1 Senator Cohen from the Committee on Finance, to which was 2 re-referred

S.F. No. 2278: A bill for an act relating to state 3 government; modifying licensing fees; expanding health care 4 program eligibility; enacting health care cost containment 5 measures; modifying mental and chemical health programs; 6 adjusting family support programs; reducing certain parental 7 fees; providing a cost-of-living adjustment for certain human 8 services program employees; modifying long-term care programs; 9 modifying continuing care programs; allowing penalties; 10 appropriating money; amending Minnesota Statutes 2004, sections 62A.65, subdivision 3; 62D.12, subdivision 19; 62J.04, 11 12 subdivision 3, by adding a subdivision; 62J.041; 62J.301, 13 subdivision 3; 62J.38; 62J.692, subdivision 3; 62L.08, 14 subdivision 8; 62M.06, subdivisions 2, 3; 62Q.37, subdivision 7; 103I.101, subdivision 6; 103I.208, subdivisions 1, 2; 103I.235, subdivision 1; 103I.601, subdivision 2; 119B.011, by adding a 15 16 17 subdivision; 119B.05, subdivision 1; 144.122; 144.147, 18 subdivision 1; 144.148, subdivision 1; 144.1501, subdivisions 1, 19 2, 3, 4; 144.226, subdivision 1, by adding subdivisions; 20 144.3831, subdivision 1; 144.551, subdivision 1; 144.562, subdivision 2; 144.9504, subdivision 2; 144.98, subdivision 3; 21 22 144A.073, subdivision 10, by adding a subdivision; 144E.101, by 23 adding a subdivision; 157.15, by adding a subdivision; 157.16, subdivisions 2, 3, by adding subdivisions; 157.20, subdivisions 24 25 2, 2a; 241.01, by adding a subdivision; 244.054; 245.4661, by 26 adding subdivisions; 245.4885, subdivisions 1, 2, by adding a 27 subdivision; 252.27, subdivision 2a; 252.291, by adding a subdivision; 254B.03, subdivision 4; 256.01, by adding a 28 29 subdivision; 256.045, subdivision 3a; 256.741, subdivision 4; 256.9365; 256.969, by adding a subdivision; 256B.02, subdivision 30 31 12; 256B.055, by adding a subdivision; 256B.056, subdivisions 5, 32 5a, 5b, 7, by adding subdivisions; 256B.057, subdivision 1; 33 256B.0621, subdivisions 2, 3, 4, 5, 6, 7; 256B.0622, subdivision 2; 256B.0625, subdivisions 2, 9, 13e, as amended, 13f, 19c, by adding subdivisions; 256B.0627, subdivisions 1, 4, 5, 9, by adding a subdivision; 256B.0916, by adding a subdivision; 256B.15, subdivisions 1, 1a, 2; 256B.19, subdivision 1; 34 35 36 37 38 256B.431, by adding subdivisions; 256B.434, subdivision 4, by 39 adding a subdivision; 256B.440, by adding a subdivision; 256B.5012, by adding a subdivision; 256B.69, subdivisions 4, 23; 40 41 256D.03, subdivision 4; 256D.045; 256D.44, subdivision 5; 256J.021; 256J.08, subdivision 65; 256J.21, subdivision 2; 42 43 256J.521, subdivision 1; 256J.53, subdivision 2; 256J.626, subdivisions 1, 2, 3, 4, 7; 256J.95, subdivisions 3, 9; 256L.01, subdivision 4; 256L.03, subdivisions 1, 1b, 5; 256L.04, subdivisions 2, 7, by adding subdivisions; 256L.05, subdivisions 44 45 46 47 48 3, 3a; 256L.07, subdivisions 1, 3, by adding a subdivision; 256L.12, subdivision 6; 256L.15, subdivisions 2, 3; 295.582; 326.01, by adding a subdivision; 326.37, subdivision 1, by 49 50 adding a subdivision; 326.38; 326.40, subdivision 1; 326.42, 51 subdivision 2; 514.981, subdivision 6; 524.3-805; 549.02, by 52 adding a subdivision; 549.04; 641.15, subdivision 2; proposing 53 coding for new law in Minnesota Statutes, chapters 62J; 144; 54 151; 256; 256B; 256J; 256L; 326; 501B; 641; repealing Minnesota Statutes 2004, sections 119B.074; 157.215; 256B.0631; 256J.37, 55 56 subdivisions 3a, 3b; 256L.035; 326.45; 514.991; 514.992; 57 514.993; 514.994; 514.995. 58

59 Reports the same back with the recommendation that the bill 60 be amended as follows:

61 Page 2, after line 25, insert:

62 "Section 1. [62J.495] [HEALTH INFORMATION TECHNOLOGY AND 63 INFRASTRUCTURE ADVISORY COMMITTEE.]

64 Subdivision 1. [ESTABLISHMENT; MEMBERS; DUTIES.] (a) The

1	commissioner shall establish a Health Information Technology and						
2	Infrastructure Advisory Committee governed by section 15.059 to						
3	advise the commissioner on the following matters:						
4	(1) assessment of the use of health information technology						
5	by the state, licensed health care providers and facilities, and						
6	local public health agencies;						
7	(2) recommendations for implementing a statewide						
8	interoperable health information infrastructure, to include						
9	estimates of necessary resources, and for determining standards						
10	for administrative data exchange, clinical support programs, and						
11	maintenance of the security and confidentiality of individual						
12	patient data; and						
13	(3) other related issues as requested by the commissioner.						
14	(b) The members of the Health Information Technology and						
15	Infrastructure Advisory Committee shall include the						
16	commissioners, or commissioners' designees, of health, human						
17	services, and commerce and additional members to be appointed by						
18	the commissioner to include persons representing Minnesota's						
19	local public health agencies, licensed hospitals and other						
20	licensed facilities and providers, the medical and nursing						
21	professions, health insurers and health plans, the state quality						
22	improvement organization, academic and research institutions,						
23	consumer advisory organizations with an interest and expertise						
24	in health information technology, and other stakeholders as						
25	identified by the Health Information Technology and						
26	Infrastructure Advisory Committee.						
27	Subd. 2. [ANNUAL REPORT.] The commissioner shall prepare						
28	and issue an annual report not later than January 30 of each						
29	year outlining progress to date in implementing a statewide						
30	health information infrastructure and recommending future						
31	projects.						
32	Subd. 3. [EXPIRATION.] Notwithstanding section 15.059,						
33	this section expires June 30, 2009."						
34	Page 11, delete lines 17 to 23						
35	Page 11, after line 35, insert:						

36 "Sec. 9. Minnesota Statutes 2004, section 144.147,

1 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

16

(3) an implementation plan.

17 The strategic plan must be developed by a committee that 18 includes representatives from the hospital, local public health 19 agencies, other health providers, and consumers from the 20 community.

(b) The grants may also be used by eligible rural hospitals 21 22 that have developed strategic plans to implement transition projects to modify the type and extent of services provided, in 23 order to reflect the needs of that plan. Grants may be used by 24 hospitals under this paragraph to develop hospital-based 25 physician practices that integrate hospital and existing medical 26 27 practice facilities that agree to transfer their practices, equipment, staffing, and administration to the hospital. The 28 29 grants may also be used by the hospital to establish a health provider cooperative, a telemedicine system, an electronic 30 health records system, or a rural health care system or to cover 31 expenses associated with being designated as a critical access 32 hospital for the Medicare rural hospital flexibility program. 33 34 Not more than one-third of any grant shall be used to offset losses incurred by physicians agreeing to transfer their 35 practices to hospitals. The commissioner shall give priority to 36

1 grant applications for projects involving electronic health
2 records systems."

Page 15, line 4, before the period, insert ", including
establishing an electronic health records system. The
commissioner shall give priority to grant applications for

6 projects involving electronic health records systems"

7 Page 15, after line 4, insert:

8 "Sec. 12. Minnesota Statutes 2004, section 144.1483, is
9 amended to read:

10 144.1483 [RURAL HEALTH INITIATIVES.]

11 The commissioner of health, through the Office of Rural 12 Health, and consulting as necessary with the commissioner of 13 human services, the commissioner of commerce, the Higher 14 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;

(2) develop-and-implement-a-program-to-assist-rural
communities-in-establishing-community-health-centers,-as
required-by-section-144-1486;

(3) (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;

29 (4) (3) develop a statewide, coordinated recruitment
30 strategy for health care personnel and maintain a database on
31 health care personnel as required under section 144.1485;

32 (5) (4) develop and administer technical assistance
33 programs to assist rural communities in: (i) planning and
34 coordinating the delivery of local health care services; and
35 (ii) hiring physicians, nurse practitioners, public health
36 nurses, physician assistants, and other health personnel;

1 (6) (5) study and recommend changes in the regulation of
2 health care personnel, such as nurse practitioners and physician
3 assistants, related to scope of practice, the amount of on-site
4 physician supervision, and dispensing of medication, to address
5 rural health personnel shortages;

6 (7) (6) support efforts to ensure continued funding for
7 medical and nursing education programs that will increase the
8 number of health professionals serving in rural areas;

9 (8) (7) support efforts to secure higher reimbursement for
10 rural health care providers from the Medicare and medical
11 assistance programs;

12 (9) (8) coordinate the development of a statewide plan for 13 emergency medical services, in cooperation with the Emergency 14 Medical Services Advisory Council;

(10) (9) establish a Medicare rural hospital flexibility 15 program pursuant to section 1820 of the federal Social Security 16 Act, United States Code, title 42, section 1395i-4, by 17 developing a state rural health plan and designating, consistent 18 19 with the rural health plan, rural nonprofit or public hospitals in the state as critical access hospitals. Critical access 20 hospitals shall include facilities that are certified by the 21 state as necessary providers of health care services to 22 residents in the area. Necessary providers of health care 23 services are designated as critical access hospitals on the 24 basis of being more than 20 miles, defined as official mileage 25 26 as reported by the Minnesota Department of Transportation, from the next nearest hospital, being the sole hospital in the 27 28 county, being a hospital located in a county with a designated medically underserved area or health professional shortage area, 29 or being a hospital located in a county contiguous to a county 30 with a medically underserved area or health professional 31 shortage area. A critical access hospital located in a county 32 with a designated medically underserved area or a health 33 professional shortage area or in a county contiguous to a county 34 35 with a medically underserved area or health professional shortage area shall continue to be recognized as a critical 36

access hospital in the event the medically underserved area or 1 health professional shortage area designation is subsequently 2 withdrawn; and 3 (11) carry out other activities necessary to address 4 rural health problems." 5 Page 17, line 33, delete "or" and after "area" insert ", or 6 specialty type" 7 Page 18, line 2, after "communities" insert "and pediatric 8 psychiatry" 9 Page 18, line 4, after "communities" insert "or pediatric 10 psychiatry" 11 Page 37, after line 22, insert: 12 "Sec. 33. Minnesota Statutes 2004, section 145.9268, is 13 amended to read: 14 145.9268 [COMMUNITY CLINIC GRANTS.] 15 Subdivision 1. [DEFINITION.] For purposes of this section, 16 "eligible community clinic" means: 17 (1) a nonprofit clinic that provides is established to 18 19 provide health services under-conditions-as-defined-in-Minnesota Rules,-part-9505.0255, to low income or rural population groups; 20 provides medical, preventive, dental, or mental health primary 21 care services; and utilizes a sliding fee scale or other 22 procedure to determine eligibility for charity care or to ensure 23 24 that no person will be denied services because of inability to 25 pay; 26 (2) a governmental entity or an Indian tribal government or Indian health service unit that provides services and utilizes a 27 28 sliding fee scale or other procedure as described under clause (1); or 29 30 (3) a consortium of clinics comprised of entities under clause (1) or (2)<u>; or</u> 31 32 (4) a nonprofit, tribal, or governmental entity proposing the establishment of a clinic that will provide services and 33 34 utilize a sliding fee scale or other procedure as described 35 under clause (1). [GRANTS AUTHORIZED.] The commissioner of health 36 Subd. 2.

shall award grants to eligible community clinics to plan, 1 establish, or operate services to improve the ongoing viability 2 of Minnesota's clinic-based safety net providers. Grants shall 3 be awarded to support the capacity of eligible community clinics 4 to serve low-income populations, reduce current or future 5 uncompensated care burdens, or provide for improved care 6 delivery infrastructure. The commissioner shall award grants to 7 community clinics in metropolitan and rural areas of the state, 8 and shall ensure geographic representation in grant awards among 9 10 all regions of the state.

11 Subd. 3. [ALLOCATION OF GRANTS.] (a) To receive a grant 12 under this section, an eligible community clinic must submit an 13 application to the commissioner of health by the deadline 14 established by the commissioner. A grant may be awarded upon 15 the signing of a grant contract. Community clinics may apply 16 for and the commissioner may award grants for one-year or 17 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 grantfunds 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

28 (4) a process for documenting and evaluating results of the
29 grant.

30 (c) The commissioner shall review each application to 31 determine whether the application is complete and whether the 32 applicant and the project are eligible for a grant. In 33 evaluating applications according to paragraph (d), the 34 commissioner shall establish criteria including, but not limited 35 to: the priority-level eligibility of the project; the 36 applicant's thoroughness and clarity in describing the problem

grant funds are intended to address; a description of the 1 applicant's proposed project; a description of the population 2 demographics and service area of the proposed project; the 3 manner in which the applicant will demonstrate the effectiveness 4 of any projects undertaken; and evidence of efficiencies and 5 effectiveness gained through collaborative efforts. The 6 commissioner may also take into account other relevant factors, 7 including, but not limited to, the percentage for which 8 uninsured patients represent the applicant's patient base and 9 the degree to which grant funds will be used to support services 10 increasing or maintaining access to health care services. 11. During application review, the commissioner may request 12 additional information about a proposed project, including 13 information on project cost. Failure to provide the information 14 requested disqualifies an applicant. The commissioner has 15 discretion over the number of grants awarded. 16

(d) In determining which eligible community clinics will 17 receive grants under this section, the commissioner shall give 18 19 preference to those grant applications that show evidence of collaboration with other eligible community clinics, hospitals, 20 health care providers, or community organizations. In-addition7 21 the-commissioner-shall-give-priority7-in-declining-order7-to 22 grant-applications-for-projects-that: In addition, the 23 24 commissioner shall give priority to grant applications for projects involving electronic health records systems. 25 Subd. 3a. [AWARDING GRANTS.] (a) The commissioner may 26 27 award grants for activities to: (1) provide a direct offset to expenses incurred for 28

29 services provided to the clinic's target population;

30 (2) establish, update, or improve information, data
 31 collection, or billing systems, including electronic health
 32 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

36 increased translation and interpretation services;  $\sigma_{\mathbf{r}}$ 

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(5) <u>build a new clinic or expand an existing facility; or</u>

 (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 10 health shall evaluate the overall effectiveness of the grant 11 The commissioner shall collect progress reports to program. 12 evaluate the grant program from the eligible community clinics 13 receiving grants. Every two years, as part of this evaluation, 14 the commissioner shall report to the legislature on priority 15 areas-for-grants-set-under-subdivision-3 the needs of community 16 17 clinics and provide any recommendations for adding or changing priority-areas eligible activities." 18

Page 53, line 9, after "sections" insert "144.1486;"
Page 56, after line 12, insert:

"Sec. 4. Minnesota Statutes 2004, section 256.045,
subdivision 3, is amended to read:

[STATE AGENCY HEARINGS.] (a) State agency Subd. 3. 23 hearings are available for the following: (1) any person 24 applying for, receiving or having received public assistance, 25 26 medical care, or a program of social services granted by the state agency or a county agency or the federal Food Stamp Act 27 28 whose application for assistance is denied, not acted upon with reasonable promptness, or whose assistance is suspended, 29 reduced, terminated, or claimed to have been incorrectly paid; 30 31 (2) any patient or relative aggrieved by an order of the commissioner under section 252.27; (3) a party aggrieved by a 32 33 ruling of a prepaid health plan; (4) except as provided under chapter 245C, any individual or facility determined by a lead 34 agency to have maltreated a vulnerable adult under section 35 626.557 after they have exercised their right to administrative 36

reconsideration under section 626.557; (5) any person whose 1 claim for foster care payment according to a placement of the 2 child resulting from a child protection assessment under section 3 626.556 is denied or not acted upon with reasonable promptness, 4 regardless of funding source; (6) any person to whom a right of 5 appeal according to this section is given by other provision of 6 7 law; (7) an applicant aggrieved by an adverse decision to an application for a hardship waiver under section 256B.15; (8) an 8 9 applicant aggrieved by an adverse decision to an application or redetermination for a Medicare Part D prescription drug subsidy 10 under section 256B.04, subdivision 4a; (9) except as provided 11 under chapter 245A, an individual or facility determined to have 12 maltreated a minor under section 626.556, after the individual 13 or facility has exercised the right to administrative 14 reconsideration under section 626.556; or (9) (10) except as 15 provided under chapter 245C, an individual disqualified under 16 sections 245C.14 and 245C.15, on the basis of serious or 17 18 recurring maltreatment; a preponderance of the evidence that the 19 individual has committed an act or acts that meet the definition 20 of any of the crimes listed in section 245C.15, subdivisions 1 to 4; or for failing to make reports required under section 21 22 626.556, subdivision 3, or 626.557, subdivision 3. Hearings regarding a maltreatment determination under clause (4) 23 24 or (8) (9) and a disqualification under this clause in which the 25 basis for a disqualification is serious or recurring 26 maltreatment, which has not been set aside under sections 245C.22 and 245C.23, shall be consolidated into a single fair 27 28 hearing. In such cases, the scope of review by the human services referee shall include both the maltreatment 29 determination and the disqualification. The failure to exercise 30 31 the right to an administrative reconsideration shall not be a bar to a hearing under this section if federal law provides an 32 individual the right to a hearing to dispute a finding of 33 34 maltreatment. Individuals and organizations specified in this 35 section may contest the specified action, decision, or final 36 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), 6  $(\theta)$ , or  $(\theta)$  (10) is the only administrative appeal to the 7 final agency determination specifically, including a challenge 8 to the accuracy and completeness of data under section 13.04. 9 10 Hearings requested under clause (4) apply only to incidents of maltreatment that occur on or after October 1, 1995. Hearings 11 requested by nursing assistants in nursing homes alleged to have 12 maltreated a resident prior to October 1, 1995, shall be held as 13 a contested case proceeding under the provisions of chapter 14. 14 Hearings requested under clause  $(\theta)$  (9) apply only to incidents 15 of maltreatment that occur on or after July 1, 1997. A hearing 16 for an individual or facility under clause  $(\theta)$  (9) is only 17 available when there is no juvenile court or adult criminal 18 action pending. If such action is filed in either court while 19 an administrative review is pending, the administrative review 20 must be suspended until the judicial actions are completed. 21 If 22 the juvenile court action or criminal charge is dismissed or the criminal action overturned, the matter may be considered in an 23 administrative hearing. 24

For purposes of this section, bargaining unit grievance
procedures are not an administrative appeal.

27 The scope of hearings involving claims to foster care 28 payments under clause (5) shall be limited to the issue of 29 whether the county is legally responsible for a child's placement under court order or voluntary placement agreement 30 31 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 32 propriety of the county's child protection determination or 33 child placement decision. 34

35 (b) A vendor of medical care as defined in section 256B.02,36 subdivision 7, or a vendor under contract with a county agency

[SENATEE ] mv SS2278R to provide social services is not a party and may not request a 1 hearing under this section, except if assisting a recipient as 2 3 provided in subdivision 4. (c) An applicant or recipient is not entitled to receive 4 social services beyond the services included in the amended 5 community social services plan. 6 (d) The commissioner may summarily affirm the county or 7 state agency's proposed action without a hearing when the sole 8 issue is an automatic change due to a change in state or federal 9 law." 10 Page 57, line 34, delete "PROGRAM" and insert "PROGRAMS" 11 Page 57, line 35, before "PROGRAM" insert "INSURANCE 12 ASSISTANCE" 13 Page 59, line 9, before "The" insert "(a) For individuals 14 who are uninsured or insured with 50 percent or less of the 15 premium by an employer," 16 Page 59, line 14, after the period, insert: 17 "(b)" 18 Page 59, line 15, strike "2" and before "must" insert "1" 19 Page 59, line 30, after "appropriate" insert "for efficient 20 program administration" 21 Page 59, line 33, before "The" insert "(a)" 22 Page 59, line 36, after the period, insert: 23 "(b)" 24 Page 60, after line 2, insert: 25 "(c) Each year following the release of the November 26 revenue forecast, the commissioner shall report to the chairs of 27 the appropriate health and human services finance committees the 28 forecasted need for the HIV health care access programs included 29 30 in this section. The report shall include information about the anticipated enrollment, service utilization, service costs, 31 state, federal, and special revenue resources available to fund 32 the program needs, and any anticipated funding shortfall. 33 34 (d) When a shortfall of funding is projected,

35 recommendations should be included to assure that the program

36 expenditures are maintained within the anticipated available

[SENATEE ] mv

SS2278R

1	funding."						
2	Page 60, line 3, before " <u>The</u> " insert " <u>(a)</u> "						
3	Page 60, line 6, after the period, insert:						
4	"(b) The policies and procedures shall consider the impacts						
5	of continued HIV treatment on:						
6	(1) reducing the risk for HIV transmission;						
7	(2) preventing program recipients from becoming drug						
8	resistant; and						
9	(3) the prevention of the development of drug-resistant						
10	strains of HIV."						
11	Page 60, line 7, delete "FEDERAL" and insert "FEDERALLY						
12	FUNDED HIV HEALTH CARE ACCESS" and before " <u>The</u> " insert " <u>(a)</u> "						
13	Page 60, line 10, after the period, insert:						
14	"(b) Within the limits of the federal funding available for						
15	these purposes, the commissioner may provide access to drugs						
16	that treat HIV and manage the side effects of HIV treatment to						
17	persons who meet the eligibility requirements in subdivision 2.						
18	(c) The commissioner may establish co-payment obligations						
19	for drugs purchased under this section."						
20	Page 60, line 22, delete " <u>, effective July 1, 2005</u> "						
21	Page 66, after line 29, insert:						
22	"Sec. 10. Minnesota Statutes 2004, section 256B.04, is						
23	amended by adding a subdivision to read:						
24	Subd. 4a. [MEDICARE PRESCRIPTION DRUG SUBSIDY.] The						
25	commissioner shall perform all duties necessary to administer						
26	eligibility determinations for the Medicare Part D prescription						
27	drug subsidy and facilitate the enrollment of eligible medical						
28	assistance recipients into Medicare prescription drug plans as						
29	required by the Medicare Prescription Drug, Improvement, and						
30	Modernization Act of 2003 (MMA), Public Law 108-173, and Code of						
31	Federal Regulations, title 42, sections 423.30 to 423.56 and						
32	423.771 to 423.800."						
33	Page 73, line 12, strike everything after "percent"						
34	Page 73, strike lines 13 to 15						
35							
	Page 73, line 16, strike everything before the period						

1	Page 79, line 1, before the period, insert ", reporting							
2	separately for managed care and fee-for-service recipients"							
3	Page 79, line 3, delete " <u>or single-physician practices</u> "							
4	Page 79, line 11, delete " <u>or single-physician practice</u> "							
5	Page 79, line 17, delete " <u>develop</u> " and insert " <u>advise on</u>							
6	the development of"							
7	Page 79, line 27, delete "provide" and insert "propose"							
8	Page 80, delete lines 15 to 17							
9	Page 80, line 18, delete " <u>(e)</u> " and insert " <u>(d)</u> "							
10	Page 80, line 19, after " <u>and</u> " insert "proposed"							
11	Page 80, line 23, delete " <u>(f)</u> " and insert " <u>(e)</u> " and delete "							
12	<u>April</u> " and insert " <u>October</u> "							
13	Page 80, line 25, delete ", single-physician practice," and							
14	delete "hospital" and insert "hospitals where possible"							
15	Page 80, line 26, after the first " <u>and</u> " insert " <u>when</u>							
16	feasible"							
17	Page 80, lines 27 and 28, delete " <u>, single-physician</u>							
18	practice,"							
19	Page 83, delete lines 14 to 24 and insert:							
20	"(a) Hennepin County, Hennepin County Medical Center,							
21	Ramsey County, Regions Hospital, the University of Minnesota,							
22	and Fairview-University Medical Center shall annually report to							
23	the commissioner by June 1, beginning June 1, 2005, payments							
24	made during the previous calendar year that may qualify for							
25	reimbursement under federal law. Subject to the reports due							
26	June 1, 2005, the amounts for calendar year 2004 are expected to							
27	be as follows:							
28	(1) Hennepin County and Hennepin County Medical Center,							
29	<u>\$31,980,000;</u>							
30	(2) Ramsey County and Regions Hospital, \$20,980,000; and							
31	(3) University of Minnesota and Fairview-University Medical							
32	Center, \$11,050,000."							
33	Page 91, after line 28, insert:							
34	"Sec. 31. Minnesota Statutes 2004, section 256L.01,							
35	subdivision 5, is amended to read:							

earned and unearned income for families and children in the 1 medical assistance program, according to the state's aid to 2 families with dependent children plan in effect as of July 16, 3 The definition does not include medical assistance income 4 1996. methodologies and deeming requirements. The earned income of 5 full-time and part-time students under age 19 is not counted as 6 Public assistance payments and supplemental security 7 income. income are not excluded income. 8

(b) For purposes of this subdivision, and unless otherwise 9 specified in this section, the commissioner shall use reasonable 10 methods to calculate gross earned and unearned income including, 11 but not limited to, projecting income based on income received 12 within the past 30 days, the last 90 days, or the last 12 months. 13 [EFFECTIVE DATE.] This section is effective July 1, 2005." 14 Page 93, line 13, strike "equal to or" 15 Page 99, line 29, after the comma, insert "an applicant or 16

17 <u>enrollee who is entitled to</u>" and after "or" insert "<u>enrolled in</u> 18 <u>Medicare Part</u>"

19 Page 99, line 31, strike "1395w-4" and insert "<u>1395w-152</u>"
20 and after "considered" insert "<u>to have</u>"

Page 99, line 32, after "enrollee" insert "who is entitled
to premium-free Medicare Part A" and after "refuse" insert "to
apply for or enroll in"

24 Page 107, delete lines 19 to 21 and insert:

"(d) This section expires July 1, 2007, or upon the
 completion of the prior authorization system required under

27 subdivision 1, paragraph (b), whichever is earlier."

28 Page 108, line 3, delete "later" and insert "earlier"
29 Page 108, delete section 49 and insert:

30 "Sec. 52. [ORAL HEALTH CARE PILOT PROJECT.]

31 The commissioner shall implement a two-year pilot project 32 to provide services for state program recipients through a new

33 oral health care delivery system. The commissioner shall

34 <u>contract with a qualified entity or entities to administer the</u> 35 pilot project."

