each cost reporting year shall begin on October 1 and end on the following September 30. Beginning in 2006, a statistical and cost report shall be filed by each nursing facility by January 15. Notice of rates shall be distributed by August 15 and the rates shall go into effect on October 1 for one year.

(c) The commissioner shall begin to phase in the new reimbursement system beginning October 1, 2007. Full phase-in shall be completed by October 1, 2011.

Subd. 2. DEFINITIONS. For purposes of this section, the terms in subdivisions 3 to 42 have the meanings given unless otherwise provided for in this section.

Subd. 3. ACTIVE BEDS. “Active beds” means licensed beds that are not currently in layaway status.

Subd. 4. ACTIVITIES COSTS. “Activities costs” means the costs for the salaries and wages of the supervisor and other activities workers, associated fringe benefits and payroll taxes, supplies, services, and consultants.

Subd. 5. ADMINISTRATIVE COSTS. “Administrative costs” means the direct costs for administering the overall activities of the nursing home. These costs include

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salaries and wages of the administrator, assistant administrator, business office employees, security guards, and associated fringe benefits and payroll taxes, fees, contracts, or purchases related to business office functions, licenses, and permits except as provided in the external fixed costs category, employee recognition, travel including meals and lodging, training, voice and data communication or transmission, office supplies, liability insurance and other forms of insurance not designated to other areas, personnel recruitment, legal services, accounting services, management or business consultants, data processing, central or home office costs, business meetings and seminars, postage, fees for professional organizations, subscriptions, security services, advertising, board of director's fees, working capital interest expense, and bad debts and bad debt collection fees.

Subd. 6. ALLOWED COSTS. "Allowed costs" means the amounts reported by the facility which are necessary for the operation of the facility and the care of residents and which are reviewed by the department for accuracy, reasonableness, and compliance with this section and generally accepted accounting principles.

Subd. 7. CENTER FOR MEDICARE AND MEDICAID SERVICES. "Center for Medicare and Medicaid services" means the federal agency, in the United States Department of Health and Human Services that administers Medicaid, also referred to as "CMS."

Subd. 8. COMMISSIONER. "Commissioner" means the commissioner of human services unless specified otherwise.

Subd. 9. DESK AUDIT. "Desk audit" means the establishment of the payment rate based on the commissioner's review and analysis of required reports, supporting documentation, and work sheets submitted by the nursing facility.

Subd. 10. DIETARY COSTS. "Dietary costs" means the costs for the salaries and wages of the dietary supervisor, dietitians, chefs, cooks, dishwashers, and other employees assigned to the kitchen and dining room, and associated fringe benefits and payroll taxes. Dietary costs also includes the salaries or fees of dietary consultants, direct costs of raw food (both normal and special diet food), dietary supplies, and food preparation and serving. Also included are special dietary supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet, even if written as a prescription item by a physician.

Subd. 11. DIRECT CARE COSTS CATEGORY. "Direct care costs category" means costs for nursing services, activities, and social services.

Subd. 12. ECONOMIC DEVELOPMENT REGIONS. "Economic development regions" are as defined in section 462.385, subdivision 1.

Subd. 13. EXTERNAL FIXED COSTS CATEGORY. "External fixed costs category" means costs related to the nursing home surcharge under section 256.9657, subdivision 1; licensure fees under section 144.122; long-term care consultation fees under section 256B.0911, subdivision 6; family advisory council fee under section 144A.35; scholarships under section 256B.431, subdivision 36; planned closure rate

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adjustments under section 256B.437; property taxes and property insurance; and PERA.

Subd. 14. FACILITY AVERAGE CASE MIX INDEX (CMI). “Facility average case mix index” or “CMI” means a numerical value score that describes the relative resource use for all residents within the groups under the resource utilization group (RUG-III) classification system prescribed by the commissioner based on an assessment of each resident. The facility average CMI shall be computed as the standardized days divided by total days for all residents in the facility.

Subd. 15. FIELD AUDIT. “Field audit” means the examination, verification, and review of the financial records, statistical records, and related supporting documentation on the nursing home and any related organization.

Subd. 16. FINAL RATE. “Final rate” means the rate established after any adjustment by the commissioner, including, but not limited to, adjustments resulting from audits.

Subd. 17. FRINGE BENEFIT COSTS. “Fringe benefit costs” means the costs for group life, health, dental, workers’ compensation, and other employee insurances and pension, profit-sharing, and retirement plans for which the employer pays all or a portion of the costs and that are available to at least all employees who work at least 20 hours per week.

Subd. 18. GENERALLY ACCEPTED ACCOUNTING PRINCIPLES. “Generally Accepted Accounting Principles” means the body of pronouncements adopted by the American Institute of Certified Public Accountants regarding proper accounting procedures, guidelines, and rules.

Subd. 19. HOSPITAL-ATTACHED NURSING FACILITY STATUS. (a) For the purpose of setting rates under this section, for rate years beginning after September 30, 2006, “hospital-attached nursing facility” means a nursing facility which meets the requirements of clauses (1) and (2); or (3); or (4), or had hospital-attached status prior to January 1, 1995, and has been recognized as having hospital-attached status by CMS continuously since that date:

(1) the nursing facility is recognized by the federal Medicare program to be a hospital-based nursing facility;

(2) the hospital and nursing facility are physically attached or connected by a corridor;

(3) a nursing facility and hospital, which have applied for hospital-based nursing facility status under the federal Medicare program during the reporting year, shall be considered a hospital-attached nursing facility for purposes of setting payment rates under this section. The nursing facility must file its cost report for that reporting year using Medicare principles and Medicare’s recommended cost allocation methods had the Medicare program’s hospital-based nursing facility status been granted to the nursing facility. For each subsequent rate year, the nursing facility must meet the

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definition requirements in clauses (1) and (2). If the nursing facility is denied hospital-based nursing facility status under the Medicare program, the nursing facility's payment rates for the rate years the nursing facility was considered to be a hospital-attached nursing facility according to this paragraph shall be recalculated treating the nursing facility as a non-hospital-attached nursing facility;

(4) if a nonprofit or community-operated hospital and attached nursing facility suspend operation of the hospital, the remaining nursing facility must be allowed to continue its status as hospital-attached for rate calculations in the three rate years subsequent to the one in which the hospital ceased operations.

(b) The nursing facility's cost report filed as hospital-attached facility shall use the same cost allocation principles and methods used in the reports filed for the Medicare program. Direct identification of costs to the nursing facility cost center will be permitted only when the comparable hospital costs have also been directly identified to a cost center which is not allocated to the nursing facility.

Subd. 20. HOUSEKEEPING COSTS. "Housekeeping costs" means the costs for the salaries and wages of the housekeeping supervisor, housekeepers, and other cleaning employees and associated fringe benefits and payroll taxes. It also includes the cost of housekeeping supplies, including cleaning and lavatory supplies and contract services.

Subd. 21. LABOR-RELATED PORTION. The "labor-related portion" of direct care costs and of support service costs shall be that portion of costs that is attributable to wages for all compensated hours, payroll taxes, and fringe benefits.

Subd. 22. LAUNDRY COSTS. "Laundry costs" means the costs for the salaries and wages of the laundry supervisor and other laundry employees, associated fringe benefits, and payroll taxes. It also includes the costs of linen and bedding, the laundering of resident clothing, laundry supplies, and contract services.

Subd. 23. LICENSEE. "Licensee" means the individual or organization listed on the form issued by the Minnesota Department of Health under chapter 144A or sections 144.50 to 144.56.

Subd. 24. MAINTENANCE AND PLANT OPERATIONS COSTS. "Maintenance and plant operations costs" means the costs for the salaries and wages of the maintenance supervisor, engineers, heating-plant employees, and other maintenance employees and associated fringe benefits and payroll taxes. It also includes direct costs for maintenance and operation of the building and grounds, including fuel, electricity, medical waste and garbage removal, water, sewer, supplies, tools, and repairs.

Subd. 25. NORMALIZED DIRECT CARE COSTS PER DAY. "Normalized direct care costs per day" means direct care costs divided by standardized days. It is the costs per day for direct care services associated with a RUG's index of 1.00.

Subd. 26. NURSING COSTS. "Nursing costs" means the costs for the wages of nursing administration, staff education, and direct care registered nurses, licensed

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practical nurses, certified nursing assistants, and trained medication aides; mental health workers and other direct care employees, and associated fringe benefits and payroll taxes; services from a supplemental nursing services agency and supplies that are stocked at nursing stations or on the floor and distributed or used individually, including: alcohol, applicators, cotton balls, incontinence pads, disposable ice bags, dressings, bandages, water pitchers, tongue depressors, disposable gloves, enemas, enema equipment, soap, medication cups, diapers, plastic waste bags, sanitary products, thermometers, hypodermic needles and syringes, and clinical reagents or similar diagnostic agents, and drugs which are not paid on a separate fee schedule by the medical assistance program or any other payer.

Subd. 27. **NURSING FACILITY.** “Nursing facility” means a facility with a medical assistance provider agreement that is licensed as a nursing home under chapter 144A or as a boarding care home under sections 144.50 to 144.56.

Subd. 28. **OPERATING COSTS.** “Operating costs” means costs associated with the direct care costs category and the support services costs category.

Subd. 29. **PAYROLL TAXES.** “Payroll taxes” means the costs for the employer’s share of the FICA and Medicare withholding tax, and state and federal unemployment compensation taxes.

Subd. 30. **PEER GROUPS.** Facilities shall be classified into three groups, called “peer groups,” which shall consist of:

(1) C&NC/Short Stay/R80 - facilities that have three or more admissions per bed per year, are hospital-attached, or are licensed under Minnesota Rules, parts 9570.2000 to 9570.3600;

(2) boarding care homes - facilities that have more than 50 percent of their beds licensed as boarding care homes; and

(3) standard - all other facilities.

Subd. 31. **PRIOR RATE-SETTING METHOD.** “Prior rate-setting method” means the rate determination process in effect prior to October 1, 2006, under Minnesota Rules and Minnesota Statutes.

Subd. 32. **PRIVATE PAYING RESIDENT.** “Private paying resident” means a nursing facility resident who is not a medical assistance recipient and whose payment rate is not established by another third party, including the veterans administration or Medicare.

Subd. 33. **RATE YEAR.** “Rate year” means the 12-month period beginning on October 1 following the second most recent reporting year.

Subd. 34. **RELATED ORGANIZATION.** “Related organization” means a person that furnishes goods or services to a nursing facility and that is a close relative of a nursing facility, an affiliate of a nursing facility, a close relative of an affiliate of a nursing facility, or an affiliate of a close relative of an affiliate of a nursing facility.

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As used in this subdivision, paragraphs (a) to (d) apply:

(a) "Affiliate" means a person that directly, or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with another person.

(b) "Person" means an individual, a corporation, a partnership, an association, a trust, an unincorporated organization, or a government or political subdivision.

(c) "Close relative of an affiliate of a nursing facility" means an individual whose relationship by blood, marriage, or adoption to an individual who is an affiliate of a nursing facility is no more remote than first cousin.

(d) "Control" including the terms "controlling," "controlled by," and "under common control with" means the possession, direct or indirect, of the power to direct or cause the direction of the management, operations, or policies of a person, whether through the ownership of voting securities, by contract, or otherwise, or to influence in any manner other than through an arms length, legal transaction.

Subd. 35. REPORTING PERIOD. "Reporting period" means the one-year period beginning on October 1 and ending on the following September 30 during which incurred costs are accumulated and then reported on the statistical and cost report.

Subd. 36. RESIDENT DAY OR ACTUAL RESIDENT DAY. "Resident day" or "actual resident day" means a day for which nursing services are rendered and billable, or a day for which a bed is held and billed. The day of admission is considered a resident day, regardless of the time of admission. The day of discharge is not considered a resident day, regardless of the time of discharge.

Subd. 37. SALARIES AND WAGES. "Salaries and wages" means amounts earned by and paid to employees or on behalf of employees to compensate for necessary services provided. Salaries and wages include accrued vested vacation and accrued vested sick leave pay. Salaries and wages must be paid within 30 days of the end of the reporting period in order to be allowable costs of the reporting period.

Subd. 38. SOCIAL SERVICES COSTS. "Social services costs" means the costs for the salaries and wages of the supervisor and other social work employees, associated fringe benefits and payroll taxes, supplies, services, and consultants.

Subd. 39. STAKEHOLDERS. "Stakeholders" means individuals and representatives of organizations interested in long-term care, including nursing homes, consumers, and labor unions.

Subd. 40. STANDARDIZED DAYS. "Standardized days" means the sum of resident days by case mix category multiplied by the RUG index for each category.

Subd. 41. STATISTICAL AND COST REPORT. "Statistical and cost report" means the forms supplied by the commissioner for annual reporting of nursing facility expenses and statistics, including instructions and definitions of items in the report.

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Subd. 42. SUPPORT SERVICES COSTS CATEGORY. “Support services costs category” means the costs for dietary, housekeeping, laundry, maintenance, and administration.

Subd. 43. REPORTING OF STATISTICAL AND COST INFORMATION.
(a) Beginning in 2006, all nursing facilities shall provide information annually to the commissioner on a form and in a manner determined by the commissioner. The commissioner may also require nursing facilities to provide statistical and cost information for a subset of the items in the annual report on a semiannual basis. Nursing facilities shall report only costs directly related to the operation of the nursing facility. The facility shall not include costs which are separately reimbursed by residents, medical assistance, or other payors. Allocations of costs from central, affiliated, or corporate office and related organization transactions shall be reported according to section 256B.432. The commissioner may grant to facilities one extension of up to 15 days for the filing of this report if the extension is requested by December 15 and the commissioner determines that the extension will not prevent the commissioner from establishing rates in a timely manner required by law. The commissioner may separately require facilities to submit in a manner specified by the commissioner documentation of statistical and cost information included in the report to ensure accuracy in establishing payment rates and to perform audit and appeal review functions under this section. Facilities shall retain all records necessary to document statistical and cost information on the report for a period of no less than seven years. The commissioner may amend information in the report according to subdivision 47. The commissioner may reject a report filed by a nursing facility under this section if the commissioner determines that the report has been filed in a form that is incomplete or inaccurate and the information is insufficient to establish accurate payment rates. In the event that a complete report is not submitted in a timely manner, the commissioner shall reduce the reimbursement payments to a nursing facility to 85 percent of amounts due until the information is filed. The release of withheld payments shall be retroactive for no more than 90 days. A nursing facility that does not submit a report or whose report is filed in a timely manner but determined to be incomplete shall be given written notice that a payment reduction is to be implemented and allowed ten days to complete the report prior to any payment reduction. The commissioner may delay the payment withhold under exceptional circumstances to be determined at the sole discretion of the commissioner.

(b) Nursing facilities may, within 12 months of the due date of a statistical and cost report, file an amendment when errors or omissions in the annual statistical and cost report are discovered and an amendment would result in a rate increase of at least 0.15 percent of the statewide weighted average operating payment rate and shall, at any time, file an amendment which would result in a rate reduction of at least 0.15 percent of the statewide weighted average operating payment rate. The commissioner shall make retroactive adjustments to the total payment rate of a nursing facility if an amendment is accepted. Where a retroactive adjustment is to be made as a result of an amended report, audit findings, or other determination of an incorrect payment rate, the commissioner may settle the payment error through a negotiated agreement with the

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facility and a gross adjustment of the payments to the facility. Retroactive adjustments shall not be applied to private pay residents. An error or omission for purposes of this item does not include a nursing facility's determination that an election between permissible alternatives was not advantageous and should be changed.

(c) If the commissioner determines that a nursing facility knowingly supplied inaccurate or false information or failed to file an amendment to a statistical and cost report that resulted in or would result in an overpayment, the commissioner shall immediately adjust the nursing facility's payment rate and recover the entire overpayment. The commissioner may also terminate the commissioner's agreement with the nursing facility and prosecute under applicable state or federal law.

Subd. 44. CALCULATION OF A QUALITY SCORE. (a) The commissioner shall determine a quality score for each nursing facility using quality measures established in section 256B.439, according to methods determined by the commissioner in consultation with stakeholders and experts. These methods shall be exempt from the rulemaking requirements under chapter 14.

(b) For each quality measure, a score shall be determined with a maximum number of points available and number of points assigned as determined by the commissioner using the methodology established according to this subdivision. The scores determined for all quality measures shall be totaled. The determination of the quality measures to be used and the methods of calculating scores may be revised annually by the commissioner.

(c) For the initial rate year under the new payment system, the quality measures shall include:

- (1) staff turnover;
- (2) staff retention;
- (3) use of pool staff;
- (4) quality indicators from the minimum data set; and
- (5) survey deficiencies.

(d) For rate years beginning after October 1, 2006, when making revisions to the quality measures or method for calculating scores, the commissioner shall publish the methodology in the State Register at least 15 months prior to the start of the rate year for which the revised methodology is to be used for rate-setting purposes. The quality score used to determine payment rates shall be established for a rate year using data submitted in the statistical and cost report from the associated reporting year, and using data from other sources related to a period beginning no more than six months prior to the associated reporting year.

Subd. 45. CALCULATION OF OPERATING PAYMENT RATE FOR DIRECT CARE AND SUPPORT SERVICES. The commissioner shall provide recommendations to the legislature by February 15, 2006, on specific methodology for

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the establishment of the operating payment rate for direct care and support services under the new system. The recommendations must not increase expenditures for the new payment system beyond the limits of the appropriation. The commissioner shall include recommendations on options for recognizing changes in staffing and services that may require a supplemental appropriation in the future.

Subd. 46. CALCULATION OF QUALITY ADD-ON. The payment rate for the quality add-on shall be a variable amount based on each facility's quality score.

(a) For the rate year beginning October 1, 2006, the maximum quality add-on percent shall be 2.4 percent and this add-on shall not be subject to a phase-in. The determination of the quality score to be used in calculating the quality add-on for October 1, 2006, shall be based on a report which must be filed with the commissioner, according to the requirements in subdivision 43, for a six-month period ending January 31, 2006. This report shall be filed with the commissioner by February 28, 2006. The commissioner shall prorate the six months of data to a full year. When new quality measures are incorporated into the quality score methodology and when existing quality measures are updated or improved, the commissioner may increase the maximum quality add-on percent.

(b) For each facility, determine the operating payment rate.

(c) For each facility determine a ratio of the quality score of the facility determined in subdivision 44, less 40 and then divided by 60. If this value is less than zero, use the value zero.

(d) For each facility, the quality add-on shall be the value determined in paragraph (b) times the value determined in paragraph (c) times the maximum quality add-on percent.

Subd. 47. AUDIT AUTHORITY. (a) The commissioner may subject reports and supporting documentation to desk and field audits to determine compliance with this section. Retroactive adjustments shall be made as a result of desk or field audit findings if the cumulative impact of the finding would result in a rate adjustment of at least 0.15 percent of the statewide weighted average operating payment rate. If a field audit reveals inadequacies in a nursing facility's record keeping or accounting practices, the commissioner may require the nursing facility to engage competent professional assistance to correct those inadequacies within 90 days so that the field audit may proceed.

(b) Field audits may cover the four most recent annual statistical and cost reports for which desk audits have been completed and payment rates have been established. The field audit must be an independent review of the nursing facility's statistical and cost report. All transactions, invoices, or other documentation that support or relate to the statistics and costs claimed on the annual statistical and cost reports are subject to review by the field auditor. If the provider fails to provide the field auditor access to supporting documentation related to the information reported on the statistical and cost report within the time period specified by the commissioner, the commissioner shall

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calculate the total payment rate by disallowing the cost of the items for which access to the supporting documentation is not provided.

(c) Changes in the total payment rate which result from desk or field audit adjustments to statistical and cost reports for reporting years earlier than the four most recent annual cost reports must be made to the four most recent annual statistical and cost reports, the current statistical and cost report, and future statistical and cost reports to the extent that those adjustments affect the total payment rate established by those reporting years.

(d) The commissioner shall extend the period for retention of records under subdivision 43 for purposes of performing field audits as necessary to enforce section 256B.48 with written notice to the facility postmarked no later than 90 days prior to the expiration of the record retention requirement.

Sec. 44. Minnesota Statutes 2004, section 256B.49, subdivision 16, is amended to read:

Subd. 16. **SERVICES AND SUPPORTS.** (a) Services and supports included in the home and community-based waivers for persons with disabilities shall meet the requirements set out in United States Code, title 42, section 1396n. The services and supports, which are offered as alternatives to institutional care, shall promote consumer choice, community inclusion, self-sufficiency, and self-determination.

(b) Beginning January 1, 2003, the commissioner shall simplify and improve access to home and community-based waived services, to the extent possible, through the establishment of a common service menu that is available to eligible recipients regardless of age, disability type, or waiver program.

(c) Consumer directed community support services shall be offered as an option to all persons eligible for services under subdivision 11, by January 1, 2002.

(d) Services and supports shall be arranged and provided consistent with individualized written plans of care for eligible waiver recipients.

(e) A transitional supports allowance shall be available to all persons under a home and community-based waiver who are moving from a licensed setting to a community setting. "Transitional supports allowance" means a onetime payment of up to \$3,000, to cover the costs, not covered by other sources, associated with moving from a licensed setting to a community setting. Covered costs include:

(1) lease or rent deposits;

(2) security deposits;

(3) utilities set-up costs, including telephone;

(4) essential furnishings and supplies; and

(5) personal supports and transports needed to locate and transition to community settings.

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(f) The state of Minnesota and county agencies that administer home and community-based waived services for persons with disabilities, shall not be liable for damages, injuries, or liabilities sustained through the purchase of supports by the individual, the individual's family, legal representative, or the authorized representative with funds received through the consumer-directed community support service under this section. Liabilities include but are not limited to: workers' compensation liability, the Federal Insurance Contributions Act (FICA), or the Federal Unemployment Tax Act (FUTA).

EFFECTIVE DATE. This section is effective upon federal approval and to the extent approved as a federal waiver amendment.

Sec. 45. Minnesota Statutes 2004, section 256B.5012, is amended by adding a subdivision to read:

Subd. 6. ICF/MR RATE INCREASES BEGINNING OCTOBER 1, 2005, AND OCTOBER 1, 2006. (a) For the rate periods beginning October 1, 2005, and October 1, 2006, the commissioner shall make available to each facility reimbursed under this section an adjustment to the total operating payment rate of 2.2553 percent.

(b) 75 percent of the money resulting from the rate adjustment under paragraph (a) must be used to increase wages and benefits and pay associated costs for all employees, except for administrative and central office employees. 75 percent of the money received by a facility as a result of the rate adjustment provided in paragraph (a) must be used only for wage, benefit, and staff increases implemented on or after the effective date of the rate increase each year, and must not be used for increases implemented prior to that date.

(c) For each facility, the commissioner shall make available an adjustment using the percentage specified in paragraph (a) multiplied by the total payment rate, excluding the property-related payment rate, in effect on the preceding day. The total payment rate shall include the adjustment provided in section 256B.501, subdivision 12.

(d) A facility whose payment rates are governed by closure agreements, receivership agreements, or Minnesota Rules, part 9553.0075, is not eligible for an adjustment otherwise granted under this subdivision.

(e) A facility may apply for the portion of the payment rate adjustment provided under paragraph (a) for employee wages and benefits and associated costs. The application must be made to the commissioner and contain a plan by which the facility will distribute the funds according to paragraph (b). For facilities in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative constitutes the plan. A negotiated agreement may constitute the plan only if the agreement is finalized after the date of enactment of all rate increases for the rate year. The commissioner shall review the plan to ensure that the payment rate adjustment per diem is used as provided in this subdivision. To be eligible, a facility must submit its

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plan by March 31, 2006, and December 31, 2006, respectively. If a facility's plan is effective for its employees after the first day of the applicable rate period that the funds are available, the payment rate adjustment per diem is effective the same date as its plan.

(f) A copy of the approved distribution plan must be made available to all employees by giving each employee a copy or by posting it in an area of the facility to which all employees have access. If an employee does not receive the wage and benefit adjustment described in the facility's approved plan and is unable to resolve the problem with the facility's management or through the employee's union representative, the employee may contact the commissioner at an address or telephone number provided by the commissioner and included in the approved plan.

Sec. 46. Minnesota Statutes 2004, section 256B.69, subdivision 23, is amended to read:

Subd. 23. ALTERNATIVE INTEGRATED LONG-TERM CARE SERVICES; ELDERLY AND DISABLED PERSONS. (a) The commissioner may implement demonstration projects to create alternative integrated delivery systems for acute and long-term care services to elderly persons and persons with disabilities as defined in section 256B.77, subdivision 7a, that provide increased coordination, improve access to quality services, and mitigate future cost increases. The commissioner may seek federal authority to combine Medicare and Medicaid capitation payments for the purpose of such demonstrations. Medicare funds and services shall be administered according to the terms and conditions of the federal waiver and demonstration provisions. For the purpose of administering medical assistance funds, demonstrations under this subdivision are subject to subdivisions 1 to 22. The provisions of Minnesota Rules, parts 9500.1450 to 9500.1464, apply to these demonstrations, with the exceptions of parts 9500.1452, subpart 2, item B; and 9500.1457, subpart 1, items B and C, which do not apply to persons enrolling in demonstrations under this section. An initial open enrollment period may be provided. Persons who disenroll from demonstrations under this subdivision remain subject to Minnesota Rules, parts 9500.1450 to 9500.1464. When a person is enrolled in a health plan under these demonstrations and the health plan's participation is subsequently terminated for any reason, the person shall be provided an opportunity to select a new health plan and shall have the right to change health plans within the first 60 days of enrollment in the second health plan. Persons required to participate in health plans under this section who fail to make a choice of health plan shall not be randomly assigned to health plans under these demonstrations. Notwithstanding section 256L.12, subdivision 5, and Minnesota Rules, part 9505.5220, subpart 1, item A, if adopted, for the purpose of demonstrations under this subdivision, the commissioner may contract with managed care organizations, including counties, to serve only elderly persons eligible for medical assistance, elderly and disabled persons, or disabled persons only. For persons with primary diagnoses of mental retardation or a related condition, serious and persistent mental illness, or serious emotional disturbance, the commissioner must ensure that the county authority has approved the demonstration and

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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 primary diagnoses of mental retardation or a related condition, 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 mental retardation or related conditions, 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 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 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

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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.

(g) Notwithstanding section 256B.0261, health plans providing services under this section are responsible for home care targeted case management and relocation targeted case management. Services must be provided according to the terms of the waivers and contracts approved by the federal government.

Sec. 47. [256B.762] REIMBURSEMENT FOR HEALTH CARE SERVICES.

Effective for services provided on or after October 1, 2005, payment rates for the following services shall be increased by five percent over the rates in effect on September 30, 2005, when these services are provided as home health services under section 256B.0625, subdivision 6a:

- (1) skilled nursing visit;
- (2) physical therapy visit;
- (3) occupational therapy visit;
- (4) speech therapy visit; and
- (5) home health aide visit.

Sec. 48. Minnesota Statutes 2004, section 256I.06, is amended by adding a subdivision to read:

Subd. 9. **COMMUNITY LIVING ADJUSTMENT.** Effective August 1, 2005, persons eligible for and residing in group residential housing under section 256I.04 shall receive a group residential housing community living adjustment of \$12 per month.

Sec. 49. Minnesota Statutes 2004, section 514.981, subdivision 6, is amended to read:

Subd. 6. TIME LIMITS; CLAIM LIMITS; LIENS ON LIFE ESTATES AND JOINT TENANCIES. (a) A medical assistance lien is a lien on the real property it describes for a period of ten years from the date it attaches according to section 514.981, subdivision 2, paragraph (a), except as otherwise provided for in sections 514.980 to 514.985. The agency may renew a medical assistance lien for an additional ten years from the date it would otherwise expire by recording or filing a certificate of renewal before the lien expires. The certificate shall be recorded or filed in the office of the county recorder or registrar of titles for the county in which the lien is recorded or filed. The certificate must refer to the recording or filing data for the medical assistance lien it renews. The certificate need not be attested, certified, or acknowledged as a condition for recording or filing. The registrar of titles or the recorder shall file, record, index, and return the certificate of renewal in the same manner as provided for medical assistance liens in section 514.982, subdivision 2.

(b) A medical assistance lien is not enforceable against the real property of an estate to the extent there is a determination by a court of competent jurisdiction, or by an officer of the court designated for that purpose, that there are insufficient assets in the estate to satisfy the agency's medical assistance lien in whole or in part because of the homestead exemption under section 256B.15, subdivision 4, the rights of the surviving spouse or minor children under section 524.2-403, paragraphs (a) and (b), or claims with a priority under section 524.3-805, paragraph (a), clauses (1) to (4). For purposes of this section, the rights of the decedent's adult children to exempt property under section 524.2-403, paragraph (b), shall not be considered costs of administration under section 524.3-805, paragraph (a), clause (1).

(c) Notwithstanding any law or rule to the contrary, the provisions in clauses (1) to (7) apply if a life estate subject to a medical assistance lien ends according to its terms, or if a medical assistance recipient who owns a life estate or any interest in real property as a joint tenant that is subject to a medical assistance lien dies.

(1) The medical assistance recipient's life estate or joint tenancy interest in the real property shall not end upon the recipient's death but shall merge into the remainder interest or other interest in real property the medical assistance recipient owned in joint tenancy with others. The medical assistance lien shall attach to and run with the remainder or other interest in the real property to the extent of the medical assistance recipient's interest in the property at the time of the recipient's death as determined under this section.

(2) If the medical assistance recipient's interest was a life estate in real property, the lien shall be a lien against the portion of the remainder equal to the percentage factor for the life estate of a person the medical assistance recipient's age on the date the life estate ended according to its terms or the date of the medical assistance recipient's death as listed in the Life Estate Mortality Table in the health care program's manual.

(3) If the medical assistance recipient owned the interest in real property in joint tenancy with others, the lien shall be a lien against the portion of that interest equal to

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the fractional interest the medical assistance recipient would have owned in the jointly owned interest had the medical assistance recipient and the other owners held title to that interest as tenants in common on the date the medical assistance recipient died.

(4) The medical assistance lien shall remain a lien against the remainder or other jointly owned interest for the length of time and be renewable as provided in paragraph (a).

(5) Subdivision 5, paragraph (a), clause (4), paragraph (b), clauses (1) and (2); and subdivision 6, paragraph (b), do not apply to medical assistance liens which attach to interests in real property as provided under this subdivision.

(6) The continuation of a medical assistance recipient's life estate or joint tenancy interest in real property after the medical assistance recipient's death for the purpose of recovering medical assistance provided for in sections 514.980 to 514.985 modifies common law principles holding that these interests terminate on the death of the holder.

(7) Notwithstanding any law or rule to the contrary, no release, satisfaction, discharge, or affidavit under section 256B.15 shall extinguish or terminate the life estate or joint tenancy interest of a medical assistance recipient subject to a lien under sections 514.980 to 514.985 on the date the recipient dies.

(8) The provisions of clauses (1) to (7) do not apply to a homestead owned of record, on the date the recipient dies, by the recipient and the recipient's spouse as joint tenants with a right of survivorship. Homestead means the real property occupied by the surviving joint tenant spouse as their sole residence on the date the recipient dies and classified and taxed to the recipient and surviving joint tenant spouse as homestead property for property tax purposes in the calendar year in which the recipient dies. For purposes of this exemption, real property the recipient and their surviving joint tenant spouse purchase solely with the proceeds from the sale of their prior homestead, own of record as joint tenants, and qualify as homestead property under section 273.124 in the calendar year in which the recipient dies and prior to the recipient's death shall be deemed to be real property classified and taxed to the recipient and their surviving joint tenant spouse as homestead property in the calendar year in which the recipient dies. The surviving spouse, or any person with personal knowledge of the facts, may provide an affidavit describing the homestead property affected by this clause and stating facts showing compliance with this clause. The affidavit shall be prima facie evidence of the facts it states. All provisions in this paragraph related to the continuation of a recipient's life estate or joint tenancy interests in real property after the recipient's death, for the purpose of recovering medical assistance but not alternative care, are effective only for life estates and joint tenancy interests established on or after August 1, 2003.

EFFECTIVE DATE. This section is effective retroactively from August 1, 2003.

Sec. 50. CONSUMER-DIRECTED COMMUNITY SUPPORTS METHOD- OLOGY.

(a) Effective upon federal approval, for persons using the home and community-based waiver for persons with developmental disabilities whose consumer-directed

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community supports budgets were reduced by the October 2004, state-set budget methodology, the commissioner of human services must allow exceptions to exceed the state-set budget formula up to the daily average cost during calendar year 2004 or for persons who graduated from school during 2004, the average daily cost during July through December 2004, less one-half of case management and home modifications over \$5,000 when the individual's county of financial responsibility determines that:

(1) necessary alternative services will cost the same or more than the person's current budget; and

(2) administrative expenses or provider rates will result in fewer hours of needed staffing for the person than under the consumer-directed community supports option. Any exceptions the county grants must be within the county's allowable aggregate amount for the home and community-based waiver for persons with developmental disabilities.

(b) This section expires on the date the commissioner of human services implements a new consumer-directed community supports budget methodology that is based on information about the services and supports intensity needs of persons using the option and that adequately accounts for the increased costs of adults who graduate from school and need services funded by the waiver during the day.

Sec. 51. COSTS ASSOCIATED WITH PHYSICAL ACTIVITIES.

Effective upon federal approval, the expenses allowed for adults under the consumer-directed community supports option shall include the costs at the lowest rate available considering daily, monthly, semi-annual, annual, or membership rates, including transportation, associated with physical exercise or other physical activities to maintain or improve the person's health and functioning.

Sec. 52. WAIVER AMENDMENT.

The commissioner of human services shall submit an amendment to the Centers for Medicare and Medicaid Services consistent with sections 50 and 51 by October 1, 2005.

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

Sec. 53. INDEPENDENT EVALUATION AND REVIEW OF UNALLOWABLE ITEMS.

The commissioner of human services shall include in the independent evaluation of the consumer-directed community supports option provided through the home and community-based services waivers for persons with disabilities under 65 years of age:

(1) provision for ongoing, regular participation by stakeholder representatives through June 30, 2007;

(2) recommendations on whether changes to the unallowable items should be made to meet the health, safety, or welfare needs of participants in the consumer-directed community supports option within the allowed budget amounts. The recom-

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mendations on allowable items shall be provided to the senate and house of representatives committees with jurisdiction over human services policy and finance issues by January 15, 2006; and

(3) a review of the statewide caseload changes for the disability waiver programs for persons under 65 years of age that occurred since the state-set budget methodology implementation on October 1, 2004, and recommendations on the fiscal impact of the budget methodology on use of the consumer-directed community supports option.

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

Sec. 54. FEDERAL APPROVAL.

By October 1, 2005, the commissioner of human services shall request any federal approval and plan amendments necessary to implement (1) the transitional supports allowance under Minnesota Statutes, sections 256B.0916, subdivision 10, and 256B.49, subdivision 16; and (2) the choice of case management service coordination provisions under Minnesota Statutes, section 256B.0621, subdivisions 4, 5, 6, and 7.

Sec. 55. COMMUNITY SERVICES PROVIDER RATE INCREASES.

(a) The commissioner of human services shall increase reimbursement rates or rate limits, as applicable, by 2.2553 percent for the rate period beginning October 1, 2005, and the rate period beginning October 1, 2006, effective for services rendered on or after those dates.

(b) The 2.2553 percent annual rate increase described in this section must be provided to:

(1) home and community-based waived services for persons with mental retardation or related conditions under Minnesota Statutes, section 256B.501;

(2) home and community-based waived services for the elderly under Minnesota Statutes, section 256B.0915;

(3) waived services under community alternatives for disabled individuals under Minnesota Statutes, section 256B.49;

(4) community alternative care waived services under Minnesota Statutes, section 256B.49;

(5) traumatic brain injury waived services under Minnesota Statutes, section 256B.49;

(6) nursing services and home health services under Minnesota Statutes, section 256B.0625, subdivision 6a;

(7) personal care services and nursing supervision of personal care services under Minnesota Statutes, section 256B.0625, subdivision 19a;

(8) private duty nursing services under Minnesota Statutes, section 256B.0625, subdivision 7;

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(9) day training and habilitation services for adults with mental retardation or related conditions under Minnesota Statutes, sections 252.40 to 252.46;

(10) alternative care services under Minnesota Statutes, section 256B.0913;

(11) adult residential program grants under Minnesota Rules, parts 9535.2000 to 9535.3000;

(12) adult and family community support grants under Minnesota Rules, parts 9535.1700 to 9535.1760;

(13) the group residential housing supplementary service rate under Minnesota Statutes, section 256L.05, subdivision 1a;

(14) adult mental health integrated fund grants under Minnesota Statutes, section 245.4661;

(15) semi-independent living services under Minnesota Statutes, section 252.275, including SILS funding under county social services grants formerly funded under Minnesota Statutes, chapter 256I;

(16) community support services for deaf and hard-of-hearing adults with mental illness who use or wish to use sign language as their primary means of communication;

(17) living skills training programs for persons with intractable epilepsy who need assistance in the transition to independent living;

(18) physical therapy services under sections 256B.0625, subdivision 8, and 256D.03, subdivision 4;

(19) occupational therapy services under sections 256B.0625, subdivision 8a, and 256D.03, subdivision 4;

(20) speech-language therapy services under section 256D.03, subdivision 4, and Minnesota Rules, part 9505.0390; and

(21) respiratory therapy services under section 256D.03, subdivision 4, and Minnesota Rules, part 9505.0295.

(c) Providers that receive a rate increase under this section shall use 75 percent of the additional revenue to increase wages and benefits and pay associated costs for all employees, except for management fees, the administrator, and central office staffs.

(d) For public employees, the increase for wages and benefits for certain staff is available and pay rates shall be increased only to the extent that they comply with laws governing public employees collective bargaining. Money received by a provider for pay increases under this section may be used only for increases implemented on or after the first day of the rate period in which the increase is available and must not be used for increases implemented prior to that date.

(e) A copy of the provider's plan for complying with paragraph (c) must be made available to all employees by giving each employee a copy or by posting a copy in an

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area of the provider's operation to which all employees have access. If an employee does not receive the adjustment, if any, described in the plan and is unable to resolve the problem with the provider, the employee may contact the employee's union representative. If the employee is not covered by a collective bargaining agreement, the employee may contact the commissioner at a telephone number provided by the commissioner and included in the provider's plan.

Sec. 56. COMMISSIONER'S DUTIES RELATED TO CHANGE IN EFFECTIVE DATE FOR LIFE ESTATE AND JOINT TENANCY INTEREST PROVISIONS.

(a) The commissioner of human services or a county agency that has recovered medical assistance or alternative care payments for recipients after they die from their life estates or jointly owned interests in real property that were established prior to August 1, 2003, and that were continued in existence or merged into another interest in real property after their death due solely to the provisions of section 256B.15 or 514.981, subdivision 6, paragraph (c), as those provisions existed prior to the amendments in this act, shall refund those recoveries, without interest. The refunds shall be paid to the surviving record owners of the real property in which the recipient had a life estate or a jointly owned interest on the date of the recipient's death in proportion to their record interests on that date. The commissioner and a county agency are not required to refund any other recoveries attributable to any other interests or assets of the deceased recipient. For purposes of this paragraph, a life estate or jointly owned interest in real property is established as of the date provided for in Minnesota Statutes, section 256B.15, subdivision 6.

(b) If the commissioner of human services or a county agency determines a person entitled to any refund under this act is dead, they may pay the refund due that person to their estate if it is still open. If the person's estate is closed or if a court has entered a decree of distribution for that person under section 525.312 that is a final decree, the commissioner or the county agency may, in their absolute discretion, pay the person's refund to their heirs or devisees as finally determined in any completed probate or under any final decree of distribution. In all other cases including, but not limited to, those in which the commissioner or a county agency determines they cannot identify or locate a person entitled to a refund under this section, they may, at their discretion, declare such person's refund to be abandoned property and pay and deliver it to the commissioner of commerce. The commissioner of commerce shall administer and dispose of the refunds according to sections 345.31 to 345.60. Neither the commissioner of human services, the Department of Human Services, a county agency, or the employees of the department or agency, shall be liable to anyone with respect to the refund after paying or delivering the refund as provided for in this section.

EFFECTIVE DATE. This section is effective retroactively from August 1, 2003.

Sec. 57. DIRECTION TO THE COMMISSIONER; LICENSING AND ALTERNATIVE QUALITY ASSURANCE STUDY.

The commissioner of human services shall arrange for a study, including recommendations for statewide development and implementation of regional or local

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quality assurance models for disability services. The study shall include a review of current projects or models; make findings regarding the best components, role, and function of such models within a statewide quality assurance system; and shall estimate the cost and sources of funding for regional and local quality assurance models on a statewide basis. The study shall be done in consultation with counties, consumers of service, providers, and representatives of the Quality Assurance Commission under Minnesota Statutes, section 256B.0951, subdivision 1.

The study shall be submitted to the chairs of the legislative committees with jurisdiction over health and human services with recommendations on implementation of a statewide system of quality assurance and licensing by July 1, 2006. The commissioner shall submit proposed legislation for implementation of a statewide system of quality assurance to the chairs of the legislative committees with jurisdiction over health and human services by December 15, 2006.

Sec. 58. **DISABILITY SERVICES INTERAGENCY WORK GROUP.**

Subdivision 1. **MEMBERSHIP.** The Department of Human Services, the Minnesota Housing Finance Agency, and the Minnesota State Council on Disability shall convene an interagency work group which includes interested stakeholders including other state agencies, counties, public housing authorities, the Metropolitan Council, disability service providers, and representatives from disability advocacy organizations to identify barriers, strengthen coordination, recommend policy and funding changes, and pursue federal financing that will assist Minnesotans with disabilities who are attempting to relocate from or avoid placement in institutional settings.

Subd. 2. **WORK GROUP ACTIVITIES.** The work group shall make recommendations to the state agencies and the legislature related to:

(1) coordinating the availability of housing, transportation, and support services needed to discharge persons with disabilities from institutions;

(2) improving information and assistance needed to make an informed choice about relocating from an institutional placement to community-based services;

(3) identifying gaps in human services, transportation, or housing access which are barriers to moving to community services;

(4) identifying strategies which would result in earlier identification of persons most at risk of institutional placement in order to promote diversion to community service or reduce length of stay in an institutional facility;

(5) identifying funding mechanisms and financial strategies to assure a financially sustainable community support system that diverts and relocates individuals from institutional placement; and

(6) identifying state changes needed to address any federal changes affecting policies, benefits, or funding used to support persons with disabilities to avoid institutional placement.

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Subd. 3. RECOMMENDATIONS. Recommendations of the work group will be submitted to each participating state agency and to the chairs of the health and human services policy and finance committees of the senate and house of representatives by October 15, 2006. This section expires October 15, 2006.

Sec. 59. REPORT TO LEGISLATURE.

The commissioner shall report to the legislature by December 15, 2006, on the redesign of case management services. In preparing the report, the commissioner shall consult with representatives for consumers, consumer advocates, counties, and service providers. The report shall include draft legislation for case management changes that will:

- (1) streamline administration;
- (2) improve consumer access to case management services;
- (3) address the use of a comprehensive universal assessment protocol for persons seeking community supports;
- (4) establish case management performance measures;
- (5) provide for consumer choice of the case management service vendor; and
- (6) provide a method of payment for case management services that is cost-effective and best supports the draft legislation in clauses (1) to (5).

Sec. 60. RECOMMENDATIONS FOR PROPERTY PAYMENT SYSTEM FOR NURSING FACILITIES.

The commissioner of human services shall provide recommendations to the legislature by February 15, 2007, on changes to the current nursing facility property payment system.

Sec. 61. REPEALER.

Minnesota Statutes 2004, sections 514.991; 514.992; 514.993; 514.994; and 514.995, are repealed retroactively from July 1, 2005. On and after the repeal date all alternative care liens of record shall be of no force and effect, shall not be liens on real property, and examiners of title shall disregard these liens and shall not carry them forward to subsequent certificates of title.

Sec. 62. EFFECTIVE DATE.

The sections in this article are effective August 1, 2005, unless another date is specified.

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ARTICLE 8

HEALTH CARE - DEPARTMENT

OF HUMAN SERVICES

Section 1. Minnesota Statutes 2004, section 16A.724, is amended to read:

16A.724 **HEALTH CARE ACCESS FUND.**

Subdivision 1. **CREATION OF FUND.** A health care access fund is created in the state treasury. The fund is a direct appropriated special revenue fund. The commissioner shall deposit to the credit of the fund money made available to the fund. Notwithstanding section 11A.20, after June 30, 1997, all investment income and all investment losses attributable to the investment of the health care access fund not currently needed shall be credited to the health care access fund.

Subd. 2. **TRANSFERS.** (a) Notwithstanding section 295.581, to the extent available resources in the health care access fund exceed expenditures in that fund, effective with the biennium beginning July 1, 2007, the commissioner of finance shall transfer the excess funds from the health care access fund to the general fund on June 30 of each year, provided that the amount transferred in any fiscal biennium shall not exceed \$96,000,000.

(b) For fiscal years 2006 to 2009, MinnesotaCare shall be a forecasted program, and, if necessary, the commissioner shall reduce these transfers from the health care access fund to the general fund to meet annual MinnesotaCare expenditures or, if necessary, transfer sufficient funds from the general fund to the health care access fund to meet annual MinnesotaCare expenditures.

Sec. 2. **[62J.82] HOSPITAL CHARGE DISCLOSURE.**

The Minnesota Hospital Association shall develop a Web-based system, available to the public free of charge, for reporting charge information, for Minnesota residents, including, but not limited to, number of discharges, average length of stay, average charge, average charge per day, and median charge, for each of the 50 most common inpatient diagnosis-related groups and the 25 most common outpatient surgical procedures as specified by the Minnesota Hospital Association. The Web site must provide information that compares hospital-specific data to hospital statewide data. The Web site must be established by October 1, 2006, and must be updated annually. If a hospital does not provide this information to the Minnesota Hospital Association, the commissioner may require the hospital to do so. The commissioner shall provide a link to this information on the department's Web site.

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 3. Minnesota Statutes 2004, section 62Q.251, as added by Laws 2005, chapter 147, article 11, section 3, is amended to read:

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62Q.251 DISCOUNTED PAYMENTS.

(a) Notwithstanding any other provision of law, a health care provider may provide care to a patient at a discounted payment amount, ~~provided that the discount does not reduce the payment below the Medicare-approved payment level.~~

(b) A health plan company or other insurer must not consider, in determining a provider's usual and customary payment, standard payment, or allowable payment used as a basis for determining the provider's payment by the health plan company or other insurer, the following discounted payment situations:

- (1) care provided to relatives of the provider; and
- (2) care for which a discount is given for hardship situations; and
- (3) care for which a discount is given in exchange for cash payment.

(c) ~~This section does not disallow~~ Nothing in this section shall prohibit a provider from providing charity care for hardship situations in which the care is provided for free.

(d) ~~A provider may not charge an uninsured person more than the provider charges a health plan company or other insurer.~~

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 4. Minnesota Statutes 2004, section 62Q.37, subdivision 7, is amended to read:

Subd. 7. **HUMAN SERVICES.** (a) The commissioner of human services shall implement this section in a manner that is consistent with applicable federal laws and regulations and that avoids the duplication of review activities performed by a nationally recognized independent organization.

(b) By December 31 of each year, the commissioner shall submit to the legislature a written report identifying the number of audits performed by a nationally recognized independent organization that were accepted, partially accepted, or rejected by the commissioner under this section. The commissioner shall provide the rationale for partial acceptance or rejection. If the rationale for the partial acceptance or rejection was based on the commissioner's determination that the standards used in the audit were not equivalent to state law, regulation, or contract requirement, the report must document the variances between the audit standards and the applicable state requirements.

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 5. Minnesota Statutes 2004, section 256.01, subdivision 2, is amended to read:

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

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(a) Administer and supervise all forms of public assistance provided for by state law and other welfare activities or services as are vested in the commissioner. Administration and supervision of human services activities or services includes, but is not limited to, assuring timely and accurate distribution of benefits, completeness of service, and quality program management. In addition to administering and supervising human services activities vested by law in the department, the commissioner shall have the authority to:

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

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

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

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

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

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

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

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

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

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the field of child welfare now vested in the State Board of Control.

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

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

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

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

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

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

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

(k) Establish county, regional, or statewide schedules of maximum fees and charges which may be paid by county agencies for medical, dental, surgical, hospital,

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nursing and nursing home care and medicine and medical supplies under all programs of medical care provided by the state and for congregate living care under the income maintenance programs.

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

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

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

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

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

(1) one-half of the total amount of the disallowance shall be borne by the county boards responsible for administering the programs. For the medical assistance and the AFDC program formerly codified in sections 256.72 to 256.87, disallowances shall be shared by each county board in the same proportion as that county's expenditures for the sanctioned program are to the total of all counties' expenditures for the AFDC program formerly codified in sections 256.72 to 256.87, and medical assistance programs. For the 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 commis-

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

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

(3) if the required reports are not received by the deadlines established in clause (2), the commissioner may delay payments and withhold funds from the county board until the next reporting period. When the report is needed to account for the use of federal funds and the late report results in a reduction in federal funding, the

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commissioner shall withhold from the county boards with late reports an amount equal to the reduction in federal funding until full federal funding is received;

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

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

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

(7) counties subject to withholding of funds under clause (3) or forfeiture or 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

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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.

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(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) 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.

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

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 6. Minnesota Statutes 2004, section 256.01, is amended by adding a subdivision to read:

Subd. 2a. **AUTHORIZATION FOR TEST SITES FOR HEALTH CARE PROGRAMS.** In coordination with the development and implementation of Health-Match, an automated eligibility system for medical assistance, general assistance medical care, and MinnesotaCare, the commissioner, in cooperation with county agencies, is authorized to test and compare a variety of administrative models to demonstrate and evaluate outcomes of integrating health care program business processes and points of access. The models will be evaluated for ease of enrollment for health care program applicants and recipients and administrative efficiencies. Test sites will combine the administration of all three programs and will include both local county and centralized statewide customer assistance. The duration of each approved test site shall be no more than one year. Based on the evaluation, the commissioner shall recommend the most efficient and effective administrative model for statewide implementation.

EFFECTIVE DATE. This section is effective retroactively from July 1, 2005.

Sec. 7. Minnesota Statutes 2004, section 256.019, subdivision 1, is amended to read:

Subdivision 1. **RETENTION RATES.** When an assistance recovery amount is collected and posted by a county agency under the provisions governing public assistance programs including general assistance medical care, general assistance, and Minnesota supplemental aid, the county may keep one-half of the recovery made by the county agency using any method other than recoupment. For medical assistance, if the recovery is made by a county agency using any method other than recoupment, the county may keep one-half of the nonfederal share of the recovery. For MinnesotaCare, if the recovery is collected and posted by the county agency, the county may keep one-half of the nonfederal share of the recovery.

This does not apply to recoveries from medical providers or to recoveries begun by the Department of Human Services' Surveillance and Utilization Review Division, State Hospital Collections Unit, and the Benefit Recoveries Division or, by the attorney general's office, or child support collections. In the food stamp or food support program, the nonfederal share of recoveries in the federal tax offset program only will be divided equally between the state agency and the involved county agency.

EFFECTIVE DATE. This section is effective retroactively from July 1, 2005.

Sec. 8. Minnesota Statutes 2004, section 256.045, subdivision 3, as amended by Laws 2005, chapter 98, article 3, section 18, is amended to read:

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Subd. 3. **STATE AGENCY HEARINGS.** (a) State agency hearings are available for the following: (1) any person applying for, receiving or having received public assistance, medical care, or a program of social services granted by the state agency or a county agency or the federal Food Stamp Act whose application for assistance is denied, not acted upon with reasonable promptness, or whose assistance is suspended, reduced, terminated, or claimed to have been incorrectly paid; (2) any patient or relative aggrieved by an order of the commissioner under section 252.27; (3) a party aggrieved by a ruling of a prepaid health plan; (4) except as provided under chapter 245C, any individual or facility determined by a lead agency to have maltreated a vulnerable adult under section 626.557 after they have exercised their right to administrative reconsideration under section 626.557; (5) any person whose claim for foster care payment according to a placement of the child resulting from a child protection assessment under section 626.556 is denied or not acted upon with reasonable promptness, regardless of funding source; (6) any person to whom a right of appeal according to this section is given by other provision of law; (7) an applicant aggrieved by an adverse decision to an application for a hardship waiver under section 256B.15; (8) an applicant aggrieved by an adverse decision to an application or redetermination for a Medicare Part D prescription drug subsidy under section 256B.04, subdivision 4; (9) except as provided under chapter 245A, an individual or facility determined to have maltreated a minor under section 626.556, after the individual or facility has exercised the right to administrative reconsideration under section 626.556; or ~~(9)~~ (10) except as provided under chapter 245C, an individual disqualified under sections 245C.14 and 245C.15, on the basis of serious or recurring maltreatment; a preponderance of the evidence that the individual has committed an act or acts that meet the definition of any of the crimes listed in section 245C.15, subdivisions 1 to 4; or for failing to make reports required under section 626.556, subdivision 3, or 626.557, subdivision 3. Hearings regarding a maltreatment determination under clause (4) or ~~(8)~~ (9) and a disqualification under this clause in which the basis for a disqualification is serious or recurring maltreatment, which has not been set aside under sections 245C.22 and 245C.23, shall be consolidated into a single fair hearing. In such cases, the scope of review by the human services referee shall include both the maltreatment determination and the disqualification. The failure to exercise the right to an administrative reconsideration shall not be a bar to a hearing under this section if federal law provides an individual the right to a hearing to dispute a finding of maltreatment. Individuals and organizations specified in this section may contest the specified action, decision, or final disposition before the state agency by submitting a written request for a hearing to the state agency within 30 days after receiving written notice of the action, decision, or final disposition, or within 90 days of such written notice if the applicant, recipient, patient, or relative shows good cause why the request was not submitted within the 30-day time limit.

The hearing for an individual or facility under clause (4), ~~(8)~~ (9), or ~~(9)~~ (10) is the only administrative appeal to the final agency determination specifically, including a challenge to the accuracy and completeness of data under section 13.04. Hearings requested under clause (4) apply only to incidents of maltreatment that occur on or

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after October 1, 1995. Hearings requested by nursing assistants in nursing homes alleged to have maltreated a resident prior to October 1, 1995, shall be held as a contested case proceeding under the provisions of chapter 14. Hearings requested under clause (8) (9) apply only to incidents of maltreatment that occur on or after July 1, 1997. A hearing for an individual or facility under clause (8) (9) is only available when there is no juvenile court or adult criminal action pending. If such action is filed in either court while an administrative review is pending, the administrative review must be suspended until the judicial actions are completed. If the juvenile court action or criminal charge is dismissed or the criminal action overturned, the matter may be considered in an administrative hearing.

For purposes of this section, bargaining unit grievance procedures are not an administrative appeal.

The scope of hearings involving claims to foster care payments under clause (5) shall be limited to the issue of whether the county is legally responsible for a child's placement under court order or voluntary placement agreement and, if so, the correct amount of foster care payment to be made on the child's behalf and shall not include review of the propriety of the county's child protection determination or child placement decision.

(b) A vendor of medical care as defined in section 256B.02, subdivision 7, or a vendor under contract with a county agency to provide social services is not a party and may not request a hearing under this section, except if assisting a recipient as provided in subdivision 4.

(c) An applicant or recipient is not entitled to receive social services beyond the services prescribed under chapter 256M or other social services the person is eligible for under state law.

(d) The commissioner may summarily affirm the county or state agency's proposed action without a hearing when the sole issue is an automatic change due to a change in state or federal law.

EFFECTIVE DATE. This section is effective retroactively from July 1, 2005.

Sec. 9. Minnesota Statutes 2004, section 256.045, subdivision 3a, is amended to read:

Subd. 3a. **PREPAID HEALTH PLAN APPEALS.** (a) All prepaid health plans under contract to the commissioner under chapter 256B or 256D must provide for a complaint system according to section 62D.11. When a prepaid health plan denies, reduces, or terminates a health service or denies a request to authorize a previously authorized health service, the prepaid health plan must notify the recipient of the right to file a complaint or an appeal. The notice must include the name and telephone number of the ombudsman and notice of the recipient's right to request a hearing under paragraph (b). ~~When a complaint is filed, the prepaid health plan must notify the ombudsman within three working days.~~ Recipients may request the assistance of the ombudsman in the complaint system process. The prepaid health plan must issue a

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written resolution of the complaint to the recipient within 30 days after the complaint is filed with the prepaid health plan. A recipient is not required to exhaust the complaint system procedures in order to request a hearing under paragraph (b).

(b) Recipients enrolled in a prepaid health plan under chapter 256B or 256D may contest a prepaid health plan's denial, reduction, or termination of health services, a prepaid health plan's denial of a request to authorize a previously authorized health service, or the prepaid health plan's written resolution of a complaint by submitting a written request for a hearing according to subdivision 3. A state human services referee shall conduct a hearing on the matter and shall recommend an order to the commissioner of human services. The commissioner need not grant a hearing if the sole issue raised by a recipient is the commissioner's authority to require mandatory enrollment in a prepaid health plan in a county where prepaid health plans are under contract with the commissioner. The state human services referee may order a second medical opinion from the prepaid health plan or may order a second medical opinion from a nonprepaid health plan provider at the expense of the prepaid health plan. Recipients may request the assistance of the ombudsman in the appeal process.