36 Page 158, line 20, delete "<u>life</u>"

1	Page 158, delete lines 21 to 24 and insert "a deceased						
2	recipient's life estates and jointly owned interests in farm and						
3	income producing real property they own of record on the date						
4	they die if their interest in the property ends at their death,						
5	the surviving remainderman or surviving joint tenant owns their						
6	interest in the property of record on that date, and all of the						
7	following conditions apply with respect to the surviving						
8	remainderman or the surviving joint tenant and their interest in						
9	the property:"						
10	Page 159, line 34, delete everything after "The"						
11	Page 159, delete lines 35 and 36						
12	Page 160, line 1, delete everything before " <u>amendments</u> "						
13	Page 161, line 15, delete " <u>relating</u> "						
14	Page 161, delete line 16 and insert "are effective"						
15	Page 161, line 17, delete " <u>2003</u> " and insert " <u>2005</u> "						
16	Page 161, line 36, delete " <u>retroactively</u> "						
17	Page 162, line 1, delete " <u>from July 1, 2003</u> " and insert						
18	" <u>July 1, 2005</u> "						
19	Page 162, line 4, delete "SEPTEMBER" and insert "OCTOBER"						
20	Page 162, lines 6 and 19, delete "September" and insert						
21	" <u>October</u> "						
22	Page 163, line 4, delete "December 31 each year" and insert						
23	"March 31, 2006, and December 31, 2006, respectively"						
24	Page 167, line 14, delete "SEPTEMBER" and insert "OCTOBER"						
25	Page 167, line 16, delete " <u>September</u> " and insert " <u>October</u> "						
26	Page 168, line 14, delete "December 31 each year" and						
27	insert "March 31, 2006, and December 31, 2006, respectively"						
28	Page 175, line 23, delete " <u>life</u> "						
29	Page 175, delete lines 24 to 27 and insert "a deceased						
30	recipient's life estates and jointly owned interests in farm and						
31	income producing real property they own of record on the date						
32	they die if their interest in the property ends at their death,						
33	the surviving remainderman or surviving joint tenant owns their						
34	interest in the property of record on that date, and all of the						
35	following conditions apply with respect to the surviving						
36	remainderman or surviving joint tenant and their interest in the						

	1	property:"						
	2	Page 178, line 1, delete " <u>retroactively</u> "						
~.	3	Page 178, line 2, delete " <u>from July 1, 2003</u> " and insert						
	4	"July 1, 2005"						
	5	Page 178, line 6, delete " <u>September</u> " and insert " <u>October</u> "						
	6	Page 181, line 31, after " <u>lien</u> " insert " <u>and estate claims</u>						
	7	recovery"						
	8	Page 181, line 35, after " <u>sections</u> " insert " <u>256B.15 and</u> "						
	9	Page 182, line 2, delete " <u>retroactively</u> "						
	10	Page 182, delete line 3 and insert "July 1, 2005."						
	11	Page 182, line 19, delete " <u>retroactively from</u> "						
	12	Page 182, delete line 20 and insert "effective July 1,						
	13	2005. On and after the repeal date all alternative care liens						
	14	of record shall be of no force and effect, shall not be liens on						
	15	real property, and examiners of title shall disregard these						
	16	liens and shall not carry them forward to subsequent						
	17	certificates of title."						
	18	Page 189, after line 19, insert:						
	19	"Sec. 7. Minnesota Statutes 2004, section 245.4874, is						
	20	amended to read:						
	21	245.4874 [DUTIES OF COUNTY BOARD.]						
	22	(a) The county board in each county shall use its share of						
	23	mental health and Community Social Services Act funds allocated						
	24	by the commissioner according to a biennial children's mental						
	25	health component of the community social services plan that is						
	26	approved by the commissioner. The county board must:						
	27	(1) develop a system of affordable and locally available						
	28	children's mental health services according to sections 245.487						
	29	to 245.4887;						
	30	(2) establish a mechanism providing for interagency						
	31	coordination as specified in section 245.4875, subdivision 6;						
	32	(3) develop a biennial children's mental health component						
	33	of the community social services plan which considers the						
••••	34	assessment of unmet needs in the county as reported by the local						
	35	children's mental health advisory council under section						
	36	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 (4) assure that parents and providers in the county receive
5 information about how to gain access to services provided
6 according to sections 245.487 to 245.4887;

7 (5) coordinate the delivery of children's mental health
8 services with services provided by social services, education,
9 corrections, health, and vocational agencies to improve the
10 availability of mental health services to children and the
11 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;

16 (7) provide the community with information about predictors 17 and symptoms of emotional disturbances and how to access 18 children's mental health services according to sections 245.4877 19 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
24 (9) provide for screening of each child under section
25 245.4885 upon admission to a residential treatment facility,
acute care hospital inpatient treatment, or informal admission
26 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;

4 (13) assure that culturally informed mental health
5 consultants are used as necessary to assist the county board in
6 assessing and providing appropriate treatment for children of
7 cultural or racial minority heritage; and

(14) consistent with section 245.486, arrange for or 8 provide a children's mental health screening to a child 9 receiving child protective services or a child in out-of-home 10 placement, a child for whom parental rights have been 11 terminated, a child found to be delinquent, and a child found to 12 have committed a juvenile petty offense for the third or 13 subsequent time, unless a screening has been performed within 14 the previous 180 days, or the child is currently under the care 15 of a mental health professional. The court or county agency 16 must notify a parent or guardian whose parental rights have not 17 been terminated of the potential mental health screening and the 18 19 option to prevent the screening by notifying the court or county agency in writing. The screening shall be conducted with a 20 screening instrument approved by the commissioner of human 21 services according to criteria that are updated and issued 22 annually to ensure that approved screening instruments are valid 23 and useful for child welfare and juvenile justice populations, 24 and shall be conducted by a mental health practitioner as 25 26 defined in section 245.4871, subdivision 26, or a probation officer or local social services agency staff person who is 27 trained in the use of the screening instrument. Training in the 28 use of the instrument shall include training in the 29 30 administration of the instrument, the interpretation of its validity given the child's current circumstances, the state and 31 federal data practices laws and confidentiality standards, the 32 parental consent requirement, and providing respect for families 33 and cultural values. If the screen indicates a need for 34 35 assessment, the child's family, or if the family lacks mental 36 health insurance, the local social services agency, in

consultation with the child's family, shall have conducted a 1 diagnostic assessment, including a functional assessment, as 2 defined in section 245.4871. The administration of the 3 screening shall safeguard the privacy of children receiving the 4 screening and their families and shall comply with the Minnesota 5 Government Data Practices Act, chapter 13, and the federal 6 Health Insurance Portability and Accountability Act of 1996, 7 Public Law 104-191. Screening results shall be considered 8 private data and the commissioner shall not collect individual 9 10 screening results.

(b) When the county board refers clients to providers of 11 children's therapeutic services and supports under section 12 256B.0943, the county board must clearly identify the 13 14 nonchildren's therapeutic services and supports covered services components and identify the reimbursement source for those 15 requested services, the method of payment, and the payment rate 16 to the provider." 17 18 Page 213, line 25, after "(2)" insert "if the adjusted 19 gross income is equal to or greater than 175 percent of the 20 federal poverty guidelines and less than or equal to 200 percent 21 of the federal poverty guidelines, the parental contribution shall be one percent of the adjusted gross income; 22 23 (3)" 24 Page 213, lines 26 and 30, strike "175" and insert "200" Page 213, lines 27 and 33, strike "375" and insert "420" 25 Page 213, line 34, strike "(3)" and insert "(4)" and strike 26 "375" and insert "420" 27 Page 214, line 2, strike "(4)" and insert "(5)" 28 Page 214, line 6, strike "(5)" and insert "(6)" 29 Page 216, delete lines 26 to 33 30 31 Page 240, line 25, delete "July 1, 2005" and insert "the first day of the second month after the date of approval by the 32 33 United States Department of Agriculture" 34 Page 254, after line 11, insert: 35 "Sec. 9. Laws 2003, First Special Session chapter 14, 36 article 13C, section 2, subdivision 6, is amended to read:

COMMISSIONER OF 1 Sec. 2. HUMAN SERVICES 2 Basic Health Care Grants 3 Subd. 6. Summary by Fund 4 1,499,941,000 1,533,016,000 5 General 268,151,000 282,605,000 Health Care Access 6 [UPDATING FEDERAL POVERTY GUIDELINES.] 7 Annual updates to the federal poverty 8 guidelines are effective each July 1, 9 following publication by the United 10 States Department of Health and Human 11 Services for health care programs under 12 Minnesota Statutes, chapters 256, 256B, 13 14 256D, and 256L. The amounts that may be spent from this 15 appropriation for each purpose are as 16 follows: 17 (a) MinnesotaCare Grants 18 19 Health Care Access 267,401,000 281,855,000 [MINNESOTACARE FEDERAL RECEIPTS.] 20 Receipts received as a result of 21 22 federal participation pertaining to administrative costs of the Minnesota 23 24 health care reform waiver shall be 25 deposited as nondedicated revenue in 26 the health care access fund. Receipts received as a result of federal 27 participation pertaining to grants 28 29 shall be deposited in the federal fund 30 and shall offset health care access 31 funds for payments to providers. [MINNESOTACARE FUNDING.] The 32 33 commissioner may expend money 34 appropriated from the health care access fund for MinnesotaCare in either fiscal year of the biennium. 35 36 37 (b) MA Basic Health Care Grants -Families and Children 38 39 568,254,000 582,161,000 General 40 [SERVICES TO PREGNANT WOMEN.] The commissioner shall use available 41 federal money for the State-Children's 42 Health Insurance Program for medical 43 44 assistance services provided to 45 pregnant women who are not otherwise 46 eligible for federal financial 47 participation beginning in fiscal year 48 2003. This federal money shall be deposited in the federal fund and shall 49 50 offset general funds for payments to 51. providers. Notwithstanding section 14, 52 this paragraph shall not expire. [MANAGED CARE RATE INCREASE.] (a) 53 <u>5</u>4 Effective January 1, 2004, the commissioner of human services shall increase the total payments to managed 55 56

21

care plans under Minnesota Statutes,

section 256B.69, by an amount equal to 1 the cost increases to the managed care 2 3 plans from by the elimination of: (1) the exemption from the taxes imposed 4 under Minnesota Statutes, section 5 297I.05, subdivision 5, for premiums paid by the state for medical 6 7 assistance, general assistance medical 8 care, and the MinnesotaCare program; 9 and (2) the exemption of gross revenues 10 subject to the taxes imposed under 11 Minnesota Statutes, sections 295.50 to 12 295.57, for payments paid by the state 13 for services provided under medical 14 assistance, general assistance medical 15 care, and the MinnesotaCare program. 16 Any increase based on clause (2) must 17 be reflected in provider rates paid by 18 the managed care plan unless the 19 managed care plan is a staff model 20 21 health plan company.

22 (b) The commissioner of human services shall increase by two-percent the applicable tax rate in effect under Minnesota Statutes, section 295.52, 23 24 the 25 fee-for-service payments under medical 26 27 assistance, general assistance medical care, and the MinnesotaCare program for 28 services subject to the hospital, 29 surgical center, or health care 30 31 provider taxes under Minnesota Statutes, sections 295.50 to 295.57, 32 effective for services rendered on or after January 1, 2004. 33 34

35 (c) The commissioner of finance shall 36 transfer from the health care access 37 fund to the general fund the following 38 amounts in the fiscal years indicated: 39 2004, \$16,587,000; 2005, \$46,322,000; 40 2006, \$49,413,000; and 2007, \$52,659,000.

42 (d) For fiscal years after 2007, the 43 commissioner of finance shall transfer 44 from the health care access fund to the 45 general fund an amount equal to the 46 revenue collected by the commissioner 47 of revenue on the following:

48 (1) gross revenues received by 49 hospitals, surgical centers, and health 50 care providers as payments for services provided under medical assistance, 51 52 general assistance medical care, and 53 the MinnesotaCare program, including 54 payments received directly from the state or from a prepaid plan, under 55 Minnesota Statutes, sections 295.50 to 56 57 295.57; and

58 (2) premiums paid by the state under
59 medical assistance, general assistance
60 medical care, and the MinnesotaCare
61 program under Minnesota Statutes,
62 section 297I.05, subdivision 5.

63 The commissioner of finance shall
64 monitor and adjust if necessary the
65 amount transferred each fiscal year

from the health care access fund to the 1 general fund to ensure that the amount 2 transferred equals the tax revenue 3 collected for the items described in 4 5 clauses (1) and (2) for that fiscal 6 year. (e) Notwithstanding section 14, these 7 provisions shall not expire. 8 (c) MA Basic Health Care Grants - Elderly 9 10 and Disabled 11 General 695,421,000 741,605,000 12 [DELAY MEDICAL ASSISTANCE FEE-FOR-SERVICE - ACUTE CARE.] The 13 following payments in fiscal year 2005 14 from the Medicaid Management 15 Information System that would otherwise 16 have been made to providers for medical 17 18 assistance and general assistance medical care services shall be delayed and included in the first payment in 19 20 fiscal year 2006: 21 22 (1) for hospitals, the last two 23 payments; and (2) for nonhospital providers, the last 24 25 payment. This payment delay shall not include 26 payments to skilled nursing facilities, 27 intermediate care facilities for mental 28 29 retardation, prepaid health plans, home health agencies, personal care nursing 30 providers, and providers of only waiver services. The provisions of Minnesota 31 32 Statutes, section 16A.124, shall not 33 34 apply to these delayed payments. 35 Notwithstanding section 14, this 36 provision shall not expire. 37 [DEAF AND HARD-OF-HEARING SERVICES.] If, after making reasonable efforts, 38 39 the service provider for mental health services to persons who are deaf or 40 41 hearing impaired is not able to earn \$227,000 through participation in 42 43 medical assistance intensive 44 rehabilitation services in fiscal year 45 2005, the commissioner shall transfer \$227,000 minus medical assistance 46 47 earnings achieved by the grantee to 48 deaf and hard-of-hearing grants to 49 enable the provider to continue 50 providing services to eligible persons. (d) General Assistance Medical Care 51 52 Grants 53 General 223,960,000 196,617,000 54 (e) Health Care Grants - Other 55 Assistance .56 General 3,067,000 3,407,000 57 Health Care Access 750,000 750,000

[MINNESOTA PRESCRIPTION DRUG DEDICATED 1 FUND.] Of the general fund 2 appropriation, \$284,000 in fiscal year 3 2005 is appropriated to the 4 5 commissioner for the prescription drug dedicated fund established under the 6 prescription drug discount program. 7 [DENTAL ACCESS GRANTS CARRYOVER 8 9 AUTHORITY.] Any unspent portion of the appropriation from the health care 10 access fund in fiscal years 2002 and 11 2003 for dental access grants under 12 Minnesota Statutes, section 256B.53, 13 shall not cancel but shall be allowed 14 to carry forward to be spent in the 15 biennium beginning July 1, 2003, for 16 17 these purposes. 18 [STOP-LOSS FUND ACCOUNT.] The appropriation to the purchasing 19 alliance stop-loss fund account 20 established under Minnesota Statutes, 21 22 section 256.956, subdivision 2, for 23 fiscal years 2004 and 2005 shall only be available for claim reimbursements 24 25 for qualifying enrollees who are members of purchasing alliances that 26 27 meet the requirements described under Minnesota Statutes, section 256.956, 28 subdivision 1, paragraph (f), clauses
(1), (2), and (3). 29 30 31 (f) Prescription Drug Program 32 General 9,239,000 9,226,000 [PRESCRIPTION DRUG ASSISTANCE PROGRAM.] 33 34 Of the general fund appropriation, \$702,000 in fiscal year 2004 and \$887,000 in fiscal year 2005 are for 35 36 the commissioner to establish and 37 38 administer the prescription drug 39 assistance program through the 40 Minnesota board on aging. [REBATE REVENUE RECAPTURE.] Any funds 41 42 received by the state from a drug 43 manufacturer due to errors in the pharmaceutical pricing used by the 44 45 manufacturer in determining the prescription drug rebate are 46 47 appropriated to the commissioner to augment funding of the prescription 48 49 drug program established in Minnesota Statutes, section 256.955." 50 51 Pages 255 to 267, delete article 8 and insert: 52 "ARTICLE 8 53 APPROPRIATIONS 54 Section 1. [HEALTH AND HUMAN SERVICES APPROPRIATIONS.]

55 The sums in the columns marked "APPROPRIATIONS" are added 56 to, or, if shown in parentheses, are subtracted from the

57 appropriations to the specified agencies in 2005 S.F. No. 1879,

article 11, if enacted. The appropriations are from the general 1 fund, unless another fund is named, and are available for the 2 fiscal year indicated for each purpose. The figures "2006" and 3 "2007," where used in this article, mean that the additions to 4 5 or subtractions from the appropriations listed under them are for the fiscal year ending June 30, 2006, or June 30, 2007, 6 respectively. The "first year" is fiscal year 2006. The 7 "second year" is fiscal year 2007. The "biennium" is fiscal 8 years 2006 and 2007. 9

10

#### SUMMARY BY FUND

11 12			2006		2007	BIENNIAL TOTAL		
13	General	\$	37,776,000	\$	64,173,000	\$ 101,949,000		
14 15	State Government Special Revenue		7,151,000		12,625,000	19,776,000		
16 17	Health Care Access		42,451,000		65,060,000	107,511,000		
18	Federal TANF		(3,665,000)		11,064,000	7,399,000		
19 20	Lottery Prize Fund		400,000		400,000	800,000		
21	TOTAL	\$	84,113,000	\$	153,322,000	\$ 237,435,00	0	
22 23 24 25					Available	RIATIONS for the Year June 30 2007		
26 27								
28 29	Subdivision 1. Tot Appropriation	al	5	\$	75,525,000	\$ 138,198,000		
30 Summary by Fund								
31	General	3	6,409,000	61,	,744,000			
32 33	Health Care Access	4	2,381,000	64	,990,000			
34	Federal TANF	(	3,665,000)	11,	,064,000			
35 36	Lottery Cash Flow		400,000		400,000			
37	7 Subd. 2. Agency Management							
38	38 Summary by Fund							
39	General		(165,000)	(	(231,000)			
40	Health Care Access		1,623,000	1,	701,000			
41 42	The amounts that ma appropriation for e	y b ach	e spent from purpose are	the as	2			

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follows: 1 (a) Financial Operations 2 424,000 424,000 3 General Health Care Access 152,000 183,000 4 5 [ADMINISTRATIVE REDUCTION.] The general 6 fund appropriation in this section includes a department-wide 7 administrative reduction of \$6,885,000 8 the first year and \$7,201,000 the second year. The commissioner shall 9 10 11 ensure that any staff reductions made 12 under this paragraph comply with Minnesota Statutes, section 43A.046. 13 (b) Legal and 14 15 Regulation Operations (5,208,000)(5, 482, 000)16 General 75,000 75,000 17 Health Care Access (c) Information Technology 18 19 Operations 4,619,000 4,827,000 20 General 21 Health Care Access 1,396,000 1,443,000 22 Subd. 3. Revenue and Pass-Through 23 Federal TANF (16,956,000)(5,221,000)24 [REDUCED TANF TRANSFER.] Notwithstanding Laws 2000, chapter 488, 25 article 8, section 2, subdivision 6, with respect to TANF funds used as 26 27 refinancing for the state share of the 28 29 child support pass-through under 30 Minnesota Statutes, section 256.741, subdivision 15, and notwithstanding 31 Minnesota Statutes, section 290.0671, 32 subdivision 6a, with respect to the 33 34 TANF-funded expansion of the Minnesota 35 working family credit, the commissioner shall reduce the combined amount of the 36 TANF funds transferred to the 37 38 commissioner of revenue for deposit in 39 the general fund by \$11,020,000 in fiscal year 2006, by \$6,860,000 in fiscal year 2007, and by \$7,000,000 in fiscal year 2008 and subsequent years. 40 41 42 Notwithstanding section 7, this 43 44 paragraph shall not expire. [TANF TRANSFER TO FEDERAL CHILD CARE 45 AND DEVELOPMENT FUND.] The following 46 47 amounts are appropriated to the 48 commissioner for the purposes of MFIP 49 transition year child care under Minnesota Statutes, section 119B.05; \$756,000 in fiscal year 2006; 50 51 52 \$4,831,000 in fiscal year 2007; \$5,183,000 in fiscal year 2008; and \$1,127,000 in fiscal year 2009. The 53 54 The commissioner shall authorize the 55 56 transfer of sufficient TANF funds to 57 the federal child care and development

fund to meet this appropriation and 1 shall ensure that all transferred funds 2 3 are expended according to the federal child care and development fund 4 regulations. Notwithstanding section 5 7, this paragraph expires June 30, 2009. 6 7 Economic Support Grants Subd. 4. Summary by Fund 8 1,722,000 7,109,000 9 General 16,285,000 13,291,000 10 Federal TANF 11 The amounts that may be spent from this appropriation for each purpose are as 12 follows: 13 (a) Minnesota Family Investment Program 14 -0-3,740,000 15 General Federal TANF 13,151,000 16,145,000 16 7 (b) MFIP Child Care Assistance Grants -0-(3,740,000)18 (c) Children Services Grants 19 20 1,119,000 6,074,000 (d) Children and Community Services 21 22 Grants 23 General Fund 3,000 11,000 Federal TANF 140,000 140,000 24 25 [NEW CHANCE PROGRAM.] Of the TANF 26 appropriation, \$140,000 each year is to the commissioner for a grant to the new 27 28 chance program. The new chance program 29 shall provide comprehensive services 30 through a private, nonprofit agency to young parents in Hennepin County who 1 have dropped out of school and are 32 33 receiving public assistance. The 34 program administrator shall report 35 annually to the commissioner on skills 36 development, education, job training, and job placement outcomes for program 37 38 participants. (e) Minnesota Supplemental Aid Grants 39 40 118,000 363,000 41 (f) Group Residential Housing Grants 122,000 301,000 42 (g) Other Children's and Economic 43 44 Assistance Grants 360,000 360,000 46 [TRANSITIONAL HOUSING.] This appropriation is to the commissioner for the transitional housing program 47 48

established in the 2005 Environment, 1 Agriculture, and Economic Development 2 omnibus appropriations bill. 3 Children and Economic 4 Subd. 5. Assistance Management 5 261,000 272,000 6 Basic Health Care Grants 7 Subd. 6. Summary by Fund 8 6,844,000 14,000 9 General 30,843,000 51,903,000 10 Health Care Access The amounts that may be spent from this 11 appropriation for each purpose are as 12 13 follows: (a) MinnesotaCare Grants 14 Health Care Access 30,843,000 51,903,000 15 [HEALTHMATCH DELAY.] Of this 16 17 appropriation, \$3,112,000 the first year and \$7,541,000 the second year is 18 for the MinnesotaCare program costs 19 related to a one-month delay in 20 implementation of the HealthMatch 21 22 program. 23 (b) MA Basic Health Care Grants -Families and Children 24 25 339,000 3,746,000 [GREATER MINNESOTA HOSPITAL PAYMENT 26 ADJUSTMENT.] Of the general fund 27 28 appropriation for medical assistance 29 basic health care grants - families and children, medical assistance basic 30 31 health care grants - elderly and disabled, and general assistance 32 medical care, \$400,000 each year is for 33 greater Minnesota payment adjustments 34 35 under Minnesota Statutes, section 256.969, subdivision 26, for admissions 36 occurring on or after July 1, 2005. 37 38 [PROVIDER RATES NOT TO INCREASE.] 39 Provider rates under medical assistance 40 and general assistance medical care, except for rates paid for dental 41 services and pharmacy services, in 42 effect on June 30, 2005, shall not be increased as a result of the repeal of 43 44 45 recipient co-payments effective July 1, 46 2005. 47 (c) MA Basic Health Care Grants - Elderly and Disabled 48 49 (1, 146, 000)(727,000)50 (d) General Assistance Medical Care Grants 51 52 1,029,000 4,349,000

(e) Health Care Grants - Other 1 Assistance 2 3 (2,500,000)(1,978,000)[PRESCRIPTION DRUG DISCOUNT PROGRAM.] 4 5 Of the general fund appropriation for the second year, \$1,022,000 is to be 6 transferred to the Minnesota 7 prescription drug dedicated fund 8 9 established in Minnesota Statutes, This. section 156.9545, subdivision 11. 10 is a onetime appropriation and shall 11 not become part of base level funding 12 for the biennium beginning July 1, 2007. 13 Subd. 7. Health Care Management 14 15 Summary by Fund 4,670,000 16 General 4,411,000 Health Care Access 9,915,000 11,386,000 17 The amounts that may be spent from this 18 appropriation for each purpose are as 19 20 follows: 21 (a) Health Care Administration 22 General 4,206,000 4,157,000 Health Care Access 7,465,000 23 10,693,000 24 (b) Health Care Operations 25 General 464,000 254,000 Health Care Access 26 2,450,000 693,000 Subd. 8. Continuing Care Grants 27 28 Summary by Fund General 6,616,000 36,090,000 29 Lottery Prize Fund 400,000 30 400,000 31 The amounts that may be spent from this appropriation for each purpose are as 32 follows: 33 34 (a) Aging and Adult Service Grant 35 3,000 10,000 36 (b) Alternative Care Grants 10,468,000 37 19,442,000 38 (c) Medical Assistance Long-Term Care Facilities Grants 39 40 (2,799,000)(12,569,000)[RATE ADJUSTMENTS UNDER NEW NURSING 41 FACILITY REIMBURSEMENT SYSTEM.] Of this 42 43 appropriation, \$12,992,000 the second 44 year is to adjust nursing facility 45

45 rates in order to facilitate the 46 transition from the current ratesetting

system to the system developed under
 Minnesota Statutes, section 256B.440.

[NURSING HOME MORATORIUM EXCEPTIONS.] 3 During the first year, the commissioner 4 of health may approve moratorium 5 exception projects under Minnesota 6 Statutes, section 144A.073, for which 7 the full annualized state share of 8 medical assistance costs does not 9 exceed \$3,000,000. 10

11 [ICF/MR DOWNSIZING.] Of this 12 appropriation, \$300,000 each year is 13 for rate adjustments for intermediate 14 care facilities for persons with mental 15 retardation that are downsizing.

16 (d) Medical Assistance Long-Term 17 Care Waivers and Home Care Grants

18 (4,354,000) (3,279,000)

[LIMITING WAIVER GROWTH.] For each year 19 of the biennium ending June 30, 2007, 20 the commissioner of human services 21 22 shall make available additional 23 allocations for community alternatives for disabled individuals waivered 24 services covered under Minnesota 25 Statutes, section 256B.49, at a rate of 26 105 per month or 1,260 per year, plus 27 any additional legislatively authorized 28 growth. Priorities for the allocation 29 30 of funds shall be for individuals anticipated to be discharged from 31 32 institutional settings or who are at imminent risk of a placement in an 33 institutional setting. 34

35 For each year of the biennium ending June 30, 2007, the commissioner shall 36 make available additional allocations 37 38 for traumatic brain injury waivered 39 services covered under Minnesota Statutes, section 256B.49, at a rate of 165 per year. Priorities for the 40 41 165 per year. allocation of funds shall be for 42 individuals anticipated to be 43 44 discharged from institutional settings 45 or who are at imminent risk of a placement in an institutional setting. 46

47 Notwithstanding 2005 S.F. No. 1879, 48 article 11, section 2, subdivision 8, paragraph (d), if enacted, for each 49 50 year of the biennium ending June 30, 2007, the commissioner shall limit the 51 new diversion caseload growth in the 52 53 mental retardation and related conditions waiver to 75 additional 54 allocations. Notwithstanding Minnesota 55 56 Statutes, section 256B.0916, 57 subdivision 5, paragraph (b), the 58 available diversion allocations shall be awarded to support individuals whose 59 health and safety needs result in an 60 61 imminent risk of an institutional 62 placement at any time during the fiscal 63 year.