(c) In the written request for a hearing to appeal from a prepaid health plan's denial, reduction, or termination of a health service, a prepaid health plan's denial of a request to authorize a previously authorized service, or the prepaid health plan's written resolution to a complaint, a recipient may request an expedited hearing. If an expedited appeal is warranted, the state human services referee shall hear the appeal and render a decision within a time commensurate with the level of urgency involved, based on the individual circumstances of the case.

EFFECTIVE DATE. This section is effective retroactively from July 1, 2005.

Sec. 10. Minnesota Statutes 2004, section 256.046, subdivision 1, is amended to read:

Subdivision 1. **HEARING AUTHORITY.** A local agency must initiate an administrative fraud disqualification hearing for individuals, including child care providers caring for children receiving child care assistance, accused of wrongfully obtaining assistance or intentional program violations, in lieu of a criminal action when it has not been pursued, in the aid to families with dependent children program formerly codified in sections 256.72 to 256.87, MFIP, the diversionary work program, child care assistance programs, general assistance, family general assistance program formerly codified in section 256D.05, subdivision 1, clause (15), Minnesota supplemental aid, food stamp programs, general assistance medical care, MinnesotaCare for adults without children, and upon federal approval, all categories of medical assistance and remaining categories of MinnesotaCare except for children through age 18. The Department of Human Services, in lieu of a local agency, may initiate an administrative fraud disqualification hearing when the state agency is directly responsible for administration of the health care program for which benefits were wrongfully obtained. The hearing is subject to the requirements of section 256.045 and the requirements in Code of Federal Regulations, title 7, section 273.16, for the food stamp program and

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title 45, section 235.112, as of September 30, 1995, for the cash grant, medical care programs, and child care assistance under chapter 119B.

EFFECTIVE DATE. This section is effective retroactively from July 1, 2005.

Sec. 11. Minnesota Statutes 2004, section 256.9657, is amended by adding a subdivision to read:

Subd. 7a. **WITHHOLDING.** If any provider obligated to pay an annual surcharge under this section is more than two months delinquent in the timely payment of a monthly surcharge installment payment, the provisions in paragraphs (a) to (f) apply.

(a) The department may withhold some or all of the amount of the delinquent surcharge, together with any interest and penalties due and owing on those amounts, from any money the department owes to the provider. The department may, at its discretion, also withhold future surcharge installment payments from any money the department owes the provider as those installments become due and owing. The department may continue this withholding until the department determines there is no longer any need to do so.

(b) The department shall give prior notice of the department's intention to withhold by mailing a written notice to the provider at the address to which remittance advices are mailed or faxing a copy of the notice to the provider at least ten business days before the date of the first payment period for which the withholding begins. The notice may be sent by ordinary or certified mail, or facsimile, and shall be deemed received as of the date of mailing or receipt of the facsimile. The notice shall:

(i) state the amount of the delinquent surcharge;

(ii) state the amount of the withholding per payment period;

(iii) state the date on which the withholding is to begin;

(iv) state whether the department intends to withhold future installments of the provider's surcharge payments;

(v) inform the provider of their rights to informally object to the proposed withholding and to appeal the withholding as provided for in this subdivision;

(vi) state that the provider may prevent the withholding during the pendency of their appeal by posting a bond; and

(vii) state other contents as the department deems appropriate.

(c) The provider may informally object to the withholding in writing anytime before the withholding begins. An informal objection shall not stay or delay the commencement of the withholding. The department may postpone the commencement of the withholding as deemed appropriate and shall not be required to give another notice at the end of the postponement and before commencing the withholding. The provider shall have the right to appeal any withholding from remittances by filing an

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appeal with Ramsey County District Court and serving notice of the appeal on the department within 30 days of the date of the written notice of the withholding. Notice shall be given and the appeal shall be heard no later than 45 days after the appeal is filed. In a hearing of the appeal, the department's action shall be sustained if the department proves the amount of the delinquent surcharges or overpayment the provider owes, plus any accrued interest and penalties, has not been repaid. The department may continue withholding for delinquent and current surcharge installment payments during the pendency of an appeal unless the provider posts a bond from a surety company licensed to do business in Minnesota in favor of the department in an amount equal to two times the provider's total annual surcharge payment for the fiscal year in which the appeal is filed with the department.

(d) The department shall refund any amounts due to the provider under any final administrative or judicial order or decree which fully and finally resolves the appeal together with interest on those amounts at the rate of three percent per annum simple interest computed from the date of each withholding, as soon as practical after entry of the order or decree.

(e) The commissioner, or the commissioner's designee, may enter into written settlement agreements with a provider to resolve disputes and other matters involving unpaid surcharge installment payments or future surcharge installment payments.

(f) Notwithstanding any law to the contrary, all unpaid surcharges, plus any accrued interest and penalties, shall be overpayments for purposes of section 256B.0641.

EFFECTIVE DATE. This section is effective retroactively from July 1, 2005.

Sec. 12. Minnesota Statutes 2004, section 256.969, subdivision 3a, is amended to read:

Subd. 3a. **PAYMENTS.** (a) Acute care hospital billings under the medical assistance program must not be submitted until the recipient is discharged. However, the commissioner shall establish monthly interim payments for inpatient hospitals that have individual patient lengths of stay over 30 days regardless of diagnostic category. Except as provided in section 256.9693, medical assistance reimbursement for treatment of mental illness shall be reimbursed based on diagnostic classifications. Individual hospital payments established under this section and sections 256.9685, 256.9686, and 256.9695, in addition to third party and recipient liability, for discharges occurring during the rate year shall not exceed, in aggregate, the charges for the medical assistance covered inpatient services paid for the same period of time to the hospital. This payment limitation shall be calculated separately for medical assistance and general assistance medical care services. The limitation on general assistance medical care shall be effective for admissions occurring on or after July 1, 1991. Services that have rates established under subdivision 11 or 12, must be limited separately from other services. After consulting with the affected hospitals, the commissioner may consider related hospitals one entity and may merge the payment

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rates while maintaining separate provider numbers. The operating and property base rates per admission or per day shall be derived from the best Medicare and claims data available when rates are established. The commissioner shall determine the best Medicare and claims data, taking into consideration variables of recency of the data, audit disposition, settlement status, and the ability to set rates in a timely manner. The commissioner shall notify hospitals of payment rates by December 1 of the year preceding the rate year. The rate setting data must reflect the admissions data used to establish relative values. Base year changes from 1981 to the base year established for the rate year beginning January 1, 1991, and for subsequent rate years, shall not be limited to the limits ending June 30, 1987, on the maximum rate of increase under subdivision 1. The commissioner may adjust base year cost, relative value, and case mix index data to exclude the costs of services that have been discontinued by the October 1 of the year preceding the rate year or that are paid separately from inpatient services. Inpatient stays that encompass portions of two or more rate years shall have payments established based on payment rates in effect at the time of admission unless the date of admission preceded the rate year in effect by six months or more. In this case, operating payment rates for services rendered during the rate year in effect and established based on the date of admission shall be adjusted to the rate year in effect by the hospital cost index.

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

(c) In addition to the reduction in paragraph (b), the total payment for fee-for-service admissions occurring on or after July 1, 2003, made to hospitals for inpatient services before third-party liability and spenddown, is reduced five percent from the current statutory rates. Mental health services within diagnosis related groups 424 to 432, and facilities defined under subdivision 16 are excluded from this paragraph.

(d) In addition to the reduction in paragraphs (b) and (c), the total payment for fee-for-service admissions occurring on or after July 1, 2005, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 6.0 percent from the current statutory rates. Mental health services within diagnosis related groups 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph. Notwithstanding section 256.9686, subdivision 7, for purposes of this paragraph, medical assistance does not include general assistance medical care. Payments made to managed care plans shall be reduced for services provided on or after January 1, 2006, to reflect this reduction.

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 13. Minnesota Statutes 2004, section 256.969, subdivision 9, is amended to read:

Subd. 9. **DISPROPORTIONATE NUMBERS OF LOW-INCOME PATIENTS SERVED.** (a) For admissions occurring on or after October 1, 1992, through

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December 31, 1992, the medical assistance disproportionate population adjustment shall comply with federal law and shall be paid to a hospital, excluding regional treatment centers and facilities of the federal Indian Health Service, with a medical assistance inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined as follows:

(1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service but less than or equal to one standard deviation above the mean, the adjustment must be determined by multiplying the total of the operating and 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; and

(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. If federal matching funds are not available for all adjustments under this subdivision, the commissioner shall reduce payments on a pro rata basis so that all adjustments qualify for federal match. 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.

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

(1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service but less than or equal to one standard deviation above the mean, the adjustment must be determined by multiplying the total of the operating and 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

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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; and

(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 made by the department and by prepaid health plans participating in general assistance medical care shall be considered Medicaid disproportionate share hospital payments, except as limited below:

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

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

(3) only those general assistance medical care expenditures made to an individual hospital that would not cause the hospital to exceed its individual hospital limits under

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section 1923 of the Social Security Act may be considered; and

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

All hospitals and prepaid health plans participating in general assistance medical care must provide any necessary expenditure, cost, and revenue information required by the commissioner as necessary for purposes of obtaining federal Medicaid matching funds for general assistance medical care expenditures.

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

Sec. 14. Minnesota Statutes 2004, section 256.969, subdivision 26, is amended to read:

Subd. 26. **GREATER MINNESOTA PAYMENT ADJUSTMENT AFTER JUNE 30, 2001.** (a) For admissions occurring after June 30, 2001, the commissioner shall pay fee-for-service inpatient admissions for the diagnosis-related groups specified in paragraph (b) at hospitals located outside of the seven-county metropolitan area at the higher of:

(1) the hospital's current payment rate for the diagnostic category to which the diagnosis-related group belongs, exclusive of disproportionate population adjustments received under subdivision 9 and hospital payment adjustments received under subdivision 23; or

(2) 90 percent of the average payment rate for that diagnostic category for hospitals located within the seven-county metropolitan area, exclusive of disproportionate population adjustments received under subdivision 9 and hospital payment adjustments received under subdivisions 20 and 23. ~~The commissioner may adjust this percentage each year so that the estimated payment increases under this paragraph are equal to the funding provided under section 256B.195 for this purpose.~~

(b) The payment increases provided in paragraph (a) apply to the following diagnosis-related groups, as they fall within the diagnostic categories:

- (1) 370 cesarean section with complicating diagnosis;
- (2) 371 cesarean section without complicating diagnosis;
- (3) 372 vaginal delivery with complicating diagnosis;
- (4) 373 vaginal delivery without complicating diagnosis;
- (5) 386 extreme immaturity and respiratory distress syndrome, neonate;
- (6) 388 full-term neonates with other problems;
- (7) 390 prematurity without major problems;

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- (8) 391 normal newborn;
- (9) 385 neonate, died or transferred to another acute care facility;
- (10) 425 acute adjustment reaction and psychosocial dysfunction;
- (11) 430 psychoses;
- (12) 431 childhood mental disorders; and
- (13) 164-167 appendectomy.

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 15. Minnesota Statutes 2004, section 256.969, is amended by adding a subdivision to read:

Subd. 27. QUARTERLY PAYMENT ADJUSTMENT. (a) In addition to any other payment under this section, the commissioner shall make the following payments effective July 1, 2007:

(1) for a hospital located in Minnesota and not eligible for payments under subdivision 20, with a medical assistance inpatient utilization rate greater than 17.8 percent of total patient days as of the base year in effect on July 1, 2005, a payment equal to 13 percent of the total of the operating and property payment rates;

(2) for a hospital located in Minnesota in a specified urban area outside of the seven-county metropolitan area and not eligible for payments under subdivision 20, with a medical assistance inpatient utilization rate less than or equal to 17.8 percent of total patient days as of the base year in effect on July 1, 2005, a payment equal to ten percent of the total of the operating and property payment rates. For purposes of this clause, the following cities are specified urban areas: Detroit Lakes, Rochester, Willmar, Alexandria, Austin, Cambridge, Brainerd, Hibbing, Mankato, Duluth, St. Cloud, Grand Rapids, Wyoming, Fergus Falls, Albert Lea, Winona, Virginia, Thief River Falls, and Wadena; and

(3) for a hospital located in Minnesota but not located in a specified urban area under clause (2), with a medical assistance inpatient utilization rate less than or equal to 17.8 percent of total patient days as of the base year in effect on July 1, 2005, a payment equal to four percent of the total of the operating and property payment rates. A hospital located in Woodbury and not in existence during the base year shall be reimbursed under this clause.

(b) The state share of payments under paragraph (a) shall be equal to federal reimbursements to the commissioner to reimburse nonstate expenditures reported under section 256B.199. The commissioner shall ratably reduce or increase payments under this subdivision in order to ensure that these payments equal the amount of reimbursement received by the commissioner under section 256B.199, except that payments shall be ratably reduced by an amount equivalent to the state share of a four percent reduction in MinnesotaCare and medical assistance payments for inpatient hospital services.

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(c) The payments under paragraph (a) shall be paid quarterly beginning on July 15, 2007, or upon federal approval of federal reimbursements under section 256B.199, whichever occurs later.

(d) The commissioner shall not adjust rates paid to a prepaid health plan under contract with the commissioner to reflect payments provided in paragraph (a).

(e) The commissioner shall maximize the use of available federal money for disproportionate share hospital payments and shall maximize payments to qualifying hospitals. In order to accomplish these purposes, the commissioner may, in consultation with the nonstate entities identified in section 256B.199, adjust, on a pro rata basis if feasible, the amounts reported by nonstate entities under section 256B.199 when application for reimbursement is made to the federal government, and otherwise adjust the provisions of this subdivision.

(f) By January 15 of each year, beginning January 15, 2006, the commissioner shall report to the chairs of the house and senate finance committees and divisions with jurisdiction over funding for the Department of Human Services the following estimates for the current and upcoming federal and state fiscal years:

(1) the difference between the Medicare upper payment limit and actual or anticipated medical assistance payments for hospital services;

(2) the amount of federal disproportionate share hospital funding available to Minnesota and the amount expected to be claimed by the state; and

(3) the methodology used to calculate the results reported for clauses (1) and (2).

(g) For purposes of this subdivision, medical assistance does not include general assistance medical care.

(h) This section sunsets on June 30, 2009. The commissioner shall report to the legislature by December 15, 2008, with recommendations for maximizing federal disproportionate share hospital payments after June 30, 2009.

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 16. Minnesota Statutes 2004, section 256.975, subdivision 9, is amended to read:

Subd. 9. PRESCRIPTION DRUG ASSISTANCE. (a) The Minnesota Board on Aging shall establish and administer a prescription drug assistance program to assist individuals in accessing programs offered by pharmaceutical manufacturers that provide free or discounted prescription drugs or provide coverage for prescription drugs. The board shall use computer software programs to:

(1) list eligibility requirements for pharmaceutical assistance programs offered by manufacturers;

(2) list drugs that are included in a supplemental rebate contract between the commissioner and a pharmaceutical manufacturer under section 256.01, subdivision 2, clause (23); and

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(3) link individuals with the pharmaceutical assistance programs most appropriate for the individual. The board shall make information on the prescription drug assistance program available to interested individuals and health care providers and shall coordinate the program with the statewide information and assistance service provided through the Senior LinkAge Line under subdivision 7.

~~(b) The board shall work with the commissioner and county social service agencies to coordinate the enrollment of individuals who are referred to the prescription drug assistance program from the prescription drug program, as required under section 256.955, subdivision 4a.~~

EFFECTIVE DATE. This section is effective January 1, 2006.

Sec. 17. Minnesota Statutes 2004, section 256B.02, subdivision 12, is amended to read:

Subd. 12. **THIRD-PARTY PAYER.** “Third-party payer” means a person, entity, or agency or government program that has a probable obligation to pay all or part of the costs of a medical assistance recipient’s health services. Third-party payer includes an entity under contract with the recipient to cover all or part of the recipient’s medical costs.

EFFECTIVE DATE. This section is effective retroactively from July 1, 2005.

Sec. 18. Minnesota Statutes 2004, section 256B.04, is amended by adding a subdivision to read:

Subd. 4a. **MEDICARE PRESCRIPTION DRUG SUBSIDY.** The commissioner shall perform all duties necessary to administer eligibility determinations for the Medicare Part D prescription drug subsidy and facilitate the enrollment of eligible medical assistance recipients into Medicare prescription drug plans as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Public Law 108-173, and Code of Federal Regulations, title 42, sections 423.30 to 423.56 and 423.771 to 423.800.

EFFECTIVE DATE. This section is effective retroactively from July 1, 2005.

Sec. 19. Minnesota Statutes 2004, section 256B.055, is amended by adding a subdivision to read:

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

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

EFFECTIVE DATE. This section is effective retroactively from July 1, 2005.

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Sec. 20. Minnesota Statutes 2004, section 256B.056, is amended by adding a subdivision to read:

Subd. 3d. REDUCTION OF EXCESS ASSETS. Assets in excess of the limits in subdivisions 3 to 3c may be reduced to allowable limits as follows:

(a) Assets may be reduced in any of the three calendar months before the month of application in which the applicant seeks coverage by:

(1) designating burial funds up to \$1,500 for each applicant, spouse, and MA-eligible dependent child; and

(2) paying health service bills incurred in the retroactive period for which the applicant seeks eligibility, starting with the oldest bill. After assets are reduced to allowable limits, eligibility begins with the next dollar of MA-covered health services incurred in the retroactive period. Applicants reducing assets under this subdivision who also have excess income shall first spend excess assets to pay health service bills and may meet the income spenddown on remaining bills.

(b) Assets may be reduced beginning the month of application by:

(1) paying bills for health services that would otherwise be paid by medical assistance; and

(2) using any means other than a transfer of assets for less than fair market value as defined in section 256B.0595, subdivision 1, paragraph (b).

EFFECTIVE DATE. This section is effective retroactively from July 1, 2005.

Sec. 21. Minnesota Statutes 2004, section 256B.056, subdivision 5, is amended to read:

Subd. 5. **EXCESS INCOME.** A person who has excess income is eligible for medical assistance if the person has expenses for medical care that are more than the amount of the person's excess income, computed by deducting incurred medical expenses from the excess income to reduce the excess to the income standard specified in subdivision 5c. The person shall elect to have the medical expenses deducted at the beginning of a one-month budget period or at the beginning of a six-month budget period. The commissioner shall allow persons eligible for assistance on a one-month spenddown basis under this subdivision to elect to pay the monthly spenddown amount in advance of the month of eligibility to the state agency in order to maintain eligibility on a continuous basis. If the recipient does not pay the spenddown amount on or before the ~~20th~~ last business day of the month, the recipient is ineligible for this option for the following month. The local agency shall code the Medicaid Management Information System (MMIS) to indicate that the recipient has elected this option. The state agency shall convey recipient eligibility information relative to the collection of the spenddown to providers through the Electronic Verification System (EVS). A recipient electing advance payment must pay the state agency the monthly spenddown amount

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on or before noon on the 20th last business day of the month in order to be eligible for this option in the following month.

EFFECTIVE DATE. This section is effective August 1, 2007, or upon HealthMatch implementation, whichever is later.

Sec. 22. Minnesota Statutes 2004, section 256B.056, subdivision 5a, is amended to read:

Subd. 5a. **INDIVIDUALS ON FIXED OR EXCLUDED INCOME.** Recipients of medical assistance who receive only fixed unearned or excluded income, when that income is excluded from consideration as income or unvarying in amount and timing of receipt throughout the year, shall report and verify their income annually every 12 months. The 12-month period begins with the month of application.

EFFECTIVE DATE. This section is effective August 1, 2007, or upon HealthMatch implementation, whichever is later.

Sec. 23. Minnesota Statutes 2004, section 256B.056, subdivision 5b, is amended to read:

Subd. 5b. **INDIVIDUALS WITH LOW INCOME.** Recipients of medical assistance not residing in a long-term care facility who have slightly fluctuating income which is below the medical assistance income limit shall report and verify their income on a semiannual basis every six months. The six-month period begins the month of application.

EFFECTIVE DATE. This section is effective August 1, 2007, or upon HealthMatch implementation, whichever is later.

Sec. 24. Minnesota Statutes 2004, section 256B.056, subdivision 7, is amended to read:

Subd. 7. **PERIOD OF ELIGIBILITY.** Eligibility is available for the month of application and for three months prior to application if the person was eligible in those prior months. Eligibility for months prior to application is determined independently from eligibility for the month of application and future months. A redetermination of eligibility must occur every 12 months. The 12-month period begins with the month of application.

EFFECTIVE DATE. This section is effective August 1, 2007, or upon HealthMatch implementation, whichever is later.

Sec. 25. Minnesota Statutes 2004, section 256B.056, is amended by adding a subdivision to read:

Subd. 9. **NOTICE.** The state agency must be given notice of monetary claims against a person, entity, or corporation that may be liable to pay all or part of the cost of medical care when the state agency has paid or becomes liable for the cost of that care. Notice must be given according to paragraphs (a) to (d).

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(a) An applicant for medical assistance shall notify the state or local agency of any possible claims when the applicant submits the application. A recipient of medical assistance shall notify the state or local agency of any possible claims when those claims arise.

(b) A person providing medical care services to a recipient of medical assistance shall notify the state agency when the person has reason to believe that a third party may be liable for payment of the cost of medical care.

(c) A party to a claim that may be assigned to the state agency under this section shall notify the state agency of its potential assignment claim in writing at each of the following stages of a claim:

(1) when a claim is filed;

(2) when an action is commenced; and

(3) when a claim is concluded by payment, award, judgment, settlement, or otherwise.

(d) Every party involved in any stage of a claim under this subdivision is required to provide notice to the state agency at that stage of the claim. However, when one of the parties to the claim provides notice at that stage, every other party to the claim is deemed to have provided the required notice for that stage of the claim. If the required notice under this paragraph is not provided to the state agency, all parties to the claim are deemed to have failed to provide the required notice. A party to the claim includes the injured person or the person's legal representative, the plaintiff, the defendants, or persons alleged to be responsible for compensating the injured person or plaintiff, and any other party to the cause of action or claim, regardless of whether the party knows the state agency has a potential or actual assignment claim.

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 26. Minnesota Statutes 2004, section 256B.056, is amended by adding a subdivision to read:

Subd. 10. ELIGIBILITY VERIFICATION. (a) The commissioner shall require women who are applying for the continuation of medical assistance coverage following the end of the 60-day postpartum period to update their income and asset information and to submit any required income or asset verification.

(b) The commissioner shall determine the eligibility of private-sector health care coverage for infants less than one year of age eligible under section 256B.055, subdivision 10, or 256B.057, subdivision 1, paragraph (d), and shall pay for private-sector coverage if this is determined to be cost-effective.

(c) The commissioner shall modify the application for Minnesota health care programs to require more detailed information related to verification of assets and income, and shall verify assets and income for all applicants, and for all recipients upon renewal.

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(d) The commissioner shall require Minnesota health care program recipients to report new or an increase in earned income within ten days of the change, and to verify new or an increase in earned income that affects eligibility within ten days of notification by the agency that the new or increased earned income affects eligibility. Recipients who fail to verify new or an increase in earned income that affects eligibility shall be disenrolled.

EFFECTIVE DATE. This section is effective September 1, 2005, except that paragraph (a) is effective September 1, 2005, or upon federal approval, whichever is later. Prior to the implementation of HealthMatch, the commissioner shall implement this section to the fullest extent possible, including the use of manual processing. Upon implementation of HealthMatch, the commissioner shall implement this section in a manner consistent with the procedures and requirements of HealthMatch.

Sec. 27. Minnesota Statutes 2004, section 256B.0575, is amended to read:

256B.0575 AVAILABILITY OF INCOME FOR INSTITUTIONALIZED PERSONS.

When an institutionalized person is determined eligible for medical assistance, the income that exceeds the deductions in paragraphs (a) and (b) must be applied to the cost of institutional care.

(a) The following amounts must be deducted from the institutionalized person's income in the following order:

(1) the personal needs allowance under section 256B.35 or, for a veteran who does not have a spouse or child, or a surviving spouse of a veteran having no child, the amount of an improved pension received from the veteran's administration not exceeding \$90 per month;

(2) the personal allowance for disabled individuals under section 256B.36;

(3) if the institutionalized person has a legally appointed guardian or conservator, five percent of the recipient's gross monthly income up to \$100 as reimbursement for guardianship or conservatorship services;

(4) a monthly income allowance determined under section 256B.058, subdivision 2, but only to the extent income of the institutionalized spouse is made available to the community spouse;

(5) a monthly allowance for children under age 18 which, together with the net income of the children, would provide income equal to the medical assistance standard for families and children according to section 256B.056, subdivision 4, for a family size that includes only the minor children. This deduction applies only if the children do not live with the community spouse and only to the extent that the deduction is not included in the personal needs allowance under section 256B.35, subdivision 1, as child support garnished under a court order;

(6) a monthly family allowance for other family members, equal to one-third of the difference between 122 percent of the federal poverty guidelines and the monthly income for that family member;

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(7) reparations payments made by the Federal Republic of Germany and reparations payments made by the Netherlands for victims of Nazi persecution between 1940 and 1945;

(8) all other exclusions from income for institutionalized persons as mandated by federal law; and

(9) amounts for reasonable expenses incurred for necessary medical or remedial care for the institutionalized person that are not medical assistance covered expenses and that are not subject to payment by a third party.

Reasonable expenses are limited to expenses that have not been previously used as a deduction from income and are incurred during the enrollee's current period of eligibility, including retroactive months associated with the current period of eligibility, for medical assistance payment of long-term care services.

For purposes of clause (6), "other family member" means a person who resides with the community spouse and who is a minor or dependent child, dependent parent, or dependent sibling of either spouse. "Dependent" means a person who could be claimed as a dependent for federal income tax purposes under the Internal Revenue Code.

(b) Income shall be allocated to an institutionalized person for a period of up to three calendar months, in an amount equal to the medical assistance standard for a family size of one if:

(1) a physician certifies that the person is expected to reside in the long-term care facility for three calendar months or less;

(2) if the person has expenses of maintaining a residence in the community; and

(3) if one of the following circumstances apply:

(i) the person was not living together with a spouse or a family member as defined in paragraph (a) when the person entered a long-term care facility; or

(ii) the person and the person's spouse become institutionalized on the same date, in which case the allocation shall be applied to the income of one of the spouses.

For purposes of this paragraph, a person is determined to be residing in a licensed nursing home, regional treatment center, or medical institution if the person is expected to remain for a period of one full calendar month or more.

EFFECTIVE DATE. This section is effective retroactively from July 1, 2005.

Sec. 28. Minnesota Statutes 2004, section 256B.06, subdivision 4, is amended to read:

Subd. 4. **CITIZENSHIP REQUIREMENTS.** (a) Eligibility for medical assistance is limited to citizens of the United States, qualified noncitizens as defined in this subdivision, and other persons residing lawfully in the United States.

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(b) "Qualified noncitizen" means a person who meets one of the following immigration criteria:

(1) admitted for lawful permanent residence according to United States Code, title 8;

(2) admitted to the United States as a refugee according to United States Code, title 8, section 1157;

(3) granted asylum according to United States Code, title 8, section 1158;

(4) granted withholding of deportation according to United States Code, title 8, section 1253(h);

(5) paroled for a period of at least one year according to United States Code, title 8, section 1182(d)(5);

(6) granted conditional entrant status according to United States Code, title 8, section 1153(a)(7);

(7) determined to be a battered noncitizen by the United States Attorney General according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, title V of the Omnibus Consolidated Appropriations Bill, Public Law 104-200;

(8) is a child of a noncitizen determined to be a battered noncitizen by the United States Attorney General according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, title V, of the Omnibus Consolidated Appropriations Bill, Public Law 104-200; or

(9) determined to be a Cuban or Haitian entrant as defined in section 501(e) of Public Law 96-422, the Refugee Education Assistance Act of 1980.

(c) All qualified noncitizens who were residing in the United States before August 22, 1996, who otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance with federal financial participation.

(d) All qualified noncitizens who entered the United States on or after August 22, 1996, and who otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance with federal financial participation through November 30, 1996.

Beginning December 1, 1996, qualified noncitizens who entered the United States on or after August 22, 1996, and who otherwise meet the eligibility requirements of this chapter are eligible for medical assistance with federal participation for five years if they meet one of the following criteria:

(i) refugees admitted to the United States according to United States Code, title 8, section 1157;

(ii) persons granted asylum according to United States Code, title 8, section 1158;

(iii) persons granted withholding of deportation according to United States Code, title 8, section 1253(h);

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(iv) veterans of the United States armed forces with an honorable discharge for a reason other than noncitizen status, their spouses and unmarried minor dependent children; or

(v) persons on active duty in the United States armed forces, other than for training, their spouses and unmarried minor dependent children.

Beginning December 1, 1996, qualified noncitizens who do not meet one of the criteria in items (i) to (v) are eligible for medical assistance without federal financial participation as described in paragraph (j).

(e) Noncitizens who are not qualified noncitizens as defined in paragraph (b), who are lawfully residing in the United States and who otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance under clauses (1) to (3). These individuals must cooperate with the Immigration and Naturalization Service to pursue any applicable immigration status, including citizenship, that would qualify them for medical assistance with federal financial participation.

(1) Persons who were medical assistance recipients on August 22, 1996, are eligible for medical assistance with federal financial participation through December 31, 1996.

(2) Beginning January 1, 1997, persons described in clause (1) are eligible for medical assistance without federal financial participation as described in paragraph (j).

(3) Beginning December 1, 1996, persons residing in the United States prior to August 22, 1996, who were not receiving medical assistance and persons who arrived on or after August 22, 1996, are eligible for medical assistance without federal financial participation as described in paragraph (j).

(f) Nonimmigrants who otherwise meet the eligibility requirements of this chapter are eligible for the benefits as provided in paragraphs (g) to (i). For purposes of this subdivision, a "nonimmigrant" is a person in one of the classes listed in United States Code, title 8, section 1101(a)(15).

(g) Payment shall also 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 such 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.

(h) For purposes of this subdivision, the term "emergency medical condition" means a medical condition that meets the requirements of United States Code, title 42, section 1396b(v).

(i) Pregnant noncitizens who are undocumented or, nonimmigrants, or eligible for medical assistance as described in paragraph (j), and who are not covered by a group health plan or health insurance coverage according to Code of Federal Regulations, title 42, section 457.310, and who otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance payment without federal financial partici-

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ation for care and services through the period of pregnancy, and including labor and delivery, to the extent federal funds are available under Title XXI of the Social Security Act, and the state children's health insurance program, followed by 60 days postpartum, except for labor and delivery without federal financial participation.

(j) Qualified noncitizens as described in paragraph (d), and all other noncitizens lawfully residing in the United States as described in paragraph (e), who are ineligible for medical assistance with federal financial participation and who otherwise meet the eligibility requirements of chapter 256B and of this paragraph, are eligible for medical assistance without federal financial participation. Qualified noncitizens as described in paragraph (d) are only eligible for medical assistance without federal financial participation for five years from their date of entry into the United States.

(k) Beginning October 1, 2003, persons who are receiving care and rehabilitation services from a nonprofit center established to serve victims of torture and are otherwise ineligible for medical assistance under this chapter are eligible for medical assistance without federal financial participation. These individuals are eligible only for the period during which they are receiving services from the center. Individuals eligible under this paragraph shall not be required to participate in prepaid medical assistance.

EFFECTIVE DATE. This section is effective September 1, 2005.

Sec. 29. Minnesota Statutes 2004, section 256B.0625, is amended by adding a subdivision to read:

Subd. 1a. **SERVICES PROVIDED IN A HOSPITAL EMERGENCY ROOM.** Medical assistance does not cover visits to a hospital emergency room that are not for emergency and emergency poststabilization care or urgent care, and does not pay for any services provided in a hospital emergency room that are not for emergency and emergency poststabilization care or urgent care.

EFFECTIVE DATE. This section is effective October 1, 2005.

Sec. 30. Minnesota Statutes 2004, section 256B.0625, subdivision 3a, is amended to read:

Subd. 3a. **GENDER SEX REASSIGNMENT SURGERY.** Gender Sex reassignment surgery and other gender reassignment medical procedures including drug therapy for gender reassignment are is not covered unless the individual began receiving gender reassignment services prior to July 1, 1998.

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 31. Minnesota Statutes 2004, section 256B.0625, is amended by adding a subdivision to read:

Subd. 3f. **CIRCUMCISION FOR NEWBORNS.** Newborn circumcision is not covered, unless the procedure is medically necessary or required because of a well-established religious practice.

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EFFECTIVE DATE. This section is effective September 1, 2005, and applies to services provided on or after that date.

Sec. 32. Minnesota Statutes 2004, section 256B.0625, subdivision 9, is amended to read:

Subd. 9. **DENTAL SERVICES.** (a) Medical assistance covers dental services. Dental services include, with prior authorization, fixed bridges that are cost-effective for persons who cannot use removable dentures because of their medical condition.

(b) Coverage of dental services for adults age 21 and over who are not pregnant is subject to a \$500 annual benefit limit and covered services are limited to:

- (1) diagnostic and preventative services;
- (2) restorative services; and
- (3) emergency services.

~~Emergency services, dentures, and extractions related to dentures are not included in the \$500 annual benefit limit.~~

EFFECTIVE DATE. This section is effective January 1, 2006.

Sec. 33. Minnesota Statutes 2004, section 256B.0625, subdivision 13, is amended to read:

Subd. 13. **DRUGS.** (a) Medical assistance covers drugs, except for fertility drugs when specifically used to enhance fertility, if prescribed by a licensed practitioner and dispensed by a licensed pharmacist, by a physician enrolled in the medical assistance program as a dispensing physician, or by a physician or a nurse practitioner employed by or under contract with a community health board as defined in section 145A.02, subdivision 5, for the purposes of communicable disease control.

(b) The dispensed quantity of a prescription drug must not exceed a 34-day supply, unless authorized by the commissioner.

(c) Medical assistance covers the following over-the-counter drugs when prescribed by a licensed practitioner or by a licensed pharmacist who meets standards established by the commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults with documented vitamin deficiencies, vitamins for children under the age of seven and pregnant or nursing women, and any other over-the-counter drug identified by the commissioner, in consultation with the formulary committee, as necessary, appropriate, and cost-effective for the treatment of certain specified chronic diseases, conditions, or disorders, and this determination shall not be subject to the requirements of chapter 14. A pharmacist may prescribe over-the-counter medications as provided under this paragraph for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter drugs under this paragraph, licensed pharmacists must consult with the recipient to determine necessity, provide drug counseling, review drug therapy for potential adverse interactions, and make referrals

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as needed to other health care professionals.

(d) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible for drug coverage as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these individuals, medical assistance may cover drugs from the drug classes listed in United States Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall not be covered.

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 34. Minnesota Statutes 2004, section 256B.0625, subdivision 13a, is amended to read:

Subd. 13a. **DRUG UTILIZATION REVIEW BOARD.** The commissioner, after receiving recommendations from professional medical associations, professional pharmacy associations, and consumer groups shall designate a nine-member Drug Utilization Review Board is established. The board is shall be comprised of at least three but no more than four licensed physicians actively engaged in the practice of medicine in Minnesota; at least three licensed pharmacists actively engaged in the practice of pharmacy in Minnesota; and one consumer representative; the remainder to be made up of health care professionals who are licensed in their field and have recognized knowledge in the clinically appropriate prescribing, dispensing, and monitoring of covered outpatient drugs. The board shall be staffed by an employee of the department who shall serve as an ex officio nonvoting member of the board. The department's medical director shall also serve as an ex officio, nonvoting member of the board. The members of the board shall be appointed by the commissioner and shall serve three-year terms. The members shall be selected from lists submitted by professional associations. The commissioner shall appoint the initial members of the board for terms expiring as follows: three members for terms expiring June 30, 1996; three members for terms expiring June 30, 1997; and three members for terms expiring June 30, 1998. Members may be reappointed once by the commissioner. The board shall annually elect a chair from among the members.

The commissioner shall, with the advice of the board:

(1) implement a medical assistance retrospective and prospective drug utilization review program as required by United States Code, title 42, section 1396r-8(g)(3);

(2) develop and implement the predetermined criteria and practice parameters for appropriate prescribing to be used in retrospective and prospective drug utilization review;

(3) develop, select, implement, and assess interventions for physicians, pharmacists, and patients that are educational and not punitive in nature;

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(4) establish a grievance and appeals process for physicians and pharmacists under this section;

(5) publish and disseminate educational information to physicians and pharmacists regarding the board and the review program;

(6) adopt and implement procedures designed to ensure the confidentiality of any information collected, stored, retrieved, assessed, or analyzed by the board, staff to the board, or contractors to the review program that identifies individual physicians, pharmacists, or recipients;

(7) establish and implement an ongoing process to (i) receive public comment regarding drug utilization review criteria and standards, and (ii) consider the comments along with other scientific and clinical information in order to revise criteria and standards on a timely basis; and

(8) adopt any rules necessary to carry out this section.

The board may establish advisory committees. The commissioner may contract with appropriate organizations to assist the board in carrying out the board's duties. The commissioner may enter into contracts for services to develop and implement a retrospective and prospective review program.

The board shall report to the commissioner annually on the date the Drug Utilization Review Annual Report is due to the Centers for Medicare and Medicaid Services. This report is to cover the preceding federal fiscal year. The commissioner shall make the report available to the public upon request. The report must include information on the activities of the board and the program; the effectiveness of implemented interventions; administrative costs; and any fiscal impact resulting from the program. An honorarium of \$100 per meeting and reimbursement for mileage shall be paid to each board member in attendance.

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

Sec. 35. Minnesota Statutes 2004, section 256B.0625, subdivision 13c, is amended to read:

Subd. 13c. **FORMULARY COMMITTEE.** The commissioner, after receiving recommendations from professional medical associations and professional pharmacy associations, and consumer groups shall designate a Formulary Committee to carry out duties as described in subdivisions 13 to 13g. The Formulary Committee shall be comprised of four licensed physicians actively engaged in the practice of medicine in Minnesota one of whom must be actively engaged in the treatment of persons with mental illness; at least three licensed pharmacists actively engaged in the practice of pharmacy in Minnesota; and one consumer representative; the remainder to be made up of health care professionals who are licensed in their field and have recognized knowledge in the clinically appropriate prescribing, dispensing, and monitoring of covered outpatient drugs. Members of the Formulary Committee shall not be employed by the Department of Human Services, but the committee shall be staffed by an

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employee of the department who shall serve as an ex officio, nonvoting member of the board. The department's medical director shall also serve as an ex officio, nonvoting member for the committee. Committee members shall serve three-year terms and may be reappointed by the commissioner. The Formulary Committee shall meet at least quarterly. The commissioner may require more frequent Formulary Committee meetings as needed. An honorarium of \$100 per meeting and reimbursement for mileage shall be paid to each committee member in attendance.

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

Sec. 36. Minnesota Statutes 2004, section 256B.0625, subdivision 13d, is amended to read:

Subd. 13d. **DRUG FORMULARY.** The commissioner shall establish a drug formulary. Its establishment and publication shall not be subject to the requirements of the Administrative Procedure Act, but the Formulary Committee shall review and comment on the formulary contents.

The formulary shall not include:

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

EFFECTIVE DATE. This section is effective September 1, 2005.

Sec. 37. Minnesota Statutes 2004, section 256B.0625, subdivision 13e, as amended by Laws 2005, chapter 155, article 3, section 5, is amended to read:

Subd. 13e. **PAYMENT RATES.** (a) The basis for determining the amount of payment shall be the lower of the actual acquisition costs of the drugs plus a fixed dispensing fee; the maximum allowable cost set by the federal government or by the commissioner plus the fixed dispensing fee; or the usual and customary price charged to the public. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The pharmacy dispensing fee shall be \$3.65, except that the dispensing fee for intravenous solutions which must be compounded by the pharmacist shall be \$8 per bag, \$14 per bag for cancer chemotherapy products, and \$30 per bag for total parenteral nutritional products

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dispensed in one liter quantities, or \$44 per bag for total parenteral nutritional products dispensed in quantities greater than one liter. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. The actual acquisition cost of a drug shall be estimated by the commissioner, at average wholesale price minus ~~11.5~~ 12 percent, ~~except that where a drug has had its wholesale price reduced as a result of the actions of the National Association of Medicaid Fraud Control Units, the estimated actual acquisition cost shall be the reduced average wholesale price, without the 11.5 percent deduction.~~ The actual acquisition cost of antihemophilic factor drugs shall be estimated at the average wholesale price minus 30 percent. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to, but no higher than, the maximum amount paid by other third-party payors in this state who have maximum allowable cost programs. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

(b) An additional dispensing fee of \$.30 may be added to the dispensing fee paid to pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities when a unit dose blister card system, approved by the department, is used. Under this type of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National Drug Code (NDC) from the drug container used to fill the blister card must be identified on the claim to the department. The unit dose blister card containing the drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider will be required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse. Over-the-counter medications must be dispensed in the manufacturer's unopened package. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply.

(c) Whenever a generically equivalent product is available, payment shall be on the basis of the actual acquisition cost of the generic drug, or on the maximum allowable cost established by the commissioner.

(d) The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the provider or the amount established for Medicare by the United States Department of Health and Human Services pursuant to title XVIII, section 1847a of the federal Social Security Act.

(e) The commissioner may negotiate lower reimbursement rates for specialty pharmacy products than the rates specified in paragraph (a). The commissioner may require individuals enrolled in the health care programs administered by the department to obtain specialty pharmacy products from providers with whom the commissioner has negotiated lower reimbursement rates. Specialty pharmacy products are defined as those used by a small number of recipients or recipients with complex and chronic diseases that require expensive and challenging drug regimens. Examples of these conditions include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C, growth hormone deficiency, Crohn's Disease, rheumatoid

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arthritis, and certain forms of cancer. Specialty pharmaceutical products include injectable and infusion therapies, biotechnology drugs, high-cost therapies, and therapies that require complex care. The commissioner shall consult with the formulary committee to develop a list of specialty pharmacy products subject to this paragraph. In consulting with the formulary committee in developing this list, the commissioner shall take into consideration the population served by specialty pharmacy products, the current delivery system and standard of care in the state, and access to care issues. The commissioner shall have the discretion to adjust the reimbursement rate to prevent access to care issues.

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 38. Minnesota Statutes 2004, section 256B.0625, subdivision 13f, as amended by Laws 2005, chapter 155, article 3, section 6, is amended to read:

Subd. 13f. **PRIOR AUTHORIZATION.** (a) The Formulary Committee shall review and recommend drugs which require prior authorization. The Formulary Committee shall establish general criteria to be used for the prior authorization of brand-name drugs for which generically equivalent drugs are available, but the committee is not required to review each brand-name drug for which a generically equivalent drug is available.

(b) Prior authorization may be required by the commissioner before certain formulary drugs are eligible for payment. The Formulary Committee may recommend drugs for prior authorization directly to the commissioner. The commissioner may also request that the Formulary Committee review a drug for prior authorization. Before the commissioner may require prior authorization for a drug:

(1) the commissioner must provide information to the Formulary Committee on the impact that placing the drug on prior authorization may have on the quality of patient care and on program costs, information regarding whether the drug is subject to clinical abuse or misuse, and relevant data from the state Medicaid program if such data is available;

(2) the Formulary Committee must review the drug, taking into account medical and clinical data and the information provided by the commissioner; and

(3) the Formulary Committee must hold a public forum and receive public comment for an additional 15 days.

The commissioner must provide a 15-day notice period before implementing the prior authorization.

(c) Prior authorization shall not be required or utilized for any atypical antipsychotic drug prescribed for the treatment of mental illness if:

(1) there is no generically equivalent drug available; and

(2) the drug was initially prescribed for the recipient prior to July 1, 2003; or

(3) the drug is part of the recipient's current course of treatment.

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This paragraph applies to any multistate preferred drug list or supplemental drug rebate program established or administered by the commissioner. Prior authorization shall automatically be granted for 60 days for brand name drugs prescribed for treatment of mental illness within 60 days of when a generically equivalent drug becomes available, provided that the brand name drug was part of the recipient's course of treatment at the time the generically equivalent drug became available.

(d) Prior authorization shall not be required or utilized for any antihemophilic factor drug prescribed for the treatment of hemophilia and blood disorders where there is no generically equivalent drug available if the prior authorization is used in conjunction with any supplemental drug rebate program or multistate preferred drug list established or administered by the commissioner. ~~This paragraph expires July 1, 2005.~~

(e) The commissioner may require prior authorization for brand name drugs whenever a generically equivalent product is available, even if the prescriber specifically indicates "dispense as written-brand necessary" on the prescription as required by section 151.21, subdivision 2.

(f) Notwithstanding this subdivision, the commissioner may automatically require prior authorization, for a period not to exceed 180 days, for any drug that is approved by the United States Food and Drug Administration on or after July 1, 2005. The 180-day period begins no later than the first day that a drug is available for shipment to pharmacies within the state. The Formulary Committee shall recommend to the commissioner general criteria to be used for the prior authorization of the drugs, but the committee is not required to review each individual drug. In order to continue prior authorizations for a drug after the 180-day period has expired, the commissioner must follow the provisions of this subdivision.

EFFECTIVE DATE. Paragraph (c) is effective August 1, 2005, and paragraph (d) is effective retroactively from June 30, 2005.

Sec. 39. Minnesota Statutes 2004, section 256B.0625, is amended by adding a subdivision to read:

Subd. 13h. MEDICATION THERAPY MANAGEMENT CARE. (a) Medical assistance and general assistance medical care cover medication therapy management services for a recipient taking four or more prescriptions to treat or prevent two or more chronic medical conditions, or a recipient with a drug therapy problem that is identified or prior authorized by the commissioner that has resulted or is likely to result in significant nondrug program costs. The commissioner may cover medical therapy management services under MinnesotaCare if the commissioner determines this is cost-effective. For purposes of this subdivision, "medication therapy management" means the provision of the following pharmaceutical care services by a licensed pharmacist to optimize the therapeutic outcomes of the patient's medications:

- (1) performing or obtaining necessary assessments of the patient's health status;
- (2) formulating a medication treatment plan;

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(3) monitoring and evaluating the patient's response to therapy, including safety and effectiveness;

(4) performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events;

(5) documenting the care delivered and communicating essential information to the patient's other primary care providers;

(6) providing verbal education and training designed to enhance patient understanding and appropriate use of the patient's medications;

(7) providing information, support services, and resources designed to enhance patient adherence with the patient's therapeutic regimens; and

(8) coordinating and integrating medication therapy management services within the broader health care management services being provided to the patient.

Nothing in this subdivision shall be construed to expand or modify the scope of practice of the pharmacist as defined in section 151.01, subdivision 27.

(b) To be eligible for reimbursement for services under this subdivision, a pharmacist must meet the following requirements:

(1) have a valid license issued under chapter 151;

(2) have graduated from an accredited college of pharmacy on or after May 1996, or completed a structured and comprehensive education program approved by the Board of Pharmacy and the American Council of Pharmaceutical Education for the provision and documentation of pharmaceutical care management services that has both clinical and didactic elements;

(3) be practicing in an ambulatory care setting as part of a multidisciplinary team or have developed a structured patient care process that is offered in a private or semiprivate patient care area that is separate from the commercial business that also occurs in the setting; and

(4) make use of an electronic patient record system that meets state standards.

(c) For purposes of reimbursement for medication therapy management services, the commissioner may enroll individual pharmacists as medical assistance and general assistance medical care providers. The commissioner may also establish contact requirements between the pharmacist and recipient, including limiting the number of reimbursable consultations per recipient.

(d) The commissioner, after receiving recommendations from professional medical associations, professional pharmacy associations, and consumer groups, shall convene an 11-member Medication Therapy Management Advisory Committee to advise the commissioner on the implementation and administration of medication therapy management services. The committee shall be comprised of: two licensed physicians; two licensed pharmacists; two consumer representatives; two health plan company representatives; and three members with expertise in the area of medication

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therapy management, who may be licensed physicians or licensed pharmacists. The committee is governed by section 15.059, except that committee members do not receive compensation or reimbursement for expenses. The advisory committee expires on June 30, 2007.

(e) The commissioner shall evaluate the effect of medication therapy management on quality of care, patient outcomes, and program costs, and shall include a description of any savings generated in the medical assistance and general assistance medical care programs that can be attributable to this coverage. The evaluation shall be submitted to the legislature by December 15, 2007. The commissioner may contract with a vendor or an academic institution that has expertise in evaluating health care outcomes for the purpose of completing the evaluation.

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 40. Minnesota Statutes 2004, section 256B.0625, subdivision 17, is amended to read:

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

(b) Medical assistance covers special transportation, as defined in Minnesota Rules, part 9505.0315, subpart 1, item F, if the recipient has a physical or mental impairment that would prohibit the recipient from safely accessing and using a bus, taxi, other commercial transportation, or private automobile.

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

(1) ~~\$18~~ \$17 for the base rate and ~~\$1.40~~ \$1.35 per mile for services to eligible persons who need a wheelchair-accessible van;

(2) ~~\$12~~ \$11.50 for the base rate and ~~\$1.35~~ \$1.30 per mile for services to eligible persons who do not need a wheelchair-accessible van; and

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(3) ~~\$36~~ \$60 for the base rate and ~~\$1.40~~ \$2.40 per mile, and an attendant rate of \$9 per trip, for services to eligible persons who need a stretcher-accessible vehicle.

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 41. Minnesota Statutes 2004, section 256B.0631, subdivision 1, is amended to read:

Subdivision 1. **CO-PAYMENTS.** (a) Except as provided in subdivision 2, the medical assistance benefit plan shall include the following co-payments for all recipients, effective for services provided on or after October 1, 2003:

(1) \$3 per nonpreventive visit. For purposes of this subdivision, a visit means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;

(2) \$3 for eyeglasses;

(3) \$6 for nonemergency visits to a hospital-based emergency room; and

(4) \$3 per brand-name drug prescription and \$1 per generic drug prescription, subject to a ~~\$20~~ \$12 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness.

(b) Recipients of medical assistance are responsible for all co-payments in this subdivision.

EFFECTIVE DATE. This section is effective January 1, 2006.

Sec. 42. Minnesota Statutes 2004, section 256B.0631, subdivision 3, is amended to read:

Subd. 3. **COLLECTION.** The medical assistance reimbursement to the provider 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~~ \$12 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 subdivision 4.

EFFECTIVE DATE. This section is effective January 1, 2006.

Sec. 43. **[256B.072] PERFORMANCE REPORTING AND QUALITY IMPROVEMENT SYSTEM.**

(a) The commissioner of human services shall establish a performance reporting system for health care providers who provide health care services to public program recipients covered under chapters 256B, 256D, and 256L, reporting separately for managed care and fee-for-service recipients.

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(b) The measures used for the performance reporting system for medical groups shall include measures of care for asthma, diabetes, hypertension, and coronary artery disease and measures of preventive care services. The measures used for the performance reporting system for inpatient hospitals shall include measures of care for acute myocardial infarction, heart failure, and pneumonia, and measures of care and prevention of surgical infections. In the case of a medical group, the measures used shall be consistent with measures published by nonprofit Minnesota or national organizations that produce and disseminate health care quality measures or evidence-based health care guidelines. In the case of inpatient hospital measures, the commissioner shall appoint the Minnesota Hospital Association and Stratis Health to advise on the development of the performance measures to be used for hospital reporting. To enable a consistent measurement process across the community, the commissioner may use measures of care provided for patients in addition to those identified in paragraph (a). The commissioner shall ensure collaboration with other health care reporting organizations so that the measures described in this section are consistent with those reported by those organizations and used by other purchasers in Minnesota.

(c) The commissioner may require providers to submit information in a required format to a health care reporting organization or to cooperate with the information collection procedures of that organization. The commissioner may collaborate with a reporting organization to collect information reported and to prevent duplication of reporting.

(d) By October 1, 2007, and annually thereafter, the commissioner shall report through a public Web site the results by medical groups and hospitals, where possible, of the measures under this section, and shall compare the results by medical groups and hospitals for patients enrolled in public programs to patients enrolled in private health plans. To achieve this reporting, the commissioner may collaborate with a health care reporting organization that operates a Web site suitable for this purpose.

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

Sec. 44. Minnesota Statutes 2004, section 256B.075, subdivision 2, is amended to read:

Subd. 2. **FEE-FOR-SERVICE.** (a) The commissioner shall develop and implement a disease management program for medical assistance and general assistance medical care recipients who are not enrolled in the prepaid medical assistance or prepaid general assistance medical care programs and who are receiving services on a fee-for-service basis. The commissioner may contract with an outside organization to provide these services.

(b) The commissioner shall seek any federal approval necessary to implement this section and to obtain federal matching funds.

(c) The commissioner shall develop and implement a pilot intensive care management program for medical assistance children with complex and chronic medical issues who are not able to participate in the metro-based U Special Kids program due to geographic distance.

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

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Sec. 45. Minnesota Statutes 2004, section 256B.0911, subdivision 1a, is amended to read:

Subd. 1a. **DEFINITIONS.** For purposes of this section, the following definitions apply:

(a) "Long-term care consultation services" means:

(1) providing information and education to the general public regarding availability of the services authorized under this section;

(2) an intake process that provides access to the services described in this section;

(3) assessment of the health, psychological, and social needs of referred individuals;

(4) assistance in identifying services needed to maintain an individual in the least restrictive environment;

(5) providing recommendations on cost-effective community services that are available to the individual;

(6) development of an individual's community support plan;

(7) providing information regarding eligibility for Minnesota health care programs;

(8) preadmission screening to determine the need for a nursing facility level of care;

(9) preliminary determination of Minnesota health care programs eligibility for individuals who need a nursing facility level of care, with appropriate referrals for final determination;

(10) providing recommendations for nursing facility placement when there are no cost-effective community services available; and

(11) assistance to transition people back to community settings after facility admission.

(b) "Minnesota health care programs" means the medical assistance program under chapter 256B, and the alternative care program under section 256B.0913, and the prescription drug program under section 256.955.

EFFECTIVE DATE. This section is effective January 1, 2006.

Sec. 46. Minnesota Statutes 2004, section 256B.0916, is amended by adding a subdivision to read:

Subd. 10. TRANSITIONAL SUPPORTS ALLOWANCE. A transitional supports allowance shall be available to all persons under a home and community-based waiver who are moving from a licensed setting to a community setting. "Transitional

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supports allowance” means a onetime payment of up to \$3,000, to cover the costs, not covered by other sources, associated with moving from a licensed setting to a community setting. Covered costs include:

- (1) lease or rent deposits;
- (2) security deposits;
- (3) utilities set-up costs, including telephone;
- (4) essential furnishings and supplies; and
- (5) personal supports and transports needed to locate and transition to community settings.

EFFECTIVE DATE. This section is effective upon federal approval and to the extent approved as a federal waiver amendment.

Sec. 47. [256B.0918] EMPLOYEE SCHOLARSHIP COSTS.

Subdivision 1. PROGRAM CRITERIA. Beginning on or after October 1, 2005, within the limits of appropriations specifically available for this purpose, the commissioner shall provide funding to qualified provider applicants for employee scholarships for education in nursing and other health care fields. Employee scholarships must be for a course of study that is expected to lead to career advancement with the provider or in the field of long-term care, including home care or care of persons with disabilities, or nursing. Providers that secure this funding must use it to award scholarships to employees who work an average of at least 20 hours per week for the provider. Management staff, registered nurses, and therapists are not eligible to receive scholarships under this section.

Subd. 2. PARTICIPATING PROVIDERS. The commissioner shall publish a request for proposals in the State Register by August 15, 2005, specifying provider eligibility requirements, provider selection criteria, program specifics, funding mechanism, and methods of evaluation. The commissioner may publish additional requests for proposals in subsequent years. Providers who provide services funded through the following programs are eligible to apply to participate in the scholarship program: home and community-based waived services for persons with mental retardation or related conditions under section 256B.501; home and community-based waived services for the elderly under section 256B.0915; waived services under community alternatives for disabled individuals under section 256B.49; community alternative care waived services under section 256B.49; traumatic brain injury waived services under section 256B.49; nursing services and home health services under section 256B.0625, subdivision 6a; personal care services and nursing supervision of personal care services under section 256B.0625, subdivision 19a; private duty nursing services under section 256B.0625, subdivision 7; day training and habilitation services for adults with mental retardation or related conditions under sections 252.40 to 252.46; and intermediate care facilities for persons with mental retardation under section 256B.5012.

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Subd. 3. PROVIDER SELECTION CRITERIA. To be considered for scholarship funding, the provider shall submit a completed application within the time frame specified by the commissioner. In awarding funding, the commissioner shall consider the following:

(1) the size of the provider as measured in annual billing to the medical assistance program. To be eligible, a provider must receive at least \$500,000 annually in medical assistance payments;

(2) the percentage of employees meeting the scholarship program recipient requirements;

(3) staff retention rates for paraprofessionals; and

(4) other criteria determined by the commissioner.