(e) Mental Health Grants 1 950,000 1,888,000 General 2 400,000 400,000 3 Lottery Prize Fund [ALTERNATIVES TO ANOKA-METRO REGIONAL 4 TREATMENT CENTER.] Of this 5 appropriation, \$350,000 the first year 6 and \$145,000 the second year is to the 7 commissioner to develop community 8 alternatives to Anoka-Metro Regional 9 Treatment Center under Minnesota 10 Statutes, section 245.4661, 11 subdivisions 8 to 11. Any amount of 12 this appropriation that is unspent 13 shall not cancel but shall be available 14 until expended. Notwithstanding 15 section 7, this paragraph shall not 16 17 expire. (f) Deaf and Hard-of-Hearing 18 Service Grants 19 33,000 9,000 20 (g) Chemical Dependency 21 Entitlement Grants 22 4,762,000 23 2,144,000 (h) Other Continuing Care 24 665,000 25 195,000 Subd. 9. Continuing Care Management 26 599,000 465,000 27 [TASK FORCE ON COLLABORATIVE SERVICES.] 28 The commissioner, in collaboration with the commissioner of education, shall 29 30 create a task force to discuss 31 collaboration between schools and 32 33 mental health providers to: promote colocation and integrated services; 34 35 identify barriers to collaboration; develop a model contract; and identify 36 examples of successful collaboration. 37 38 The task force shall also develop 39 recommendations on how to pay for 40 children's mental health screenings. The task force shall include 41 representatives of school boards; 42 43 administrative personnel; special education directors; counties; parent 44 advocacy organizations; school social workers, counselors, nurses, and 45 46 47 psychologists; community mental health professionals; health plans; and other 48 49 interested parties. The task force 50 shall present a report to the chairs of the education and health policy 51 52 committees by February 1, 2006. Of the general fund appropriation, 53 54 \$5,000 the first year is to the commissioner to contract with a 55

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nonprofit organization that is

knowledgeable about children's mental health issues to provide the research

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necessary for the task force to make
 recommendations and complete the report.

3 Subd. 10. State-Operated Services

4 22,682,000 6,796,000

[EVIDENCE-BASED PRACTICE FOR 5 METHAMPHETAMINE TREATMENT.] Of the 6 general fund appropriation, \$300,000 7 each year is to support development of 8 evidence-based practices for the 9 treatment of methamphetamine abuse at 10 the state-operated services chemical 11 dependency program in Willmar. These 12 funds shall be used to support research 13 on evidence-based practices for the 14 15 treatment of methamphetamine abuse, dissemination of the results of the 16 evidence-based practice research 17 18 statewide, and creation of training for addiction counselors specializing in 19 the treatment of methamphetamine abuse. 20

21 Sec. 3. COMMISSIONER OF HEALTH

22 Subdivision 1. Total 6,271,000 23 Appropriation 24 Summary by Fund 25 General 1,367,000 2,429,000 26 State Government 4,834,000 10,619,000 27 Special Revenue Health Care Access 70,000 70,000 28

29 [RENTAL COSTS, ADMINISTRATIVE 30 REDUCTIONS, FEE INCREASES, AND REVENUE 31 TRANSFER.] (a) Of this appropriation, 32 \$722,000 the first year and \$2,583,000 33 the second year is for rental costs in 34 the new public health laboratory 35 building.

(b) The general fund appropriation in 36 this section includes a department-wide 37 administrative reduction of \$242,000 38 39 the first year and \$1,007,000 the second year. The commissioner shall 40 ensure that any staff reductions made 41 42 under this paragraph comply with 43 Minnesota Statutes, section 43A.046.

44 (c) The commissioner shall increase all 45 fees levied by the commissioner a pro 46 rata amount in order to generate 47 revenue of \$731,000 the first year and \$1,823,000 the second year. 48 These amounts shall be deposited in the 49 general fund. This paragraph shall not 50 51 apply to fees paid by occupational 52 therapists.

53 (d) \$254,000 each year shall be
54 transferred from the state government
55 special revenue fund to the general
56 fund.

57 Subd. 2. Community and Family

13,118,000

Health Improvement 1 2 Summary by Fund General 159,000 (640,000)3 State Government 4 Special Revenue 335,000 335,000 5 Health Care Access 70,000 70,000 6 [TANF CARRYFORWARD.] Any unexpended balance of the TANF appropriation in 7 8 the first year of the biennium in this 9 section and 2005 S.F. No. 1879, article 10

11 11, section 3, if enacted, does not 12 cancel but is available for the second 13 year. 14 [WORK GROUP ON CHILDHOOD OBESITY.] (a) 15 Of the general fund appropriation, 16 \$5,000 the first year and \$1,000 the

17 second year is to the commissioner to 18 convene an interagency work group with 19 the commissioners of human services and 20 education to study and make 21 recommendations on reducing the rate of 22 obesity among the children in Minnesota.

23 (b) The work group shall determine the number of children who are currently obese and set a goal, including 24 25 26 measurable outcomes for the state in 27 terms of reducing the rate of childhood The work group shall make 28 obesity. 29 recommendations on how to achieve this goal, including, but not limited to, 30 increasing physical activities; 31 32 exploring opportunities to promote 33 physical education and healthy eating programs; improving the nutritional offerings through breakfast and lunch 34 35 36 menus; and evaluating the availability 37 and choice of nutritional products 38 offered in public schools.

39 (c) The work group may include 40 representatives of the Minnesota Medical Association; the Minnesota 41 Nurses Association; the Local Public 42 Health Association of Minnesota; the 43 Minnesota Dietetic Association; the 44 45 Minnesota School Food Service 46 Association; the Minnesota Association of Health, Physical Education, 47 Recreation, and Dance; the Minnesota 48 School Boards Association; the 49 50 Minnesota School Administrators 51 Association; the Minnesota Secondary Principals Association; the vending 52 53 industry; and consumers.

54 (d) The commissioner must submit the 55 recommendations of the work group to 56 the legislature by January 15, 2007.

57 Subd. 3. Policy Quality and 58 Compliance

59

#### Summary by Fund

1 State Government 2 Special Revenue

770,000

3 [STATEWIDE TRAUMA SYSTEM.] (a) Of the 4 general fund appropriation, \$382,000 5 the first year and \$352,000 the second 6 year is for development of a statewide 7 trauma system.

8 (b) The commissioner shall increase
9 hospital licensing fees a pro rata
10 amount to increase fee revenue by
11 \$382,000 the first year and \$352,000
12 the second year. This revenue shall be
13 deposited in the general fund.

[AIDS PREVENTION FOR AFRICAN-BORN 14 RESIDENTS.] For fiscal year 2006 only, 15 the commissioner shall reallocate 16 \$300,000 from the grant program under 17 Minnesota Statutes, section 145.928, 18 for grants in accordance with Minnesota 19 Statutes, section 145.924, paragraph 20 (b), for a public education and 21 22 awareness campaign targeting communities of African-born Minnesota residents. The grants shall be 23 24 designed to: 25

26 (1) promote knowledge and understanding
27 about HIV and to increase knowledge in
28 order to eliminate and reduce the risk
29 for HIV infection;

30 (2) encourage screening and testing for 31 HIV; and

(3) connect individuals to public 32 33 health and health care resources. The 34 grants must be awarded to collaborative 35 efforts that bring together nonprofit community-based groups with 36 37 demonstrated experience in addressing 38 the public health, health care, and social service needs of African-born 39 40 communities.

41 [FAMILY PLANNING GRANTS.] Of the 42 general fund appropriation, \$500,000 43 each year is to the commissioner for 44 grants under Minnesota Statutes, 45 section 145.925, to family planning 46 clinics serving outstate Minnesota that 47 demonstrate financial need.

48 Subd. 4. Health Protection

49 Summary by Fund

 50
 State Government

 51
 Special Revenue
 3,729,000
 9,514,000

52 Subd. 5. Administrative Support 53 Services

54 1,208,000 3,069,000

55 Sec. 4. VETERANS NURSING HOMES BOARD

56 [VETERANS HOMES SPECIAL REVENUE 57 ACCOUNT.] The general fund

appropriations made to the board in 1 2005 S.F. No. 1879, if enacted, may be 2 transferred to a veterans homes special 3 revenue account in the special revenue 4 fund in the same manner as other 5 receipts are deposited according to 6 Minnesota Statutes, section 198.34, and 7 are appropriated to the board for the 8 operation of board facilities and 9 10 programs. Sec. 5. HEALTH-RELATED BOARDS 11 Subdivision 1. Total 12 2,006,000 2,317,000 13 Appropriation Summary by Fund 14 15 State Government 2,317,000 2,006,000 Special Revenue 16 STATE GOVERNMENT SPECIAL REVENUE 17 FUND.] The appropriations in this 18 19 section are from the state government special revenue fund, except where 20 21 noted. [NO SPENDING IN EXCESS OF REVENUES.] 22 The commissioner of finance shall not 23 24 permit the allotment, encumbrance, or expenditure of money appropriated in 25 this section in excess of the 26 27 anticipated biennial revenues or 28 accumulated surplus revenues from fees collected by the boards. Neither this 29 provision nor Minnesota Statutes, 30 section 214.06, applies to transfers 31 from the general contingent account. 32 33 Subd. 2. Board of Dentistry Summary by Fund 34 35 State Government Special Revenue 150,000 36 -0-37 [ORAL HEALTH PILOT PROJECT.] Of this appropriation, \$150,000 the first year 38 39 is to be transferred to the commissioner of human services for an 40 41 oral health care system pilot project. 42 Subd. 3. Board of Nursing 1,563,000 43 1,407,000 [MINNESOTA CENTER OF NURSING.] (a) Of 44 45 this appropriation, \$500,000 in fiscal 46 year 2006 is to be used as start-up 47 funding to establish a Minnesota Center 48 of Nursing. The goals of the center 49 shall be to: 50 (1) maintain information on the current and projected supply and demand of 51 nurses through the collection and 52 53 analysis of data on the nursing 54 workforce; (2) develop a strategic statewide plan 55 for the nursing workforce; 56

(3) convene work groups of stakeholders 1 to examine issues and make 2 recommendations regarding factors 3 affecting nursing education, 4 recruitment, and retention; 5 (4) promote recognition, reward, and 6 renewal activities for nurses in 7 8 Minnesota; and (5) provide consultation, technical 9 assistance, and data on the nursing 10 workforce to the legislature. 11 (b) The board shall report to the 12 legislature by January 15, 2007, on the 13 Center of Nursing's progress, the 14 15 center's collaboration efforts with other organizations and governmental 16 entities, and the activities conducted 17 by the center in achieving the goals 18 19 outlined. [TRANSFERS FROM SPECIAL REVENUE FUND.] 20 21 Of this appropriation, the following transfers shall be made as directed 22 from the state government special 23 revenue fund: 24 (a) \$938,000 the first year and 25 \$1,207,000 the second year shall be 26 27 transferred to the commissioner of human services for the long-term care 28 and home and community-based care 29 employee scholarship program. This 30 appropriation shall not become part of 31 base level funding for the biennium 32 33 beginning July 1, 2007. 34 (b) \$125,000 the first year and 35 \$200,000 the second year shall be transferred to the health professional 36 education loan forgiveness program 37 38 account for loan forgiveness for nurses 39 under Minnesota Statutes, section 40 144.1501. This appropriation shall become part of base level funding for 41 the commissioner for the biennium 42 beginning July 1, 2007, but shall not 43 44 be part of base level funding for the 45 biennium beginning July 1, 2009. Notwithstanding section 7, this 46 47 paragraph expires on June 30, 2009. 48 Subd. 4. Board of Pharmacy

### 49 499,000 499,000

50 [RURAL PHARMACY PROGRAM.] Of this 51 appropriation, \$200,000 each year shall be transferred to the commissioner of 52 health for the rural pharmacy planning 53 and transition grant program under 54 Minnesota Statutes, section 144.1476. Of this transferred amount, \$20,000 55 56 each year may be retained by the 57 58 commissioner for related administrative 59 costs. This appropriation shall become part of base level funding for the commissioner for the biennium beginning 60 61 July 1, 2007. Notwithstanding section 62

1 7, this paragraph expires on June 30, 2 2009.

[PHARMACIST LOAN FORGIVENESS.] \$200,000 each year shall be transferred to the 3 4 health professional education loan 5 forgiveness program account for loan 6 forgiveness for pharmacists under 7 Minnesota Statutes, section 144.501. This appropriation shall become part of 8 9 base level funding for the commissioner 10 for the biennium beginning July 1, 2007. Notwithstanding section 7, this 11 12 paragraph expires on June 30, 2009. 13

14 [DRUG MANUFACTURER PRICING DISCLOSURE.] 15 (a) The board shall increase the 16 licensing or registration fee for 17 wholesale drug distributors and drug 18 manufacturers required under Minnesota 19 Statutes, chapter 151, by \$65 per year 20 beginning July 1, 2005.

(b) Of the appropriation in this subdivision, \$74,000 each year is to be transferred to the commissioner of human services for the data received under Minnesota Statutes, section 151.52.

[CANCER DRUG REPOSITORY PROGRAM.] Of 27 this appropriation, \$25,000 each year 28 is for the cancer drug repository 29 program under Minnesota Statutes, 30 section 151.55. This appropriation 31 shall become part of base level funding 32 for the board for the biennium beginning July 1, 2007, but shall not 33 34 be part of the base for the biennium 35 36 beginning July 1, 2009. Notwithstanding section 7, this 37 paragraph expires June 30, 2009. 38

39 Subd. 5. Board of Social
40 Work

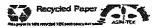
41 105,000 100,000

42 [ADMINISTRATIVE MANAGEMENT.] This appropriation is to provide 43 44 administrative management under 45 Minnesota Statutes, section 148B.61, subdivision 4. The following boards 46 47 shall be assessed a prorated amount depending on the number of licensees 48 49 under the board's regulatory authority providing mental health services within 50 51 their scope of practice: Board of 52 Medical Practice, the Board of Nursing, 53 the Board of Psychology, the Board of Social Work, the Board of Marriage and 54 Family Therapy, and the Board of 55 Behavioral Health and Therapy. 56

57 Sec. 6. [BASE LEVEL FUNDING ADJUSTMENTS.]

58 <u>Base level funding for the biennium beginning July 1, 2007,</u> 59 <u>for nonentitlement grants and administration appropriations in</u> 60 this article shall be shown in legislative tracking documents.

[SENATEE ] mv SS2278R Notwithstanding section 7, this section shall expire on June 30, 1 2 2009. Sec. 7. [SUNSET OF UNCODIFIED LANGUAGE.] 3 All uncodified language in this article expires on June 30, 4 2007, unless a different expiration date is explicit." 5 Renumber the sections in sequence 6 Amend the title as follows: 7 Page 1, line 20, delete the first "subdivision 1" and 8 insert "subdivisions 1, 2" and after the second semicolon, 9 10 insert "144.1483;" Page 1, line 26, after the second semicolon, insert 11 12 "145.9268;" 13 Page 1, line 30, after the semicolon, insert "245.4874;" Page 1, line 34, delete the second "subdivision" and insert 14 15 "subdivisions 3," Page 1, line 36, after the second semicolon, insert 16 "256B.04, by adding a subdivision;" 17 Page 2, line 7, delete "subdivision 4" and insert 18 "subdivisions 4, 5" 19 Page 2, line 17, after the semicolon, insert "Laws 2003, 20 First Special Session chapter 14, article 13C, section 2, 21 subdivision 6;" 22 23 Page 2, line 20, after the first semicolon, insert 24 "144.1486;" 25 And when so amended the bill do pass. Amendments adopted. Report adopted. 26 27 28 (Committee Chair) 29 30 May 3, 2005.... 31 (Date of Committee recommendation)



# SENATE STATE OF MINNESOTA EIGHTY-FOURTH LEGISLATURE

# S.F. No. 2278

# (SENATE AUTHORS: COHEN)

#### **OFFICIAL STATUS**

04/28/2005 04/28/2005 04/29/2005

DATE

2248

**D-PG** 

Introduction and first reading Under Senate rules, laid over one day Second reading

# A bill for an act

relating to state government; modifying licensing fees; expanding health care program eligibility; enacting health care cost containment measures; modifying mental and chemical health programs; adjusting family support programs; reducing certain parental fees; providing a cost-of-living adjustment for certain human services program employees; modifying long-term care programs; modifying continuing care programs; allowing penalties; appropriating money; amending Minnesota Statutes 2004, sections 62A.65, subdivision 3; 62D.12, subdivision 19; 62J.04, subdivision 3, by adding a subdivision; 62J.041; 62J.301, subdivision 3; 62J.38; 62J.692, subdivision 3; 62L.08, subdivision 8; 62M.06, subdivisions 2, 3; 620.37, subdivision 7; 103I.101, subdivision 6; 103I.208, subdivisions 1, 2; 103I.235, subdivision 1; 103I.601, subdivision 2; 119B.011, by adding a subdivision; 119B.05, subdivision 1; 144.122; 144.147, subdivision 1; 144.148, subdivision 1; 144.1501, subdivisions 1, 2, 3, 4; 144.226, subdivision 1, 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; 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; 244.054; 245.4661, by adding subdivisions; 245.4885, subdivisions 1, 2, by adding a subdivision; 252.27, subdivision 2a; 252.291, by adding a subdivision; 254B.03, subdivision 4; 256.01, by adding a subdivision; 256.045, subdivision 3a; 256.741, subdivision 4; 256.9365; 256.969, by adding a subdivision; 256B.02, subdivision 12; 256B.055, by adding a subdivision: 256B.056 articles 5 adding a subdivision; 256B.02, subdivision 12; 256B.035, by adding a subdivision; 256B.056, subdivisions 5, 5a, 5b, 7, by adding subdivisions; 256B.057, subdivision 1; 256B.0621, subdivisions 2, 3, 4, 5, 6, 7; 256B.0622, subdivision 2; 256B.0625, subdivisions 2, 9, 13e, as amended, 13f, 19c, by adding subdivisions; 256B.0627, subdivisions 1, 4, 5, 9, by adding a subdivision: 256B.0916, by adding a subdivision: subdivision; 256B.0916, by adding a subdivision; 256B.15, subdivisions 1, 1a, 2; 256B.19, subdivision 1; 256B.431, by adding subdivisions; 256B.434, subdivision 4, by adding a subdivision; 256B.440, by

> 3 4

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46

adding a subdivision; 256B.5012, by adding a 1 subdivision; 256B.69, subdivisions 4, 23; 256D.03, 2 3 subdivision 4; 256D.045; 256D.44, subdivision 5; 4 256J.021; 256J.08, subdivision 65; 256J.21, subdivision 2; 256J.521, subdivision 1; 256J.53, subdivision 2; 256J.626, subdivisions 1, 2, 3, 4, 7; 5 6 7 8 9 256J.95, subdivisions 3, 9; 256L.01, subdivision 4; 256L.03, subdivisions 1, 1b, 5; 256L.04, subdivisions 2, 7, by adding subdivisions; 256L.05, subdivisions 3, 3a; 256L.07, subdivisions 1, 3, by adding a 10 11 subdivision; 256L.12, subdivision 6; 256L.15, subdivisions 2, 3; 295.582; 326.01, by adding a 12 subdivision; 326.37, subdivision 1, by adding a subdivision; 326.38; 326.40, subdivision 1; 326.42, subdivision 2; 514.981, subdivision 6; 524.3-805; 13 14 15 549.02, by adding a subdivision; 549.04; 641.15, 16 subdivision 2; proposing coding for new law in 17 Minnesota Statutes, chapters 62J; 144; 151; 256; 256B; 18 256J; 256L; 326; 501B; 641; repealing Minnesota 19 Statutes 2004, sections 119B.074; 157.215; 256B.0631; 20 21 256J.37, subdivisions 3a, 3b; 256L.035; 326.45; 22 514.991; 514.992; 514.993; 514.994; 514.995. BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA: 23 ARTICLE 1 24 25<sup>·</sup> HEALTH DEPARTMENT 26 Section 1. Minnesota Statutes 2004, section 103I.101, 27 subdivision 6, is amended to read: 28 Subd. 6. [FEES FOR VARIANCES.] The commissioner shall 29 charge a nonrefundable application fee of \$150 \$175 to cover the 30 administrative cost of processing a request for a variance or 31 modification of rules adopted by the commissioner under this 32 chapter. 33 [EFFECTIVE DATE.] This section is effective July 1, 2006. 34 Sec. 2. Minnesota Statutes 2004, section 103I.208, subdivision 1, is amended to read: 35 36 Subdivision 1. [WELL NOTIFICATION FEE.] The well 37 notification fee to be paid by a property owner is: 38 (1) for a new well,  $\$15\theta$  \$175, which includes the state 39 core function fee; 40 (2) for a well sealing,  $\$3\theta$  \$35 for each well, which includes the state core function fee, except that for monitoring 41 42 wells constructed on a single property, having depths within a 43 25 foot range, and sealed within 48 hours of start of construction, a single fee of \$30 \$35; and 44 45 (3) for construction of a dewatering well,  $\frac{1}{50}$   $\frac{1}{50}$ , which 46 includes the state core function fee, for each well except a

		04/28/05 [REVISOR ] S/MD 05-4117
	1	dewatering project comprising five or more wells shall be
	2	assessed a single fee of $\$75\theta$ $\$875$ for the wells recorded on the
	3	notification.
	4	[EFFECTIVE DATE.] This section is effective July 1, 2006.
	5	Sec. 3. Minnesota Statutes 2004, section 103I.208,
	6	subdivision 2, is amended to read:
	, <b>7</b>	Subd. 2. [PERMIT FEE.] The permit fee to be paid by a
	8	property owner is:
	9	(1) for a well that is not in use under a maintenance
	10	permit, <del>\$125</del> <u>\$150</u> annually;
	11	(2) for construction of a monitoring well, $\frac{150}{100}$ , which
	12	includes the state core function fee;
····	13	(3) for a monitoring well that is unsealed under a
	14	maintenance permit, \$125 \$150 annually;
	15	(4) for monitoring wells used as a leak detection device at
	16	a single motor fuel retail outlet, a single petroleum bulk
	17	storage site excluding tank farms, or a single agricultural
	18	chemical facility site, the construction permit fee
	19	is $\frac{150}{5150}$ , which includes the state core function fee, per
	20	site regardless of the number of wells constructed on the site,
	21	and the annual fee for a maintenance permit for unsealed
	22	monitoring wells is $\frac{125}{125}$ per site regardless of the number
	23	of monitoring wells located on site;
(instance) -	24	(5) for a groundwater thermal exchange device, in addition
	25	to the notification fee for wells, $\frac{150}{500}$ , which includes the
	26	state core function fee;
	27	<pre>(6) for a vertical heat exchanger, \$150 \$175;</pre>
	28	(7) for a dewatering well that is unsealed under a
	29	maintenance permit, $\frac{125}{150}$ annually for each well, except a
	30	dewatering project comprising more than five wells shall be
	31	issued a single permit for $625$ $5750$ annually for wells recorded
	32	on the permit; and
,	33	(8) for excavating holes for the purpose of installing
	34	elevator shafts, $\frac{150}{100}$ for each hole.
	35	[EFFECTIVE DATE.] This section is effective July 1, 2006.
	36	Sec. 4. Minnesota Statutes 2004, section 103I.235,
	Ar	ticle 1 Section 4 3

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1 subdivision 1, is amended to read:

Subdivision 1. [DISCLOSURE OF WELLS TO BUYER.] (a) Before 2 signing an agreement to sell or transfer real property, the 3 seller must disclose in writing to the buyer information about 4 5 the status and location of all known wells on the property, by delivering to the buyer either a statement by the seller that 6 the seller does not know of any wells on the property, or a 7 disclosure statement indicating the legal description and 8 county, and a map drawn from available information showing the 9 location of each well to the extent practicable. In the 10 disclosure statement, the seller must indicate, for each well, 11 whether the well is in use, not in use, or sealed. 12

(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."

24 (d) If a deed is given pursuant to a contract for deed, the 25 well disclosure certificate required by this subdivision shall be signed by the buyer or a person authorized to act on behalf 26 of the buyer. If the buyer knows of no wells on the property, a 27 well disclosure certificate is not required if the following 28 statement appears on the deed followed by the signature of the 29 30 grantee or, if there is more than one grantee, the signature of at least one of the grantees: "The Grantee certifies that the 31 32 Grantee does not know of any wells on the described real 33 property." The statement and signature of the grantee may be on 34 the front or back of the deed or on an attached sheet and an 35 acknowledgment of the statement by the grantee is not required for the deed to be recordable. 36

Article 1 Section 4

(e) This subdivision does not apply to the sale, exchange,
 or transfer of real property:

3 (1) that consists solely of a sale or transfer of severed4 mineral interests; or

5 (2) that consists of an individual condominium unit as 6 described in chapters 515 and 515B.

7 (f) For an area owned in common under chapter 515 or 515B 8 the association or other responsible person must report to the 9 commissioner by July 1, 1992, the location and status of all 10 wells in the common area. The association or other responsible 11 person must notify the commissioner within 30 days of any change 12 in the reported status of wells.

13 (g) For real property sold by the state under section 14 92.67, the lessee at the time of the sale is responsible for 15 compliance with this subdivision.

(h) If the seller fails to provide a required well
disclosure certificate, the buyer, or a person authorized to act
on behalf of the buyer, may sign a well disclosure certificate
based on the information provided on the disclosure statement
required by this section or based on other available information.

(i) A county recorder or registrar of titles may not record 21 22 a deed or other instrument of conveyance dated after October 31, 1990, for which a certificate of value is required under section 23 24 272.115, or any deed or other instrument of conveyance dated 25 after October 31, 1990, from a governmental body exempt from the payment of state deed tax, unless the deed or other instrument 26 of conveyance contains the statement made in accordance with 27 paragraph (c) or (d) or is accompanied by the well disclosure 28 certificate containing all the information required by paragraph 29 30 (b) or (d). The county recorder or registrar of titles must not accept a certificate unless it contains all the required 31 32 information. The county recorder or registrar of titles shall 33 note on each deed or other instrument of conveyance accompanied by a well disclosure certificate that the well disclosure 34 certificate was received. The notation must include the 35 statement "No wells on property" if the disclosure certificate 36

5

Article 1

Section 4

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states there are no wells on the property. The well disclosure 1 certificate shall not be filed or recorded in the records 2 maintained by the county recorder or registrar of titles. After 3 noting "No wells on property" on the deed or other instrument of 4 conveyance, the county recorder or registrar of titles shall 5 destroy or return to the buyer the well disclosure certificate. 6 The county recorder or registrar of titles shall collect from 7 the buyer or the person seeking to record a deed or other 8 instrument of conveyance, a fee of 330 \$40 for receipt of a 9 completed well disclosure certificate. By the tenth day of each 10 month, the county recorder or registrar of titles shall transmit 11 the well disclosure certificates to the commissioner of health. 12 By the tenth day after the end of each calendar quarter, the 13 county recorder or registrar of titles shall transmit to the 14 commissioner of health 27-50 32.50 of the fee for each well 15 disclosure certificate received during the quarter. 16 The commissioner shall maintain the well disclosure certificate for 17 at least six years. The commissioner may store the certificate 18 as an electronic image. A copy of that image shall be as valid 19 as the original. 20

21 (j) No new well disclosure certificate is required under 22 this subdivision if the buyer or seller, or a person authorized to act on behalf of the buyer or seller, certifies on the deed 23 24 or other instrument of conveyance that the status and number of wells on the property have not changed since the last previously 25 filed well disclosure certificate. The following statement, if 26 27 followed by the signature of the person making the statement, is 28 sufficient to comply with the certification requirement of this "I am familiar with the property described in this 29 paragraph: 30 instrument and I certify that the status and number of wells on 31 the described real property have not changed since the last previously filed well disclosure certificate." The 32 33 certification and signature may be on the front or back of the deed or on an attached sheet and an acknowledgment of the 34 statement is not required for the deed or other instrument of 35 conveyance to be recordable. 36

Article 1 Section 4

#### [REVISOR ] ;S/MD 05-4117

04/28/05

(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.