Subd. 4. FUNDING SPECIFICS. Within the limits of appropriations specifically available for this purpose, for the rate period beginning on or after October 1, 2005, to September 30, 2007, the commissioner shall provide to each provider listed in subdivision 2 and awarded funds under subdivision 3 a medical assistance rate increase to fund scholarships up to two-tenths percent of the medical assistance reimbursement rate. The commissioner shall require providers to repay any portion of funds awarded under subdivision 3 that is not used to fund scholarships. If applications exceed available funding, funding shall be targeted to providers that employ a higher percentage of paraprofessional staff or have lower rates of turnover of paraprofessional staff. During the subsequent years of the program, the rate adjustment may be recalculated, at the discretion of the commissioner. In making a recalculation the commissioner may consider the provider's success at granting scholarships based on the amount spent during the previous year and the availability of appropriations to continue the program.

Subd. 5. REPORTING REQUIREMENTS. Participating providers shall report to the commissioner on a schedule determined by the commissioner and on a form supplied by the commissioner for a scholarship rate for rate periods beginning October 1, 2007. The report shall include the amount spent during the reporting period on eligible scholarships, and, for each scholarship recipient, the name of the recipient, the amount awarded, the educational institution attended, the nature of the educational program, the expected or actual program completion date, and a determination of the amount spent as a percentage of the provider's reimbursement. The commissioner shall require providers to repay all of the funds awarded under subdivision 3 if the report required in this subdivision is not filled according to the schedule determined by the commissioner.

Subd. 6. EVALUATION. The commissioner shall report to the legislature annually, beginning March 15, 2007, on the use of these funds.

Sec. 48. Minnesota Statutes 2004, section 256B.19, subdivision 1c, is amended to read:

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Subd. 1c. **ADDITIONAL PORTION OF NONFEDERAL SHARE.** (a) Hennepin County shall be responsible for a monthly transfer payment of \$1,500,000, due before noon on the 15th of each month and the University of Minnesota shall be responsible for a monthly transfer payment of \$500,000 due before noon on the 15th of each month, beginning July 15, 1995. These sums shall be part of the designated governmental unit's portion of the nonfederal share of medical assistance costs.

(b) Beginning July 1, 2001, Hennepin county's payment under paragraph (a) shall be \$2,066,000 each month.

(c) Beginning July 1, 2001, the commissioner shall increase annual capitation payments to the metropolitan health plan under section 256B.69 for the prepaid medical assistance program by approximately \$3,400,000, plus any available federal matching funds, to recognize higher than average medical education costs.

(d) Effective August 1, 2005, Hennepin County's payment under paragraphs (a) and (b) shall be reduced to \$566,000, and the University of Minnesota's payment under paragraph (a) shall be reduced to zero.

Sec. 49. Minnesota Statutes 2004, section 256B.195, subdivision 3, is amended to read:

Subd. 3. **PAYMENTS TO CERTAIN SAFETY NET PROVIDERS.** (a) Effective July 15, 2001, the commissioner shall make the following payments to the hospitals indicated after noon on the 15th of each month:

(1) to Hennepin County Medical Center, any federal matching funds available to match the payments received by the medical center under subdivision 2, to increase payments for medical assistance admissions and to recognize higher medical assistance costs in institutions that provide high levels of charity care; and

(2) to Regions Hospital, any federal matching funds available to match the payments received by the hospital under subdivision 2, to increase payments for medical assistance admissions and to recognize higher medical assistance costs in institutions that provide high levels of charity care.

(b) Effective July 15, 2001, the following percentages of the transfers under subdivision 2 shall be retained by the commissioner for deposit each month into the general fund:

(1) 18 percent, plus any federal matching funds, shall be allocated for the following purposes:

(i) during the fiscal year beginning July 1, 2001, of the amount available under this clause, 39.7 percent shall be allocated to make increased hospital payments under section 256.969, subdivision 26; 34.2 percent shall be allocated to fund the amounts due from small rural hospitals, as defined in section 144.148, for overpayments under section 256.969, subdivision 5a, resulting from a determination that medical assistance and general assistance payments exceeded the charge limit during the period from 1994 to 1997; and 26.1 percent shall be allocated to the commissioner of health for rural

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hospital capital improvement grants under section 144.148; and

(ii) during fiscal years beginning on or after July 1, 2002, of the amount available under this clause, 55 percent shall be allocated to make increased hospital payments under section 256.969, subdivision 26, and 45 percent shall be allocated to the commissioner of health for rural hospital capital improvement grants under section 144.148; and

(2) 11 percent shall be allocated to the commissioner of health to fund community clinic grants under section 145.9268.

(c) This subdivision shall apply to fee-for-service payments only and shall not increase capitation payments or payments made based on average rates. The allocation in paragraph (b), clause (1), item (ii), to increase hospital payments under section 256.969, subdivision 26, shall not limit payments under that section.

(d) Medical assistance rate or payment changes, including those required to obtain federal financial participation under section 62J.692, subdivision 8, shall precede the determination of intergovernmental transfer amounts determined in this subdivision. Participation in the intergovernmental transfer program shall not result in the offset of any health care provider's receipt of medical assistance payment increases other than limits resulting from hospital-specific charge limits and limits on disproportionate share hospital payments.

(e) Effective July 1, 2003, if the amount available for allocation under paragraph (b) is greater than the amounts available during March 2003, after any increase in intergovernmental transfers and payments that result from section 256.969, subdivision 3a, paragraph (c), are paid to the general fund, any additional amounts available under this subdivision after reimbursement of the transfers under subdivision 2 shall be allocated to increase medical assistance payments, subject to hospital-specific charge limits and limits on disproportionate share hospital payments, as follows:

(1) if the payments under subdivision 5 are approved, the amount shall be paid to the largest ten percent of hospitals as measured by 2001 payments for medical assistance, general assistance medical care, and MinnesotaCare in the nonstate government hospital category. Payments shall be allocated according to each hospital's proportionate share of the 2001 payments; or

(2) if the payments under subdivision 5 are not approved, the amount shall be paid to the largest ten percent of hospitals as measured by 2001 payments for medical assistance, general assistance medical care, and MinnesotaCare in the nonstate government category and to the largest ten percent of hospitals as measured by payments for medical assistance, general assistance medical care, and MinnesotaCare in the nongovernment hospital category. Payments shall be allocated according to each hospital's proportionate share of the 2001 payments in their respective category of nonstate government and nongovernment. The commissioner shall determine which hospitals are in the nonstate government and nongovernment hospital categories.

EFFECTIVE DATE. This section is effective August 1, 2005.

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Sec. 50. [256B.199] PAYMENTS REPORTED BY GOVERNMENTAL ENTITIES.

(a) Hennepin County, Hennepin County Medical Center, Ramsey County, Regions Hospital, the University of Minnesota, and Fairview-University Medical Center shall report quarterly to the commissioner beginning June 1, 2007, payments made during the second previous quarter that may qualify for reimbursement under federal law.

(b) Based on these reports, the commissioner shall apply for federal matching funds. These funds are appropriated to the commissioner for the payments under section 256.969, subdivision 27.

(c) By May 1 of each year, beginning May 1, 2007, the commissioner shall inform the nonstate entities listed in paragraph (a) of the amount of federal disproportionate share hospital payment money expected to be available in the current federal fiscal year.

(d) This section sunsets on June 30, 2009. The commissioner shall report to the legislature by December 15, 2008, with recommendations for maximizing federal disproportionate share hospital payments after June 30, 2009.

Sec. 51. Minnesota Statutes 2004, section 256B.69, subdivision 4, is amended to read:

Subd. 4. **LIMITATION OF CHOICE.** (a) The commissioner shall develop criteria to determine when limitation of choice may be implemented in the experimental counties. The criteria shall ensure that all eligible individuals in the county have continuing access to the full range of medical assistance services as specified in subdivision 6.

(b) The commissioner shall exempt the following persons from participation in the project, in addition to those who do not meet the criteria for limitation of choice:

(1) persons eligible for medical assistance according to section 256B.055, subdivision 1;

(2) persons eligible for medical assistance due to blindness or disability as determined by the Social Security Administration or the state medical review team, unless:

(i) they are 65 years of age or older; or

(ii) they reside in Itasca County or they reside in a county in which the commissioner conducts a pilot project under a waiver granted pursuant to section 1115 of the Social Security Act;

(3) recipients who currently have private coverage through a health maintenance organization;

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(4) recipients who are eligible for medical assistance by spending down excess income for medical expenses other than the nursing facility per diem expense;

(5) recipients who receive benefits under the Refugee Assistance Program, established under United States Code, title 8, section 1522(e);

(6) children who are both determined to be severely emotionally disturbed and receiving case management services according to section 256B.0625, subdivision 20;

(7) adults who are both determined to be seriously and persistently mentally ill and received case management services according to section 256B.0625, subdivision 20;

(8) persons eligible for medical assistance according to section 256B.057, subdivision 10; and

(9) persons with access to cost-effective employer-sponsored private health insurance or persons enrolled in an non-Medicare individual health plan determined to be cost-effective according to section 256B.0625, subdivision 15.

Children under age 21 who are in foster placement may enroll in the project on an elective basis. Individuals excluded under clauses (1), (6), and (7) may choose to enroll on an elective basis. The commissioner may enroll recipients in the prepaid medical assistance program for seniors who are (1) age 65 and over, and (2) eligible for medical assistance by spending down excess income.

(c) The commissioner may allow persons with a one-month spenddown who are otherwise eligible to enroll to voluntarily enroll or remain enrolled, if they elect to prepay their monthly spenddown to the state.

(d) The commissioner may require those individuals to enroll in the prepaid medical assistance program who otherwise would have been excluded under paragraph (b), clauses (1), (3), and (8), and under Minnesota Rules, part 9500.1452, subpart 2, items H, K, and L.

(e) Before limitation of choice is implemented, eligible individuals shall be notified and after notification, shall be allowed to choose only among demonstration providers. The commissioner may assign an individual with private coverage through a health maintenance organization, to the same health maintenance organization for medical assistance coverage, if the health maintenance organization is under contract for medical assistance in the individual's county of residence. After initially choosing a provider, the recipient is allowed to change that choice only at specified times as allowed by the commissioner. If a demonstration provider ends participation in the project for any reason, a recipient enrolled with that provider must select a new provider but may change providers without cause once more within the first 60 days after enrollment with the second provider.

(f) An infant born to a woman who is eligible for and receiving medical assistance and who is enrolled in the prepaid medical assistance program shall be retroactively enrolled to the month of birth in the same managed care plan as the mother once the

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child is enrolled in medical assistance unless the child is determined to be excluded from enrollment in a prepaid plan under this section.

EFFECTIVE DATE. This section is effective September 1, 2005.

Sec. 52. Minnesota Statutes 2004, section 256D.03, subdivision 3, as amended by Laws 2005, chapter 98, article 2, section 14, is amended to read:

Subd. 3. **GENERAL ASSISTANCE MEDICAL CARE; ELIGIBILITY.** (a) General assistance medical care may be paid for any person who is not eligible for medical assistance under chapter 256B, including eligibility for medical assistance based on a spenddown of excess income according to section 256B.056, subdivision 5, or MinnesotaCare as defined in paragraph (b), except as provided in paragraph (c), and:

(1) who is receiving assistance under section 256D.05, except for families with children who are eligible under Minnesota family investment program (MFIP), or who is having a payment made on the person's behalf under sections 256I.01 to 256I.06; or

(2) who is a resident of Minnesota; and

(i) who has gross countable income not in excess of 75 percent of the federal poverty guidelines for the family size, using a six-month budget period and whose equity in assets is not in excess of \$1,000 per assistance unit. Exempt assets, the reduction of excess assets, and the waiver of excess assets must conform to the medical assistance program in section 256B.056, subdivision 3, with the following exception: the maximum amount of undistributed funds in a trust that could be distributed to or on behalf of the beneficiary by the trustee, assuming the full exercise of the trustee's discretion under the terms of the trust, must be applied toward the asset maximum;

(ii) who has gross countable income above 75 percent of the federal poverty guidelines but not in excess of 175 percent of the federal poverty guidelines for the family size, using a six-month budget period, whose equity in assets is not in excess of the limits in section 256B.056, subdivision 3c, and who applies during an inpatient hospitalization; or

(iii) the commissioner shall adjust the income standards under this section each July 1 by the annual update of the federal poverty guidelines following publication by the United States Department of Health and Human Services.

(b) Effective for applications and renewals processed on or after September 1, 2006, general assistance medical care may not be paid for applicants or recipients who meet all eligibility requirements of MinnesotaCare as defined in sections 256L.01 to 256L.16, and are adults with dependent children under 21 whose gross family income is equal to or less than 275 percent of the federal poverty guidelines who are not described in paragraph (e).

(c) Effective for applications and renewals processed on or after September 1, 2006, general assistance medical care may be paid for applicants and recipients who meet all eligibility requirements of paragraph (a), clause (2), item (i), for a temporary period beginning the date of application. Immediately following approval of general

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assistance medical care, enrollees shall be enrolled in MinnesotaCare under section 256L.04, subdivision 7, with covered services as provided in section 256L.03 for the rest of the six-month eligibility period, until their six-month renewal.

(d) To be eligible for general assistance medical care following enrollment in MinnesotaCare as required by paragraph (c), an individual must complete a new application.

(e) Applicants and recipients eligible under paragraph (a), clause (1), or who have applied for and are awaiting a determination of blindness or disability by the state medical review team or a determination of eligibility for Supplemental Security Income or Social Security Disability Insurance by the Social Security Administration, or who fail to meet the requirements of section 256L.09, subdivision 2, are exempt from the MinnesotaCare enrollment requirements of this subdivision.

(f) For applications received on or after October 1, 2003, eligibility may begin no earlier than the date of application. For individuals eligible under paragraph (a), clause (2), item (i), a redetermination of eligibility must occur every 12 months. Individuals are eligible under paragraph (a), clause (2), item (ii), only during inpatient hospitalization but may reapply if there is a subsequent period of inpatient hospitalization.

(g) Beginning January September 1, 2000 2006, Minnesota health care program applications and renewals completed by recipients and applicants who are persons described in paragraph (b), may be returned (c) and submitted to the county agency to be forwarded to the Department of Human Services or sent directly to the Department of Human Services for enrollment in MinnesotaCare shall be determined for MinnesotaCare eligibility by the county agency. If all other eligibility requirements of this subdivision are met, eligibility for general assistance medical care shall be available in any month during which a MinnesotaCare eligibility determination and enrollment are is pending. Upon notification of eligibility for MinnesotaCare, notice of termination for eligibility for general assistance medical care shall be sent to an applicant or recipient. If all other eligibility requirements of this subdivision are met, eligibility for general assistance medical care shall be available until enrollment in MinnesotaCare subject to the provisions of paragraph (e) paragraphs (c), (c), and (f).

(d) (h) The date of an initial Minnesota health care program application necessary to begin a determination of eligibility shall be the date the applicant has provided a name, address, and Social Security number, signed and dated, to the county agency or the Department of Human Services. If the applicant is unable to provide a name, address, Social Security number, and signature when health care is delivered due to a medical condition or disability, a health care provider may act on an applicant's behalf to establish the date of an initial Minnesota health care program application by providing the county agency or Department of Human Services with provider identification and a temporary unique identifier for the applicant. The applicant must complete the remainder of the application and provide necessary verification before eligibility can be determined. The county agency must assist the applicant in obtaining verification if necessary.

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~~(e)~~ (i) County agencies are authorized to use all automated databases containing information regarding recipients' or applicants' income in order to determine eligibility for general assistance medical care or MinnesotaCare. Such use shall be considered sufficient in order to determine eligibility and premium payments by the county agency.

~~(f)~~ (j) General assistance medical care is not available for a person in a correctional facility unless the person is detained by law for less than one year in a county correctional or detention facility as a person accused or convicted of a crime, or admitted as an inpatient to a hospital on a criminal hold order, and the person is a recipient of general assistance medical care at the time the person is detained by law or admitted on a criminal hold order and as long as the person continues to meet other eligibility requirements of this subdivision.

~~(g)~~ (k) General assistance medical care is not available for applicants or recipients who do not cooperate with the county agency to meet the requirements of medical assistance.

~~(h)~~ (l) In determining the amount of assets of an individual eligible under paragraph (a), clause (2), item (i), there shall be included any asset or interest in an asset, including an asset excluded under paragraph (a), that was given away, sold, or disposed of for less than fair market value within the 60 months preceding application for general assistance medical care or during the period of eligibility. Any transfer described in this paragraph shall be presumed to have been for the purpose of establishing eligibility for general assistance medical care, unless the individual furnishes convincing evidence to establish that the transaction was exclusively for another purpose. For purposes of this paragraph, the value of the asset or interest shall be the fair market value at the time it was given away, sold, or disposed of, less the amount of compensation received. For any uncompensated transfer, the number of months of ineligibility, including partial months, shall be calculated by dividing the uncompensated transfer amount by the average monthly per person payment made by the medical assistance program to skilled nursing facilities for the previous calendar year. The individual shall remain ineligible until this fixed period has expired. The period of ineligibility may exceed 30 months, and a reapplication for benefits after 30 months from the date of the transfer shall not result in eligibility unless and until the period of ineligibility has expired. The period of ineligibility begins in the month the transfer was reported to the county agency, or if the transfer was not reported, the month in which the county agency discovered the transfer, whichever comes first. For applicants, the period of ineligibility begins on the date of the first approved application.

~~(i)~~ (m) When determining eligibility for any state benefits under this subdivision, the income and resources of all noncitizens shall be deemed to include their sponsor's income and resources as defined in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, title IV, Public Law 104-193, sections 421 and 422, and subsequently set out in federal rules.

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(n) Undocumented noncitizens and nonimmigrants are ineligible for general assistance medical care. For purposes of this subdivision, a nonimmigrant is an individual in one or more of the classes listed in United States Code, title 8, section 1101(a)(15), and an undocumented noncitizen is an individual who resides in the United States without the approval or acquiescence of the Immigration and Naturalization Service.

(o) Notwithstanding any other provision of law, a noncitizen who is ineligible for medical assistance due to the deeming of a sponsor's income and resources, is ineligible for general assistance medical care.

(p) Effective July 1, 2003, general assistance medical care emergency services end.

EFFECTIVE DATE. This section is effective September 1, 2006.

Sec. 53. Minnesota Statutes 2004, section 256D.03, subdivision 4, is amended to read:

Subd. 4. **GENERAL ASSISTANCE MEDICAL CARE; SERVICES.** (a)(i) For a person who is eligible under subdivision 3, paragraph (a), clause (2), item (i), general assistance medical care covers, except as provided in paragraph (c):

- (1) inpatient hospital services;
- (2) outpatient hospital services;
- (3) services provided by Medicare certified rehabilitation agencies;
- (4) prescription drugs and other products recommended through the process established in section 256B.0625, subdivision 13;
- (5) equipment necessary to administer insulin and diagnostic supplies and equipment for diabetics to monitor blood sugar level;
- (6) eyeglasses and eye examinations provided by a physician or optometrist;
- (7) hearing aids;
- (8) prosthetic devices;
- (9) laboratory and X-ray services;
- (10) physician's services;
- (11) medical transportation except special transportation;
- (12) chiropractic services as covered under the medical assistance program;
- (13) podiatric services;
- (14) dental services and dentures, subject to the limitations specified in section 256B.0625, subdivision 9 as covered under the medical assistance program;

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(15) outpatient services provided by a mental health center or clinic that is under contract with the county board and is established under section 245.62;

(16) day treatment services for mental illness provided under contract with the county board;

(17) prescribed medications for persons who have been diagnosed as mentally ill as necessary to prevent more restrictive institutionalization;

(18) psychological services, medical supplies and equipment, and Medicare premiums, coinsurance and deductible payments;

(19) medical equipment not specifically listed in this paragraph when the use of the equipment will prevent the need for costlier services that are reimbursable under this subdivision;

(20) services performed by a certified pediatric nurse practitioner, a certified family nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological nurse practitioner, a certified neonatal nurse practitioner, or a certified geriatric nurse practitioner in independent practice, if (1) the service is otherwise covered under this chapter as a physician service, (2) the service provided on an inpatient basis is not included as part of the cost for inpatient services included in the operating payment rate, and (3) the service is within the scope of practice of the nurse practitioner's license as a registered nurse, as defined in section 148.171;

(21) services of a certified public health nurse or a registered nurse practicing in a public health nursing clinic that is a department of, or that operates under the direct authority of, a unit of government, if the service is within the scope of practice of the public health nurse's license as a registered nurse, as defined in section 148.171; and

(22) telemedicine consultations, to the extent they are covered under section 256B.0625, subdivision 3b.

(ii) Effective October 1, 2003, for a person who is eligible under subdivision 3, paragraph (a), clause (2), item (ii), general assistance medical care coverage is limited to inpatient hospital services, including physician services provided during the inpatient hospital stay. A \$1,000 deductible is required for each inpatient hospitalization.

(b) Gender Effective August 1, 2005, sex reassignment surgery and related services ~~are is not covered services under this subdivision unless the individual began receiving gender reassignment services prior to July 1, 1995.~~

(c) In order to contain costs, the commissioner of human services shall select vendors of medical care who can provide the most economical care consistent with high medical standards and shall where possible contract with organizations on a prepaid capitation basis to provide these services. The commissioner shall consider proposals by counties and vendors for prepaid health plans, competitive bidding programs, block grants, or other vendor payment mechanisms designed to provide services in an economical manner or to control utilization, with safeguards to ensure

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that necessary services are provided. Before implementing prepaid programs in counties with a county operated or affiliated public teaching hospital or a hospital or clinic operated by the University of Minnesota, the commissioner shall consider the risks the prepaid program creates for the hospital and allow the county or hospital the opportunity to participate in the program in a manner that reflects the risk of adverse selection and the nature of the patients served by the hospital, provided the terms of participation in the program are competitive with the terms of other participants considering the nature of the population served. Payment for services provided pursuant to this subdivision shall be as provided to medical assistance vendors of these services under sections 256B.02, subdivision 8, and 256B.0625. For payments made during fiscal year 1990 and later years, the commissioner shall consult with an independent actuary in establishing prepayment rates, but shall retain final control over the rate methodology.

(d) Recipients eligible under subdivision 3, paragraph (a), clause (2), item (i), shall pay the following co-payments for services provided on or after October 1, 2003:

(1) ~~\$3 per nonpreventive visit. For purposes of this subdivision, a visit means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;~~

~~(2) \$25 for eyeglasses;~~

~~(3) (2) \$25 for nonemergency visits to a hospital-based emergency room;~~

~~(4) (3) \$3 per brand-name drug prescription and \$1 per generic drug prescription, subject to a \$20 \$12 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness; and~~

~~(5) (4) 50 percent coinsurance on restorative dental services.~~

(e) Co-payments shall be limited to one per day per provider for nonpreventive visits, eyeglasses, and nonemergency visits to a hospital-based emergency room. Recipients of general assistance medical care are responsible for all co-payments in this subdivision. The general assistance medical care reimbursement to the provider 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 \$12 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 (f).

(f) 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.

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(g) Any county may, from its own resources, provide medical payments for which state payments are not made.

(h) Chemical dependency services that are reimbursed under chapter 254B must not be reimbursed under general assistance medical care.

(i) The maximum payment for new vendors enrolled in the general assistance medical care program after the base year shall be determined from the average usual and customary charge of the same vendor type enrolled in the base year.

(j) The conditions of payment for services under this subdivision are the same as the conditions specified in rules adopted under chapter 256B governing the medical assistance program, unless otherwise provided by statute or rule.

(k) Inpatient and outpatient payments shall be reduced by five percent, effective July 1, 2003. This reduction is in addition to the five percent reduction effective July 1, 2003, and incorporated by reference in paragraph (i).

(l) Payments for all other health services except inpatient, outpatient, and pharmacy services shall be reduced by five percent, effective July 1, 2003.

(m) Payments to managed care plans shall be reduced by five percent for services provided on or after October 1, 2003.

(n) A hospital receiving a reduced payment as a result of this section may apply the unpaid balance toward satisfaction of the hospital's bad debts.

(o) Fee-for-service payments for nonpreventive visits shall be reduced by \$3 for services provided on or after January 1, 2006. For purposes of this subdivision, a visit means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, advance practice nurse, audiologist, optician, or optometrist.

(p) Payments to managed care plans shall not be increased as a result of the removal of the \$3 nonpreventive visit co-payment effective January 1, 2006.

EFFECTIVE DATE. Paragraph (b) is effective August 1, 2005, and paragraph (d) is effective January 1, 2006.

Sec. 54. Minnesota Statutes 2004, section 256D.045, is amended to read:

256D.045 SOCIAL SECURITY NUMBER REQUIRED.

To be eligible for general assistance under sections 256D.01 to 256D.21, an individual must provide the individual's Social Security number to the county agency or submit proof that an application has been made. An individual who refuses to provide a Social Security number because of a well-established religious objection as described in Code of Federal Regulations, title 42, section 435.910, may be eligible for general assistance medical care under section 256D.03. The provisions of this section do not apply to the determination of eligibility for emergency general assistance under

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section 256D.06, subdivision 2. This provision applies to eligible children under the age of 18 effective July 1, 1997.

EFFECTIVE DATE. This section is effective August 1, 2007, or upon HealthMatch implementation, whichever is later.

Sec. 55. Minnesota Statutes 2004, section 256L.01, subdivision 4, is amended to read:

Subd. 4. **GROSS INDIVIDUAL OR GROSS FAMILY INCOME.** (a) "Gross individual or gross family income" for nonfarm self-employed means income calculated for the six-month period of eligibility using as the baseline the adjusted gross income the net profit or loss reported on the applicant's federal income tax form for the previous year and adding back in reported depreciation, carryover loss, and net operating loss amounts that apply to the business in which the family is currently engaged using the medical assistance families with children methodology for determining allowable and nonallowable self-employment expenses and countable income.

(b) "Gross individual or gross family income" for farm self-employed means income calculated for the six-month period of eligibility using as the baseline the adjusted gross income reported on the applicant's federal income tax form for the previous year and adding back in reported depreciation amounts that apply to the business in which the family is currently engaged.

(c) Applicants shall report the most recent financial situation of the family if it has changed from the period of time covered by the federal income tax form. The report may be in the form of percentage increase or decrease "Gross individual or gross family income" means the total income for all family members, calculated for the six-month period of eligibility.

EFFECTIVE DATE. This section is effective August 1, 2007, or upon HealthMatch implementation, whichever is later.

Sec. 56. Minnesota Statutes 2004, section 256L.01, subdivision 5, is amended to read:

Subd. 5. **INCOME.** (a) "Income" has the meaning given for earned and unearned income for families and children in the medical assistance program, according to the state's aid to families with dependent children plan in effect as of July 16, 1996. The definition does not include medical assistance income methodologies and deeming requirements. The earned income of full-time and part-time students under age 19 is not counted as income. Public assistance payments and supplemental security income are not excluded income.

(b) For purposes of this subdivision, and unless otherwise specified in this section, the commissioner shall use reasonable methods to calculate gross earned and unearned income including, but not limited to, projecting income based on income received within the past 30 days, the last 90 days, or the last 12 months.

EFFECTIVE DATE. This section is effective retroactively from July 1, 2005.

New language is indicated by underline, deletions by strikeout.

Sec. 57. Minnesota Statutes 2004, section 256L.03, subdivision 1, is amended to read:

Subdivision 1. **COVERED HEALTH SERVICES.** For individuals under section 256L.04, subdivision 7, with income no greater than 75 percent of the federal poverty guidelines or for families with children under section 256L.04, subdivision 1, all subdivisions of this section apply. "Covered health services" means the health services reimbursed under chapter 256B, with the exception of inpatient hospital services, special education services, private duty nursing services, adult dental care services other than services covered under section 256B.0625, subdivision 9, paragraph (b), orthodontic services, nonemergency medical transportation services, personal care assistant and case management services, nursing home or intermediate care facilities services, inpatient mental health services, and chemical dependency services. Outpatient mental health services covered under the MinnesotaCare program are limited to diagnostic assessments, psychological testing, explanation of findings, medication management by a physician, day treatment, partial hospitalization, and individual, family, and group psychotherapy.

No public funds shall be used for coverage of abortion under MinnesotaCare except where the life of the female would be endangered or substantial and irreversible impairment of a major bodily function would result if the fetus were carried to term; or where the pregnancy is the result of rape or incest.

Covered health services shall be expanded as provided in this section.

EFFECTIVE DATE. This section is effective January 1, 2006.

Sec. 58. Minnesota Statutes 2004, section 256L.03, subdivision 1b, is amended to read:

Subd. 1b. **PREGNANT WOMEN; ELIGIBILITY FOR FULL MEDICAL ASSISTANCE SERVICES.** Beginning January 1, 1999, A pregnant woman who is enrolled in MinnesotaCare when her pregnancy is diagnosed is eligible for coverage of all services provided under the medical assistance program according to chapter 256B retroactive to the date the pregnancy is medically diagnosed of conception. Co-payments totaling \$30 or more, paid after the date the pregnancy is diagnosed of conception, shall be refunded.

EFFECTIVE DATE. This section is effective September 1, 2005.

Sec. 59. Minnesota Statutes 2004, section 256L.03, subdivision 5, is amended to read:

Subd. 5. **CO-PAYMENTS AND COINSURANCE.** (a) Except as provided in paragraphs (b) and (c), the MinnesotaCare benefit plan shall include the following co-payments and coinsurance requirements for all enrollees:

(1) ten percent of the paid charges for inpatient hospital services for adult enrollees, subject to an annual inpatient out-of-pocket maximum of \$1,000 per individual and \$3,000 per family;

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- (2) \$3 per prescription for adult enrollees;
- (3) \$25 for eyeglasses for adult enrollees; and

(4) \$3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;

- (5) \$6 for nonemergency visits to a hospital-based emergency room; and

(6) 50 percent of the fee-for-service rate for adult dental care services other than preventive care services for persons eligible under section 256L.04, subdivisions 1 to 7, with income equal to or less than 175 percent of the federal poverty guidelines.

(b) Paragraph (a), clause (1), does not apply to parents and relative caretakers of children under the age of 21 in households with family income equal to or less than 175 percent of the federal poverty guidelines. Paragraph (a), clause (1), does not apply to parents and relative caretakers of children under the age of 21 in households with family income greater than 175 percent of the federal poverty guidelines for inpatient hospital admissions occurring on or after January 1, 2001.

(c) Paragraph (a), clauses (1) to (4), do not apply to pregnant women and children under the age of 21.

(d) 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.

EFFECTIVE DATE. This section is effective January 1, 2006.

Sec. 60. Minnesota Statutes 2004, section 256L.035, is amended to read:

256L.035 LIMITED BENEFITS COVERAGE FOR CERTAIN SINGLE ADULTS AND HOUSEHOLDS WITHOUT CHILDREN.

(a) "Covered health services" for individuals under section 256L.04, subdivision 7, with income above 75 percent, but not exceeding 175 percent, of the federal poverty guideline means:

- (1) inpatient hospitalization benefits with a ten percent co-payment up to \$1,000 and subject to an annual limitation of \$10,000;
- (2) physician services provided during an inpatient stay; and

New language is indicated by underline, deletions by ~~strikeout~~.

(3) physician services not provided during an inpatient stay; outpatient hospital services; freestanding ambulatory surgical center services; chiropractic services; lab and diagnostic services; diabetic supplies and equipment; and prescription drugs; subject to an aggregate cap of \$2,000 per calendar year and the following co-payments:

- (i) \$50 co-pay per emergency room visit;
- (ii) \$3 co-pay per prescription drug; and
- (iii) \$5 co-pay per nonpreventive physician visit.

The services covered under this section may be provided by a physician, physician ancillary, chiropractor, psychologist, or licensed independent clinical social worker if the services are within the scope of practice of that health care professional.

For purposes of this subdivision section, "a visit" means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary any health care provider identified in this paragraph.

Enrollees are responsible for all co-payments in this subdivision section.

(b) The November 2006 MinnesotaCare forecast for the biennium beginning July 1, 2007, shall assume an adjustment in the aggregate cap on the services identified in paragraph (a), clause (3), in \$1,000 increments up to a maximum of \$10,000, but not less than \$2,000, to the extent that the balance in the health care access fund is sufficient in each year of the biennium to pay for this benefit level. The aggregate cap shall be adjusted according to the forecast.

(e) 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 (d) (c).

(d) (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, 2006.

Sec. 61. Minnesota Statutes 2004, section 256L.04, is amended by adding a subdivision to read:

Subd. 1a. SOCIAL SECURITY NUMBER REQUIRED. (a) Individuals and families applying for MinnesotaCare coverage must provide a Social Security number.

(b) The commissioner shall not deny eligibility to an otherwise eligible applicant who has applied for a Social Security number and is awaiting issuance of that Social Security number.

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(c) Newborns enrolled under section 256L.05, subdivision 3, are exempt from the requirements of this subdivision.

(d) Individuals who refuse to provide a Social Security number because of well-established religious objections are exempt from the requirements of this subdivision. The term "well-established religious objections" has the meaning given in Code of Federal Regulations, title 42, section 435.910.

EFFECTIVE DATE. This section is effective August 1, 2007, or upon HealthMatch implementation, whichever is later.

Sec. 62. Minnesota Statutes 2004, section 256L.04, subdivision 2, is amended to read:

Subd. 2. **COOPERATION IN ESTABLISHING THIRD-PARTY LIABILITY, PATERNITY, AND OTHER MEDICAL SUPPORT.** (a) To be eligible for MinnesotaCare, individuals and families must cooperate with the state agency to identify potentially liable third-party payers and assist the state in obtaining third-party payments. "Cooperation" includes, but is not limited to, complying with the notice requirements in section 256B.056, subdivision 9, identifying any third party who may be liable for care and services provided under MinnesotaCare to the enrollee, providing relevant information to assist the state in pursuing a potentially liable third party, and completing forms necessary to recover third-party payments.

(b) A parent, guardian, relative caretaker, or child enrolled in the MinnesotaCare program must cooperate with the Department of Human Services and the local agency in establishing the paternity of an enrolled child and in obtaining medical care support and payments for the child and any other person for whom the person can legally assign rights, in accordance with applicable laws and rules governing the medical assistance program. A child shall not be ineligible for or disenrolled from the MinnesotaCare program solely because the child's parent, relative caretaker, or guardian fails to cooperate in establishing paternity or obtaining medical support.

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 63. Minnesota Statutes 2004, section 256L.04, is amended by adding a subdivision to read:

Subd. 2a. **APPLICATIONS FOR OTHER BENEFITS.** To be eligible for MinnesotaCare, individuals and families must take all necessary steps to obtain other benefits as described in Code of Federal Regulations, title 42, section 435.608. Applicants and enrollees must apply for other benefits within 30 days of notification.

EFFECTIVE DATE. This section is effective August 1, 2007, or upon HealthMatch implementation, whichever is later.

Sec. 64. Minnesota Statutes 2004, section 256L.05, is amended by adding a subdivision to read:

Subd. 1b. **MINNESOTACARE ENROLLMENT BY COUNTY AGENCIES.** Beginning September 1, 2006, county agencies shall enroll single adults and

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households with no children formerly enrolled in general assistance medical care in MinnesotaCare according to section 256D.03, subdivision 3. County agencies shall perform all duties necessary to administer the MinnesotaCare program ongoing for these enrollees, including the redetermination of MinnesotaCare eligibility at six-month renewal.

EFFECTIVE DATE. This section is effective September 1, 2006.

Sec. 65. Minnesota Statutes 2004, section 256L.05, subdivision 2, is amended to read:

Subd. 2. **COMMISSIONER'S DUTIES.** (a) The commissioner or county agency shall use electronic verification as the primary method of income verification. If there is a discrepancy between reported income and electronically verified income, an individual may be required to submit additional verification. In addition, the commissioner shall perform random audits to verify reported income and eligibility. The commissioner may execute data sharing arrangements with the Department of Revenue and any other governmental agency in order to perform income verification related to eligibility and premium payment under the MinnesotaCare program.

(b) In determining eligibility for MinnesotaCare, the commissioner shall require applicants and enrollees seeking renewal of eligibility to verify both earned and unearned income. The commissioner shall also require applicants and enrollees to submit the names of their employers and a contact name with a telephone number for each employer for purposes of verifying whether the applicant or enrollee, and any dependents, are eligible for employer-subsidized coverage. Data collected is nonpublic data as defined in section 13.02, subdivision 9.

EFFECTIVE DATE. This section is effective September 1, 2005. Prior to the implementation of HealthMatch, the commissioner shall implement this section to the fullest extent possible, including the use of manual processing. Upon implementation of HealthMatch, the commissioner shall implement this section in a manner consistent with the procedures and requirements of HealthMatch.

Sec. 66. Minnesota Statutes 2004, section 256L.05, subdivision 3, is amended to read:

Subd. 3. **EFFECTIVE DATE OF COVERAGE.** (a) The effective date of coverage is the first day of the month following the month in which eligibility is approved and the first premium payment has been received. As provided in section 256B.057, coverage for newborns is automatic from the date of birth and must be coordinated with other health coverage. The effective date of coverage for eligible newly adoptive children added to a family receiving covered health services is the date of entry into the family month of placement. The effective date of coverage for other new recipients members added to the family receiving covered health services is the first day of the month following the month in which eligibility is approved or at renewal, whichever the family receiving covered health services prefers the change is reported. All eligibility criteria must be met by the family at the time the new family

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member is added. The income of the new family member is included with the family's gross income and the adjusted premium begins in the month the new family member is added.

(b) The initial premium must be received by the last working day of the month for coverage to begin the first day of the following month.

(c) Benefits are not available until the day following discharge if an enrollee is hospitalized on the first day of coverage.

(d) Notwithstanding any other law to the contrary, benefits under sections 256L.01 to 256L.18 are secondary to a plan of insurance or benefit program under which an eligible person may have coverage and the commissioner shall use cost avoidance techniques to ensure coordination of any other health coverage for eligible persons. The commissioner shall identify eligible persons who may have coverage or benefits under other plans of insurance or who become eligible for medical assistance.

(e) The effective date of coverage for single adults and households with no children formerly enrolled in general assistance medical care and enrolled in MinnesotaCare according to section 256D.03, subdivision 3, is the first day of the month following the last day of general assistance medical care coverage.

EFFECTIVE DATE. Paragraph (a) is effective August 1, 2007, or upon HealthMatch implementation, whichever is later, and paragraph (e) is effective September 1, 2006.

Sec. 67. Minnesota Statutes 2004, section 256L.05, subdivision 3a, is amended to read:

Subd. 3a. **RENEWAL OF ELIGIBILITY.** (a) Beginning January 1, 1999, an enrollee's eligibility must be renewed every 12 months. The 12-month period begins in the month after the month the application is approved.

(b) Beginning October 1, 2004, an enrollee's eligibility must be renewed every six months. The first six-month period of eligibility begins in the month after the month the application is approved received by the commissioner. The effective date of coverage within the first six-month period of eligibility is as provided in subdivision 3. Each new period of eligibility must take into account any changes in circumstances that impact eligibility and premium amount. An enrollee must provide all the information needed to redetermine eligibility by the first day of the month that ends the eligibility period. The premium for the new period of eligibility must be received as provided in section 256L.06 in order for eligibility to continue.

(c) For single adults and households with no children formerly enrolled in general assistance medical care and enrolled in MinnesotaCare according to section 256D.03, subdivision 3, the first six-month period of eligibility begins the month the enrollee submitted the application or renewal for general assistance medical care.

EFFECTIVE DATE. Paragraph (b) is effective August 1, 2007, or upon HealthMatch implementation, whichever is later, and paragraph (c) is effective September 1, 2006.

New language is indicated by underline, deletions by strikeout.

Sec. 68. Minnesota Statutes 2004, section 256L.06, subdivision 3, is amended to read:

Subd. 3. **COMMISSIONER'S DUTIES AND PAYMENT.** (a) Premiums are dedicated to the commissioner for MinnesotaCare.

(b) The commissioner shall develop and implement procedures to: (1) require enrollees to report changes in income; (2) adjust sliding scale premium payments, based upon changes both increases and decreases in enrollee income, at the time the change in income is reported; and (3) disenroll enrollees from MinnesotaCare for failure to pay required premiums. Failure to pay includes payment with a dishonored check, a returned automatic bank withdrawal, or a refused credit card or debit card payment. The commissioner may demand a guaranteed form of payment, including a cashier's check or a money order, as the only means to replace a dishonored, returned, or refused payment.

(c) Premiums are calculated on a calendar month basis and may be paid on a monthly, quarterly, or semiannual basis, with the first payment due upon notice from the commissioner of the premium amount required. The commissioner shall inform applicants and enrollees of these premium payment options. Premium payment is required before enrollment is complete and to maintain eligibility in MinnesotaCare. Premium payments received before noon are credited the same day. Premium payments received after noon are credited on the next working day.

(d) Nonpayment of the premium will result in disenrollment from the plan effective for the calendar month for which the premium was due. Persons disenrolled for nonpayment or who voluntarily terminate coverage from the program may not reenroll until four calendar months have elapsed. Persons disenrolled for nonpayment who pay all past due premiums as well as current premiums due, including premiums due for the period of disenrollment, within 20 days of disenrollment, shall be reenrolled retroactively to the first day of disenrollment. Persons disenrolled for nonpayment or who voluntarily terminate coverage from the program may not reenroll for four calendar months unless the person demonstrates good cause for nonpayment. Good cause does not exist if a person chooses to pay other family expenses instead of the premium. The commissioner shall define good cause in rule.

EFFECTIVE DATE. This section is effective September 1, 2005, or upon federal approval, whichever is later. Prior to the implementation of HealthMatch, the commissioner shall implement this section to the fullest extent possible, including the use of manual processing. Upon implementation of HealthMatch, the commissioner shall implement this section in a manner consistent with the procedures and requirements of HealthMatch.

Sec. 69. Minnesota Statutes 2004, section 256L.07, subdivision 1, as amended by Laws 2005, chapter 10, article 1, section 56, is amended to read:

Subdivision 1. **GENERAL REQUIREMENTS.** (a) Children enrolled in the original children's health plan as of September 30, 1992, children who enrolled in the

New language is indicated by underline, deletions by strikeout.

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

(b) Families enrolled in MinnesotaCare under section 256L.04, subdivision 1, whose income increases above 275 percent of the federal poverty guidelines, are no longer eligible for the program and shall be disenrolled by the commissioner. Individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose income increases above 175 percent of the federal poverty guidelines are no longer eligible for the program and shall be disenrolled by the commissioner. For persons disenrolled under this subdivision, MinnesotaCare coverage terminates the last day of the calendar month following the month in which the commissioner determines that the income of a family or individual exceeds program income limits.

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

(d) Notwithstanding paragraphs (b) and (c), parents are not eligible for MinnesotaCare if gross household income exceeds ~~\$50,000~~ \$25,000 for the six-month period of eligibility.

EFFECTIVE DATE. This section is effective August 1, 2007, or upon HealthMatch implementation, whichever is later.

Sec. 70. Minnesota Statutes 2004, section 256L.07, is amended by adding a subdivision to read:

Subd. 2a. MUST NOT HAVE ACCESS TO HEALTH COVERAGE THROUGH A POSTSECONDARY EDUCATION INSTITUTION. To be eligible, an individual under 21 years of age who is enrolled in a program of study at a postsecondary education institution, including an emancipated minor and an emancipated minor's spouse, must not have access to health coverage through the postsecondary education institution.

New language is indicated by underline, deletions by ~~strikeout~~.

EFFECTIVE DATE. This section is effective September 1, 2005, or upon federal approval, whichever is later. Prior to implementation of HealthMatch, the commissioner shall implement the section to the fullest extent possible, including the use of manual processing. Upon implementation of HealthMatch, the commissioner shall implement this section in a manner consistent with the procedures and requirements of HealthMatch.

Sec. 71. Minnesota Statutes 2004, section 256L.07, subdivision 3, is amended to read:

Subd. 3. **OTHER HEALTH COVERAGE.** (a) Families and individuals enrolled in the MinnesotaCare program must have no health coverage while enrolled or for at least four months prior to application and renewal. Children enrolled in the original children's health plan and children in families with income equal to or less than 150 percent of the federal poverty guidelines, who have other health insurance, are eligible if the coverage:

(1) lacks two or more of the following:

(i) basic hospital insurance;

(ii) medical-surgical insurance;

(iii) prescription drug coverage;

(iv) dental coverage; or

(v) vision coverage;

(2) requires a deductible of \$100 or more per person per year; or

(3) lacks coverage because the child has exceeded the maximum coverage for a particular diagnosis or the policy excludes a particular diagnosis.

The commissioner may change this eligibility criterion for sliding scale premiums in order to remain within the limits of available appropriations. The requirement of no health coverage does not apply to newborns.

(b) Medical assistance, general assistance medical care, and the Civilian Health and Medical Program of the Uniformed Service, CHAMPUS, or other coverage provided under United States Code, title 10, subtitle A, part II, chapter 55, are not considered insurance or health coverage for purposes of the four-month requirement described in this subdivision.

(c) For purposes of this subdivision, an applicant or enrollee who is entitled to Medicare Part A or enrolled in Medicare Part B coverage under title XVIII of the Social Security Act, United States Code, title 42, sections 1395c to 1395w-4 1395w-152, is considered to have health coverage. An applicant or enrollee who is entitled to premium-free Medicare Part A may not refuse to apply for or enroll in Medicare coverage to establish eligibility for MinnesotaCare.

New language is indicated by underline, deletions by ~~strikeout~~.

(d) Applicants who were recipients of medical assistance or general assistance medical care within one month of application must meet the provisions of this subdivision and subdivision 2.

(e) ~~Effective October 1, 2003, applicants who were recipients of medical assistance and had Cost-effective health insurance which that was paid for by medical assistance are exempt from is not considered health coverage for purposes of the four-month requirement under this section, except if the insurance continued after medical assistance no longer considered it cost-effective or after medical assistance closed.~~

EFFECTIVE DATE. This section is effective September 1, 2005.

Sec. 72. Minnesota Statutes 2004, section 256L.07, is amended by adding a subdivision to read:

Subd. 6. EXCEPTION FOR CERTAIN ADULTS. Single adults and households with no children formerly enrolled in general assistance medical care and enrolled in MinnesotaCare according to section 256D.03, subdivision 3, are eligible without meeting the requirements of this section until six-month renewal.

EFFECTIVE DATE. This section is effective September 1, 2006.

Sec. 73. Minnesota Statutes 2004, section 256L.12, is amended by adding a subdivision to read:

Subd. 9b. RATE SETTING; RATABLE REDUCTION. In addition to the reduction in subdivision 9a, the total payment made to managed care plans under the MinnesotaCare program shall be reduced for services provided on or after January 1, 2006, to reflect a 6.0 percent reduction in reimbursement for inpatient hospital services.

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 74. Minnesota Statutes 2004, section 256L.15, subdivision 2, as amended by Laws 2005, chapter 10, article 1, section 57, is amended to read:

Subd. 2. SLIDING FEE SCALE TO DETERMINE PERCENTAGE OF MONTHLY GROSS INDIVIDUAL OR FAMILY INCOME. (a) The commissioner shall establish a sliding fee scale to determine the percentage of monthly gross individual or family income that households at different income levels must pay to obtain coverage through the MinnesotaCare program. The sliding fee scale must be based on the enrollee's monthly gross individual or family income. The sliding fee scale must contain separate tables based on enrollment of one, two, or three or more persons. The sliding fee scale begins with a premium of 1.5 percent of monthly gross individual or family income for individuals or families with incomes below the limits for the medical assistance program for families and children in effect on January 1, 1999, and proceeds through the following evenly spaced steps: 1.8, 2.3, 3.1, 3.8, 4.8, 5.9, 7.4, and 8.8 percent. These percentages are matched to evenly spaced income steps ranging from the medical assistance income limit for families and children in effect on

New language is indicated by underline, deletions by ~~strikeout~~.

January 1, 1999, to 275 percent of the federal poverty guidelines for the applicable family size, up to a family size of five. The sliding fee scale for a family of five must be used for families of more than five. Effective October 1, 2003, the commissioner shall increase each percentage by 0.5 percentage points for enrollees with income greater than 100 percent but not exceeding 200 percent of the federal poverty guidelines and shall increase each percentage by 1.0 percentage points for families and children with incomes greater than 200 percent of the federal poverty guidelines. The sliding fee scale and percentages are not subject to the provisions of chapter 14. If a family or individual reports increased income after enrollment, premiums shall not be adjusted until eligibility renewal at the time the change in income is reported.

(b) Children in families whose gross income is above 275 percent of the federal poverty guidelines shall pay the maximum premium.

The maximum premium is defined as a base charge for one, two, or three or more enrollees so that if all MinnesotaCare cases paid the maximum premium, the total revenue would equal the total cost of MinnesotaCare medical coverage and administration. In this calculation, administrative costs shall be assumed to equal ten percent of the total. The costs of medical coverage for pregnant women and children under age two and the enrollees in these groups shall be excluded from the total. The maximum premium for two enrollees shall be twice the maximum premium for one, and the maximum premium for three or more enrollees shall be three times the maximum premium for one.

(c) After calculating the percentage of premium each enrollee shall pay under paragraph (a), eight percent shall be added to the premium.

EFFECTIVE DATE. The amendment to paragraph (a) changing gross family or individual income to monthly gross family or individual income is effective August 1, 2007, or upon implementation of HealthMatch, whichever is later. The amendment to paragraph (a) related to premium adjustments and changes of income and the amendment to paragraph (c) are effective September 1, 2005, or upon federal approval, whichever is later. Prior to the implementation of HealthMatch, the commissioner shall implement this section to the fullest extent possible, including the use of manual processing. Upon implementation of HealthMatch, the commissioner shall implement this section in a manner consistent with the procedures and requirements of HealthMatch.

Sec. 75. Minnesota Statutes 2004, section 256L.15, subdivision 3, is amended to read:

Subd. 3. **EXCEPTIONS TO SLIDING SCALE.** An annual premium of \$48 is required for all Children in families with income at or less than below 150 percent of the federal poverty guidelines pay a monthly premium of \$4. .

EFFECTIVE DATE. This section is effective August 1, 2007, or upon HealthMatch implementation, whichever is later.

Sec. 76. Minnesota Statutes 2004, section 256L.15, is amended by adding a subdivision to read:

New language is indicated by underline, deletions by ~~strikeout~~.

Subd. 4. EXCEPTION FOR TRANSITIONED ADULTS. County agencies shall pay premiums for single adults and households with no children formerly enrolled in general assistance medical care and enrolled in MinnesotaCare according to section 256D.03, subdivision 3, until six-month renewal. The county agency has the option of continuing to pay premiums for these enrollees past the first six-month renewal period.

EFFECTIVE DATE. This section is effective September 1, 2006.

Sec. 77. Minnesota Statutes 2004, section 256L.17, is amended by adding a subdivision to read:

Subd. 7. EXCEPTION FOR CERTAIN ADULTS. Single adults and households with no children formerly enrolled in general assistance medical care and enrolled in MinnesotaCare according to section 256D.03, subdivision 3, are exempt from the requirements of this section until six-month renewal.

EFFECTIVE DATE. This section is effective September 1, 2006.

Sec. 78. Minnesota Statutes 2004, section 549.02, is amended by adding a subdivision to read:

Subd. 3. LIMITATION. Notwithstanding subdivisions 1 and 2, where the state agency is named or intervenes as a party to enforce the agency's rights under section 256B.056, the agency shall not be liable for costs to any prevailing defendant.

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 79. Minnesota Statutes 2004, section 549.04, is amended to read:

549.04 DISBURSEMENTS; TAXATION AND ALLOWANCE.

Subdivision 1. GENERALLY. In every action in a district court, the prevailing party, including any public employee who prevails in an action for wrongfully denied or withheld employment benefits or rights, shall be allowed reasonable disbursements paid or incurred, including fees and mileage paid for service of process by the sheriff or by a private person.

Subd. 2. LIMITATION. Notwithstanding subdivision 1, where the state agency is named or intervenes as a party to enforce the agency's rights under section 256B.056, the agency shall not be liable for disbursements to any prevailing defendant.

EFFECTIVE DATE. This section is effective August 1, 2005.

Sec. 80. Laws 2003, First Special Session chapter 14, article 12, section 93, is amended to read:

Sec. 93. REVIEW OF SPECIAL TRANSPORTATION ELIGIBILITY CRITERIA AND POTENTIAL COST SAVINGS.

The commissioner of human services, in consultation with the commissioner of transportation and special transportation service providers, shall review eligibility

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criteria for medical assistance special transportation services and shall evaluate whether the level of special transportation services provided should be based on the degree of impairment of the client, as well as the medical diagnosis. The commissioner shall also evaluate methods for reducing the cost of special transportation services, including, but not limited to:

- (1) requiring providers to maintain a daily log book confirming delivery of clients to medical facilities;
- (2) requiring providers to implement commercially available computer mapping programs to calculate mileage for purposes of reimbursement;
- (3) restricting special transportation service from being provided solely for trips to pharmacies;
- (4) modifying eligibility for special transportation;
- (5) expanding alternatives to the use of special transportation services;
- (6) improving the process of certifying persons as eligible for special transportation services; and
- (7) examining the feasibility and benefits of licensing special transportation providers.

The commissioner shall present recommendations for changes in the eligibility criteria and potential cost-savings for special transportation services to the chairs and ranking minority members of the house and senate committees having jurisdiction over health and human services spending by January 15, 2004. The commissioner is prohibited from using a broker or coordinator to manage special transportation services until July 1, 2005 2006, except for the purposes of checking for recipient eligibility, authorizing recipients for appropriate level of transportation, and monitoring provider compliance with Minnesota Statutes, section 256B.0625, subdivision 17. The commissioner shall not amend the initial contract to broker or manage nonemergency medical transportation to extend beyond two consecutive years. The commissioner shall not enter into a broker or management contract for transportation services which denies a medical assistance recipient the free choice of health service provider, including a special transportation provider, as specified in Code of Federal Regulations, title 42, section 431.51. This prohibition does not apply to the purchase or management of common carrier transportation.

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

Sec. 81. ADVISORY COMMITTEE ON NONEMERGENCY TRANSPORTATION SERVICES.

The commissioner of human services shall establish a seven-member advisory committee on medical assistance nonemergency transportation services. The committee shall consist of: a representative of the commissioner of human services, who shall serve as chair; two special transportation service providers, appointed by the trade

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associations representing special transportation service providers; one representative of nursing facilities; one representative of the disability community; and one house and one senate member, appointed respectively by the chairs of the house and senate committees with jurisdiction over medical assistance funding. The advisory committee shall monitor and evaluate the provision of medical assistance nonemergency medical transportation services, and present recommendations for any necessary changes to the commissioner.

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

Sec. 82. LIMITING COVERAGE OF HEALTH CARE SERVICES FOR MEDICAL ASSISTANCE, GENERAL ASSISTANCE MEDICAL CARE, AND MINNESOTACARE PROGRAMS.

Subdivision 1. PRIOR AUTHORIZATION OF SERVICES. (a) Effective September 1, 2005, prior authorization is required for the services described in subdivision 2 for reimbursement under chapters 256B, 256D, and 256L.

(b) Prior authorization shall be conducted under the direction of the medical director of the Department of Human Services in conjunction with a medical policy advisory council. To the extent available, the medical director shall use publicly available evidence-based guidelines developed by an independent, nonprofit organization or by the professional association of the specialty that typically provides the service or by a multistate Medicaid evidence-based practice center. If the commissioner does not have a medical director and medical policy director in place, the commissioner shall contract prior authorization to a Minnesota-licensed utilization review organization or to another entity such as a peer review organization eligible to operate in Minnesota.

(c) A prepaid health plan shall use prior authorization for the services described in subdivision 2 unless the prepaid health plan is otherwise using evidence-based practices to address these services.

Subd. 2. SERVICES REQUIRING PRIOR AUTHORIZATION. The following services require prior authorization:

(1) elective outpatient high-technology imaging to include positive emission tomography (PET) scans, magnetic resonance imaging (MRI), computed tomography (CT), and nuclear cardiology;

(2) spinal fusion, unless in an emergency situation related to trauma;

(3) bariatric surgery;

(4) cesarean section or insertion of tympanostomy tubes except in an emergency situation;

(5) hysterectomy; and

(6) orthodontia.

New language is indicated by underline, deletions by ~~strikeout~~.

Subd. 3. RATE REDUCTION. Effective for the services identified in subdivision 2, rendered on or after September 1, 2005, the payment rate shall be reduced by ten percent from the rate in effect on June 30, 2005. This subdivision expires July 1, 2006, or upon the completion of the prior authorization system required under subdivision 1, whichever is earlier.

Subd. 4. APPEALS. (a) For review of an initial determination not to certify conducted under section 62M.06, subdivision 2 or 3, of a service that is subject to prior authorization under this section, the health care provider conducting the review must follow, when available, published evidence-based health care guidelines as established by a nonprofit Minnesota quality improvement organization, a nationally recognized guideline development organization, or by the professional association of the specialty that typically provides the service.