5 (1) Failure to comply with a requirement of this6 subdivision does not impair:

7 (1) the validity of a deed or other instrument of 8 conveyance as between the parties to the deed or instrument or 9 as to any other person who otherwise would be bound by the deed 10 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. 5. Minnesota Statutes 2004, section 103I.601,
subdivision 2, is amended to read:

17 Subd. 2. [LICENSE REQUIRED TO MAKE BORINGS.] (a) Except as 18 provided in paragraph (b) (d), a person may must not make an 19 exploratory boring without an exploratory-borer's explorer's 20 license. The fee for an explorer's license is \$75. The 21 explorer's license is valid until the date prescribed in the 22 license by the commissioner.

23 (b) <u>A person must file an application and renewal</u>
24 <u>application fee to renew the explorer's license by the date</u>
25 <u>stated in the license. The renewal application fee is \$75.</u>
26 (c) If the licensee submits an application fee after the

27 required renewal date, the licensee:

28

(1) must include a late fee of \$75; and

29 (2) may not conduct activities authorized by an explorer's 30 license until the renewal application, renewal application fee, 31 late fee, and sealing reports required in subdivision 9 are 32 submitted.

33 (d) An explorer may must designate a responsible individual
34 to supervise and oversee the making of exploratory borings.
35 Before an individual supervises or oversees an exploratory
36 boring, the individual must <u>file an application and application</u>

Article 1 Section 5

# [REVISOR ] /S/MD 05-4117

fee of \$75 to qualify as a responsible individual. The 1 individual must take and pass an examination relating to 2 construction, location, and sealing of exploratory borings. A 3 professional engineer registered or geoscientist licensed under 4 sections 326.02 to 326.15 or a certified professional geologist 5 certified by the American Institute of Professional Geologists 6 is not required to take the examination required in this 7 subdivision, but must be licensed certified as a responsible 8 individual to make supervise an exploratory boring. 9

Sec. 6. Minnesota Statutes 2004, section 144.122, is amended to read:

12

144.122 [LICENSE, PERMIT, AND SURVEY FEES.]

(a) The state commissioner of health, by rule, may 13 prescribe reasonable procedures and fees for filing with the 14 15 commissioner as prescribed by statute and for the issuance of original and renewal permits, licenses, registrations, and 16 17 certifications issued under authority of the commissioner. The expiration dates of the various licenses, permits, 18 19 registrations, and certifications as prescribed by the rules 20 shall be plainly marked thereon. Fees may include application 21 and examination fees and a penalty fee for renewal applications submitted after the expiration date of the previously issued 22 permit, license, registration, and certification. 23 The 24 commissioner may also prescribe, by rule, reduced fees for 25 permits, licenses, registrations, and certifications when the application therefor is submitted during the last three months 26 27 of the permit, license, registration, or certification period. Fees proposed to be prescribed in the rules shall be first 28 approved by the Department of Finance. All fees proposed to be 29 prescribed in rules shall be reasonable. The fees shall be in 30 31 an amount so that the total fees collected by the commissioner will, where practical, approximate the cost to the commissioner 32 in administering the program. All fees collected shall be 33 deposited in the state treasury and credited to the state 34 35 government special revenue fund unless otherwise specifically appropriated by law for specific purposes. 36

Article 1 Section 6

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1	(b) The commissioner shall adopt rules establishing
2	criteria and procedures for refusal to grant or renew licenses
3	and registrations, and for suspension and revocation of licenses
4	and registrations.
5	(c) The commissioner may refuse to grant or renew licenses
6	and registrations, or suspend or revoke licenses and
7	registrations, according to the commissioner's criteria and
8	procedures as adopted by rule.
9	(d) The commissioner may charge a fee for voluntary
10	certification of medical laboratories and environmental
11	laboratories, and for environmental and medical laboratory
12	services provided by the department, without complying with
13	paragraph (a) or chapter 14. Fees charged for environment and
14	medical laboratory services provided by the department must be
15	approximately equal to the costs of providing the services.
16	(e) The commissioner may develop a schedule of fees for
17	diagnostic evaluations conducted at clinics held by the services
18	for children with handicaps program. All receipts generated by
19	the program are annually appropriated to the commissioner for
20	use in the maternal and child health program.
21	(d) (f) The commissioner shall set license fees for
22	hospitals and nursing homes that are not boarding care homes at
23	the following levels:
24	Joint Commission on Accreditation of Healthcare
25	Organizations (JCAHO hospitals) \$77055 <u>\$7,555 plus \$13 per bed</u>
26	Non-JCAHO hospitals \$47680 \$5,180 plus \$234
27	<u>\$247</u> per bed
28	Nursing home \$183 plus \$91 per bed
29	The commissioner shall set license fees for outpatient
30	surgical centers, boarding care homes, and supervised living
31	facilities at the following levels:
32	Outpatient surgical centers \$17512 \$3,349
33	Boarding care homes \$183 plus \$91 per bed
34	Supervised living facilities \$183 plus \$91 per bed.
35	(g) Unless prohibited by federal law, the commissioner
36	of health shall charge applicants the following fees to cover
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1 the cost of any initial certification surveys required to

2 determine a provider's eligibility to participate in the

3 Medicare or Medicaid program:

4 5	Prospective payment surveys for hospitals	\$ 900
6 7	Swing bed surveys for nursing homes	\$1,200
8 9	Psychiatric hospitals	\$1,400
10 11	Rural health facilities	\$1,100
12 13 14	Portable x-ray providers	\$ 500
14 15 16	Home health agencies	\$1,800
10 17 18	Outpatient therapy agencies	\$ 800
19 20	End stage renal dialysis providers	\$2,100
20 21 22	Independent therapists	\$ 800
23 24 25	Comprehensive rehabilitation outpatient facilities	\$1,200
25 26 27	Hospice providers	\$1,700
28 29	Ambulatory surgical providers	\$1,800
30 31	Hospitals	\$4,200
32 33 34	Other provider categories or additional resurveys required to complete initial certification	Actual surverage

Actual surveyor costs: average surveyor cost x number of hours for the survey process.

36 These fees shall be submitted at the time of the 37 application for federal certification and shall not be 38 refunded. All fees collected after the date that the imposition 39 of fees is not prohibited by federal law shall be deposited in 40 the state treasury and credited to the state government special 41 revenue fund.

42 (h) The commissioner shall charge the following fees for examinations, registrations, licenses, and inspections: 43 44 Plumbing examination <u>\$ 50</u> <u>\$ 50</u> Water conditioning examination 45 46 Plumbing bond registration fee \$ 40 47 Water conditioning bond registration fee <u>\$ 40</u> 48 Master plumber's license \$120 49 Restricted plumbing contractor license <u>\$ 90</u> 50 Journeyman plumber's license <u>\$ 55</u> 51 <u>\$ 25</u> Apprentice registration

1 Water conditioning contractor license <u>\$ 70</u> 2 Water conditioning installer license \$ 35 3 Residential inspection fee (each visit) \$ 50 4 Public, commercial, and Inspection fee 5 industrial inspections 25 or fewer drainage 6 <u>\$ 300</u> 7 fixture units 26 to 50 drainage 8 \$ 900 9 fixture units 51 to 150 drainage 10 11 fixture units \$1,200 12 151 to 249 drainage 13 fixture units \$1,500 250 or more drainage 14 15 fixture units \$1,800 Callback fee (each visit) <u>\$ 100</u> 16 (i) Plumbing installations that require only fixture 17 installation or replacement require a minimum of one 18 19 inspection. Residence remodeling involving plumbing installations requires a minimum of two inspections. New 20 residential plumbing installations require a minimum of three 21 22 inspections. For purposes of this paragraph and paragraph (h), residences of more than four units are considered commercial. 23 Sec. 7. Minnesota Statutes 2004, section 144.147, 24 subdivision 1, is amended to read: 25 Subdivision 1. [DEFINITION.] "Eligible rural hospital" 26 27 means any nonfederal, general acute care hospital that: (1) is either located in a rural area, as defined in the 28 federal Medicare regulations, Code of Federal Regulations, title 29 30 42, section 405.1041, or located in a community with a population of less than  $\frac{1}{20,000}$ , according to United 31 States Census Bureau statistics, outside the seven-county 32 metropolitan area; 33 34 (2) has 50 or fewer beds; and (3) is not for profit. 35 36 Sec. 8. [144.1476] [RURAL PHARMACY PLANNING AND TRANSITION

Article 1 Section 8

1	GRANT PROGRAM.]
2	Subdivision 1. [DEFINITIONS.] (a) For the purposes of this
3	section, the following definitions apply.
4	(b) "Eligible rural community" means:
5	(1) a Minnesota community that is located in a rural area,
6	as defined in the federal Medicare regulations, Code of Federal
7	Regulations, title 42, section 405.1041; or
8	(2) a Minnesota community that has a population of less
9	than 10,000, according to the United States Bureau of
10	Statistics, and that is outside the seven-county metropolitan
11	area, excluding the cities of Duluth, Mankato, Moorhead,
12	Rochester, and St. Cloud.
13	(c) "Health care provider" means a hospital, clinic,
14	pharmacy, long-term care institution, or other health care
15	facility that is licensed, certified, or otherwise authorized by
16	the laws of this state to provide health care.
17	(d) "Pharmacist" means an individual with a valid license
18	issued under chapter 151 to practice pharmacy.
19	(e) "Pharmacy" has the meaning given under section 151.01,
20	subdivision 2.
21	Subd. 2. [GRANTS AUTHORIZED; ELIGIBILITY.] (a) The
22	commissioner of health shall establish a program to award grants
23	to eligible rural communities or health care providers in
24	eligible rural communities for planning, establishing, keeping
25	in operation, or providing health care services that preserve
26	access to prescription medications and the skills of a
27	pharmacist according to sections 151.01 to 151.40.
28	(b) To be eligible for a grant, an applicant must develop a
29	strategic plan for preserving or enhancing access to
30	prescription medications and the skills of a pharmacist. At a
31	minimum, a strategic plan must consist of:
32	(1) a needs assessment to determine what pharmacy services
33	are needed and desired by the community. The assessment must
34	include interviews with or surveys of area and local health
35	professionals, local community leaders, and public officials;
36	(2) an assessment of the feasibility of providing needed

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1	pharmacy services that identifies priorities and timelines for
2	potential changes; and
3	(3) an implementation plan.
4	(c) A grant may be used by a recipient that has developed a
5	strategic plan to implement transition projects to modify the
6	type and extent of pharmacy services provided, in order to
7	reflect the needs of the community. Grants may also be used by
8	recipients:
9	(1) to develop pharmacy practices that integrate pharmacy
10	and existing health care provider facilities; or
11	(2) to establish a pharmacy provider cooperative or
12	initiatives that maintain local access to prescription
13	medications and the skills of a pharmacist.
14	Subd. 3. [CONSIDERATION OF GRANTS.] In determining which
15	applicants shall receive grants under this section, the
16	commissioner of health shall appoint a committee comprised of
17	members with experience and knowledge about rural pharmacy
18	issues, including, but not limited to, two rural pharmacists
19	with a community pharmacy background, two health care providers
20	from rural communities, one representative from a statewide
21	pharmacist organization, and one representative of the Board of
22	Pharmacy. A representative of the commissioner may serve on the
23	committee in an ex officio status. In determining who shall
24	receive a grant, the committee shall take into account:
25	(1) improving or maintaining access to prescription
26	medications and the skills of a pharmacist;
27	(2) changes in service populations;
28	(3) the extent community pharmacy needs are not currently
29	met by other providers in the area;
30	(4) the financial condition of the applicant;
31	(5) the integration of pharmacy services into existing
32	health care services; and
33	(6) community support.
34	The commissioner may also take into account other relevant
35	factors.
36	Subd. 4. [ALLOCATION OF GRANTS.] (a) The commissioner
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1	shall establish a deadline for receiving applications and must
2	make a final decision on the funding of each application within
3	60 days of the deadline. An applicant must apply no later than
4	March 1 of each fiscal year for grants awarded for that fiscal
5	year.
6	(b) Any grant awarded must not exceed \$50,000 a year and
7	may not exceed a one-year term.
8	(c) Applicants may apply to the program each year they are
9	eligible.
10	(d) Project grants may not be used to retire debt incurred
11	with respect to any capitol expenditure made prior to the date
12	on which the project is initiated.
13	Subd. 5. [EVALUATION.] The commissioner shall evaluate the
14	overall effectiveness of the grant program and may collect
15	progress reports and other information from grantees needed for
16	program evaluation. An academic institution that has the
17	expertise in evaluating rural pharmacy outcomes may participate
18	in the program evaluation if asked by a grantee or the
19	commissioner. The commissioner shall compile summaries of
20	successful grant projects and other model community efforts to
21	preserve access to prescription medications and the skills of a
22	pharmacist, and make this information available to Minnesota
23	communities seeking to address local pharmacy issues.
24	Sec. 9. Minnesota Statutes 2004, section 144.148,
25	subdivision 1, is amended to read:
26	Subdivision 1. [DEFINITION.] (a) For purposes of this
27	section, the following definitions apply.
28	(b) "Eligible rural hospital" means any nonfederal, general
29	acute care hospital that:
30	(1) is either located in a rural area, as defined in the
31	federal Medicare regulations, Code of Federal Regulations, title
32	42, section 405.1041, or located in a community with a
33	population of less than $\frac{1}{207}000$ $\frac{15,000}{000}$ , according to United
34	States Census Bureau statistics, outside the seven-county
35	metropolitan area;
36	(2) has 50 or fewer beds; and

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(3) is not for profit. 1 (c) "Eligible project" means a modernization project to 2 3 update, remodel, or replace aging hospital facilities and equipment necessary to maintain the operations of a hospital. 4 Sec. 10. Minnesota Statutes 2004, section 144.1501, 5 subdivision 1, is amended to read: 6 Subdivision 1. [DEFINITIONS.] (a) For purposes of this 7 section, the following definitions apply. 8 (b) "Designated rural area" means: 9 (1) an area in Minnesota outside the counties of Anoka, 10 Carver, Dakota, Hennepin, Ramsey, Scott, and Washington, 11 excluding the cities of Duluth, Mankato, Moorhead, Rochester, 12 13 and St. Cloud; or (2) a municipal corporation, as defined under section 14 471.634, that is physically located, in whole or in part, in an 15 area defined as a designated rural area under clause (1). 16 (c) "Emergency circumstances" means those conditions that 17 make it impossible for the participant to fulfill the service 18 commitment, including death, total and permanent disability, or 19 20 temporary disability lasting more than two years. (d) "Medical resident" means an individual participating in 21 a medical residency in family practice, internal medicine, 22 23 obstetrics and gynecology, pediatrics, or psychiatry. 24 (e) "Midlevel practitioner" means a nurse practitioner, nurse-midwife, nurse anesthetist, advanced clinical nurse 25 specialist, or physician assistant. 26 27 (f) "Nurse" means an individual who has completed training 28 and received all licensing or certification necessary to perform 29 duties as a licensed practical nurse or registered nurse. 30 (g) "Nurse-midwife" means a registered nurse who has 31 graduated from a program of study designed to prepare registered 32 nurses for advanced practice as nurse-midwives. 33 (h) "Nurse practitioner" means a registered nurse who has 34 graduated from a program of study designed to prepare registered nurses for advanced practice as nurse practitioners. 35

36 (i) "Pharmacist" means an individual with a valid license

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1 issued under chapter 151 to practice pharmacy.

(j) "Physician" means an individual who is licensed to
practice medicine in the areas of family practice, internal
medicine, obstetrics and gynecology, pediatrics, or psychiatry.

5 (j) (k) "Physician assistant" means a person registered
6 under chapter 147A.

7 (k) (1) "Qualified educational loan" means a government, 8 commercial, or foundation loan for actual costs paid for 9 tuition, reasonable education expenses, and reasonable living 10 expenses related to the graduate or undergraduate education of a 11 health care professional.

12 (1) (m) "Underserved urban community" means a Minnesota 13 urban area or population included in the list of designated 14 primary medical care health professional shortage areas (HPSAs), 15 medically underserved areas (MUAs), or medically underserved 16 populations (MUPs) maintained and updated by the United States 17 Department of Health and Human Services.

18 Sec. 11. Minnesota Statutes 2004, section 144.1501, 19 subdivision 2, is amended to read:

20 Subd. 2. [CREATION OF ACCOUNT.] (a) A health professional 21 education loan forgiveness program account is established. The 22 commissioner of health shall use money from the account to 23 establish a loan forgiveness program:

24 (1) for medical residents agreeing to practice in
25 designated rural areas or underserved urban communities, or
26 specializing in the area of pediatric psychiatry;

27 (2) for midlevel practitioners agreeing to practice in
28 designated rural areas-and or to teach for at least 20 hours
29 per week in the nursing field in a postsecondary program;

30 (3) for nurses who agree to practice in a Minnesota nursing 31 home or intermediate care facility for persons with mental 32 retardation or related conditions or to teach for at least 20 33 hours per week in the nursing field in a postsecondary program; 34 (4) for other health care technicians agreeing to teach for

35 <u>at least 20 hours per week in their designated field in a</u>
36 postsecondary program. The commissioner, in consultation with

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1	the Healthcare Education-Industry Partnership, shall determine
2	the health care fields where the need is the greatest,
3	including, but not limited to, respiratory therapy, clinical
4	laboratory technology, radiologic technology, and surgical
5	technology; and
6	(5) for pharmacists who agree to practice in designated
7	<u>rural areas</u> .
8	(b) Appropriations made to the account do not cancel and
9	are available until expended, except that at the end of each
10	biennium, any remaining balance in the account that is not
11	committed by contract and not needed to fulfill existing
12	commitments shall cancel to the fund.
13	Sec. 12. Minnesota Statutes 2004, section 144.1501,
14	subdivision 3, is amended to read:
15	Subd. 3. [ELIGIBILITY.] (a) To be eligible to participate
16	in the loan forgiveness program, an individual must:
17	(1) be a medical resident or a licensed pharmacist or be
18	enrolled in a midlevel practitioner, registered nurse, or a
19	licensed practical nurse training program; and
20	(2) submit an application to the commissioner of health.
21	(b) An applicant selected to participate must sign a
22	contract to agree to serve a minimum three-year full-time
23	service obligation according to subdivision 2, which shall begin
24	no later than March 31 following completion of required training.
25	Sec. 13. Minnesota Statutes 2004, section 144.1501,
26	subdivision 4, is amended to read:
27	Subd. 4. [LOAN FORGIVENESS.] The commissioner of health
28	may select applicants each year for participation in the loan
29	forgiveness program, within the limits of available funding. The
30	commissioner shall distribute available funds for loan
31	forgiveness proportionally among the eligible professions
32	according to the vacancy rate for each profession in the
. 33	required geographic area o <del>r</del> , facility type, or teaching area
34	specified in subdivision 2. The commissioner shall allocate
35	funds for physician loan forgiveness so that 75 percent of the
36	funds available are used for rural physician loan forgiveness

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and 25 percent of the funds available are used for underserved 1 urban communities loan forgiveness. If the commissioner does 2 3 not receive enough qualified applicants each year to use the entire allocation of funds for urban underserved communities, 4 the remaining funds may be allocated for rural physician loan 5 forgiveness. Applicants are responsible for securing their own 6 7 qualified educational loans. The commissioner shall select participants based on their suitability for practice serving the 8 required geographic area or facility type specified in 9 subdivision 2, as indicated by experience or training. The 10 commissioner shall give preference to applicants closest to 11 completing their training. For each year that a participant 12 meets the service obligation required under subdivision 3, up to 13 a maximum of four years, the commissioner shall make annual 14 15 disbursements directly to the participant equivalent to 15 percent of the average educational debt for indebted graduates 16 17 in their profession in the year closest to the applicant's 18 selection for which information is available, not to exceed the balance of the participant's qualifying educational loans. 19 20 Before receiving loan repayment disbursements and as requested, 21 the participant must complete and return to the commissioner an affidavit of practice form provided by the commissioner 22 23 verifying that the participant is practicing as required under subdivisions 2 and 3. The participant must provide the 24 25 commissioner with verification that the full amount of loan 26 repayment disbursement received by the participant has been applied toward the designated loans. After each disbursement, 27 28 verification must be received by the commissioner and approved 29 before the next loan repayment disbursement is made. 30 Participants who move their practice remain eligible for loan repayment as long as they practice as required under subdivision 31 32 2. 33 Sec. 14. Minnesota Statutes 2004, section 144.226,

34 subdivision 1, is amended to read:

35 Subdivision 1. [WHICH SERVICES ARE FOR FEE.] The fees for 36 the following services shall be the following or an amount

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1 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 \$8 <u>\$9</u>.
No fee shall be charged for a certified birth 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. <u>The fee is nonrefundable.</u>

8 (b) The fee for processing a request for the replacement of
9 a birth record for all events, except when filing a recognition
10 of parentage pursuant to section 257.73, subdivision 1,
11 is \$20 \$40. The fee is payable at the time of application and

12 <u>is nonrefundable.</u>

13 (c) The fee for processing a request for the filing of a
14 delayed registration of birth or death is \$20 \$40. The fee is
15 payable at the time of application and is nonrefundable. This
16 fee includes one subsequent review of the request if the request
17 is not acceptable upon the initial receipt.

(d) The fee for processing a request for the amendment of 18 any vital record when requested more than 45 days after the 19 filing of the vital record is 20 40. No fee shall be charged 20 for an amendment requested within 45 days after the filing of 21 the vital record. The fee is payable at the time of application 22 and is nonrefundable. This fee includes one subsequent review 23 24 of the request if the request is not acceptable upon the initial 25 receipt.

(e) The fee for processing a request for the verification 26 of information from vital records is \$8 <u>\$9</u> when the applicant 27 furnishes the specific information to locate the vital record. 28 When the applicant does not furnish specific information, the 29 30 fee is \$20 per hour for staff time expended. Specific information includes the correct date of the event and the 31 32 correct name of the registrant. Fees charged shall approximate the costs incurred in searching and copying the vital records. 33 The fee shall-be is payable at the time of application and is 34 35 nonrefundable.

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(f) The fee for processing a request for the issuance of a

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copy of any document on file pertaining to a vital record or 1 statement that a related document cannot be found is \$8 \$9. 2 The fee is payable at the time of application and is nonrefundable. 3 Sec. 15. Minnesota Statutes 2004, section 144.226, is 4 amended by adding a subdivision to read: 5 Subd. 5. [ELECTRONIC VERIFICATION.] A fee for the 6 7 electronic verification of a vital event, when the information being verified is obtained from a certified birth or death 8 9 record, shall be established through contractual or interagency agreements with interested local, state, or federal government 10 11 agencies. Sec. 16. Minnesota Statutes 2004, section 144.226, is 12 13 amended by adding a subdivision to read: 14 Subd. 6. [ALTERNATIVE PAYMENT METHODS.] Notwithstanding 15 subdivision 1, alternative payment methods may be approved and 16 implemented by the state registrar or a local registrar. 17 Sec. 17. Minnesota Statutes 2004, section 144.3831, 18 subdivision 1, is amended to read: 19 Subdivision 1. [FEE SETTING.] The commissioner of health 20 may assess an annual fee of \$5.21 \$6.36 for every service 21 connection to a public water supply that is owned or operated by 22 a home rule charter city, a statutory city, a city of the first 23 class, or a town. The commissioner of health may also assess an 24 annual fee for every service connection served by a water user 25 district defined in section 110A.02. 26 [EFFECTIVE DATE.] This section is effective July 1, 2006. 27 Sec. 18. Minnesota Statutes 2004, section 144.551, subdivision 1, is amended to read: 28 29 Subdivision 1. [RESTRICTED CONSTRUCTION OR MODIFICATION.] 30 (a) The following construction or modification may not be 31 commenced: 32 (1) any erection, building, alteration, reconstruction, 33 modernization, improvement, extension, lease, or other acquisition by or on behalf of a hospital that increases the bed 34 capacity of a hospital, relocates hospital beds from one 35 physical facility, complex, or site to another, or otherwise 36

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results in an increase or redistribution of hospital beds within
 the state; and

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(2) the establishment of a new hospital.

(b) This section does not apply to:

5 (1) construction or relocation within a county by a 6 hospital, clinic, or other health care facility that is a 7 national referral center engaged in substantial programs of 8 patient care, medical research, and medical education meeting 9 state and national needs that receives more than 40 percent of 10 its patients from outside the state of Minnesota;

11 (2) a project for construction or modification for which a 12 health care facility held an approved certificate of need on May 13 1, 1984, regardless of the date of expiration of the 14 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;

18 (4) a project exempted from certificate of need 19 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;

25 (6) a project involving the temporary relocation of 26 pediatric-orthopedic hospital beds to an existing licensed hospital that will allow for the reconstruction of a new 27 28 philanthropic, pediatric-orthopedic hospital on an existing site and that will not result in a net increase in the number of 29 30 hospital beds. Upon completion of the reconstruction, the 31 licenses of both hospitals must be reinstated at the capacity 32 that existed on each site before the relocation;

33 (7) the relocation or redistribution of hospital beds
34 within a hospital building or identifiable complex of buildings
35 provided the relocation or redistribution does not result in:
36 (i) an increase in the overall bed capacity at that site; (ii)

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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 4 hospital corporate system that involves the transfer of beds 5 from a closed facility site or complex to an existing site or 6 complex provided that: (i) no more than 50 percent of the 7 8 capacity of the closed facility is transferred; (ii) the capacity of the site or complex to which the beds are 9 transferred does not increase by more than 50 percent; (iii) the 10 11 beds are not transferred outside of a federal health systems agency boundary in place on July 1, 1983; and (iv) the 12 relocation or redistribution does not involve the construction 13 of a new hospital building; 14

(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;

19 (10) a project to replace a hospital or hospitals with a combined licensed capacity of 130 beds or less if: (i) the new 20 21 hospital site is located within five miles of the current site; and (ii) the total licensed capacity of the replacement 22 23 hospital, either at the time of construction of the initial 24 building or as the result of future expansion, will not exceed 70 licensed hospital beds, or the combined licensed capacity of 25 26 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;

34 (12) the construction or relocation of hospital beds
35 operated-by-a-hospital within or among hospitals having a
36 statutory obligation to provide hospital and medical services

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1 for the indigent that does not result in a net increase in the 2 number of hospital beds;

3 (13) a construction project involving the addition of up to
4 31 new beds in an existing nonfederal hospital in Beltrami
5 County;

6 (14) a construction project involving the addition of up to
7 eight new beds in an existing nonfederal hospital in Otter Tail
8 County with 100 licensed acute care beds;

(15) a construction project involving the addition of 20 9 new hospital beds used for rehabilitation services in an 10 existing hospital in Carver County serving the southwest 11 suburban metropolitan area. Beds constructed under this clause 12 13 shall not be eligible for reimbursement under medical assistance, general assistance medical care, or MinnesotaCare; 14 (16) a project for the construction or relocation of up to 15 20 hospital beds for the operation of up to two psychiatric 16 facilities or units for children provided that the operation of 17

18 the facilities or units have received the approval of the 19 commissioner of human services;

20 (17) a project involving the addition of 14 new hospital
21 beds to be used for rehabilitation services in an existing
22 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 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 (10), 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.