(b) For appeals conducted under section 256.045, subdivision 3a, of a decision by a prepaid health plan to deny, reduce, or terminate a health care service that is subject to prior authorization under this section, the referee must base the decision on the application of the publicly available evidence-based health care guidelines referred to in subdivision 1 or as established by the commissioner of human services provided that the guidelines meet the criteria set forth in section 62J.43, subdivision 2.

Subd. 5. EXPIRATION. This section expires July 1, 2007.

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

Sec. 83. ORAL HEALTH CARE PILOT PROJECT.

The commissioner shall implement a two-year pilot project to provide services for state program recipients through a new oral health care delivery system. The commissioner shall contract with a qualified entity or entities to administer the pilot project.

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

Sec. 84. SOLE-SOURCE OR SINGLE-PLAN MANAGED CARE CONTRACT.

Notwithstanding Minnesota Statutes, section 256B.692, subdivision 6, the commissioner of human services shall not reject a county-based purchasing health plan proposal that requires county-based purchasing on a sole-source or single-plan basis if the implementation of the sole-source or single-plan purchasing proposal does not limit an enrollee's provider choice or access to services. The commissioner shall request federal approval, if necessary, to permit or maintain a sole-source or single-plan purchasing option even if choice is available in the area.

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

Sec. 85. PLANNING PROCESS FOR MANAGED CARE.

The commissioner of human services shall develop a planning process for the purposes of implementing at least one additional managed care arrangement to provide

New language is indicated by underline, deletions by strikeout.

medical assistance services, excluding continuing care services, to recipients enrolled in the medical assistance fee-for-service program, effective January 1, 2007. This planning process shall include an advisory committee composed of current fee-for-service consumers, consumer advocates, and providers, as well as representatives of health plans and other provider organizations qualified to provide basic health care services to persons with disabilities. The commissioner shall seek any additional federal authority necessary to provide basic health care services through contracted managed care arrangements.

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

Sec. 86. DIRECTIVE TO SEEK FEDERAL MATCH FOR ALTERNATIVE CARE PROGRAM.

The commissioner of human services shall seek federal matching funds for the alternative care program during negotiations with the federal government over the repeal of certain intergovernmental transfers under Minnesota Statutes, section 256B.19, subdivision 1c, paragraph (d). By December 15, 2005, the commissioner shall report to the chairs of the house and senate finance committees and divisions with jurisdiction over funding for the Department of Human Services regarding the results of these negotiations.

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

Sec. 87. FEDERAL APPROVAL.

The commissioner of human services shall seek federal waivers and approvals necessary to allow the commissioner to charge medical assistance recipients with gross family incomes greater than 175 percent of the federal poverty guidelines sliding scale premiums, based on the sliding scale used for the MinnesotaCare program under Minnesota Statutes, section 256L.15.

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

Sec. 88. REPEALER.

(a) Minnesota Statutes 2004, section 256.955, is repealed effective January 1, 2006.

(b) Minnesota Statutes 2004, section 256B.075, subdivision 5, is repealed the day following final enactment.

(c) Minnesota Statutes 2004, section 256L.04, subdivision 11, MinnesotaCare outreach grants, is repealed effective August 1, 2005.

New language is indicated by underline, deletions by strikeout.

ARTICLE 9**APPROPRIATIONS****Section 1. HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

The sums shown in the columns marked "APPROPRIATIONS" are appropriated from the general fund, or any other fund named, to the agencies and for the purposes specified in the sections of this article, to be available for the fiscal years indicated for each purpose. The figures "2006" and "2007" where used in this article, mean that the appropriation or appropriations listed under them are available for the fiscal year ending June 30, 2006, or June 30, 2007, respectively. The first year is fiscal year 2006. The second year is fiscal year 2007. The biennium is fiscal years 2006 and 2007.

SUMMARY BY FUND

	2006	2007	BIENNIAL TOTAL
General	\$4,093,090,000	\$4,242,843,000	\$8,335,933,000
State Government			
Special Revenue	50,740,000	51,536,000	102,276,000
Health Care Access	334,301,000	430,860,000	765,161,000
Federal TANF	285,678,000	313,355,000	599,033,000
Lottery Prize Fund	1,456,000	1,456,000	2,912,000
TOTAL	\$4,765,265,000	\$5,040,050,000	\$9,805,315,000

APPROPRIATIONS

Available for the Year

Ending June 30

2006

2007

**Sec. 2. COMMISSIONER OF HUMAN
SERVICES**

Subdivision 1. Total Appropriation	\$4,603,330,000	\$4,875,483,000
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Summary by Fund

General	3,993,634,000	4,141,557,000
State Government		
Special Revenue	534,000	534,000
Health Care Access	328,028,000	424,581,000
Federal TANF	279,678,000	307,355,000
Lottery Cash Flow	1,456,000	1,456,000

RECEIPTS FOR SYSTEMS

PROJECTS. Appropriations and federal receipts for information system projects for

MAXIS, PRISM, MMIS, AND SSIS must be deposited in the state system account authorized in Minnesota Statutes, section 256.014. Money appropriated for computer projects approved by the Minnesota Office of Technology, funded by the legislature, and approved by the commissioner of finance, may be transferred from one project to another and from development to operations as the commissioner of human services considers necessary. Any unexpended balance in the appropriation for these projects does not cancel but is available for ongoing development and operations.

SYSTEMS CONTINUITY. In the event of disruption of technical systems or computer operations, the commissioner may use available grant appropriations to ensure continuity of payments for maintaining the health, safety, and well-being of clients served by programs administered by the Department of Human Services. Grant funds must be used in a manner consistent with the original intent of the appropriation.

NONFEDERAL SHARE TRANSFERS.

The nonfederal share of activities for which federal administrative reimbursement is appropriated to the commissioner may be transferred to the special revenue fund.

GIFTS. Notwithstanding Minnesota Statutes, sections 16A.013 to 16A.016, the commissioner may accept, on behalf of the state, additional funding from sources other than state funds for the purpose of financing the cost of assistance program grants or nongrant administration. All additional funding is appropriated to the commissioner for use as designated by the grantor of funding.

TANF FUNDS APPROPRIATED TO OTHER ENTITIES. Any expenditures

from the TANF block grant shall be expended according to the requirements and limitations of part A of title IV of the Social Security Act, as amended, and any other applicable federal requirement or limitation. Prior to any expenditure of these funds, the commissioner shall ensure that funds are expended in compliance with the requirements and limitations of federal law and that any reporting requirements of federal law are met. It shall be the responsibility of any entity to which these funds are appropriated to implement a memorandum of understanding with the commissioner that provides the necessary assurance of compliance prior to any expenditure of funds. The commissioner shall receipt TANF funds appropriated to other state agencies and coordinate all related interagency accounting transactions necessary to implement these appropriations. Unexpended TANF funds appropriated to any state, local, or nonprofit entity cancel at the end of the state fiscal year unless appropriating language permits otherwise.

TANF MAINTENANCE OF EFFORT.

(a) In order to meet the basic maintenance of effort (MOE) requirements of the TANF block grant specified under Code of Federal Regulations, title 45, section 263.1, the commissioner may only report nonfederal money expended for allowable activities listed in the following clauses as TANF/MOE expenditures:

- (1) MFIP cash, diversionary work program, and food assistance benefits under Minnesota Statutes, chapter 256J;
- (2) the child care assistance programs under Minnesota Statutes, sections 119B.03 and 119B.05, and county child care admin-

istrative costs under Minnesota Statutes, section 119B.15;

(3) state and county MFIP administrative costs under Minnesota Statutes, chapters 256J and 256K;

(4) state, county, and tribal MFIP employment services under Minnesota Statutes, chapters 256J and 256K;

(5) expenditures made on behalf of noncitizen MFIP recipients who qualify for the medical assistance without federal financial participation program under Minnesota Statutes, section 256B.06, subdivision 4, paragraphs (d), (e), and (j); and

(6) qualifying working family credit expenditures under Minnesota Statutes, section 290.0671.

(b) The commissioner shall ensure that sufficient qualified nonfederal expenditures are made each year to meet the state's TANF/MOE requirements. For the activities listed in paragraph (a), clauses (2) to (6), the commissioner may only report expenditures that are excluded from the definition of assistance under Code of Federal Regulations, title 45, section 260.31.

(c) The commissioner shall ensure that the maintenance of effort used by the commissioner of finance for the February and November forecasts required under Minnesota Statutes, section 16A.103, contains expenditures under paragraph (a), clause (1), equal to at least 25 percent of the total required under Code of Federal Regulations, title 45, section 263.1.

(d) Minnesota Statutes, section 256.011, subdivision 3, which requires that federal grants or aids secured or obtained under that subdivision be used to reduce any direct appropriations provided by law, does

not apply if the grants or aids are federal TANF funds.

(e) Notwithstanding section 15, paragraph (a), clauses (1) to (6), and paragraphs (b) to (d), expire June 30, 2009.

WORKING FAMILY CREDIT EXPENDITURES AS TANF/MOE. The commissioner may claim as TANF maintenance of effort up to the following amounts of working family credit expenditures for the following fiscal years:

- (1) fiscal year 2006, \$6,942,000; and
- (2) fiscal year 2007 and thereafter, \$6,707,000.

INCREASE WORKING FAMILY CREDIT EXPENDITURES TO BE CLAIMED FOR TANF/MOE. In addition to the amounts provided in this section, the commissioner may count the following amounts of working family credit expenditure as TANF/MOE:

- (1) fiscal year 2006, \$52,610,000; and
- (2) fiscal year 2007, \$52,655,000.

FOOD STAMPS EMPLOYMENT AND TRAINING FUNDS. Notwithstanding Minnesota Statutes, sections 256J.626 and 256D.051, subdivisions 1a, 6b, and 6c, federal food stamps employment and training funds received as reimbursement of Minnesota family investment program consolidated fund grant expenditures must be deposited in the general fund. Consistent with the receipt of these federal funds, the commissioner may adjust the level of working family credit expenditures claimed as TANF maintenance of effort. Notwithstanding section 15, this provision expires June 30, 2009.

SPECIAL REVENUE FUND TRANSFER. Notwithstanding any law to the contrary, excluding accounts authorized under Minnesota Statutes, section 16A.1286, and Minnesota Statutes, chapter 254B, the commissioner shall transfer \$1,139,000 of uncommitted special revenue fund balances to the general fund. The actual transfers shall be identified within the standard information provided to the chairs of the legislative committees with jurisdiction over health and human services issues in December 2005.

CAPITATION RATE INCREASE. Of the health care access fund appropriations to the University of Minnesota in the higher education omnibus appropriation bill, \$2,157,000 in fiscal year 2006 and \$2,157,000 in fiscal year 2007 are to be used to increase the capitation payments under Minnesota Statutes, section 256B.69. Notwithstanding section 15, this provision shall not expire.

Subd. 2. Agency Management

Summary by Fund

General	46,899,000	46,782,000
State Government		
Special Revenue	415,000	415,000
Health Care Access	5,164,000	5,242,000
Federal TANF	222,000	222,000

The amounts that may be spent from the appropriation for each purpose are as follows:

(a) Financial Operations

General	10,473,000	10,473,000
Health Care Access	848,000	879,000
Federal TANF	122,000	122,000

ADMINISTRATIVE BASE ADJUSTMENT - WEB PAYMENT. The health care access fund base is increased by \$37,000 in fiscal year 2008 and \$80,000 in

fiscal year 2009 for fees associated with web-based payment collections.

TRANSFER OF FUNDS. Of the appropriation in Laws 2005, chapter 156, article 1, section 11, subdivision 2, \$4,670,000 shall be transferred to the commissioner of human services for agency relocation.

(b) Legal and Regulation Operations

General	9,983,000	9,636,000
State Government		
Special Revenue	415,000	415,000
Health Care Access	319,000	319,000
Federal TANF	100,000	100,000

(c) Management Operations

General	3,281,000	3,281,000
Health Care Access	68,000	68,000

(d) Information Technology Operations

General	23,162,000	23,392,000
Health Care Access	3,929,000	3,976,000

Subd. 3. Revenue and Pass-Through Expenditures

Summary by Fund

Federal TANF	60,767,000	58,224,000
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TANF TRANSFER TO FEDERAL CHILD CARE AND DEVELOPMENT FUND. \$6,692,000 in fiscal year 2006, \$3,192,000 in fiscal year 2007, and \$3,192,000 in fiscal year 2008 and each fiscal year thereafter is appropriated to the commissioner for the purposes of MFIP/Transition Year child care under Minnesota Statutes, section 119B.05. The commissioner shall authorize transfer of sufficient TANF funds to the federal child care and development fund to meet this appropriation and shall ensure that all transferred funds are expended according to the federal child care and development fund regulations. Notwithstanding section 15, this paragraph shall not expire.

Subd. 4. Children and Economic
 Assistance Grants

Summary by Fund

General	386,449,000	395,589,000
Federal TANF	218,223,000	248,457,000

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) MFIP/DWP Grants

General	35,640,000	31,902,000
Federal TANF	114,232,000	117,093,000

(b) Support Services Grants

General	8,697,000	8,715,000
Federal TANF	102,594,000	102,632,000

(c) MFIP Child Care Assistance Grants

General	55,034,000	33,555,000
Federal TANF	-0-	27,335,000

MFIP CHILD CARE; TANF APPROPRIATION. The federal TANF appropriation is a onetime appropriation.

TANF TRANSFER TO FEDERAL CHILD CARE AND DEVELOPMENT FUND. \$27,335,000 in fiscal year 2007 is appropriated to the commissioner for the purposes of MFIP/Transition Year child care under Minnesota Statutes, section 119B.05. The commissioner shall authorize transfer of sufficient TANF funds to the federal child care and development fund to meet this appropriation and shall ensure that all transferred funds are expended according to the federal child care and development fund regulations.

(d) Basic Sliding Fee Child Care Assistance Grants

General	7,503,000	28,570,000
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CHILD CARE AND DEVELOPMENT FUND UNEXPENDED BALANCE. In addition to the amount provided in this section, the commissioner shall expend \$16,254,000 in fiscal year 2006 and \$2,085,000 in fiscal year 2007 from the federal child care and development fund unexpended balance for basic sliding fee child care under Minnesota Statutes, section 119B.03. The commissioner shall ensure that all child care and development funds are expended according to the federal child care and development fund regulations.

BASE ADJUSTMENT FOR FREEZE MAXIMUM RATES FOR CHILD CARE ASSISTANCE. The general fund base is increased by \$3,233,000 in fiscal year 2008 and \$4,399,000 in fiscal year 2009 for basic sliding fee child care assistance.

(e) Child Care Development Grants

General	1,540,000	1,540,000
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(f) Child Support Enforcement Grants

General	3,255,000	3,255,000
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(g) Children's Services Grants

General	40,527,000	47,308,000
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BASE ADJUSTMENT FOR ADOPTION ASSISTANCE GRANTS. The general fund base is increased by \$449,000 in fiscal year 2008 and \$449,000 in fiscal year 2009 for adoption assistance grants.

BASE ADJUSTMENT FOR RELATIVE CUSTODY ASSISTANCE GRANTS. The general fund base is increased by \$1,042,000 in fiscal year 2008 and \$1,042,000 in fiscal year 2009 for relative custody assistance grants.

ADOPTION ASSISTANCE AND RELATIVE CUSTODY ASSISTANCE. The commissioner may transfer unencum-

bered appropriation balances for adoption assistance and relative custody assistance between fiscal years and between programs.

PRIVATIZED ADOPTION GRANTS.

Federal reimbursement for privatized adoption grant and foster care recruitment grant expenditures is appropriated to the commissioner for adoption grants and foster care and adoption administrative purposes.

CHILDREN'S MENTAL HEALTH GRANTS BASE ADJUSTMENT.

The general fund base is increased by \$44,000 in fiscal year 2008 and fiscal year 2009 for costs associated with the long-term care provider cost-of-living adjustment.

AMERICAN INDIAN CHILD WELFARE PROJECT BASE ADJUSTMENT.

The general fund base is increased by \$2,419,000 in fiscal year 2008 and \$2,419,000 in fiscal year 2009 for the American Indian child welfare project.

(h) Children and Community Services Grants

General	68,492,000	68,498,000
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CHILDREN'S COMMUNITY SERVICE GRANTS BASE ADJUSTMENT.

The general fund base is increased by \$3,000 in fiscal year 2008 and fiscal year 2009 for costs associated with the long-term care provider cost-of-living adjustment.

(i) General Assistance Grants

General	30,823,000	31,157,000
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GENERAL ASSISTANCE STANDARD.

The commissioner shall set the monthly standard of assistance for general assistance units consisting of an adult recipient who is childless and unmarried or living

apart from parents or a legal guardian at \$203. The commissioner may reduce this amount according to Laws 1997, chapter 85, article 3, section 54.

EMERGENCY GENERAL ASSISTANCE. The amount appropriated for emergency general assistance funds is limited to no more than \$7,889,812 in fiscal year 2006 and \$7,889,812 in fiscal year 2007. Funds to counties shall be allocated by the commissioner using the allocation method specified in Minnesota Statutes, section 256D.06.

(j) Minnesota Supplemental Aid Grants

General	30,315,000	30,801,000
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EMERGENCY MINNESOTA SUPPLEMENTAL AID FUNDS. The amount appropriated for emergency Minnesota supplemental aid funds is limited to no more than \$1,100,000 in fiscal year 2006 and \$1,100,000 in fiscal year 2007. Funds to counties shall be allocated by the commissioner using the allocation method specified in Minnesota Statutes, section 256D.46.

(k) Group Residential Housing Grants

General	87,989,000	94,033,000
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(l) Other Children and Economic Assistance Grants

General	16,634,000	16,255,000
Federal TANF	1,397,000	1,397,000

TRANSITIONAL HOUSING. \$3,238,000 in fiscal year 2006 and \$3,238,000 in fiscal year 2007 are appropriated for transitional housing under Minnesota Statutes, section 119A.43. Of this amount, \$1,397,000 in fiscal year 2006 and \$1,397,000 in fiscal year 2007 are onetime appropriations from the federal TANF fund. The general fund base for transitional

housing shall be \$2,988,000 each year for the fiscal 2008-2009 biennium.

Subd. 5. Children and Economic Assistance Management

Summary by Fund

General	42,559,000	42,603,000
Health Care Access	261,000	261,000
Federal TANF	466,000	452,000

The amounts that may be spent from the appropriation for each purpose are as follows:

(a) Children and Economic Assistance Administration

General	7,838,000	7,832,000
Federal TANF	452,000	452,000

(b) Children and Economic Assistance Operations

General	34,721,000	34,771,000
Health Care Access	261,000	261,000
Federal TANF	14,000	-0-

BASE REDUCTIONS. (a) The general fund base is decreased by \$50,000 in fiscal year 2008 and \$50,000 in fiscal year 2009.

(b) The health care access fund base is decreased by \$12,000 in fiscal year 2008 and \$12,000 in fiscal year 2009.

SPENDING AUTHORITY FOR FOOD STAMPS BONUS AWARDS. In the event that Minnesota qualifies for the United States Department of Agriculture Food and Nutrition Services Food Stamp Program performance bonus awards beginning in federal fiscal year 2004, the funding is appropriated to the commissioner. The commissioner shall retain 25 percent of the funding, with the other 75 percent divided among the counties according to a formula that takes into account each county's im-

pact on state performance in the applicable bonus categories.

CHILD SUPPORT PAYMENT CENTER. Payments to the commissioner from other governmental units, private enterprises, and individuals for services performed by the child support payment center must be deposited in the state systems account authorized under Minnesota Statutes, section 256.014. These payments are appropriated to the commissioner for the operation of the child support payment center or system, according to Minnesota Statutes, section 256.014.

CHILD SUPPORT COST RECOVERY FEES. The commissioner shall transfer \$34,000 of child support cost recovery fees collected in fiscal year 2006 and fiscal year 2007 to the PRISM special revenue account to offset PRISM system costs of maintaining the fee.

FINANCIAL INSTITUTION DATA MATCH AND PAYMENT OF FEES. The commissioner is authorized to allocate up to \$310,000 each year in fiscal year 2006 and fiscal year 2007 from the PRISM special revenue account to make payments to financial institutions in exchange for performing data matches between account information held by financial institutions and the public authority's database of child support obligors as authorized by Minnesota Statutes, section 13B.06, subdivision 7.

Subd. 6. Basic Health Care Grants

Summary by Fund

General	1,702,015,000	1,797,642,000
Health Care Access	299,723,000	397,125,000

FULL FUNDING FOR DIAGNOSIS-RELATED GROUPS PAYMENT AD-

JUSTMENT. In order to provide full funding for the diagnosis-related groups for hospitals located in Greater Minnesota under Minnesota Statutes, section 256.969, subdivision 26, the following increases are hereby appropriated:

\$722,000 in fiscal year 2006 and \$1,076,000 in fiscal year 2007 for MA Basic Care-Families and Children;

\$903,000 in fiscal year 2006 and \$1,345,000 in fiscal year 2007 for MA Basic Care-Elderly and Disabled; and

\$361,000 in fiscal year 2006 and \$538,000 in fiscal year 2007 for General Assistance Medical Care.

The amounts that may be spent from the appropriation for each purpose are as follows:

(a) MinnesotaCare Grants

Health Care Access	299,723,000	397,125,000
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HEALTHMATCH DELAY. Of this appropriation, \$6,411,000 the first year and \$96,305,000 the second year are for the MinnesotaCare program costs related to a 17-month delay in implementation of the HealthMatch program.

MINNESOTACARE FEDERAL RECEIPTS. Receipts received as a result of federal participation pertaining to administrative costs of the Minnesota health care reform waiver shall be deposited as non-dedicated revenue in the health care access fund. Receipts received as a result of federal participation pertaining to grants shall be deposited in the federal fund and shall offset health care access funds for payments to providers.

MINNESOTACARE FUNDING. The commissioner may expend money appro-

priated from the health care access fund for MinnesotaCare in either fiscal year of the biennium.

(b) MA Basic Health Care - Families and Children

General	608,938,000	697,432,000
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HOSPITAL PAYMENT DELAY. Payments from the Medicaid Management Information System that would otherwise have been made for inpatient hospital services for Minnesota health care program enrollees shall be delayed as follows:

(1) for fiscal year 2008, the last payments shall be ratably reduced by a total of \$12,000,000 and included in the first payments in fiscal year 2009; and

(2) for fiscal year 2009, the last payments shall be ratably reduced by a total of \$24,000,000 and included in the first payment of fiscal year 2010.

The provisions of Minnesota Statutes, section 16A.124, shall not apply to these delayed payments. Notwithstanding section 15, this paragraph shall not expire.

(c) MA Basic Health Care - Elderly and Disabled

General	808,554,000	863,216,000
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(d) General Assistance Medical Care Grants

General	277,244,000	236,935,000
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(e) Prescription Drug Program Grants

General	4,313,000	
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PDP TO MEDICARE PART D TRANSITION. The commissioner of human services, with the approval of the commissioner of finance, and after notification of the chair of the senate Health and Human

Services Budget Division and the chair of the house Health Policy and Finance Committee, may transfer fiscal year 2006 appropriations between the medical assistance program and the prescription drug program.

(f) Health Care Grants - Other Assistance

General	2,967,000	59,000
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Subd. 7. Health Care Management

Summary by Fund

General	27,148,000	25,353,000
Health Care Access	22,880,000	21,953,000

The amounts that may be spent from the appropriation for each purpose are as follows:

(a) Health Care Policy Administration

General	10,405,000	9,158,000
Health Care Access	7,564,000	6,885,000

ADMINISTRATIVE BASE ADJUST-

MENT. The health care access fund base is decreased by \$1,486,000 in fiscal year 2008 and \$1,778,000 in fiscal year 2009, for implementation of business process redesign in health care. The general fund base is increased by \$3,563,000 in fiscal year 2008 and \$2,395,000 in fiscal year 2009.

MINNESOTA SENIOR HEALTH OPTIONS REIMBURSEMENT. Federal administrative reimbursement resulting from the Minnesota senior health options project is appropriated to the commissioner for this activity.

UTILIZATION REVIEW. Federal administrative reimbursement resulting from prior authorization and inpatient admission certification by a professional review organization shall be dedicated to the commissioner for these purposes. A portion of

these funds must be used for activities to decrease unnecessary pharmaceutical costs in medical assistance.

TICKET TO WORK. Effective the day following final enactment, supplemental funding made available by the Centers for Medicare and Medicaid Services under the Ticket to Work Medicaid Infrastructure Grant to support outreach and education activities on Medicare Part D for persons receiving medical assistance for employed persons with disabilities is appropriated to the commissioner for required grant and administrative activities.

MEDICAL EDUCATION ASSIGNMENT. The commissioner shall continue to seek approval from the Centers for Medicare and Medicaid Services to transfer to physician clinics 40 percent of the current medical education and research costs currently assigned to hospitals under Minnesota Statutes, section 62J.692, subdivision 8. The commissioner shall report to the house and senate chairs with funding authority over the Department of Human Services by January 15, 2006, regarding the results of this effort.

(b) Health Care Operations

General	16,743,000	16,195,000
Health Care Access	15,316,000	15,068,000

BASE ADJUSTMENT. The health care access fund base is increased by \$1,508,000 in fiscal year 2008 and is decreased by \$48,000 in fiscal year 2009.

COUNTY ADMINISTRATIVE COST REIMBURSEMENT. Of the general fund appropriation, \$1,000,000 the first year is to the commissioner to be allocated to the counties for county costs associated with training county workers for enrolling eligible general assistance medical care cli-

ents into MinnesotaCare as required under Minnesota Statutes, sections 256D.03 and 256L.05. Funds appropriated for this purpose shall be distributed to counties by January 15, 2006, based on the average monthly number of general assistance medical care clients in the county during calendar year 2004. This appropriation shall not become part of base level funding for the biennium beginning July 1, 2007.

Subd. 8. Continuing Care Grants

Summary by Fund

General	1,549,939,000	1,618,201,000
Lottery Prize	1,308,000	1,308,000

The amounts that may be spent from the appropriation for each purpose are as follows:

(a) Aging and Adult Services Grant

General	13,954,000	13,960,000
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(b) Alternative Care Grants

General	58,278,000	45,944,000
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ALTERNATIVE CARE TRANSFER.

Any money allocated to the alternative care program that is not spent for the purposes indicated does not cancel but shall be transferred to the medical assistance account.

ALTERNATIVE CARE BASE. Base level funding for alternative care grants is increased by \$2,704,000 in fiscal year 2008 and by \$3,908,000 in fiscal year 2009.

IMPLEMENTATION OF ALTERNATIVE CARE CHANGES. Changes to Minnesota Statutes, section 256B.0913, subdivisions 2, 4, paragraph (a), 5, and 5a, are effective September 1, 2005, for all persons found eligible for the alternative care program on and after September 1, 2005. All persons who are alternative care

clients as of August 31, 2005, must be subject to Minnesota Statutes, section 256B.0913, subdivisions 2, 4, paragraph (a), 5, and 5a, on the annual redetermination of program eligibility due after August 31, 2005, but no later than January 1, 2006.

(c) Medical Assistance Grants - Long-term Care Facilities

General	517,436,000	505,995,000
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NURSING HOME MORATORIUM

EXCEPTIONS. During the first year, the commissioner of health may approve moratorium exception projects under Minnesota Statutes, section 144A.073, for which the full annualized state share of medical assistance costs does not exceed \$1,500,000. During the second year, the commissioner of health may approve moratorium exception projects under Minnesota Statutes, section 144A.073, for which the full annualized state share of medical assistance costs does not exceed \$1,500,000 less the amount approved during the first year. Priority shall be given to proposals that entail: (1) complete building replacement in conjunction with reductions in the number of beds in a county, with greater weight given to projects in counties with a greater than average number of beds per 1,000 elderly; (2) technology improvements; (3) improvements in life safety; (4) construction of nursing facilities that are part of senior services campuses; and (5) improvements in the work environment.

(d) Medical Assistance Grants - Long-Term Care Waivers and Home Care Grants

General	833,247,000	918,334,000
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LIMITING GROWTH IN COMMUNITY ALTERNATIVES FOR DISABLED INDIVIDUALS WAIVER. Not-

withstanding Laws 2005, chapter 155, article 3, section 8, for each year of the biennium ending June 30, 2007, the commissioner shall make available additional allocations for home and community-based services covered under Minnesota Statutes, section 256B.49, at a rate of 95 per month or 1,140 per year, plus any additional legislatively authorized growth. Priorities for the allocation of funds shall be for individuals anticipated to be discharged from institutional settings or who are at imminent risk of a placement in an institutional setting.