36 Sec. 19. Minnesota Statutes 2004, section 144.562,

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subdivision 2, is amended to read:

Subd. 2. [ELIGIBILITY FOR LICENSE CONDITION.] (a) A 2 hospital is not eligible to receive a license condition for 3 swing beds unless (1) it either has a licensed bed capacity of 4 less than 50 beds defined in the federal Medicare regulations, 5 Code of Federal Regulations, title 42, section 482.66, or it has 6 a licensed bed capacity of 50 beds or more and has swing beds 7 that were approved for Medicare reimbursement before May 1, 8 1985, or it has a licensed bed capacity of less than 65 beds and 9 the available nursing homes within 50 miles have had, in the 10 aggregate, an average occupancy rate of 96 percent or higher in 11 the most recent two years as documented on the statistical 12 reports to the Department of Health; and (2) it is located in a 13 rural area as defined in the federal Medicare regulations, Code 14 of Federal Regulations, title 42, section 482.66. 15

16 (b) Except for those critical access hospitals established under section 144.1483, clause (10), and section 1820 of the 17 federal Social Security Act, United States Code, title 42, 18 section 1395i-4, that have an attached nursing home, eligible 19 hospitals are allowed a total of  $\frac{1}{746\theta}$  2,000 days of swing bed 20 21 use per year7-provided-that-no-more-than-ten-hospital-beds-are used-as-swing-beds-at-any-one-time. Critical access hospitals 22 23 that have an attached nursing home are allowed swing bed use as 24 provided in federal law.

25 (c) Except for critical access hospitals that have an 26 attached nursing home, the commissioner of health must may 27 approve swing bed use beyond  $\frac{1}{746\theta} \frac{2,000}{2,000}$  days as long as there are no Medicare certified skilled nursing facility beds 28 29 available within 25 miles of that hospital that are willing to admit the patient. Critical access hospitals exceeding 2,000 30 31 swing bed days must maintain documentation that they have 32 contacted skilled nursing facilities within 25 miles to 33 determine if any skilled nursing facility beds are available that are willing to admit the patient. 34

35 (d) After reaching 2,000 days of swing bed use in a year,
36 an eligible hospital to which this limit applies may admit six

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1	additional patients to swing beds each year without seeking
2	approval from the commissioner or being in violation of this
3	subdivision. These six swing bed admissions are exempt from the
4	limit of 2,000 annual swing bed days for hospitals subject to
5	this limit.
6	(e) A health care system that is in full compliance with
7	this subdivision may allocate its total limit of swing bed days
8	among the hospitals within the system, provided that no hospital
9	in the system without an attached nursing home may exceed 2,000
10	swing bed days per year.
11	Sec. 20. [144.602] [DEFINITIONS.]
12	Subdivision 1. [APPLICABILITY.] For purposes of sections
13	144.601 to 144.608, the terms defined in this section have the
14	meanings given them.
15	Subd. 2. [COMMISSIONER.] "Commissioner" means the
16	commissioner of health.
17	Subd. 3. [MAJOR TRAUMA.] "Major trauma" means a sudden
18	severe injury or damage to the body caused by an external force
19	that results in potentially life-threatening injuries or that
20	could result in the following disabilities:
21	(1) impairment of cognitive or mental abilities;
22	(2) impairment of physical functioning; or
23	(3) disturbance of behavioral or emotional functioning.
24	Subd. 4. [TRAUMA HOSPITAL.] "Trauma hospital" means a
25	hospital that voluntarily meets the commissioner's criteria
26	under section 144.603 and that has been designated as a trauma
27	hospital under section 144.605.
28	Sec. 21. [144.603] [STATEWIDE TRAUMA SYSTEM CRITERIA.]
29	Subdivision 1. [CRITERIA ESTABLISHED.] The commissioner
30	shall adopt criteria to ensure that severely injured people are
31	promptly transported and treated at trauma hospitals appropriate
32	to the severity of injury. Minimum criteria shall govern
33	emergency medical service trauma triage and transportation
34	guidelines, designation of hospitals as trauma hospitals,
35	interhospital transfers, a trauma registry, and a trauma system
36	governance structure.

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1	Subd. 2. [BASIS; VERIFICATION.] The commissioner shall
2	base the establishment, implementation, and modifications to the
3	criteria under subdivision 1 on the department-published
4	Minnesota comprehensive statewide trauma system plan. The
5	commissioner shall seek the advice of the Trauma Advisory
6	Council in implementing and updating the criteria, using
7	accepted and prevailing trauma transport, treatment, and
8	referral standards of the American College of Surgeons, the
9	American College of Emergency Physicians, the Minnesota
10	Emergency Medical Services Regulatory Board, the national Trauma
11	Resources Network, and other widely recognized trauma experts.
12	The commissioner shall adapt and modify the standards as
13	appropriate to accommodate Minnesota's unique geography and the
14	state's hospital and health professional distribution and shall
15	verify that the criteria are met by each hospital voluntarily
16	participating in the statewide trauma system.
17	Subd. 3. [RULE EXEMPTION AND REPORT TO LEGISLATURE.] In
18	developing and adopting the criteria under this section, the
19	commissioner of health is exempt from chapter 14, including
20	section 14.386. By September 1, 2009, the commissioner must
21	report to the legislature on implementation of the voluntary
22	trauma system, including recommendations on the need for
23	including the trauma system criteria in rule.
24	Sec. 22. [144.604] [TRAUMA TRIAGE AND TRANSPORTATION.]
25	Subdivision 1. [TRANSPORT REQUIREMENT.] Unless the
26	Emergency Medical Services Regulatory Board has approved a
27	licensed ambulance service's deviation from the guidelines under
28	section 144E.101, subdivision 14, the ambulance service must
29	transport major trauma patients from the scene to the highest
30	state-designated trauma hospital within 30 minutes' transport
31	time.
32	Subd. 2. [EXCEPTIONS.] Notwithstanding subdivision 1:
33	(1) patients with compromised airways must be transported
34	immediately to the nearest designated trauma hospital; and
35	(2) level II trauma hospitals capable of providing
36	definitive trauma care must not be bypassed to reach a level I
Ar	ticle 1 Section 22 26

	1	trauma hospital.
	2	Subd. 3. [UNDESIGNATED HOSPITALS.] No major trauma patient
	3	shall be transported to a hospital not participating in the
	4	<u>statewide trauma system unless no trauma hospital is available</u>
	5	within 30 minutes' transport time.
	6	[EFFECTIVE DATE.] This section is effective July 1, 2009.
	7	Sec. 23. [144.605] [DESIGNATING TRAUMA HOSPITALS.]
	8	Subdivision 1. [NAMING PRIVILEGES.] Unless it has been
	9	designated a trauma hospital by the commissioner, no hospital
	10	shall use the term trauma center or trauma hospital in its name
	11	or its advertising or shall otherwise indicate it has trauma
	12	treatment capabilities.
~~.	13	Subd. 2. [DESIGNATION; REVERIFICATION.] The commissioner
	14	shall designate four levels of trauma hospitals. A hospital
	15	that voluntarily meets the criteria for a particular level of
	16	trauma hospital shall apply to the commissioner for designation
	17	and, upon the commissioner's verifying the hospital meets the
	18	criteria, be designated a trauma hospital at the appropriate
	19	level for a three-year period. Prior to the expiration of the
	20	three-year designation, a hospital seeking to remain part of the
	21	voluntary system must apply for and successfully complete a
	22	reverification process, be awaiting the site visit for the
	23	reverification, or be awaiting the results of the site visit.
~~ .	24	The commissioner may extend a hospital's existing designation
	25	for up to 18 months on a provisional basis if the hospital has
	26	applied for reverification in a timely manner but has not yet
	27	completed the reverification process within the expiration of
	28	the three-year designation and the extension is in the best
	29	interest of trauma system patient safety. To be granted a
	30	provisional extension, the hospital must be:
	31	(1) scheduled and awaiting the site visit for
	32	reverification;
	33	(2) awaiting the results of the site visit; or
	34	(3) responding to and correcting identified deficiencies
	35	identified in the site visit.
	36	Subd. 3. [ACS VERIFICATION.] The commissioner shall grant
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1	the appropriate level I, II, or III trauma hospital designation
2	to a hospital that successfully completes and passes the
3	American College of Surgeons (ACS) verification standards at the
4	hospital's cost, submits verification documentation to the
5	Trauma Advisory Council, and formally notifies the Trauma
6	Advisory Council of ACS verification.
7	Subd. 4. [LEVEL III DESIGNATION; NOT ACS VERIFIED.] (a)
8	The commissioner shall grant the appropriate level III trauma
9	hospital designation to a hospital that is not ACS verified but
10	that successfully completes the designation process under
11	paragraph (b).
12	(b) The hospital must complete and submit a self-reported
13	survey and application to the Trauma Advisory Council for
14	review, verifying that the hospital meets the criteria as a
15	level III trauma hospital. When the Trauma Advisory Council is
16	satisfied the application is complete, the commissioner shall
17	arrange a site review visit. Upon successful completion of the
18	site review, the review team shall make written recommendations
19	to the Trauma Advisory Council. If approved by the Trauma
20	Advisory Council, a letter of recommendation shall be sent to
21	the commissioner for final approval and designation.
22	Subd. 5. [LEVEL IV DESIGNATION.] (a) The commissioner
23	shall grant the appropriate level IV trauma hospital designation
24	to a hospital that successfully completes the designation
25	process under paragraph (b).
26	(b) The hospital must complete and submit a self-reported
27	survey and application to the Trauma Advisory Council for
28	review, verifying that the hospital meets the criteria as a
29	level IV trauma hospital. When the Trauma Advisory Council is
30	satisfied the application is complete, the council shall review
31	the application and, if the council approves the application,
32	send a letter of recommendation to the commissioner for final
33	approval and designation. The commissioner shall grant a level
34	IV designation and shall arrange a site review visit within
35	three years of the designation and every three years thereafter,
36	to coincide with the three-year reverification process.

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1	Subd. 6. [CHANGES IN DESIGNATION.] Changes in a trauma
2	hospital's ability to meet the criteria for the hospital's level
3	of designation must be self-reported to the Trauma Advisory
4	Council and to other regional hospitals and local emergency
5	medical services providers and authorities. If the hospital
6	cannot correct its ability to meet the criteria for its level
7	within six months, the hospital may apply for redesignation at a
8	different level.
9	Subd. 7. [HIGHER DESIGNATION.] A trauma hospital may apply
10	for a higher trauma hospital designation one time during the
11	hospital's three-year designation by completing the designation
12	process for that level of trauma hospital.
13	Subd. 8. [LOSS OF DESIGNATION.] The commissioner may
14	refuse to designate or redesignate or may revoke a previously
15	issued trauma hospital designation if a hospital does not meet
16	the criteria of the statewide trauma plan, in the interests of
17	patient safety, or if a hospital denies or refuses a reasonable
18	request by the commissioner or the commissioner's designee to
19	verify information by correspondence or an on-site visit.
20	Sec. 24. [144.606] [INTERHOSPITAL TRANSFERS.]
21	Subdivision 1. [WRITTEN PROCEDURES REQUIRED.] A level III
22	or IV trauma hospital must have predetermined, written
23	procedures that direct the internal process for rapidly and
24	efficiently transferring a major trauma patient to definitive
25	care, including:
26	(1) clearly identified anatomic and physiologic criteria
27	that, if met, will immediately initiate transfer to definitive
28	care;
29	(2) a listing of appropriate ground and air transport
30	services, including primary and secondary telephone contact
31	numbers; and
32	(3) immediately available supplies, records, or other
33	necessary resources that will accompany a patient.
34	Subd. 2. [TRANSFER AGREEMENTS.] (a) A level III or IV
35	trauma hospital may transfer patients to a hospital with which
36	the trauma hospital has a written transfer agreement.

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[REVISOR ] \_3S/MD 05-4117 04/28/05 (b) Each agreement must be current and with a trauma **1** . hospital or trauma hospitals capable of caring for major trauma 2 3 injuries. (c) A level III or IV trauma hospital must have a current 4 transfer agreement with a hospital that has special capabilities 5 in the treatment of burn injuries and a transfer agreement with 6 a second hospital that has special capabilities in the treatment 7 of burn injuries, should the primary transfer hospital be unable 8 to accept a burn patient. 9 Sec. 25. [144.607] [TRAUMA REGISTRY.] 10 Subdivision 1. [REGISTRY PARTICIPATION REQUIRED.] A trauma 11 hospital must participate in the statewide trauma registry. 12 Subd. 2. [TRAUMA REPORTING.] A trauma hospital must report 13 major trauma injuries as part of the reporting for the traumatic 14 brain injury and spinal cord injury registry required in 15 sections 144.661 to 144.665. 16 Subd. 3. [APPLICATION OF OTHER LAW.] Sections 144.661 to 17 144.665 apply to a major trauma reported to the statewide trauma 18 19 registry, with the exception of sections 144.662, clause (2), and 144.664, subdivision 3. 20 Sec. 26. [144.608] [TRAUMA ADVISORY COUNCIL.] 21 Subdivision 1. [TRAUMA ADVISORY COUNCIL ESTABLISHED.] (a) 22 23 A Trauma Advisory Council is established to advise, consult 24 with, and make recommendations to the commissioner on the 25 development, maintenance, and improvement of a statewide trauma 26 system. 27 (b) The council shall consist of the following members: 28 (1) a trauma surgeon certified by the American College of Surgeons who practices in a level I or II trauma hospital; 29 30 (2) a general surgeon certified by the American College of 31 Surgeons whose practice includes trauma and who practices in a 32 designated rural area as defined under section 144.1501, 33 subdivision 1, paragraph (b); 34 (3) a neurosurgeon certified by the American Board of 35 Neurological Surgery who practices in a level I or II trauma 36 hospital;

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1	(4) a trauma program nurse manager or coordinator
2	practicing in a level I or II trauma hospital;
3	(5) an emergency physician certified by the American
4	College of Emergency Physicians whose practice includes
5	emergency room care in a level I, II, III, or IV trauma
6	hospital;
7	(6) an emergency room nurse manager who practices in a
8	level III or IV trauma hospital;
9	(7) a family practice physician whose practice includes
10	emergency room care in a level III or IV trauma hospital located
11	in a designated rural area as defined under section 144.1501,
1 <b>2</b>	<pre>subdivision 1, paragraph (b);</pre>
13	(8) a nurse practitioner, as defined under section
14	144.1501, subdivision 1, paragraph (h), or a physician
15	assistant, as defined under section 144.1501, subdivision 1,
16	paragraph (j), whose practice includes emergency room care in a
17	level IV trauma hospital located in a designated rural area as
18	defined under section 144.1501, subdivision 1, paragraph (b);
19	(9) a pediatrician certified by the American Academy of
20	Pediatrics whose practice includes emergency room care in a
21	level I, II, III, or IV trauma hospital;
22	(10) an orthopedic surgeon certified by the American Board
23	of Orthopedic Surgery whose practice includes trauma and who
24	practices in a level I, II, or III trauma hospital;
25	(11) the state emergency medical services medical director
26	appointed by the Emergency Medical Services Regulatory Board;
27	(12) a hospital administrator of a level III or IV trauma
28	hospital located in a designated rural area as defined under
29	section 144.1501, subdivision 1, paragraph (b);
30	(13) a rehabilitation specialist whose practice includes
31	rehabilitation of patients with major trauma injuries or
32	traumatic brain injuries and spinal cord injuries as defined
33	under section 144.661;
34	(14) an attendant or ambulance director who is an EMT,
35	EMT-I, or EMT-P within the meaning of section 144E.001 and who
36	actively practices with a licensed ambulance service in a
Ar	ticle 1 Section 26 31

[REVISOR ] 3S/MD 05-4117 04/28/05 primary service area located in a designated rural area as 1 defined under section 144.1501, subdivision 1, paragraph (b); 2 3 and (15) the commissioner of public safety or the 4 commissioner's designee. 5 6 (c) Council members whose appointment is dependent on practice in a level III or IV trauma hospital may be appointed 7 to an initial term based upon their statements that the hospital 8 intends to become a level III or IV facility by July 1, 2009. 9 Subd. 2. [COUNCIL ADMINISTRATION.] (a) The council must 10 meet at least twice a year but may meet more frequently at the 11 call of the chair, a majority of the council members, or the 12 13 commissioner. (b) The terms, compensation, and removal of members of the 14 council are governed by section 15.059, except that the council 15 16 expires June 30, 2015. (c) The council may appoint subcommittees and workgroups. 17 18 Subcommittees shall consist of council members. Workgroups may include noncouncil members. Noncouncil members shall be 19 20 compensated for workgroup activities under section 15.059, subdivision 3, but shall receive expenses only. 21 22 Subd. 3. [REGIONAL TRAUMA ADVISORY COUNCILS.] (a) Up to 23 eight regional trauma advisory councils may be formed as needed. (b) Regional trauma advisory councils shall advise, consult 24 25 with, and make recommendation to the state Trauma Advisory 26 Council on suggested regional modifications to the statewide 27 trauma criteria that will improve patient care and accommodate specific regional needs. 28 29 (c) Each regional advisory council must have no more than 30 15 members. The commissioner, in consultation with the 31 Emergency Medical Services Regulatory Board and the commissioner 32 of public safety, shall name the council members. 33 (d) Regional council members may receive expenses in the 34 same manner and amount as authorized by the plan adopted under section 43A.18, subdivision 2. 35 36 Sec. 27. Minnesota Statutes 2004, section 144.9504, Article 1 Section 27 32

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l subdivision 2, is amended to read:

2 Subd. 2. [LEAD RISK ASSESSMENT.] (a) An assessing agency 3 shall conduct a lead risk assessment of a residence according to 4 the venous blood lead level and time frame set forth in clauses 5 (1) to <del>(5)</del> (4) for purposes of secondary prevention:

6 (1) within 48 hours of a child or pregnant female in the 7 residence being identified to the agency as having a venous 8 blood lead level equal to or greater than  $7\theta$  <u>60</u> micrograms of 9 lead per deciliter of whole blood;

10 (2) within five working days of a child or pregnant female 11 in the residence being identified to the agency as having a 12 venous blood lead level equal to or greater than 45 micrograms 13 of lead per deciliter of whole blood;

14 (3) within ten working days of a child in the residence 15 being identified to the agency as having a venous blood lead 16 level equal to or greater than  $2\theta$  <u>15</u> micrograms of lead per 17 deciliter of whole blood; <u>or</u>

18 (4) within-ten-working-days-of-a-child-in-the-residence
19 being-identified-to-the-agency-as-having-a-venous-blood-lead
20 level-that-persists-in-the-range-of-l5-to-l9-micrograms-of-lead
21 per-deciliter-of-whole-blood-for-90-days-after-initial
22 identification;-or

23 (5) within ten working days of a pregnant female in the
24 residence being identified to the agency as having a venous
25 blood lead level equal to or greater than ten micrograms of lead
26 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

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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 5 agency shall identify the known addresses for the previous 12 6 months of the child or pregnant female with venous blood lead 7 levels of at least  $2\theta$  15 micrograms per deciliter for the child 8 or at least ten micrograms per deciliter for the pregnant 9 female; notify the property owners, landlords, and tenants at 10 those addresses that an elevated blood lead level was found in a 11 person who resided at the property; and give them primary 12 prevention information. Within the limits of appropriations, 13 the assessing agency may perform a risk assessment and issue 14 corrective orders in the properties, if it is likely that the 15 previous address contributed to the child's or pregnant female's 16 blood lead level. The assessing agency shall provide the notice 17 required by this subdivision without identifying the child or 18 pregnant female with the elevated blood lead level. 19 The assessing agency is not required to obtain the consent of the 20 21 child's parent or guardian or the consent of the pregnant female for purposes of this subdivision. This information shall be 22 classified as private data on individuals as defined under 23 24 section 13.02, subdivision 12.

25 (e) The assessing agency shall conduct the lead risk 26 assessment according to rules adopted by the commissioner under 27 section 144.9508. An assessing agency shall have lead risk assessments performed by lead risk assessors licensed by the 28 29 commissioner according to rules adopted under section 144.9508. 30 If a property owner refuses to allow a lead risk assessment, the assessing agency shall begin legal proceedings to gain entry to 31 32 the property and the time frame for conducting a lead risk 33 assessment set forth in this subdivision no longer applies. A 34 lead risk assessor or assessing agency may observe the 35 performance of lead hazard reduction in progress and shall 36 enforce the provisions of this section under section 144.9509.

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Deteriorated painted surfaces, bare soil, and dust must be 1 2 tested with appropriate analytical equipment to determine the lead content, except that deteriorated painted surfaces or bare 3 soil need not be tested if the property owner agrees to engage 4 in lead hazard reduction on those surfaces. The lead content of 5 6 drinking water must be measured if another probable source of lead exposure is not identified. Within a standard metropolitan 7 statistical area, an assessing agency may order lead hazard 8 reduction of bare soil without measuring the lead content of the 9 bare soil if the property is in a census tract in which soil 10 sampling has been performed according to rules established by 11 the commissioner and at least 25 percent of the soil samples 12 contain lead concentrations above the standard in section 13 14 144.9508.

(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.

25 Sec. 28. Minnesota Statutes 2004, section 144.98,
26 subdivision 3, is amended to read:

27 Subd. 3. [FEES.] (a) An application for certification 28 under subdivision 1 must be accompanied by the biennial fee 29 specified in this subdivision. The fees are for:

30 (1) nonrefundable base certification fee, \$1,7200 31 \$1,600; and

32 (2) <u>sample preparation techniques fees</u>, \$100 per technique;
33 <u>and</u>

34 (3) test category certification fees:

35 Test Category

36 Clean water program bacteriology

Certification Fee \$600 <u>\$800</u>

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1	Safe drinking water program bacteriology	<del>\$600</del> <u>\$800</u>
2	Clean water program inorganic chemistry	<del>\$600</del>
3	Safe drinking water program inorganic chemistry	<del>\$600</del> \$800
4	Clean water program chemistry metals	<del>\$800</del> <u>\$1,200</u>
5	Safe drinking water program chemistry metals	<del>\$800</del> \$1,200
6	Resource conservation and recovery program	
7	chemistry metals	<del>\$800</del> <u>\$1,200</u>
8	Clean water program volatile organic compounds	<del>\$1,200</del> <u>\$1,500</u>
9	Safe drinking water program	
10	volatile organic compounds	<del>\$1,200</del> <u>\$1,500</u>
11	Resource conservation and recovery program	
12	volatile organic compounds	<del>\$1,200</del> <u>\$1,500</u>
13	Underground storage tank program	
14	volatile organic compounds	\$ <del>1,200</del> <u>\$1,500</u>
15	Clean water program other organic compounds	\$ <del>1,500</del>
16	Safe drinking water program other organic compounds	s <del>\$1,200</del> <u>\$1,500</u>
17	Resource conservation and recovery program	
18	other organic compounds	\$1,500 <u>\$1,500</u>
19	Clean water program radiochemistry	\$2,500
20	Safe drinking water program radiochemistry	\$2,500
21	Resource conservation and recovery program	
22	agricultural contaminants	\$2,500
23	Resource conservation and recovery program	
24	emerging contaminants	\$2,500
25	(b) The-total-biennial-certification-fee-is-t	he-base-fee
26	plus-the-applicable-test-category-fees.	
27	<del>(c)</del> Laboratories located outside of this state	e that require
28	an on-site survey-will inspection shall be assessed	d an
29	additional <del>\$2,500</del> <u>\$3,750</u> fee.	
30	(c) The total biennial certification fee incl	
31	fee, the sample preparation techniques fees, the t	
32	fees, and, when applicable, the on-site inspection	
33	(d) Fees must be set so that the total fees s	£ *
34	laboratory certification program. Direct costs of	
35	certification service include program administration	
36	inspections, the agency's general support costs, a	na actorney
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general costs attributable to the fee function. 1 (e) A change fee shall be assessed if a laboratory requests 2 additional analytes or methods at any time other than when 3 applying for or renewing its certification. The change fee is 4 equal to the test category certification fee for the analyte. 5 (f) A variance fee shall be assessed if a laboratory 6 requests and is granted a variance from a rule adopted under 7 this section. The variance fee is \$500 per variance. 8 (q) Refunds or credits shall not be made for analytes or 9 methods requested but not approved. 10 (h) Certification of a laboratory shall not be awarded 11 until all fees are paid. 12 Sec. 29. Minnesota Statutes 2004, section 144E.101, is 13 amended by adding a subdivision to read: 14 Subd. 14. [TRAUMA TRIAGE AND TRANSPORT GUIDELINES.] A 15 licensee shall have written age appropriate trauma triage and 16 transport guidelines consistent with the criteria established by 17 the Trauma Advisory Council established under section 144.608, 18 and approved by the board. The board may approve a licensee's 19 requested deviations to the guidelines due to the availability 20 21 of local or regional trauma resources if the changes are in the best interest of the patient's health. 22 Sec. 30. Minnesota Statutes 2004, section 157.15, is 23 amended by adding a subdivision to read: 24 Subd. 19. [STATEWIDE HOSPITALITY FEE.] "Statewide 25 26 hospitality fee" means a fee to fund statewide food, beverage, 27 and lodging program development activities, including training for inspection staff, technical assistance, maintenance of a 28 29 statewide integrated food safety and security information 30 system, and other related statewide activities that support the food, beverage, and lodging program activities. 31 Sec. 31. Minnesota Statutes 2004, section 157.16, 32 subdivision 2, is amended to read: 33 Subd. 2. [LICENSE RENEWAL.] Initial and renewal licenses 34 for all food and beverage service establishments, hotels, 35 motels, lodging establishments, and resorts shall be issued for 36

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the calendar year for which application is made and shall expire 1 on December 31 of such year. Any person who operates a place of 2 business after the expiration date of a license or without 3 having submitted an application and paid the fee shall be deemed 4 to have violated the provisions of this chapter and shall be 5 subject to enforcement action, as provided in the Health 6 Enforcement Consolidation Act, sections 144.989 to 144.993. In 7 addition, a penalty of 25 50 shall be added to the total of 8 the license fee for any food and beverage service establishment 9 operating without a license as a mobile food unit, a seasonal 10 temporary or seasonal permanent food stand, or a special event 11 food stand, and a penalty of 50 100 shall be added to the 12 total of the license fee for all restaurants, food carts, 13 hotels, motels, lodging establishments, and resorts operating 14 15 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 16 operating more than 30 days without a license. 17

18 Sec. 32. Minnesota Statutes 2004, section 157.16, is 19 amended by adding a subdivision to read:

<u>Subd. 2a.</u> [FOOD MANAGER CERTIFICATION.] <u>An applicant for</u>
<u>certification or certification renewal as a food manager must</u>
<u>submit to the commissioner a \$28 nonrefundable certification fee</u>
payable to the Department of Health.

Sec. 33. Minnesota Statutes 2004, section 157.16,
subdivision 3, is amended to read:

26 Subd. 3. [ESTABLISHMENT FEES; DEFINITIONS.] (a) The following fees are required for food and beverage service 27 28 establishments, hotels, motels, lodging establishments, and 29 resorts licensed under this chapter. Food and beverage service 30 establishments must pay the highest applicable fee under paragraph (e) (d), clause (1), (2), (3), or (4), and 31 establishments serving alcohol must pay the highest applicable 32 33 fee under paragraph <del>(e)</del> <u>(d)</u>, clause (6) or (7). The license fee for new operators previously licensed under this chapter for the 34 35 same calendar year is one-half of the appropriate annual license 36 fee, plus any penalty that may be required. The license fee for

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1 operators opening on or after October 1 is one-half of the 2 appropriate annual license fee, plus any penalty that may be 3 required.

4 (b) All food and beverage service establishments, except
5 special event food stands, and all hotels, motels, lodging
6 establishments, and resorts shall pay an annual base fee of
7 \$145 \$150.

8 (c) A special event food stand shall pay a flat fee 9 of \$35 <u>\$40</u> annually. "Special event food stand" means a fee 10 category where food is prepared or served in conjunction with 11 celebrations, county fairs, or special events from a special 12 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:

19 (1) Limited food menu selection, \$40 \$50. "Limited food
20 menu selection" means a fee category that provides one or more
21 of the following:

(i) prepackaged food that receives heat treatment and isserved in the package;

24 (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.

30 (2) Small establishment, including boarding establishments,
31 \$75 \$100. "Small establishment" means a fee category that has
32 no salad bar and meets one or more of the following:

33 (i) possesses food service equipment that consists of no 34 more than a deep fat fryer, a grill, two hot holding containers, 35 and one or more microwave ovens;

36 (ii) serves dipped ice cream or soft serve frozen desserts;

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(iii) serves breakfast in an owner-occupied bed and
 breakfast establishment;

(iv) is a boarding establishment; or

4 (v) meets the equipment criteria in clause (3), item (i) or
5 (ii), and has a maximum patron seating capacity of not more than
6 50.

7 (3) Medium establishment, \$210 \$260. "Medium establishment"
8 means a fee category that meets one or more of the following:

9 (i) possesses food service equipment that includes a range,10 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

14 (iii) is an establishment where food is prepared at one15 location and served at one or more separate locations.

16 Establishments meeting criteria in clause (2), item (v), 17 are not included in this fee category.

18 (4) Large establishment, \$350 \$460. "Large establishment"
19 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.

31 (6) Beer or wine table service, \$40 \$50. "Beer or wine
32 table service" means a fee category where the only alcoholic
33 beverage service is beer or wine, served to customers seated at
34 tables.

35 (7) Alcoholic beverage service, other than beer or wine
36 table service, \$105 \$135.

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"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.

4 (8) Lodging per sleeping accommodation unit, \$6 <u>\$8</u>,
5 including hotels, motels, lodging establishments, and resorts,
6 up to a maximum of \$600 <u>\$800</u>. "Lodging per sleeping
7 accommodation unit" means a fee category including the number of
8 guest rooms, cottages, or other rental units of a hotel, motel,
9 lodging establishment, or resort; or the number of beds in a
10 dormitory.

(9) First public swimming pool, \$140 \$180; each additional public swimming pool, \$00 \$100. "Public swimming pool" means a fee category that has the meaning given in Minnesota Rules, part 4717.0250, subpart 8.

(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.

24 (12) Additional food service, \$130. "Additional food
25 service" means a location at a food service establishment, other
26 than the primary food preparation and service area, used to
27 prepare or serve food to the public.

28 (13) Additional inspection fee, \$300. "Additional
29 inspection fee" means a fee to conduct the second inspection
30 each year for elementary and secondary education facility school
31 lunch programs when required by the Richard B. Russell National
32 School Lunch Act.

33 (e) A fee of \$150 \$350 for review of the construction plans
34 must accompany the initial license application for food-and
35 beverage-service-establishments restaurants, hotels, motels,
36 lodging establishments, or resorts with five or more sleeping

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1 units. (f) When existing food and beverage service establishments, 2 3 hotels, motels, lodging establishments, or resorts are extensively remodeled, a fee of  $\frac{150}{5150}$  must be submitted with 4 the remodeling plans. A fee of \$250 must be submitted for new 5 construction or remodeling for a restaurant with a limited food 6 menu selection, a seasonal permanent food stand, a mobile food 7 unit, or a food cart, or for a hotel, motel, resort, or lodging 8 establishment addition of less than five sleeping units. 9 (g) Seasonal temporary food stands and special event food 10 stands are not required to submit construction or remodeling 11 12 plans for review. Sec. 34. Minnesota Statutes 2004, section 157.16, is 13 amended by adding a subdivision to read: 14 Subd. 3a. [STATEWIDE HOSPITALITY FEE.] Every person, firm, 15 or corporation that operates a licensed boarding establishment, 16 17 food and beverage service establishment, seasonal temporary or 18 permanent food stand, special event food stand, mobile food 19 unit, food cart, resort, hotel, motel, or lodging establishment 20 in Minnesota must submit to the commissioner a \$35 annual statewide hospitality fee for each licensed activity. The fee 21 22 for establishments licensed by the Department of Health is required at the same time the licensure fee is due. For 23 establishments licensed by local governments, the fee is due by 24 July 1 of each year. 25 Sec. 35. Minnesota Statutes 2004, section 157.20, 26 27 subdivision 2, is amended to read: 28 Subd. 2. [INSPECTION FREQUENCY.] The frequency of 29 inspections of the establishments shall be based on the degree 30 of health risk. (a) High-risk establishments must be inspected at least 31 32 once a-year every 12 months. 33 (b) Medium-risk establishments must be inspected at least 34 once every 18 months. 35 (c) Low-risk establishments must be inspected at least once 36 every two-years 24 months.

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[REVISOR ] JS/MD 05-4117 04/28/05 Sec. 36. Minnesota Statutes 2004, section 157.20, 1 subdivision 2a, is amended to read: 2 Subd. 2a. [RISK CATEGORIES.] (a) [HIGH-RISK 3 ESTABLISHMENT.] "High-risk establishment" means any food and 4 beverage service establishment, hotel, motel, lodging 5 establishment, or resort that: 6 (1) serves potentially hazardous foods that require 7 extensive processing on the premises, including manual handling, 8 cooling, reheating, or holding for service; 9 (2) prepares foods several hours or days before service; 10 (3) serves menu items that epidemiologic experience has 11 demonstrated to be common vehicles of food-borne illness; 12 (4) has a public swimming pool; or 13 (5) draws its drinking water from a surface water supply. 14 [MEDIUM-RISK ESTABLISHMENT.] "Medium-risk 15 (b) establishment" means a food and beverage service establishment, 16 hotel, motel, lodging establishment, or resort that: 17 (1) serves potentially hazardous foods but with minimal 18 holding between preparation and service; or 19 (2) serves foods, such as pizza, that require extensive 20 21 handling followed by heat treatment. 22 [LOW-RISK ESTABLISHMENT.] "Low-risk establishment" (C) means a food and beverage service establishment, hotel, motel, 23 24 lodging establishment, or resort that is not a high-risk or medium-risk establishment. 25 [RISK EXCEPTIONS.] Mobile food units, seasonal 26 (d) 27 permanent and seasonal temporary food stands, food carts, and 28 special event food stands are not inspected on an established schedule and therefore are not defined as high-risk, 29 30 medium-risk, or low-risk establishments. 31 (e) [SCHOOL INSPECTION FREQUENCY.] Elementary and 32 secondary school food service establishments must be inspected 33 according to the assigned risk category or by the frequency required in the Richard B. Russell National School Lunch Act, 34 35 whichever frequency is more restrictive. 36 Sec. 37. Minnesota Statutes 2004, section 326.01, is Article 1 Section 37 43

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1 amended by adding a subdivision to read: Subd. 9a. [RESTRICTED PLUMBING CONTRACTOR.] A "restricted 2 plumbing contractor" is any person skilled in the planning, 3 superintending, and practical installation of plumbing who is 4 5 otherwise lawfully qualified to contract for plumbing and installations and to conduct the business of plumbing, who is 6 7 familiar with the laws and rules governing the business of plumbing, and who performs the plumbing trade in cities and 8 9 towns with a population of fewer than 5,000 according to federal 10 census. 11 Sec. 38. Minnesota Statutes 2004, section 326.37, 12 subdivision 1, is amended to read: 13 Subdivision 1. [RULES.] The state commissioner of 14 health may shall, by rule, prescribe minimum uniform standards which-shall-be-uniform,-and-which-standards-shall-thereafter-be 15 effective for all new plumbing installations, including 16 additions, extensions, alterations, and replacements connected 17 18 with-any-water-or-sewage-disposal-system-owned-or-operated-by-or 19 for-any-municipality,-institution,-factory,-office-building, 20 hotel;-apartment-building;-or-any-other-place-of-business 21 regardless-of-location-or-the-population-of-the-city-or-town-in 22 which-located. Notwithstanding the provisions of Minnesota Rules, part 4715.3130, as they apply to review of plans and 23 specifications, the commissioner may allow plumbing 24 construction, alteration, or extension to proceed without 25 approval of the plans or specifications by the commissioner. 26 The commissioner shall administer the provisions of 27 28 sections 326.37 to 326.45 <u>326.451</u> and for such purposes may 29 employ plumbing inspectors and other assistants. Sec. 39. Minnesota Statutes 2004, section 326.37, is 30 31 amended by adding a subdivision to read: 32 Subd. la. [INSPECTION.] All new plumbing installations, including additions, extensions, alterations, and replacements, 33 shall be inspected by the commissioner for compliance with 34 accepted standards of construction for health, safety to life 35 36 and property, and compliance with applicable codes. The

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Department of Health must have full implementation of its 1 inspections plan in place and operational July 1, 2007. This 2 subdivision does not apply where a political subdivision 3 requires, by ordinance, plumbing inspections similar to the 4 requirements of this subdivision. 5 Sec. 40. Minnesota Statutes 2004, section 326.38, is 6 7 amended to read: 326.38 [LOCAL REGULATIONS.] 8

Any city having a system of waterworks or sewerage, or any 9 town in which reside over 5,000 people exclusive of any 10 statutory cities located therein, or the metropolitan airports 11 commission, may, by ordinance, adopt local regulations providing 12 for plumbing permits, bonds, approval of plans, and inspections 13 of plumbing, which regulations are not in conflict with the 14 plumbing standards on the same subject prescribed by the state 15 commissioner of health. No city or such town shall prohibit 16 plumbers licensed by the state commissioner of health from 17 engaging in or working at the business, except cities and 18 statutory cities which, prior to April 21, 1933, by ordinance 19 required the licensing of plumbers. No city or such town may 20 require a license for persons performing building sewer or water 21 service installation who have completed pipe laying training as 22 prescribed by the commissioner of health. Any city by ordinance 23 24 may prescribe regulations, reasonable standards, and inspections and grant permits to any person, firm, or corporation engaged in 25 26 the business of installing water softeners, who is not licensed as a master plumber or journeyman plumber by the state 27 commissioner of health, to connect water softening and water 28 filtering equipment to private residence water distribution 29 30 systems, where provision has been previously made therefor and openings left for that purpose or by use of cold water 31 32 connections to a domestic water heater; where it is not 33 necessary to rearrange, make any extension or alteration of, or addition to any pipe, fixture or plumbing connected with the 34 water system except to connect the water softener, and provided 35 the connections so made comply with minimum standards prescribed 36

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[REVISOR ] JS/MD 05-4117 04/28/05 by the state commissioner of health. 1 Sec. 41. Minnesota Statutes 2004, section 326.40, 2 3 subdivision 1, is amended to read: Subdivision 1. [Phumbers-must-be-bicensed-in-certain 4 CITIES;-MASTER-AND-JOURNEYMAN-PLUMBERS MASTER, JOURNEYMAN, AND 5 RESTRICTED PLUMBING CONTRACTORS; PLUMBING ON ONE'S OWN PREMISES; 6 7 RULES FOR EXAMINATION.] In-any-city-now-or-hereafter-having 5,000-or-more-population,-according-to-the-last-federal-census, 8 and-having-a-system-of-waterworks-or-sewerage;-no-person;-firm; 9 10 or-corporation-shall-engage-in-or-work-at-the-business-of-a 11 master-plumber-or-journeyman-plumber-unless-licensed-to-do-so-by the-state-commissioner-of-health. No person, firm, or 12 corporation may engage in or work at the business of a master 13 14 plumber, restricted plumbing contractor, or journeyman plumber 15 unless licensed to do so by the commissioner of health under sections 326.37 to 326.451. A license is not required for: 16 17 (1) persons performing building sewer or water service 18 installation who have completed pipe laying training as 19 prescribed by the commissioner of health; or 20 (2) persons selling an appliance plumbing installation 21 service at point of sale if the installation work is performed 22 by a plumber licensed under sections 326.37 to 326.451. A master plumber may also work as a journeyman plumber. 23 24 Anyone not so licensed may do plumbing work which complies with 25 the provisions of the minimum standard prescribed by the state 26 commissioner of health on premises or that part of premises owned and actually occupied by the worker as a residence, unless 27 28 otherwise forbidden to do so by a local ordinance. **29**° In-any-such-city No person, firm, or corporation shall 30 engage in the business of installing plumbing nor install plumbing in connection with the dealing in and selling of 31 32 plumbing material and supplies unless at all times a licensed 33 master plumber or restricted plumbing contractor, who shall be responsible for proper installation, is in charge of the 34 35 plumbing work of the person, firm, or corporation. The Department of Health shall prescribe rules, not 36

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	1	inconsistent herewith, for the examination and licensing of
	2	plumbers.
	3	Sec. 42. [326.402] [RESTRICTED PLUMBING CONTRACTOR
	4	LICENSE.]
	5	Subdivision 1. [LICENSURE.] The commissioner shall grant a
	6	restricted plumbing contractor license to any person who applies
	7	to the commissioner and provides evidence of having at least two
	8	years of practical plumbing experience in the plumbing trade
	9	preceding application for licensure.
	10	Subd. 2. [USE OF LICENSE.] A restricted plumbing
	11	contractor may engage in the plumbing trade only in cities and
	12	towns with a population of fewer than 5,000 according to federal
	13	census.
	14	Subd. 3. [APPLICATION PERIOD.] Applications for restricted
	15	plumbing contractor licenses must be submitted to the
	16	commissioner prior to January 1, 2006.
	17	Subd. 4. [USE PERIOD FOR RESTRICTED PLUMBING CONTRACTOR
	18	LICENSE.] A restricted plumbing contractor license does not
	19	expire and remains in effect for as long as that person engages
	20	in the plumbing trade.
	21	Subd. 5. [PROHIBITION OF TRANSFERENCE.] A restricted
	22	plumbing contractor license must not be transferred or sold to
	23	any other person.
~.	24	Subd. 6. [RESTRICTED PLUMBING CONTRACTOR LICENSE RENEWAL.]
	25	The commissioner shall adopt rules for renewal of the restricted
	26	plumbing contractor license.
	27	Sec. 43. Minnesota Statutes 2004, section 326.42,
	28	subdivision 2, is amended to read:
	29	Subd. 2. [FEES.] Plumbing system plans and specifications
	30	that are submitted to the commissioner for review shall be
	31	accompanied by the appropriate plan examination fees. If the
	32	commissioner determines, upon review of the plans, that
	33	inadequate fees were paid, the necessary additional fees shall
	34	be paid prior to plan approval. The commissioner shall charge
	35	the following fees for plan reviews and audits of plumbing
	36	installations for public, commercial, and industrial buildings:

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[REVISOR ] JS/MD 05-4117 04/28/05 (1) systems with both water distribution and drain, waste, 1 2 and vent systems and having: (i) 25 or fewer drainage fixture units, \$150; 3 (ii) 26 to 50 drainage fixture units, \$250; 4 (iii) 51 to 150 drainage fixture units, \$350; 5 (iv) 151 to 249 drainage fixture units, \$500; 6 (v) 250 or more drainage fixture units, \$3 per drainage 7 fixture unit to a maximum of \$4,000; and 8 (vi) interceptors, separators, or catch basins, \$70 per 9 interceptor, separator, or catch basin design; 10 (2) building sewer service only, \$150; 11 (3) building water service only, \$150; 12 (4) building water distribution system only, no drainage 13 system, \$5 per supply fixture unit or \$150, whichever is 14 15 greater; (5) storm drainage system, a minimum fee of \$150 or: 16 (i) \$50 per drain opening, up to a maximum of \$500; and 17 (ii) \$70 per interceptor, separator, or catch basin design; 18 (6) manufactured home park or campground, one to 25 sites, 19 20 \$300; (7) manufactured home park or campground, 26 to 50 sites, 21 \$350; 22 23 (8) manufactured home park or campground, 51 to 125 sites, 24 \$400; (9) manufactured home park or campground, more than 125 25 26 sites, \$500; 27 (10) accelerated review, double the regular fee, one-half 28 to be refunded if no response from the commissioner within 15 29 business days; and (11) revision to previously reviewed or incomplete plans: 30 31 (i) review of plans for which commissioner has issued two or more requests for additional information, per review, \$100 or 32 33 ten percent of the original fee, whichever is greater; 34 (ii) proposer-requested revision with no increase in 35 project scope, \$50 or ten percent of original fee, whichever is greater; and 36

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1	(iii) proposer-requested revision with an increase in
2	project scope, \$50 plus the difference between the original
3	project fee and the revised project fee.
4	Sec. 44. [326.451] [INSPECTORS.]
5	(a) The commissioner shall set all reasonable criteria and
6	procedures by rule for inspector certification, certification
<b>7</b> .	period, examinations, examination fees, certification fees, and
8	renewal of certifications.
9	(b) The commissioner shall adopt reasonable rules
10	establishing criteria and procedures for refusal to grant or
11	renew inspector certifications, and for suspension and
12	revocation of inspector certifications.
13	(c) The commissioner shall refuse to renew or grant
14	inspector certifications, or suspend or revoke inspector
15	certifications, in accordance with the commissioner's criteria
16	and procedures as adopted by rule.
17	Sec. 45. [CERVICAL CANCER ELIMINATION STUDY.]
18	(a) The commissioner of health shall develop a statewide
19	integrated and comprehensive cervical cancer prevention plan,
20	including strategies for promoting and implementing the plan.
21	The plan must include activities that identify and implement
22	methods to improve the cervical cancer screening rates in
23	Minnesota, including, but not limited to:
24	(1) identifying and disseminating appropriate
25	evidence-based cervical cancer screening guidelines to be used
26	<u>in Minnesota;</u>
27	(2) increasing the use of appropriate screening based on
28	these guidelines for patients seen by medical groups in
29	Minnesota and monitoring results of these medical groups; and
30	(3) reducing the number of women who should but have not
31	been screened.
32	(b) In developing the plan, the commissioner shall also
33	identify and examine limitations and barriers in providing
34	cervical cancer screening, diagnosis tools, and treatment,
35	including, but not limited to, medical care reimbursement,
36	treatment costs, and the availability of insurance coverage.
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1	(c) The commissioner may work with a nonprofit quality
2	improvement organization in Minnesota to identify evidence-based
3	guidelines for cervical cancer screening and to identify methods
4	to improve the cervical cancer screening rates among medical
5	groups; and may work with a nonprofit health care result
6	reporting organization to monitor results by medical groups in
7	Minnesota.
8	(d) The commissioner may convene an advisory committee that
9	includes representatives of health care providers, the American
10	Cancer Society, health plan companies, the University of
11	Minnesota Academic Health Center, community health boards, and
12	the general public.
13	(e) The commissioner shall submit a report to the
14	legislature by January 15, 2006, on:
15	(1) the statewide cervical cancer prevention plan,
16	including a description of the plan activities and strategies
17	developed for promoting and implementing the plan;
18	(2) methods for monitoring the results by medical groups
19	and by the entire state of cervical cancer screening improvement
20	activities; and
21	(3) recommended changes to existing laws, programs, or
22	services in terms of reducing the occurrence of cervical cancer
23	by improving insurance coverage for the prevention, diagnosis,
24	and treatment for cervical cancer.
25	Sec. 46. [CLINICAL TRIAL WORK GROUP; REPORT.]
26	The commissioners of health and commerce shall, in
27	consultation with the commissioner of employee relations,
28	convene a work group regarding health plan coverage of routine
29	care associated with clinical trials. The work group must
30	explore what high-quality clinical trials beyond cancer-only
31	clinical trials should be covered by health plans. All other
32	types of clinical trials, disease-based or technology-based such
33	as drug trials or device trials should be considered. The work
34	group shall use the current, cancer-only model voluntary
35	agreement that includes definitions of high-quality clinical
36	trials, protocol induced costs, and routine care costs as a

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1	starting point for discussions. As determined appropriate, the
2	work group shall establish model voluntary agreement guidelines
3	for health plan coverage of routine patient care costs incurred
4	by patients participating in high quality clinical trials. The
5	work group shall be made up of representatives of consumers,
6	patient advocates, health plan companies, fully insured and
7	self-insured purchasers, providers, and other health care
8	professionals involved in the care and treatment of patients.
9	The commissioners shall submit the findings and recommendations
10	of the work group to the chairs of the senate and house
11	committees having jurisdiction over health policy and finance by
12	January 15, 2006.
13	Sec. 47. [PUBLIC HEALTH INFORMATION NETWORK.]
14	(a) The commissioner of health shall work with local public
15	health departments to develop a public health information
16	network. The development of the network must be consistent with
17	the recommendations, goals, and strategies of the Minnesota
18	public health information network report to the 2005 legislature
19	and the e-health initiative.
20	(b) The commissioner of health shall work with the
21	commissioner of human services to determine how data from care
22	systems can be utilized to assist with population health needs
23	assessments and targeted prevention efforts. The commissioner
24	of health shall incorporate these findings into the development
25	of a Minnesota public health information network and the
26	e-health initiative.
27	Sec. 48. [REPORT TO LEGISLATURE ON SWING BED USAGE.]
28	The commissioner of health shall review swing bed and
29	related data reported under Minnesota Statutes, sections
30	144.562, subdivision 3, paragraph (f); 144.564; and 144.698.
31	The commissioner shall report and make any appropriate
32	recommendations to the legislature by January 31, 2007, on:
33	(1) the use of swing bed days by all hospitals and by
34	critical access hospitals;
35	(2) occupancy rates in skilled nursing facilities within 25
36	miles of hospitals with swing beds; and
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[REVISOR ] JS/MD 05-4117 04/28/05 (3) information provided by rural providers on the use of 1 swing beds and the adequacy of rural services across the 2 continuum of care. 3 Sec. 49. [IMPLEMENTATION OF AN ELECTRONIC HEALTH RECORDS 4 SYSTEM.] 5 The commissioner of health, in consultation with the 6 electronic health record planning work group established in Laws 7 2004, chapter 288, article 7, section 7, shall develop a 8 statewide plan for all hospitals and physician group practices 9 10 to have in place an interoperable electronic health records system by January 1, 2015. In developing the plan, the 11 12 commissioner shall consider: (1) creating financial assistance to hospitals and 13 14 providers for implementing or updating an electronic health records system, including, but not limited to, the establishment 15 of grants, financial incentives, or low-interest loans; 16 (2) addressing specific needs and concerns of safety-net 17 18 hospitals, community health clinics, and other health care providers who serve low-income patients in implementing an 19 20 electronic records system within the hospital or practice; and 21 (3) providing assistance in the development of possible 22 alliances or collaborations among providers. 23 The commissioner shall provide preliminary reports to the 24 chairs of the senate and house committees with jurisdiction over health care policy and finance biennially beginning January 15, 25 26 2007, on the status of reaching the goal for all hospitals and physician group practices to have an interoperable electronic 27 28 health records system in place by January 1, 2015. The reports 29 shall include recommendations on statutory language necessary to implement the plan, including possible financing options. 30 31 Sec. 50. [RULE AMENDMENT.] 32 The commissioner of health shall amend Minnesota Rules, part 4626.2015, subparts 3, item C; and 6, item B, to conform 33 34 with Minnesota Statutes, section 157.16, subdivision 2a. The commissioner may use the good cause exemption under Minnesota 35 36 Statutes, section 14.388, subdivision 1, clause (3). Minnesota

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	l	Statutes, section 14.386, does not apply, except to the extent
	2	provided under Minnesota Statutes, section 14.388.
	3	Sec. 51. [REVISOR'S INSTRUCTION.]
	4	The revisor of statutes shall change all references to
	5	Minnesota Statutes, section 326.45, to Minnesota Statutes,
	6	section 326.451, in Minnesota Statutes, sections 144.99, 326.44,
	7	326.61, and 326.65.
	8	Sec. 52. [REPEALER.]
	9	Minnesota Statutes 2004, sections 157.215; and 326.45, are
	10	repealed.
	11	ARTICLE 2
	12	HEALTH CARE - DEPARTMENT OF HUMAN SERVICES
	13	Section 1. Minnesota Statutes 2004, section 62D.12,
	14	subdivision 19, is amended to read:
	15	Subd. 19. [COVERAGE OF SERVICE.] A health maintenance
	16	organization may not deny or limit coverage of a service which
	17	the enrollee has already received solely on the basis of lack of
	18	prior authorization or second opinion, to the extent that the
	19	service would otherwise have been covered under the member's
	20	contract by the health maintenance organization had prior
	21	authorization or second opinion been obtained. This subdivision
	22	does not apply to health maintenance organizations for services
	23	provided in the prepaid health programs administered under
	24	chapter 256B, 256D, or 256L.
	25	Sec. 2. Minnesota Statutes 2004, section 62M.06,
	26	subdivision 2, is amended to read:
	27	Subd. 2. [EXPEDITED APPEAL.] (a) When an initial
	28	determination not to certify a health care service is made prior
	29	to or during an ongoing service requiring review and the
	30	attending health care professional believes that the
	31	determination warrants an expedited appeal, the utilization
	32	review organization must ensure that the enrollee and the
_	33	attending health care professional have an opportunity to appeal
	34	the determination over the telephone on an expedited basis. In
	35	such an appeal, the utilization review organization must ensure
	36	reasonable access to its consulting physician or health care

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provider. For review of initial determinations not to certify a 1 2 service for prepaid health care programs under chapter 256B, 3 256D, or 256L, the health care provider conducting the review must follow coverage policies adopted by the health plan company 4 that are based upon published evidence-based care guidelines as 5 established by a nonprofit Minnesota quality improvement 6 organization, a nationally recognized guideline development 7 8 organization, or by the professional association of the specialty that typically provides the service. 9

10 (b) The utilization review organization shall notify the 11 enrollee and attending health care professional by telephone of 12 its determination on the expedited appeal as expeditiously as 13 the enrollee's medical condition requires, but no later than 72 14 hours after receiving the expedited appeal.