LIMITING GROWTH IN TBI WAIVER. Notwithstanding Laws 2005, chapter 155, article 3, section 8, for each year of the biennium ending June 30, 2007, the commissioner shall make available additional allocations for home and community-based services covered under Minnesota Statutes, section 256B.49, at a rate of 150 per year. Priorities for the allocation of funds shall be for individuals anticipated to be discharged from institutional settings or who are at imminent risk of a placement in an institutional setting.

LIMITING GROWTH IN MR/RC WAIVER. Notwithstanding Laws 2005, chapter 155, article 3, section 8, for each year of the biennium ending June 30, 2007, the commissioner shall limit the new diversion caseload growth in the MR/RC waiver to 50 additional allocations. Notwithstanding Minnesota Statutes, section 256B.0916, subdivision 5, paragraph (b), the available diversion allocations shall be awarded to support individuals whose health and safety needs result in an imminent risk of an institutional placement at any time during the fiscal year.

(e) Mental Health Grants

General	46,731,000	47,516,000
Lottery Prize	1,308,000	1,308,000

MENTAL HEALTH GRANT BASE.

Base level funding for mental health grants is increased by \$428,000 in fiscal year 2008 and by \$428,000 in fiscal year 2009.

(f) Deaf and Hard-of-Hearing Grants

General	1,454,000	1,475,000
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**DEAF AND HARD-OF-HEARING
BASE FUNDING.**

Base level funding for the deaf and hard-of-hearing grants is increased by \$5,000 in fiscal year 2008 and \$5,000 in fiscal year 2009.

**(g) Chemical Dependency Entitlement
Grants**

General	63,183,000	68,744,000
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**(h) Chemical Dependency Nonentitlement
Grants**

General	1,055,000	1,055,000
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(i) Other Continuing Care Grants

General	14,601,000	15,178,000
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**OTHER CONTINUING CARE
GRANTS BASE FUNDING.**

Base level funding for other continuing care grants is increased by \$208,000 in fiscal year 2008 and \$251,000 in fiscal year 2009.

Subd. 9. Continuing Care Management**Summary by Fund**

General	15,043,000	14,939,000
State Government		
Special Revenue	119,000	119,000
Lottery Prize	148,000	148,000

BASE ADJUSTMENT. The general fund base is decreased by \$341,000 for fiscal year 2008 and by \$340,000 in fiscal year 2009.

QUALITY ASSURANCE COMMISSION. \$151,000 in fiscal year 2007 is appropriated from the general fund to the commissioner of human services for the Quality Assurance Commission under Minnesota Statutes, section 256B.0951. This funding is added to the base appropriation for the quality assurance commission program for the fiscal year beginning July 1, 2006.

TASK FORCE ON COLLABORATIVE SERVICES. The commissioner, in collaboration with the commissioner of education, shall create a task force to discuss collaboration between schools and mental health providers to: promote colocation and integrated services; identify barriers to collaboration; develop a model contract; and identify examples of successful collaboration. The task force shall also develop recommendations on how to pay for children's mental health screenings. The task force shall include representatives of school boards; administrative personnel; special education directors; counties; parent advocacy organizations; school social workers, counselors, nurses, and psychologists; community mental health professionals; health plans; and other interested parties. The task force shall present a report to the chairs of the education and health policy committees by February 1, 2006.

Subd. 10. State-Operated Services

Summary by Fund

General	223,581,000	200,448,000
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BASE ADJUSTMENT. The general fund base is decreased by \$3,174,000 for fiscal year 2008 and by \$6,472,000 in fiscal year 2009.

EVIDENCE-BASED PRACTICE FOR METHAMPHETAMINE TREATMENT.

Of the general fund appropriation, \$300,000 each year is to the commissioner of human services to support development of evidence-based practices for the treatment of methamphetamine abuse at the state-operated services chemical dependency program in Willmar. These funds shall be used to support research on evidence-based practices for the treatment of methamphetamine abuse, to disseminate the results of the evidence-based practice research statewide, and to create training for addiction counselors specializing in the treatment of methamphetamine abuse.

TRANSFER AUTHORITY RELATED TO STATE-OPERATED SERVICES.

Money appropriated to finance state-operated services programs and administrative services may be transferred between fiscal years of the biennium with the approval of the commissioner of finance.

APPROPRIATION LIMITATION. No part of the appropriation in this article to the commissioner for mental health treatment services at the regional treatment centers shall be used for the Minnesota sex offender program.

BASE ADJUSTMENT FOR STATE-OPERATED SERVICES UTILIZATION. The general fund base is increased by \$3,174,000 in fiscal year 2008 and by \$6,472,000 in fiscal year 2009 for state-operated services forensic operations, with corresponding adjustments to nondedicated revenue estimates.

Sec. 3. COMMISSIONER OF HEALTH

Subdivision 1. Total Appropriation		113,331,000	115,553,000
	Summary by Fund		
General	64,738,000	66,568,000	
State Government			
Special Revenue	36,320,000	36,706,000	

Health Care Access	6,273,000	6,279,000
Federal TANF	6,000,000	6,000,000

RENTAL COSTS, ADMINISTRATIVE REDUCTIONS, FEE INCREASES, AND REVENUE TRANSFER. (a) Of this appropriation, \$722,000 the first year and \$2,583,000 the second year are for rental costs in the new public health laboratory building.

(b) The general fund appropriation in this section includes a departmentwide administrative reduction of \$61,000 the first year and \$62,000 the second year. The commissioner shall ensure that any staff reductions made under this paragraph comply with Minnesota Statutes, section 43A.046.

(c) \$985,000 in fiscal year 2006 and \$2,077,000 in fiscal year 2007 shall be transferred from the state government special revenue fund to the general fund.

TANF APPROPRIATIONS. (a) \$4,000,000 of TANF funds is appropriated each year to the commissioner for home visiting and nutritional services listed under Minnesota Statutes, section 145.882, subdivision 7, clauses (6) and (7). Funding shall be distributed to community health boards based on Minnesota Statutes, section 145A.131, subdivision 1, and tribal governments based on Minnesota Statutes, section 145A.14, subdivision 2, paragraph (b).

(b) \$2,000,000 of TANF funds is appropriated each year to the commissioner for decreasing racial and ethnic disparities in infant mortality rates under Minnesota Statutes, section 145.928, subdivision 7.

TANF CARRYFORWARD. Any unexpended balance of the TANF appropriation in the first year of the biennium does not cancel but is available for the second year.

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 the revenue received is to be deposited in the state government special revenue fund.

Subd. 3. Policy Quality and Compliance

Summary by Fund

General	3,665,000	3,665,000
State Government		
Special Revenue	11,528,000	11,428,000
Health Care Access	2,763,000	2,763,000

BASE ADJUSTMENT. The state government special revenue base is increased by \$800,000 each year for fiscal years 2008 and 2009.

STATEWIDE TRAUMA SYSTEM. (a) Of the general fund appropriation, \$382,000 the first year and \$352,000 the second year are for development of a statewide trauma system.

(b) The commissioner shall increase hospital licensing fees a pro rata amount to increase fee revenue by \$382,000 the first year and \$352,000 the second year. This revenue shall be deposited in the general fund.

FAMILY PLANNING GRANTS. Of the general fund appropriation, \$500,000 each year is to the commissioner for grants under Minnesota Statutes, section 145.925, to family planning clinics serving outstate Minnesota that demonstrate financial need.

Subd. 4. Health Protection

Summary by Fund

General	9,068,000	9,068,000
State Government		
Special Revenue	24,316,000	24,815,000

BASE ADJUSTMENT. The state government special revenue base is increased by \$935,000 each year for fiscal years 2008 and 2009.

Subd. 5. Minority and Multicultural Health

Summary by Fund

General	6,190,000	8,051,000
State Government		
Special Revenue	335,000	335,000
Subd. 6. Administrative Support Services		

Summary by Fund

General	5,402,000	5,402,000
Sec. 4. VETERANS NURSING HOMES BOARD		
General	30,030,000	30,030,000

VETERANS HOMES SPECIAL REVENUE ACCOUNT. The general fund appropriations made to the board may be transferred to a veterans homes special revenue account in the special revenue fund in the same manner as other receipts are deposited according to Minnesota Statutes, section 198.34, and are appropriated to the board for the operation of board facilities and programs.

Sec. 5. HEALTH-RELATED BOARDS

Subdivision 1. State Government Special Revenue

13,340,000 13,750,000

NO SPENDING IN EXCESS OF REVENUES. The commissioner of finance shall not permit the allotment, encumbrance, or expenditure of money appropriated in this section in excess of the anticipated biennial revenues or accumulated surplus revenues from fees collected by the boards. Neither this provision nor Minnesota Statutes, section 214.06, applies to transfers from the general contingent account.

Subd. 2. Board of Behavioral Health and Therapy

673,000 673,000

Subd. 3. Board of Chiropractic Examiners

414,000 414,000

BOARD OF CHIROPRACTIC EXAMINERS APPROPRIATIONS INCREASE. Of this appropriation, \$30,000 each year is for the increased cost of board operations, excluding salary increases.

Subd. 4. Board of Dentistry	1,038,000	888,000
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BOARD OF DENTISTRY APPROPRIATIONS INCREASE. Of this appropriation, \$30,000 each year is for the increased cost of board meetings, board member compensation, and board operations, excluding salary increases.

ORAL HEALTH PILOT PROJECT. Of this appropriation, \$150,000 the first year is to be transferred to the commissioner of human services for an oral health care system pilot project.

Subd. 5. Board of Dietetic and Nutrition Practice	101,000	101,000
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The Board of Dietetic and Nutrition Practice may lower its fees by an amount not to exceed \$36,000 in fiscal years 2006, 2007, 2008, and 2009.

Subd. 6. Board of Marriage and Family Therapy	127,000	131,000
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BOARD OF MARRIAGE AND FAMILY THERAPY APPROPRIATIONS INCREASE. Of this appropriation, \$9,000 the first year and \$13,000 the second year are to increase the executive director to 0.6 full-time equivalent from 0.5 full-time equivalent, for an increase in technology costs related to the small boards' database system, and for added costs related to rule changes.

Subd. 7. Board of Medical Practice	3,729,000	3,769,000
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BOARD OF MEDICAL PRACTICE APPROPRIATIONS INCREASE. Of this appropriation, \$125,000 the first year and \$165,000 the second year are for the added costs of rent, legal and investigative services provided by the board, and services provided by the attorney general's office and the Office of Administrative Hearings for services on behalf of the board.

PHYSICIAN LOAN FORGIVENESS. \$200,000 each year shall be transferred to the health professional education loan forgiveness program account for loan forgiveness for physician under Minnesota Statutes, section 144.1501. This appropriation shall become part of base level funding for the commissioner for the biennium beginning July 1, 2007. Notwithstanding section 15, this paragraph expires on June 30, 2009.

Subd. 8. Board of Nursing	3,078,000	3,631,000
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BASE ADJUSTMENT. The base for the board of nursing is increased by \$141,000 in fiscal year 2008 and by \$216,000 in fiscal year 2009.

BOARD OF NURSING APPROPRIATIONS INCREASE. Of this appropriation, \$120,000 the first year and \$126,000 the second year are for the increased cost of board operations, excluding salary increases and \$85,000 each year is to hire an advanced practice registered nurse.

TRANSFERS FROM SPECIAL REVENUE FUND. Of this appropriation, the following transfers shall be made as directed from the state government special revenue fund:

(a) \$392,000 in fiscal year 2006, \$864,000 in fiscal year 2007, \$930,000 in fiscal year 2008, and \$930,000 in fiscal year 2009 shall be transferred to the general fund and is appropriated to the Department of Human Services to offset the state share of the medical assistance program costs of the long-term care and home and community-based care employee scholarship program and associated administrative costs. At the end of each biennium, any funds not expended for the scholarship program and associated administrative costs shall be transferred to the state government special revenue fund. Notwithstanding section 15, this paragraph expires June 30, 2009.

(b) \$125,000 the first year and \$200,000 the second year shall be transferred to the health professional education loan forgiveness program account for loan forgiveness for nurses under Minnesota Statutes, section 144.1501. This appropriation shall become part of base level funding for the commissioner for the biennium beginning July 1, 2007, but shall not be part of base level funding for the biennium beginning July 1, 2009. Notwithstanding section 15, this paragraph expires on June 30, 2009.

Subd. 9. Board of Nursing Home Administrators

616,000

619,000

ADMINISTRATIVE SERVICES UNIT.

Of this appropriation, \$418,000 the first year and \$421,000 the second year are for the health boards administrative services unit, of which \$59,000 each year is for a rent increase for the health-related licensing boards. The administrative services unit may receive and expend reimbursements for services performed for other agencies.

Subd. 10. Board of Optometry

96,000

96,000

Subd. 11. Board of Pharmacy

1,389,000

1,344,000

BOARD OF PHARMACY APPROPRIATIONS INCREASE. Of this appropriation, \$137,000 the first year and \$92,000 the second year are for the increased cost of board operations, including retirement payouts and increased costs related to technology, but excluding salary increases.

RURAL PHARMACY PROGRAM. Of this appropriation, \$200,000 each year shall be transferred to the commissioner of health for the rural pharmacy planning and transition grant program under Minnesota Statutes, section 144.1476. Of this transferred amount, \$20,000 each year may be retained by the commissioner for related administrative costs. This appropriation shall become part of base level funding for the commissioner for the biennium beginning July 1, 2007. Notwithstanding section 15, this paragraph expires on June 30, 2009.

CANCER DRUG REPOSITORY PROGRAM. Of this appropriation, \$25,000 each year is for the cancer drug repository program under Minnesota Statutes, section 151.55. This appropriation shall become part of base level funding for the board for the biennium beginning July 1, 2007, but shall not be part of the base for the biennium beginning July 1, 2009. Notwithstanding section 15, this paragraph expires June 30, 2009.

Subd. 12. Board of Physical Therapy

201,000

207,000

BOARD OF PHYSICAL THERAPY APPROPRIATIONS INCREASE. Of

this appropriation, \$4,000 the first year and \$10,000 the second year are for the added costs of continued work on electronic access to the small boards' database and to provide flexible staff levels to assist in meeting peak demands related to the annual license renewal period and the handling of complex complaint and disciplinary cases.

Subd. 13. Board of Podiatry	49,000	53,000
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BOARD OF PODIATRY APPROPRIATIONS INCREASE. Of this appropriation, \$4,000 the first year and \$8,000 the second year are for increased costs of rent, board member per diems, and other increases in board operations costs, excluding salary increases.

Subd. 14. Board of Psychology	680,000	680,000
Subd. 15. Board of Social Work	978,000	973,000

ADMINISTRATIVE MANAGEMENT.

Of this appropriation, \$105,000 the first year and \$100,000 the second year are to provide administrative management under Minnesota Statutes, section 148B.61, subdivision 4. The following boards shall be assessed a prorated amount depending on the number of licensees under the board's regulatory authority providing mental health services within their scope of practice: Board of Medical Practice, the Board of Nursing, the Board of Psychology, the Board of Social Work, the Board of Marriage and Family Therapy, and the Board of Behavioral Health and Therapy.

Subd. 16. Board of Veterinary Medicine	171,000	171,000
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BOARD OF VETERINARY MEDICINE APPROPRIATIONS INCREASE.

Of this appropriation, \$8,000 each year is for the increased costs of a growing complaint caseload, rent, and other increased board operating costs, excluding salary increases.

Sec. 6. EMERGENCY MEDICAL SERVICES BOARD

Total Appropriation		3,027,000	3,027,000
	Summary by Fund		
General	2,481,000	2,481,000	
State Government			
Special Revenue	546,000	546,000	

HEALTH PROFESSIONAL SERVICES

ACTIVITY. \$546,000 each year from the state government special revenue fund is for the health professional services activity. Of this amount, \$50,000 each year is to hire an additional case manager and to continue employing a part-time student worker.

Sec. 7. COUNCIL ON DISABILITY

General		500,000	500,000
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Sec. 8. OMBUDSMAN FOR MENTAL HEALTH AND MENTAL RETARDATION

General		1,462,000	1,462,000
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Sec. 9. OMBUDSMAN FOR FAMILIES

General		245,000	245,000
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Sec. 10. Laws 2005, chapter 159, article 1, section 14, is amended to read:

Sec. 14. LAWS 2005, CHAPTER 14; EFFECTIVE DATE.

Laws 2005, chapter 14, section 1, takes effect August 1, 2006, and Laws 2005, chapter 14, section 2, takes effect August 1, 2005.

Sec. 11. Laws 2003, First Special Session chapter 14, article 13C, section 2, subdivision 6, is amended to read:

Subd. 6. Basic Health Care Grants

	Summary by Fund		
General	1,499,941,000	1,533,016,000	
Health Care Access	268,151,000	282,605,000	

New language is indicated by underline, deletions by ~~strikeout~~.

UPDATING FEDERAL POVERTY GUIDELINES. Annual updates to the federal poverty guidelines are effective each July 1, following publication by the United States Department of Health and Human Services for health care programs under Minnesota Statutes, chapters 256, 256B, 256D, and 256L.

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) MinnesotaCare Grants

Health Care Access	267,401,000	281,855,000
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MINNESOTACARE FEDERAL RECEIPTS. Receipts received as a result of federal participation pertaining to administrative costs of the Minnesota health care reform waiver shall be deposited as non-dedicated revenue in the health care access fund. Receipts received as a result of federal participation pertaining to grants shall be deposited in the federal fund and shall offset health care access funds for payments to providers.

MINNESOTACARE FUNDING. The commissioner may expend money appropriated from the health care access fund for MinnesotaCare in either fiscal year of the biennium.

(b) MA Basic Health Care Grants -
Families and Children

General	568,254,000	582,161,000
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SERVICES TO PREGNANT WOMEN. The commissioner shall use available federal money for the State-Children's Health Insurance Program for medical assistance services provided to pregnant women who are not otherwise eligible for federal finan-

New language is indicated by underline, deletions by ~~strikeout~~.

cial participation beginning in fiscal year 2003. This federal money shall be deposited in the federal fund and shall offset general funds for payments to providers. Notwithstanding section 14, this paragraph shall not expire.

MANAGED CARE RATE INCREASE.

(a) Effective January 1, 2004, the commissioner of human services shall increase the total payments to managed care plans under Minnesota Statutes, section 256B.69, by an amount equal to the cost increases to the managed care plans from by the elimination of: (1) the exemption from the taxes imposed under Minnesota Statutes, section 297I.05, subdivision 5, for premiums paid by the state for medical assistance, general assistance medical care, and the MinnesotaCare program; and (2) the exemption of gross revenues subject to the taxes imposed under Minnesota Statutes, sections 295.50 to 295.57, for payments paid by the state for services provided under medical assistance, general assistance medical care, and the MinnesotaCare program. Any increase based on clause (2) must be reflected in provider rates paid by the managed care plan unless the managed care plan is a staff model health plan company.

(b) The commissioner of human services shall increase by two percent the fee-for-service payments under medical assistance, general assistance medical care, and the MinnesotaCare program for services subject to the hospital, surgical center, or health care provider taxes under Minnesota Statutes, sections 295.50 to 295.57, effective for services rendered on or after January 1, 2004.

(c) The commissioner of finance shall transfer from the health care access fund to the general fund the following amounts in

New language is indicated by underline, deletions by ~~strikeout~~.

the fiscal years indicated: 2004, \$16,587,000; 2005, \$46,322,000; 2006, \$49,413,000; and 2007, \$52,659,000 \$58,695,000.

(d) For fiscal years after 2007, the commissioner of finance shall transfer from the health care access fund to the general fund an amount equal to the revenue collected by the commissioner of revenue on the following:

(1) gross revenues received by hospitals, surgical centers, and health care providers as payments for services provided under medical assistance, general assistance medical care, and the MinnesotaCare program, including payments received directly from the state or from a prepaid plan, under Minnesota Statutes, sections 295.50 to 295.57; and

(2) premiums paid by the state under medical assistance, general assistance medical care, and the MinnesotaCare program under Minnesota Statutes, section 297I.05, subdivision 5.

The commissioner of finance shall monitor and adjust if necessary the amount transferred each fiscal year from the health care access fund to the general fund to ensure that the amount transferred equals the tax revenue collected for the items described in clauses (1) and (2) for that fiscal year.

(e) Notwithstanding section 14, these provisions shall not expire.

(c) MA Basic Health Care Grants - Elderly and Disabled

General	695,421,000	741,605,000
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DELAY MEDICAL ASSISTANCE FEE-FOR-SERVICE - ACUTE CARE. The following payments in fiscal year 2005

New language is indicated by underline, deletions by ~~strikeout~~.

from the Medicaid Management Information System that would otherwise have been made to providers for medical assistance and general assistance medical care services shall be delayed and included in the first payment in fiscal year 2006:

(1) for hospitals, the last two payments; and

(2) for nonhospital providers, the last payment.

This payment delay shall not include payments to skilled nursing facilities, intermediate care facilities for mental retardation, prepaid health plans, home health agencies, personal care nursing providers, and providers of only waiver services. The provisions of Minnesota Statutes, section 16A.124, shall not apply to these delayed payments. Notwithstanding section 14, this provision shall not expire.

DEAF AND HARD-OF-HEARING SERVICES. If, after making reasonable efforts, the service provider for mental health services to persons who are deaf or hearing impaired is not able to earn \$227,000 through participation in medical assistance intensive rehabilitation services in fiscal year 2005, the commissioner shall transfer \$227,000 minus medical assistance earnings achieved by the grantee to deaf and hard-of-hearing grants to enable the provider to continue providing services to eligible persons.

(d) General Assistance Medical Care Grants

General	223,960,000	196,617,000
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(e) Health Care Grants - Other Assistance

General	3,067,000	3,407,000
Health Care Access	750,000	750,000

New language is indicated by underline, deletions by ~~strikeout~~.

MINNESOTA PRESCRIPTION DRUG DEDICATED FUND. Of the general fund appropriation, \$284,000 in fiscal year 2005 is appropriated to the commissioner for the prescription drug dedicated fund established under the prescription drug discount program.

DENTAL ACCESS GRANTS CARRY-OVER AUTHORITY. Any unspent portion of the appropriation from the health care access fund in fiscal years 2002 and 2003 for dental access grants under Minnesota Statutes, section 256B.53, shall not cancel but shall be allowed to carry forward to be spent in the biennium beginning July 1, 2003, for these purposes.

STOP-LOSS FUND ACCOUNT. The appropriation to the purchasing alliance stop-loss fund account established under Minnesota Statutes, section 256.956, subdivision 2, for fiscal years 2004 and 2005 shall only be available for claim reimbursements for qualifying enrollees who are members of purchasing alliances that meet the requirements described under Minnesota Statutes, section 256.956, subdivision 1, paragraph (f), clauses (1), (2), and (3).

(f) Prescription Drug Program

General	9,239,000	9,226,000
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PRESCRIPTION DRUG ASSISTANCE PROGRAM. Of the general fund appropriation, \$702,000 in fiscal year 2004 and \$887,000 in fiscal year 2005 are for the commissioner to establish and administer the prescription drug assistance program through the Minnesota board on aging.

REBATE REVENUE RECAPTURE. Any funds received by the state from a drug manufacturer due to errors in the

New language is indicated by underline, deletions by ~~strikeout~~.

pharmaceutical pricing used by the manufacturer in determining the prescription drug rebate are appropriated to the commissioner to augment funding of the prescription drug program established in Minnesota Statutes, section 256.955.

Sec. 12. TRANSFERS.

Subdivision 1. GRANTS. The commissioner of human services, with the approval of the commissioner of finance, and after notification of the chairs of the relevant senate budget division and house finance committee, may transfer unencumbered appropriation balances for the biennium ending June 30, 2007, within fiscal years among the MFIP, general assistance, general assistance medical care, medical assistance, MFIP child care assistance under Minnesota Statutes, section 119B.05, Minnesota supplemental aid, and group residential housing programs, and the entitlement portion of the chemical dependency consolidated treatment fund, and between fiscal years of the biennium.

Subd. 2. ADMINISTRATION. Positions, salary money, and nonsalary administrative money may be transferred within the Departments of Human Services and Health and within the programs operated by the Veterans Nursing Homes Board as the commissioners and the board consider necessary, with the advance approval of the commissioner of finance. The commissioner or the board shall inform the chairs of the relevant house and senate health committees quarterly about transfers made under this provision.

Subd. 3. PROHIBITED TRANSFERS. Grant money shall not be transferred to operations within the Departments of Human Services and Health and within the programs operated by the Veterans Nursing Homes Board without the approval of the legislature.

Sec. 13. SPECIAL REVENUE TRANSFER FOR CERTAIN PROGRAMS.

(a) The balance of indirect cost reimbursement attributable to federal grants transferred from the Department of Education to the Department of Human Services and available at the close of fiscal year 2005 shall be transferred to the general fund.

(b) The balance of the child care child support recoveries in the special revenue account established under Minnesota Statutes, section 119B.074, and available at the close of fiscal year 2005, shall be transferred to the general fund.

Sec. 14. INDIRECT COSTS NOT TO FUND PROGRAMS.

The commissioners of health and of human services shall not use indirect cost allocations to pay for the operational costs of any program for which they are responsible.

New language is indicated by underline, deletions by ~~strikeout~~.

Sec. 15. SUNSET OF UNCODIFIED LANGUAGE.

All uncodified language contained in this article expires on June 30, 2007, unless a different expiration date is explicit.

Sec. 16. EFFECTIVE DATE; RELATIONSHIP TO OTHER APPROPRIATIONS.

Appropriations in this act are effective retroactively from July 1, 2005, and supersede and replace funding authorized by order of the Ramsey County District Court in Case No. C9-05-5928, as well as by Laws 2005, First Special Session chapter 2, which provided temporary funding through July 14, 2005. The other language in this article is effective August 1, 2005.

Presented to the governor July 13, 2005

Signed by the governor July 14, 2005, 1:05 p.m.

CHAPTER 5—H.F.No. 141

An act relating to the operation and financing of government; providing for early childhood, adult, family, and kindergarten through grade 12 education including general education, education excellence, special programs, facilities and technology, nutrition and accounting, libraries, early childhood education, prevention, self-sufficiency and lifelong learning, state agencies, and technical and conforming amendments; reestablishing statutory authority for the Humanities Commission; authorizing certain nonprofit contracts; reimbursing local governments; authorizing certain state agencies and constitutional officers to carry forward unencumbered balances for fiscal year 2005; appropriating money for lets go fishing to promote opportunities for fishing in the state; authorizing rulemaking; providing for reports; appropriating money; amending Minnesota Statutes 2004, sections 13.32, subdivision 8; 13.321, by adding a subdivision; 119A.46, subdivisions 1, 2, 3, 8; 120A.05, by adding a subdivision; 120A.22, subdivision 12; 120B.02; 120B.021, by adding a subdivision; 120B.11, subdivisions 1, 2, 3, 4, 5, 8; 120B.13, subdivisions 1, 3, by adding a subdivision; 120B.22, subdivision 1; 120B.30, subdivisions 1, 1a, by adding a subdivision; 120B.31, subdivision 4; 121A.03, subdivision 1; 121A.06, subdivisions 2, 3; 121A.15, subdivision 3; 121A.17, subdivisions 1, 5; 121A.19; 121A.41, subdivision 10; 121A.47, subdivision 14; 121A.53; 121A.66, subdivision 5, by adding subdivisions; 121A.67; 122A.06, subdivision 4; 122A.12, subdivision 2; 122A.18, subdivision 2a; 122A.33; 122A.40, subdivision 5, as amended; 122A.41, subdivisions 2, as amended, 5a, 14; 122A.413; 122A.414; 122A.415, subdivisions 1, 3; 122A.60, subdivision 1, by adding subdivisions; 123A.05, subdivision 2; 123B.02, by adding subdivisions; 123B.04, subdivisions 1, 2; 123B.42, by adding a subdivision; 123B.49, subdivision 4; 123B.492; 123B.53, subdivision 1; 123B.54; 123B.59, subdivisions 3, 3a; 123B.63, subdivision 2; 123B.71, subdivisions 8, 9, 12; 123B.75, subdivision 5, by adding a subdivision; 123B.76, subdivision 3; 123B.79, subdivision 6; 123B.81, subdivision 1; 123B.82; 123B.83, subdivision 2; 123B.88, by adding a subdivision; 123B.92, subdivisions 1, 5; 124D.09, subdivision 12; 124D.095, subdivisions 2, 4, 8, by adding a subdivision; 124D.10, subdivisions 4, 6, 15, 23; 124D.11, subdivisions 1, 2, 5, 6; 124D.111, subdivisions 1, 2; 124D.118, subdivision 4; 124D.135, subdivisions 1, 5; 124D.15, subdivisions 1, 3, 5, 10, 12, by adding subdivisions; 124D.16, subdivisions 2, 3; 124D.20,

New language is indicated by underline, deletions by ~~strikeout~~.