(c) If the determination not to certify is not reversed through the expedited appeal, the utilization review organization must include in its notification the right to submit the appeal to the external appeal process described in section 62Q.73 and the procedure for initiating the process. This information must be provided in writing to the enrollee and the attending health care professional as soon as practical.

Sec. 3. Minnesota Statutes 2004, section 62M.06,
subdivision 3, is amended to read:

Subd. 3. [STANDARD APPEAL.] The utilization review organization must establish procedures for appeals to be made either in writing or by telephone.

27 (a) A utilization review organization shall notify in 28 writing the enrollee, attending health care professional, and claims administrator of its determination on the appeal within 29 30 30 days upon receipt of the notice of appeal. If the 31 utilization review organization cannot make a determination 32 within 30 days due to circumstances outside the control of the utilization review organization, the utilization review 33 34 organization may take up to 14 additional days to notify the 35 enrollee, attending health care professional, and claims administrator of its determination. If the utilization review 36

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1 organization takes any additional days beyond the initial 30-day 2 period to make its determination, it must inform the enrollee, 3 attending health care professional, and claims administrator, in 4 advance, of the extension and the reasons for the extension.

5 (b) The documentation required by the utilization review 6 organization may include copies of part or all of the medical 7 record and a written statement from the attending health care 8 professional.

(c) Prior to upholding the initial determination not to 9 certify for clinical reasons, the utilization review 10 organization shall conduct a review of the documentation by a 11 physician who did not make the initial determination not to 12 certify. For review of initial determinations not to certify a 13 service for prepaid health care programs under chapter 256B, 14 256D, or 256L, the physician conducting the review must follow 15 16 coverage policies adopted by the health plan company that are 17 based upon publicly available evidence-based care guidelines as established by a nonprofit Minnesota quality improvement 18 19 organization, a nationally recognized guideline development 20 organization, or by the professional association of the specialty that typically provides the service. 21

(d) The process established by a utilization review
organization may include defining a period within which an
appeal must be filed to be considered. The time period must be
communicated to the enrollee and attending health care
professional when the initial determination is made.

(e) An attending health care professional or enrollee who
has been unsuccessful in an attempt to reverse a determination
not to certify shall, consistent with section 72A.285, be
provided the following:

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a complete summary of the review findings;

32 (2) qualifications of the reviewers, including any license,
33 certification, or specialty designation; and

(3) the relationship between the enrollee's diagnosis and
the review criteria used as the basis for the decision,
including the specific rationale for the reviewer's decision.

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1 (f) In cases of appeal to reverse a determination not to 2 certify for clinical reasons, the utilization review 3 organization must ensure that a physician of the utilization 4 review organization's choice in the same or a similar specialty 5 as typically manages the medical condition, procedure, or 6 treatment under discussion is reasonably available to review the 7 case.

8 (g) If the initial determination is not reversed on appeal, 9 the utilization review organization must include in its 10 notification the right to submit the appeal to the external 11 review process described in section 62Q.73 and the procedure for 12 initiating the external process.

Sec. 4. Minnesota Statutes 2004, section 256.045,subdivision 3a, is amended to read:

15 Subd. 3a. [PREPAID HEALTH PLAN APPEALS.] (a) All prepaid health plans under contract to the commissioner under chapter 16 256B or 256D must provide for a complaint system according to 17 section 62D.11. When a prepaid health plan denies, reduces, or 18 19 terminates a health service or denies a request to authorize a previously authorized health service, the prepaid health plan 20 must notify the recipient of the right to file a complaint or an 21 22 The notice must include the name and telephone number appeal. of the ombudsman and notice of the recipient's right to request 23 24 a hearing under paragraph (b). When-a-complaint-is-filed,-the 25 prepaid-health-plan-must-notify-the-ombudsman-within-three 26 working-days. Recipients may request the assistance of the 27 ombudsman in the complaint system process. The prepaid health 28 plan must issue a written resolution of the complaint to the 29 recipient within 30 days after the complaint is filed with the 30 prepaid health plan. A recipient is not required to exhaust the 31 complaint system procedures in order to request a hearing under 32 paragraph (b).

33 (b) Recipients enrolled in a prepaid health plan under
34 chapter 256B or 256D may contest a prepaid health plan's denial,
35 reduction, or termination of health services, a prepaid health
36 plan's denial of a request to authorize a previously authorized

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health service, or the prepaid health plan's written resolution 1 of a complaint by submitting a written request for a hearing 2 according to subdivision 3. A state human services referee 3 shall conduct a hearing on the matter and shall recommend an 4 order to the commissioner of human services. The referee may 5 not overturn a decision by a prepaid health plan to deny or 6 7 limit coverage for services if the prepaid health plan has used coverage policies adopted by the health plan company that are 8 based upon published evidence-based criteria or guidelines in 9 10 making the determination unless the recipient can show by clear 11 and convincing evidence that the determination should be 12 overturned. The commissioner need not grant a hearing if the sole issue raised by a recipient is the commissioner's authority 13 to require mandatory enrollment in a prepaid health plan in a 14 15 county where prepaid health plans are under contract with the commissioner. The state human services referee may order a 16 17 second medical opinion from the prepaid health plan or may order 18 a second medical opinion from a nonprepaid health plan provider 19 at the expense of the prepaid health plan. Recipients may 20 request the assistance of the ombudsman in the appeal process. 21 (c) In the written request for a hearing to appeal from a

22 prepaid health plan's denial, reduction, or termination of a 23 health service, a prepaid health plan's denial of a request to authorize a previously authorized service, or the prepaid health 24 25 plan's written resolution to a complaint, a recipient may 26 request an expedited hearing. If an expedited appeal is 27 warranted, the state human services referee shall hear the 28 appeal and render a decision within a time commensurate with the 29 level of urgency involved, based on the individual circumstances 30 of the case.

31 Sec. 5. Minnesota Statutes 2004, section 256.9365, is
32 amended to read:

33 256.9365 [PURCHASE-OF-CONTINUATION-COVERAGE-FOR-AIDS
34 PATIENTS <u>HIV HEALTH CARE ACCESS PROGRAM.</u>]

35 Subdivision 1. [PROGRAM ESTABLISHED.] The commissioner of 36 human services shall establish a program-to-pay-private-health

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Section 5

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plan-premiums-for-persons-who-have-contracted-human 1 immunodeficiency-virus-(HIV)-to-enable-them-to-continue-coverage 2 under-a-group-or-individual-health-plan---If-a-person-is 3 determined-to-be-eligible-under-subdivision-27-the-commissioner 4 shall-pay-the-portion-of-the-group-plan-premium-for-which-the 5 individual-is-responsible,-if-the-individual-is-responsible-for 6 at-least-50-percent-of-the-cost-of-the-premium,-or-pay-the 7 individual-plan-premium---The-commissioner-shall-not-pay-for 8 that-portion-of-a-premium-that-is-attributable-to-other-family 9 10 members-or-dependents health care access program for low-income Minnesotans living with HIV that provides access to HIV 11 treatment consistent with the guidelines of the United States 12 Public Health Service. The program shall provide assistance 13 with medical insurance premiums to secure or maintain necessary 14 health care insurance coverage. 15 [ELIGIBILITY REQUIREMENTS.] To be eligible for 16 Subd. 2. 17 the HIV health care access program, an applicant must satisfy 18 the-following-requirements: 19 (1) the applicant must provide a physician's statement 20 verifying that the applicant is infected with HIV and-is7-or 21 within-three-months-is-likely-to-become7-too-ill-to-work-in-the 22 applicant's-current-employment-because-of-HIV-related-disease; 23 (2) the applicant's have a monthly gross family income must 24 that does not exceed 300 percent of the federal poverty 25 guidelines, after deducting medical expenses and insurance premiums; 26 27 (3) the applicant must not own assets with a combined value 28 of more than \$25,000, excluding: 29 (i) all assets excluded under section 256B.056; 30 (ii) retirement accounts, Keogh plans, and pension plans; 31 and 32 (iii) medical expense accounts set up through the 33 individual's employer; and 34 (4) if-applying-for-payment-of-group-plan-premiums,-the

35 applicant-must-be-covered-by-an-employer's-or-former-employer's 36 group-insurance-plan have no health insurance coverage; have no

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1	health insurance coverage because of ineligibility due to a
2	preexisting condition; or face loss of health insurance coverage
3	due to a change in employment status;
4	(5) reside in Minnesota;
5	(6) have been determined ineligible for Medicare, Medicaid,
6	MinnesotaCare, and general assistance medical care; and
7	(7) meet monthly cost-sharing obligations as provided for
8	in subdivision 4.
9	Subd. 3. [COST-EFFECTIVE-COVERAGE BENEFITS.] The
10	commissioner shall pay that portion of the group plan premium
11	for which the individual is responsible or shall pay the
12	individual plan premium. The commissioner shall not pay for
13	that portion of a premium that is attributable to other family
14	members or dependents. Requirements for the payment of
15	individual plan premiums under subdivision 27-elause-(5)7 must
16	be designed to ensure that the state cost of paying an
17	individual plan premium does not exceed the estimated state cost
18	that would otherwise be incurred in the medical assistance or
19	general assistance medical care program. The commissioner shall
20	purchase the most cost-effective coverage available for eligible
21	individuals. Efforts shall be made to obtain coverage that is
22	consistent with the guidelines of the United States Public
23	Health Service for HIV treatment, and to the extent possible,
24	provides comprehensive coverage that includes medical, mental
25	health, and substance abuse treatment.
26	Subd. 4. [COST-SHARING RESPONSIBILITIES.] The commissioner
27	may establish cost-sharing responsibilities for individuals
28	determined to be eligible for the HIV health care access program
29	that are consistent with guidelines established in the federal
30	Ryan White Care Act. These obligations, when appropriate,
31	should be consistent with cost-sharing requirements for other
32	Minnesota health care programs.
33	Subd. 5. [FISCAL INTEGRITY.] The commissioner shall manage
 34	the HIV health care access program to assure that the program
35	spending does not exceed the resources made available by the
36	federal government and the legislature. The commissioner shall
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[REVISOR ] JS/MD 05-4117 04/28/05 1 make necessary program changes to assure the fiscal integrity of 2 the program. Subd. 6. [CONTINUATION OF CARE.] The commissioner shall 3 establish policies and procedures to ensure that initial and 4 continued access to HIV treatment is provided to recipients who 5 meet the eligibility requirements in subdivision 2. 6 Subd. 7. [COORDINATION WITH FEDERAL PROGRAMS.] The 7 commissioner shall administer the HIV health care access program 8 in coordination with funding received from the Ryan White Care 9 10 Act. Subd. 8. [COMMUNITY ADVISORY PROCESS.] The commissioner 11 12 shall establish a community advisory process for assessing the effectiveness of the policies and procedures established for the 13 HIV health care access program. As appropriate to minimize 14 duplicative efforts, the process shall include consultation 15 16 with, coordination with, and reporting to the Minnesota HIV Services Planning Council. Public notification shall be made of 17 18 the committee's members and meetings. 19 Sec. 6. [256.9545] [PRESCRIPTION DRUG DISCOUNT PROGRAM.] 20 Subdivision 1. [ESTABLISHMENT; ADMINISTRATION.] The commissioner shall establish and administer the prescription 21 22 drug discount program, effective July 1, 2005. 23 Subd. 2. [COMMISSIONER'S AUTHORITY.] The commissioner 24 shall administer a drug rebate program for drugs purchased 25 according to the prescription drug discount program. The commissioner shall execute a rebate agreement from all 26 27 manufacturers that choose to participate in the program for 28 those drugs covered under the medical assistance program. For each drug, the amount of the rebate shall be equal to the rebate 29 as defined for purposes of the federal rebate program in United 30 31 States Code, title 42, section 1396r-8. The rebate program 32 shall utilize the terms and conditions used for the federal rebate program established according to section 1927 of title 33 34 XIX of the federal Social Security Act. 35 Subd. 3. [DEFINITIONS.] For the purpose of this section, 36 the following terms have the meanings given them.

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	l	(a) "Commissioner" means the commissioner of human services.
	2	(b) "Participating manufacturer" means a manufacturer as
~.	3	defined in section 151.44, paragraph (c), that agrees to
	4	participate in the prescription drug discount program.
	5	(c) "Covered prescription drug" means a prescription drug
	6	as defined in section 151.44, paragraph (d), that is covered
	7	under medical assistance as described in section 256B.0625,
	8	subdivision 13, and that is provided by a participating
	° 9	
		manufacturer that has a fully executed rebate agreement with the
	10	commissioner under this section and complies with that agreement.
	11	(d) "Health carrier" means an insurance company licensed
	12	under chapter 60A to offer, sell, or issue an individual or
	13	group policy of accident and sickness insurance as defined in
	14	section 62A.01; a nonprofit health service plan corporation
	15	operating under chapter 62C; a health maintenance organization
	16	operating under chapter 62D; a joint self-insurance employee
	17	health plan operating under chapter 62H; a community integrated
	18	service network licensed under chapter 62N; a fraternal benefit
	19	society operating under chapter 64B; a city, county, school
	20	district, or other political subdivision providing self-insured
	21	health coverage under section 471.617 or sections 471.98 to
	22	471.982; and a self-funded health plan under the Employee
	23	Retirement Income Security Act of 1974, as amended.
1944-a.,	24	(e) "Participating pharmacy" means a pharmacy as defined in
	25	section 151.01, subdivision 2, that agrees to participate in the
	26	prescription drug discount program.
	27	(f) "Enrolled individual" means a person who is eligible
	28	for the program under subdivision 4 and has enrolled in the
	29	program according to subdivision 5.
	30	Subd. 4. [ELIGIBILITY.] To be eligible for the program, an
	31	applicant must:
	32	(1) be a permanent resident of Minnesota as defined in
	33	section 256L.09, subdivision 4;
	34	(2) not be enrolled in Medicare, medical assistance,
	35	general assistance medical care, or MinnesotaCare;
	36	(3) not be enrolled in and have currently available
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l	prescription drug coverage under a health plan offered by a
2	health carrier or employer or under a pharmacy benefit program
3	offered by a pharmaceutical manufacturer; and
4	(4) not be enrolled in and have currently available
5	prescription drug coverage under a Medicare supplement plan, as
6	defined in sections 62A.31 to 62A.44, or policies, contracts, or
7	certificates that supplement Medicare issued by health
8	maintenance organizations or those policies, contracts, or
9	certificates governed by section 1833 or 1876 of the federal
10	Social Security Act, United States Code, title 42, section 1395,
11	et seq., as amended.
12	Subd. 5. [APPLICATION PROCEDURE.] (a) Applications and
13	information on the program must be made available at county
14	social services agencies, health care provider offices, and
15	agencies and organizations serving senior citizens. Individuals
16	shall submit applications and any information specified by the
17	commissioner as being necessary to verify eligibility directly
18	to the commissioner. The commissioner shall determine an
19	applicant's eligibility for the program within 30 days from the
20	date the application is received. Upon notice of approval, the
21	applicant must submit to the commissioner the enrollment fee
22	specified in subdivision 10. Eligibility begins the month after
23	the enrollment fee is received by the commissioner.
24	(b) An enrollee's eligibility must be renewed every 12
25	months with the 12-month period beginning in the month after the
26	application is approved.
27	(c) The commissioner shall develop an application form that
28	does not exceed one page in length and requires information
29	necessary to determine eligibility for the program.
30	Subd. 6. [PARTICIPATING PHARMACY.] (a) Upon implementation
31	of the prescription drug discount program, until January 1,
32	2008, a participating pharmacy, in accordance with a valid
33	prescription, must sell a covered prescription drug to an
34	enrolled individual at the medical assistance rate.
35	(b) After January 1, 2008, a participating pharmacy, in
36	accordance with a valid prescription, must sell a covered

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1	prescription drug to an enrolled individual at the medical
2	assistance rate, minus an amount that is equal to the rebate
3	amount described in subdivision 8, plus the amount of any switch
4	fee established by the commissioner under subdivision 10,
5	paragraph (b).
6	(c) Each participating pharmacy shall provide the
7	commissioner with all information necessary to administer the
8	program, including, but not limited to, information on
9	prescription drug sales to enrolled individuals and usual and
10	customary retail prices.
11	Subd. 7. [NOTIFICATION OF REBATE AMOUNT.] The commissioner
12	shall notify each participating manufacturer, each calendar
13	quarter or according to a schedule to be established by the
14	commissioner, of the amount of the rebate owed on the
15	prescription drugs sold by participating pharmacies to enrolled
16	individuals.
17	Subd. 8. [PROVISION OF REBATE.] To the extent that a
18	participating manufacturer's prescription drugs are prescribed
19	to a resident of this state, the manufacturer must provide a
20	rebate equal to the rebate provided under the medical assistance
21	program for any prescription drug distributed by the
22	manufacturer that is purchased by an enrolled individual at a
23	participating pharmacy. The participating manufacturer must
24	provide full payment within 38 days of receipt of the state
25	invoice for the rebate, or according to a schedule to be
26	established by the commissioner. The commissioner shall deposit
27	all rebates received into the Minnesota prescription drug
28	dedicated fund established under subdivision ll. The
29	manufacturer must provide the commissioner with any information
30	necessary to verify the rebate determined per drug.
31	Subd. 9. [PAYMENT TO PHARMACIES.] Beginning January 1,
32	2008, the commissioner shall distribute on a biweekly basis an
33	amount that is equal to an amount collected under subdivision 8
34	to each participating pharmacy based on the prescription drugs
35	sold by that pharmacy to enrolled individuals on or after
36	January 1, 2008.

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1	Subd. 10. [ENROLLMENT FEE; SWITCH FEE.] (a) The
2	commissioner shall establish an annual enrollment fee that
3	covers the commissioner's expenses for enrollment, processing
4	claims, and distributing rebates under this program.
5	(b) The commissioner shall establish a reasonable switch
6	fee that covers expenses incurred by participating pharmacies in
7	formatting for electronic submission claims for prescription
8	drugs sold to enrolled individuals.
9	Subd. 11. [DEDICATED FUND; CREATION; USE OF FUND.] (a) The
10	Minnesota prescription drug dedicated fund is established as an
11	account in the state treasury. The commissioner of finance
12	shall credit to the dedicated fund all rebates paid under
13	subdivision 8, any federal funds received for the program, all
14	enrollment fees paid by the enrollees, and any appropriations or
15	allocations designated for the fund. The commissioner of
16	finance shall ensure that fund money is invested under section
17	11A.25. All money earned by the fund must be credited to the
18	fund. The fund shall earn a proportionate share of the total
19	state annual investment income.
20	(b) Money in the fund is appropriated to the commissioner
21	to reimburse participating pharmacies for prescription drugs the
22	rebate discount provided to enrolled individuals under
23	subdivision 6, paragraph (b); to reimburse the commissioner for
24	costs related to enrollment, processing claims, and distributing
25	rebates and for other reasonable administrative costs related to
26	administration of the prescription drug discount program; and to
27	repay the appropriation provided for this section. The
28	commissioner must administer the program so that the costs total
29	no more than funds appropriated plus the drug rebate proceeds.
30	[EFFECTIVE DATE.] This section is effective August 1, 2006,
31	or upon HealthMatch implementation, whichever is later.
32	Sec. 7. Minnesota Statutes 2004, section 256.969, is
33	amended by adding a subdivision to read:
34	Subd. 27. [ANNUAL NONMEDICAL ASSISTANCE PAYMENT.] (a) In
35	addition to any other payment under this section, the
36	commissioner shall make the following payments:

1	(1) for a hospital located in Minnesota and not eligible
2	for payments under subdivision 20, with a medical assistance
3	inpatient utilization rate greater than 19 percent of total
4	patient days during the base year, a payment equal to 13 percent
5	of the total of the operating and payment rates;
6	(2) for a hospital located in Minnesota in a specified
7	urban area outside of the seven-county metropolitan area and not
8	eligible for payments under subdivision 20, with a medical
9	assistance inpatient utilization rate less than or equal to 19
10	percent of total patient days during the base year, a payment
11	equal to ten percent of the total of the operating and property
12	payment rates. For purposes of this clause, the following
13	cities are specified urban areas: Detroit Lakes, Rochester,
14	Willmar, Hutchinson, Alexandria, Austin, Cambridge, Brainerd,
15	Hibbing, Mankato, Duluth, St. Cloud, Grand Rapids, Wyoming,
16	Fergus Falls, Albert Lea, Winona, Virginia, Thief River Falls,
17	and Wadena; and
18	(3) for a hospital located in Minnesota but not located in
19	a specified urban area under clause (2) and not eligible for
20	payments under subdivision 20, with a medical assistance
21	inpatient utilization rate less than or equal to 19 percent of
22	total patient days during the base year, a payment equal to five
23	percent of the total of the operating and property payment rates.
24	(b) The payments under paragraph (a) shall be 100 percent
25	state dollars derived from federal reimbursements to the
26	commissioner to reimburse nonstate expenditures reported under
27	section 256B.199.
28	(c) The payments under paragraph (a) shall be paid annually
29	on July 1, beginning July 1, 2005, or upon the receipt of
30	federal reimbursements under section 256B.199, whichever occurs
31	last, for services to be rendered in the fiscal year beginning
32	on July 1, based on services rendered in the previous calendar
33	year.
34	(d) The commissioner shall not adjust rates paid to a
35	prepaid health plan under contract with the commissioner to
36	reflect payments provided in paragraph (a).

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1	(e) If federal reimbursements are not available under
2	section 256B.199 for all payments under paragraph (a), the
3	commissioner shall reduce payments under paragraph (a) on a pro
4	rata basis so that payments under paragraph (a) do not exceed
5	the federal reimbursements.
б	(f) For purposes of this subdivision, medical assistance
7	does not include general assistance medical care.
8	(g) The commissioner may ratably reduce or increase the
9	payments under this subdivision in order to ensure that these
10	total payments equal the amount of reimbursement received by the
11	commissioner under section 256B.199.
12	(h) The commissioner may, in consultation with the nonstate
13	entities identified in section 256B.199, adjust the amounts
14	reported by nonstate entities under section 256B.199 when
15	application for reimbursement is made to the federal government,
16	and otherwise adjust the provisions of this subdivision in order
17	to maximize payments to qualifying hospitals.
18	[EFFECTIVE DATE.] This section is effective the day
19	following final enactment. The commissioner of human services
20	shall submit necessary medical assistance plan amendments to
21	implement this section within 30 days of enactment.
22	Sec. 8. Minnesota Statutes 2004, section 256B.02,
23	subdivision 12, is amended to read:
24	Subd. 12. [THIRD-PARTY PAYER.] "Third-party payer" means a
25	person, entity, or agency or government program that has a
26	probable obligation to pay all or part of the costs of a medical
27	assistance recipient's health services. <u>Third-party payer</u>
28	includes an entity under contract with the recipient to cover
29	all or part of the recipient's medical costs.
30	Sec. 9. Minnesota Statutes 2004, section 256B.055, is
31	amended by adding a subdivision to read:
32	Subd. 14. [PERSONS DETAINED BY LAW.] (a) An inmate of a
33	correctional facility who is conditionally released as
34	authorized under section 241.26, 244.065, or 631.425 may be
35	eligible for medical assistance if the individual does not
36	require the security of a public detention facility and is
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1	housed in a halfway house or community correction center, or
2	under house arrest and monitored by electronic surveillance in a
3	residence approved by the commissioner of corrections.
4	(b) An individual, regardless of age, who is considered an
5	inmate of a public institution as defined in Code of Federal
6	Regulations, title 42, section 435.1009, is not eligible for
7	medical assistance.
8	Sec. 10. Minnesota Statutes 2004, section 256B.056, is
9	amended by adding a subdivision to read:
10	Subd. 3d. [REDUCTION OF EXCESS ASSETS.] Assets in excess
11	of the limits in subdivisions 3 to 3c may be reduced to
12	allowable limits as follows:
13	(a) Assets may be reduced in any of the three calendar
14	months before the month of application in which the applicant
15	seeks coverage by:
16	(1) designating burial funds up to \$1,500 for each
17	applicant, spouse, and MA-eligible dependent child; and
18	(2) paying health service bills incurred in the retroactive
19	period for which the applicant seeks eligibility, starting with
20	the oldest bill. After assets are reduced to allowable limits,
21	eligibility begins with the next dollar of MA-covered health
22	services incurred in the retroactive period. Applicants
23	reducing assets under this subdivision who also have excess
24	income shall first spend excess assets to pay health service
25	bills and may meet the income spenddown on remaining bills.
26	(b) Assets may be reduced beginning the month of
27	application by:
28	(1) paying bills for health services that would otherwise
29	be paid by medical assistance; and
30	(2) using any means other than a transfer of assets for
31	less than fair market value as defined in section 256B.0595,
32	subdivision 1, paragraph (b).
33	Sec. 11. Minnesota Statutes 2004, section 256B.056,
34	subdivision 5, is amended to read:
35	Subd. 5. [EXCESS INCOME.] A person who has excess income
36	is eligible for medical assistance if the person has expenses

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for medical care that are more than the amount of the person's 1 excess income, computed by deducting incurred medical expenses 2 from the excess income to reduce the excess to the income 3 standard specified in subdivision 5c. The person shall elect to 4 have the medical expenses deducted at the beginning of a 5 one-month budget period or at the beginning of a six-month 6 budget period. The commissioner shall allow persons eligible 7 for assistance on a one-month spenddown basis under this 8 subdivision to elect to pay the monthly spenddown amount in 9 advance of the month of eligibility to the state agency in order 10 to maintain eligibility on a continuous basis. If the recipient 11 does not pay the spenddown amount on or before the 20th last 12 business day of the month, the recipient is ineligible for this 13 option for the following month. The local agency shall code the 14 Medicaid Management Information System (MMIS) to indicate that 15 the recipient has elected this option. The state agency shall 16 convey recipient eligibility information relative to the 17 collection of the spenddown to providers through the Electronic 18 19 Verification System (EVS). A recipient electing advance payment 20 must pay the state agency the monthly spenddown amount on or before noon on the 20th last business day of the month in order 21 22 to be eligible for this option in the following month.

[EFFECTIVE DATE.] This section is effective August 1, 2006,
or upon HealthMatch implementation, whichever is later.

Sec. 12. Minnesota Statutes 2004, section 256B.056,
subdivision 5a, is amended to read:

27 Subd. 5a. [INDIVIDUALS ON FIXED OR EXCLUDED INCOME.] 28 Recipients of medical assistance who receive only fixed unearned 29 or excluded income, when that income is excluded from 30 consideration as income or unvarying in amount and timing of 31 receipt throughout the year, shall report and verify their 32 income annually every 12 months. The 12-month period begins 33 with the month of application.

34 [EFFECTIVE DATE.] This section is effective August 1, 2006,
 35 or upon HealthMatch implementation, whichever is later.

36 Sec. 13. Minnesota Statutes 2004, section 256B.056,

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subdivision 5b, is amended to read: 1 Subd. 5b. [INDIVIDUALS WITH LOW INCOME.] Recipients of 2 medical assistance not residing in a long-term care facility who 3 have slightly fluctuating income which is below the medical 4 assistance income limit shall report and verify their income on 5 a-semiannual-basis every six months. The six-month period 6 begins the month of application. 7 [EFFECTIVE DATE.] This section is effective August 1, 2006, 8 or upon HealthMatch implementation, whichever is later. 9 10 Sec. 14. Minnesota Statutes 2004, section 256B.056, subdivision 7, is amended to read: 11 Subd. 7. [PERIOD OF ELIGIBILITY.] Eligibility is available 12 for the month of application and for three months prior to 13 application if the person was eligible in those prior 14 15 months. Eligibility for months prior to application is 16 determined independently from eligibility for the month of application and future months. A redetermination of eligibility 17 must occur every 12 months. The 12-month period begins with the 18 19 month of application. [EFFECTIVE DATE.] This section is effective August 1, 2006, 20 or upon HealthMatch implementation, whichever is later. 21 Sec. 15. Minnesota Statutes 2004, section 256B.056, is 22 23 amended by adding a subdivision to read: 24 Subd. 9. [NOTICE.] The state agency must be given notice 25 of monetary claims against a person, entity, or corporation that 26 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 27 28 that care. Notice must be given according to paragraphs (a) to 29 (d). 30 (a) An applicant for medical assistance shall notify the 31 state or local agency of any possible claims when the applicant submits the application. A recipient of medical assistance 32 shall notify the state or local agency of any possible claims 33 34 when those claims arise. (b) A person providing medical care services to a recipient 35 36 of medical assistance shall notify the state agency when the

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person has reason to believe that a third party may be liable 1 for payment of the cost of medical care. 2 (c) A party to a claim that may be assigned to the state 3 agency under this section shall notify the state agency of its 4 potential assignment claim in writing at each of the following 5 stages of a claim: 6 (1) when a claim is filed; 7 8 (2) when an action is commenced; and 9 (3) when a claim is concluded by payment, award, judgment, settlement, or otherwise. 10 (d) Every party involved in any stage of a claim under this 11 subdivision is required to provide notice to the state agency at 12 that stage of the claim. However, when one of the parties to 13 14 the claim provides notice at that stage, every other party to the claim is deemed to have provided the required notice for 15 that stage of the claim. If the required notice under this 16 17 paragraph is not provided to the state agency, all parties to the claim are deemed to have failed to provide the required 18 notice. A party to the claim includes the injured person or the 19 20 person's legal representative, the plaintiff, the defendants, or 21 persons alleged to be responsible for compensating the injured 22 person or plaintiff, and any other party to the cause of action or claim, regardless of whether the party knows the state agency 23 24 has a potential or actual assignment claim. Sec. 16. Minnesota Statutes 2004, section 256B.057, 25 subdivision 1, is amended to read: 26 27 Subdivision 1. [INFANTS AND PREGNANT WOMEN.] (a) (++ An 28 infant less than one year of age is eligible for medical assistance if countable family income is equal to or less than 29 30 275 percent of the federal poverty guideline for the same family 31 size. A pregnant woman who has written verification of a positive pregnancy test from a physician or licensed registered 32 33 nurse is eligible for medical assistance if countable family

35 poverty guideline for the same family size. For purposes of 36 this subdivision, "countable family income" means the amount of

income is equal to or less than  $2\theta\theta$  275 percent of the federal

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1 income considered available using the methodology of the AFDC
2 program under the state's AFDC plan as of July 16, 1996, as
3 required by the Personal Responsibility and Work Opportunity
4 Reconciliation Act of 1996 (PRWORA), Public Law 104-193, except
5 for the earned income disregard and employment deductions.

(2)-For-applications-processed-within-one-calendar-month 6 prior-to-the-effective-date;-eligibility-shall-be-determined-by 7 applying-the-income-standards-and-methodologies-in-effect-prior 8 to-the-effective-date-for-any-months-in-the-six-month-budget 9 period-before-that-date-and-the-income-standards-and 10 11 methodologies-in-effect-on-the-effective-date-for-any-months-in 12 the-six-month-budget-period-on-or-after-that-date---The-income 13 standards-for-each-month-shall-be-added-together-and-compared-to the-applicant's-total-countable-income-for-the-six-month-budget 14 15 period-to-determine-eligibility-

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# (b)(1) (Expired, 1Sp2003 c 14 art 12 s 19)

17 (2)-For-applications-processed-within-one-calendar-month prior-to-July-17-20037-eligibility-shall-be-determined-by 18 applying-the-income-standards-and-methodologies-in-effect-prior 19 to-July-1,-2003,-for-any-months-in-the-six-month-budget-period 20 before-July-17-20037-and-the-income-standards-and-methodologies 21 22 in-effect-on-the-expiration-date-for-any-months-in-the-six-month budget-period-on-or-after-July-17-2003---The-income-standards 23 24 for-each-month-shall-be-added-together-and-compared-to-the applicant's-total-countable-income-for-the-six-month-budget 25 26 period-to-determine-eligibility. (C) Bependent-care-and-child-support-paid-under-court-order 27

shall-be-deducted-from-the-countable-income-of-pregnant 28 29 women. An amount equal to the amount of earned income exceeding 30 275 percent of the federal poverty guideline plus the earned income disregards and deductions of the AFDC program under the 31 state's AFDC plan as of July 16, 1996, as required by the 32 33 Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law 104-193, that exceeds 275 percent 34 35 of the federal poverty guideline will be deducted for pregnant women and infants less than one year of age. 36

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(d) An infant born on or after January 1, 1991, to a woman 1 who was eligible for and receiving medical assistance on the 2 3 date of the child's birth shall continue to be eligible for medical assistance without redetermination until the child's 4 first birthday, as long as the child remains in the woman's 5 household. 6 [EFFECTIVE DATE.] The amendments to paragraphs (a) and (b) 7 are effective retroactively from July 1, 2004, and the amendment 8 to paragraph (c) is effective retroactively from October 1, 2003. 9 Sec. 17. Minnesota Statutes 2004, section 256B.0625, 10 11 subdivision 9, is amended to read: 12 Subd. 9. [DENTAL SERVICES.] (a) Medical assistance covers dental services. Dental services include, with prior 13 authorization, fixed bridges that are cost-effective for persons 14 who cannot use removable dentures because of their medical 15 condition. 16 17 (b)-Coverage-of-dental-services-for-adults-age-21-and-over 18 who-are-not-pregnant-is-subject-to-a-\$500-annual-benefit-limit 19 and-covered-services-are-limited-to: 20 (1)-diagnostic-and-preventative-services; 21 (2)-restorative-services;-and 22 (3)-emergency-services. 23 Emergency-services7-dentures7-and-extractions-related-to 24 dentures-are-not-included-in-the-\$500-annual-benefit-limit. 25 Sec. 18. Minnesota Statutes 2004, section 256B.0625, 26 subdivision 13e, as amended by 2005 S.F. No. 1879, article 13, 27 section 7, subdivision 13e, if enacted, is amended to read: [PAYMENT RATES.] (a) The basis for determining 28 Subd. 13e. 29 the amount of payment shall be the lower of the actual 30 acquisition costs of the drugs plus a fixed dispensing fee; the maximum allowable cost set by the federal government or by the 31 commissioner plus the fixed dispensing fee; or the usual and 32 33 customary price charged to the public. The amount of payment 34 basis must be reduced to reflect all discount amounts applied to the charge by any provider/insurer agreement or contract for 35 36 submitted charges to medical assistance programs. The net

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submitted charge may not be greater than the patient liability 1 The pharmacy dispensing fee shall be \$3.65, 2 for the service. except that the dispensing fee for intravenous solutions which 3 must be compounded by the pharmacist shall be \$8 per bag, \$14 4 per bag for cancer chemotherapy products, and \$30 per bag for 5 total parenteral nutritional products dispensed in one liter 6 quantities, or \$44 per bag for total parenteral nutritional 7 products dispensed in quantities greater than one liter. Actual 8 acquisition cost includes quantity and other special discounts 9 10 except time and cash discounts. The actual acquisition cost of a drug shall be estimated by the commissioner, at average 11 wholesale price minus 11.5 percent, except that where a drug has 12 had its wholesale price reduced as a result of the actions of 13 the National Association of Medicaid Fraud Control Units, the 14 estimated actual acquisition cost shall be the reduced average 15 wholesale price, without the 11.5 percent deduction. The actual 16 acquisition cost of antihemophilic factor drugs shall be 17 18 estimated at the average wholesale price minus 30 percent. The 19 maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to, but no higher than, 20 21 the maximum amount paid by other third-party payors in this 22 state who have maximum allowable cost programs. Establishment of the amount of payment for drugs shall not be subject to the 23 requirements of the Administrative Procedure Act. 24

25 (b) An additional dispensing fee of \$.30 may be added to 26 the dispensing fee paid to pharmacists for legend drug 27 prescriptions dispensed to residents of long-term care 28 facilities when a unit dose blister card system, approved by the 29 department, is used. Under this type of dispensing system, the 30 pharmacist must dispense a 30-day supply of drug. The National Drug Code (NDC) from the drug container used to fill the blister 31 card must be identified on the claim to the department. 32 The 33 unit dose blister card containing the drug must meet the 34 packaging standards set forth in Minnesota Rules, part 35 6800.2700, that govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider will be required to 36

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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.

6 (c) Whenever a generically equivalent product is available, 7 payment shall be on the basis of the actual acquisition cost of 8 the generic drug, or on the maximum allowable cost established 9 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 16 rates for specialty pharmacy products than the rates specified 17 in paragraph (a). The commissioner may require individuals 18 enrolled in the health care programs administered by the 19 department to obtain specialty pharmacy products from providers 20 with whom the commissioner has negotiated lower reimbursement 21 22 rates. Specialty pharmacy products are defined as those used by a small number of recipients or recipients with complex and 23 chronic diseases that require expensive and challenging drug 24 regimens. Examples of these conditions include, but are not 25 limited to: multiple sclerosis, HIV/AIDS, transplantation, 26 27 hepatitis C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of cancer. Specialty 28 29 pharmaceutical products include injectable and infusion 30 therapies, biotechnology drugs, high-cost therapies, and therapies that require complex care. The commissioner shall 31 consult with the formulary committee to develop a list of 32 33 specialty pharmacy products subject to this paragraph. In 34 consulting with the formulary committee in developing this list, 35 the commissioner shall take into consideration the population served by special pharmacy products, the current delivery system 36

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and standard of care in the state, and any access to care issues
 that lower reimbursement rates may create. The commissioner
 shall have the discretion to adjust the reimbursement rate to
 prevent access to care issues.

5 Sec. 19. Minnesota Statutes 2004, section 256B.0625, 6 subdivision 13f, is amended to read:

7 Subd. 13f. [PRIOR AUTHORIZATION.] (a) The Formulary 8 Committee shall review and recommend drugs which require prior 9 authorization. The Formulary Committee shall establish general 10 criteria to be used for the prior authorization of brand-name 11 drugs for which generically equivalent drugs are available, but 12 the committee is not required to review each brand-name drug for 13 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

30 (3) the Formulary Committee must hold a public forum and31 receive public comment for an additional 15 days.

32 The commissioner must provide a 15-day notice period before 33 implementing the prior authorization.

34 (c) Prior authorization shall not be required or utilized
 35 for any atypical antipsychotic drug prescribed for the treatment
 36 of mental illness if:

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(1) there is no generically equivalent drug available; and 1 (2) the drug was initially prescribed for the recipient 2 3 prior to July 1, 2003; or

(3) the drug is part of the recipient's current course of 4 treatment. 5

This paragraph applies to any multistate preferred drug list or 6 supplemental drug rebate program established or administered by 7 the commissioner. 8

(d) Prior authorization shall not be required or utilized 9 10 for any antihemophilic factor drug prescribed for the treatment of hemophilia and blood disorders where there is no generically 11 equivalent drug available if the prior authorization is used in 12 conjunction with any supplemental drug rebate program or 13 multistate preferred drug list established or administered by 14 the commissioner. This-paragraph-expires-July-1,-2005. 15

(e) The commissioner may require prior authorization for 16 brand name drugs whenever a generically equivalent product is 17 available, even if the prescriber specifically indicates 18 "dispense as written-brand necessary" on the prescription as 19 required by section 151.21, subdivision 2. 20

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[EFFECTIVE DATE.] This section is effective June 30, 2005. Sec. 20. Minnesota Statutes 2004, section 256B.0625, is 22 23 amended by adding a subdivision to read:

24 Subd. 13h. [MEDICATION THERAPY MANAGEMENT CARE.] (a) Medical assistance covers medication therapy management services 25 26 for a recipient taking four or more prescriptions to treat or 27 prevent two or more chronic medical conditions, or a recipient 28 with a drug therapy problem that is identified or prior 29 authorized by the commissioner that has resulted or is likely to result in significant nondrug program costs. For purposes of 30 this subdivision, "medication therapy management" means the 31 32 provision of the following pharmaceutical care services by a licensed pharmacist to optimize the therapeutic outcomes of the 33 34 patient's medications: 35 (1) performing or obtaining necessary assessments of the

36 patient's health status;

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l	(2) formulating a medication treatment plan;
2	(3) monitoring and evaluating the patient's response to
3	therapy, including safety and effectiveness;
4	(4) performing a comprehensive medication review to
5	identify, resolve, and prevent medication-related problems,
6	including adverse drug events;
7	(5) documenting the care delivered and communicating
8	essential information to the patient's other primary care
9	providers;
10	(6) providing verbal education and training designed to
11	enhance patient understanding and appropriate use of the
12	patient's medications;
13	(7) providing information, support services, and resources
14	designed to enhance patient adherence with the patient's
15	therapeutic regimens; and
16	(8) coordinating and integrating medication therapy
17	management services within the broader health care management
18	services being provided to the patient.
19	Nothing in this subdivision shall be construed to expand or
20	modify the scope of practice of the pharmacist as defined in
<b>2</b> 1	section 151.01, subdivision 27.
22	(b) To be eligible for reimbursement for services under
23	this subdivision, a pharmacist must meet the following
24	requirements:
25	(1) have a valid license issued under chapter 151;
26	(2) have graduated from an accredited college of pharmacy
27	on or after May 1996 or completed a structured and comprehensive
28	education program approved by the Board of Pharmacy and the
29	American Council of Pharmaceutical Education for the provision
30	and documentation of pharmaceutical care management services
31	that has both clinical and didactic elements;
32	(3) be practicing in an ambulatory care setting as part of
33	a multidisciplinary team or have developed a structured patient
34	care process that is offered in a private or semiprivate patient
35	care area that is separate from the commercial business that
36	also occurs in the setting; and

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l	(4) make use of an electronic patient record system that
2	meets state standards.
3	(c) For the purposes of reimbursement for medication
4	therapy management services, the commissioner may enroll
5	individual pharmacists as medical assistance providers. The
6	commissioner may also establish contact requirements between the
7	pharmacist and recipient, including limiting the number of
8	reimbursable consultations per recipient.
9	(d) The commissioner, after receiving recommendations from
10	professional medical associations, professional pharmacy
11	associations, and consumer groups shall convene an ll-member
12	Medication Therapy Management Advisory Committee, to advise the
13	commissioner on the implementation and administration of
14	medication therapy management services. The committee shall be
15	comprised of two licensed physicians; two licensed pharmacists;
16	two consumer representatives; two health plan representatives;
17	and three members with expertise in the area of medication
18	therapy management, who may be licensed physicians or licensed
19	pharmacists. The committee is governed by section 15.059,
20	except that committee members do not receive compensation or
21	reimbursement for expenses. The advisory committee shall expire
22	on June 30, 2007.
23	(e) The commissioner shall evaluate the effect of
24	medication therapy management on quality of care, patient
25	outcomes, and program costs, and shall include a description of
26	any savings generated in the medical assistance program that can
27	be attributable to this coverage. The evaluation shall be
28	submitted to the legislature by December 15, 2007. The
29	commissioner may contract with a vendor or an academic
30	institution that has expertise in evaluating health care
31	outcomes for the purpose of completing the evaluation.
32	Sec. 21. [256B.072] [PERFORMANCE REPORTING AND QUALITY
33	IMPROVEMENT PAYMENT SYSTEM.]
34	(a) The commissioner of human services shall establish a
35	performance reporting and payment system for health care
36 -	providers who provide health care services to public program
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	1	recipients covered under chapters 256B, 256D, and 256L.
	2	(b) The measures used for the performance reporting and
	3	payment system for medical groups or single-physician practices
	4	shall include, but are not limited to, measures of care for
	5	asthma, diabetes, hypertension, and coronary artery disease and
	6	measures of preventive care services. The measures used for the
	7	performance reporting and payment system for inpatient hospitals
	8	shall include, but are not limited to, measures of care for
	9	acute myocardial infarction, heart failure, and pneumonia, and
	10	measures of care and prevention of surgical infections. In the
	11	case of a medical group or single-physician practice, the
	12	measures used shall be consistent with measures published by
	13	nonprofit Minnesota or national organizations that produce and
	14	disseminate health care quality measures or evidence-based
	15	health care guidelines. In the case of inpatient hospital
	16	measures, the commissioner shall appoint the Minnesota Hospital
	17	Association and Stratis Health to develop the performance
	18	measures to be used for hospital reporting. To enable a
	19	consistent measurement process across the community, the
	20	commissioner may use measures of care provided for patients in
	21	addition to those identified in paragraph (a). The commissioner
	22	shall ensure collaboration with other health care reporting
···.	23	organizations so that the measures described in this section are
~	24	consistent with those reported by those organizations and used
	25	by other purchasers in Minnesota.
	26	(c) For recipients seen on or after January 1, 2007, the
	27	commissioner shall provide a performance bonus payment to
	28	providers who have achieved certain levels of performance
	29	established by the commissioner with respect to the measures or
	30	who have achieved certain rates of improvement established by
	31	the commissioner with respect to the measures or whose rates of
	32	achievement have increased over a previous period, as
×	33	established by the commissioner. The performance bonus payment
	34	may be a fixed dollar amount per patient, paid quarterly or
	35	annually, or alternatively payment may be made as a percentage
	36	increase over payments allowed elsewhere in statute for the

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l	recipients identified in paragraph (a). In order for providers
2	to be eligible for a performance bonus payment under this
3	section, the commissioner may require the providers to submit
4	information in a required format to a health care reporting
5	organization or to cooperate with the information collection
6	procedures of that organization. The commissioner may contract
7	with a reporting organization to assist with the collection of
8	reporting information and to prevent duplication of reporting.
9	The commissioner may limit application of the performance bonus
10	payment system to providers that provide a sufficiently large
11	volume of care to permit adequate statistical precision in the
12	measurement of that care, as established by the commissioner,
13	after consulting with other health care quality reporting
14	organizations.
15	(d) The performance bonus payments shall be funded with the
16	projected savings in the program costs due to improved results
17	of these measures with the eligible providers.
18	(e) The commissioner shall publish a description of the
19	proposed performance reporting and payment system for the
20	calendar year beginning January 1, 2007, and each subsequent
21	calendar year, at least three months prior to the beginning of
22	that calendar year.
23	(f) By April 1, 2007, and annually thereafter, the
24	commissioner shall report through a public Web site the results
25	by medical group, single-physician practice, and hospital of the
26	measures and the performance payments under this section, and
27	shall compare the results by medical group, single-physician
28	practice, and hospital for patients enrolled in public programs
29	to patients enrolled in private health plans. To achieve this
30	reporting, the commissioner may contract with a health care
31	reporting organization that operates a Web site suitable for
32	this purpose.
33	Sec. 22. Minnesota Statutes 2004, section 256B.0916, is
34	amended by adding a subdivision to read:
35	Subd. 10. [TRANSITIONAL SUPPORTS ALLOWANCE.] A
36	transitional supports allowance shall be available to all

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1	persons under a home and community-based waiver who are moving
2	from a licensed setting to a community setting. "Transitional
3	supports allowance" means a onetime payment of up to \$3,000, to
4	cover the costs, not covered by other sources, associated with
5	moving from a licensed setting to a community setting. Covered
6	costs include:
7	(1) lease or rent deposits;
8	(2) security deposits;
9	(3) utilities set-up costs, including telephone;
10	(4) essential furnishings and supplies; and
11	(5) personal supports and transports needed to locate and
12	transition to community settings.
13	[EFFECTIVE DATE.] This section is effective upon federal
14	approval and to the extent approved as a federal waiver
15	amendment.
16	Sec. 23. [256B.0918] [EMPLOYEE SCHOLARSHIP COSTS AND
17	TRAINING IN ENGLISH AS A SECOND LANGUAGE.]
18	(a) For the fiscal year beginning July 1, 2005, the
19	commissioner shall provide to each provider listed in paragraph
20	(c) a scholarship reimbursement increase of two-tenths percent
21	of the reimbursement rate for that provider to be used:
22	(1) for employee scholarships that satisfy the following
23	requirements:
24	(i) scholarships are available to all employees who work an
25	average of at least 20 hours per week for the provider, except
26	administrators, department supervisors, and registered nurses;
27	and
28	(ii) the course of study is expected to lead to career
29	advancement with the provider or in long-term care, including
30	home care or care of persons with disabilities, including
31	medical care interpreter services and social work; and
32	(2) to provide job-related training in English as a second
33	language.
34	(b) A provider receiving a rate adjustment under this
35	subdivision with an annualized value of at least \$1,000 shall
36	maintain documentation to be submitted to the commissioner on a
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1	schedule determined by the commissioner and on a form supplied
2	by the commissioner of the scholarship rate increase received,
3	including:
4	(1) the amount received from this reimbursement increase;
5	(2) the amount used for training in English as a second
6	language;
7	(3) the number of persons receiving the training;
8	(4) the name of the person or entity providing the
9	training; and
10	(5) for each scholarship recipient, the name of the
11	recipient, the amount awarded, the educational institution
12	attended, the nature of the educational program, the program
13	completion date, and a determination of the amount spent as a
14	percentage of the provider's reimbursement.
15	The commissioner shall report to the legislature annually,
16	beginning January 15, 2006, with information on the use of these
17	funds.
18	(c) The rate increases described in this section shall be
19	provided to home and community-based waivered services for
20	persons with mental retardation or related conditions under
21	section 256B.501; home and community-based waivered services for
22	the elderly under section 256B.0915; waivered services under
23	community alternatives for disabled individuals under section
24	256B.49; community alternative care waivered services under
25	section 256B.49; traumatic brain injury waivered services under
26	section 256B.49; nursing services and home health services under
27	section 256B.0625, subdivision 6a; personal care services and
28	nursing supervision of personal care services under section
29	256B.0625, subdivision 19a; private duty nursing services under
30	section 256B.0625, subdivision 7; day training and habilitation
31	services for adults with mental retardation or related
32	conditions under sections 252.40 to 252.46; alternative care
33	services under section 256B.0913; adult residential program
34	grants under Minnesota Rules, parts 9535.2000 to 9535.3000;
35	semi-independent living services (SILS) under section 252.275,
36	including SILS funding under county social services grants

1	formerly funded under chapter 2561; community support services
2	for deaf and hard-of-hearing adults with mental illness who use
3	or wish to use sign language as their primary means of
4	communication; the group residential housing supplementary
5	service rate under section 2561.05, subdivision la; chemical
6	dependency residential and nonresidential service providers
7	under section 254B.03; and intermediate care facilities for
8	persons with mental retardation under section 256B.5012.
9	(d) These increases shall be included in the provider's
10	reimbursement rate for the purpose of determining future rates
11	for the provider.
12	Sec. 24. [256B.199] [PAYMENTS REPORTED BY GOVERNMENTAL
13	ENTITIES.]
14	(a) Hennepin County, Ramsey County, and the University of
15	Minnesota shall annually report to the commissioner by June $1_r$
16	beginning June 1, 2005, payments to Hennepin County Medical
17	Center, Regions Hospital, and Fairview-University Medical Center
18	respectively made during the previous calendar year that are
19	certified public expenditures that may qualify for reimbursement
20	under federal law. Subject to the reports due June 1, 2005, the
21	amounts for calendar year 2004 are expected to be as follows:
22	(1) Hennepin County, \$60,000,000;
23	(2) Ramsey County, \$27,000,000; and
24	(3) University of Minnesota, \$18,000,000.
25	(b) Based on these reports, the commissioner shall apply
26	for federal matching funds. These funds are appropriated to the
27	commissioner for the annual payments under section 256.969,
28	subdivision 27.
29	[EFFECTIVE DATE.] This section is effective the day
30	following final enactment. The commissioner of human services
31	shall submit necessary medical assistance plan amendments to
32	implement this section within 30 days of enactment.
33	Sec. 25. Minnesota Statutes 2004, section 256B.69,
34	subdivision 4, is amended to read:
35	Subd. 4. [LIMITATION OF CHOICE.] (a) The commissioner
36	shall develop criteria to determine when limitation of choice
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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.

5 (b) The commissioner shall exempt the following persons 6 from participation in the project, in addition to those who do 7 not meet the criteria for limitation of choice:

8 (1) persons eligible for medical assistance according to
9 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:

13

(i) they are 65 years of age or older; or

14 (ii) they reside in Itasca County or they reside in a 15 county in which the commissioner conducts a pilot project under 16 a waiver granted pursuant to section 1115 of the Social Security 17 Act;

18 (3) recipients who currently have private coverage through19 a health maintenance organization;

20 (4) recipients who are eligible for medical assistance by 21 spending down excess income for medical expenses other than the 22 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;

32 (8) persons eligible for medical assistance according to
33 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

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cost-effective according to section 256B.0625, subdivision 15. 1 Children under age 21 who are in foster placement may enroll in 2 the project on an elective basis. Individuals excluded under 3 clauses (1), (6), and (7) may choose to enroll on an elective 4 basis. The commissioner may enroll recipients in the prepaid 5 medical assistance program for seniors who are (1) age 65 and 6 over, and (2) eligible for medical assistance by spending down 7 excess income. 8

9 (c) The commissioner may allow persons with a one-month 10 spenddown who are otherwise eligible to enroll to voluntarily 11 enroll or remain enrolled, if they elect to prepay their monthly 12 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 18 19 individuals shall be notified and after notification, shall be 20 allowed to choose only among demonstration providers. The 21 commissioner may assign an individual with private coverage through a health maintenance organization, to the same health 22 maintenance organization for medical assistance coverage, if the 23 24 health maintenance organization is under contract for medical assistance in the individual's county of residence. After 25 initially choosing a provider, the recipient is allowed to 26 change that choice only at specified times as allowed by the 27 28 commissioner. If a demonstration provider ends participation in 29 the project for any reason, a recipient enrolled with that provider must select a new provider but may change providers 30 31 without cause once more within the first 60 days after 32 enrollment with the second provider.

33 (f) An infant born to a woman who is eligible for and 34 receiving medical assistance and who is enrolled in the prepaid 35 medical assistance program shall be retroactively enrolled to 36 the month of birth in the same managed care plan as the mother

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1 under contract with the county board;

2 (17) prescribed medications for persons who have been
3 diagnosed as mentally ill as necessary to prevent more
4 restrictive institutionalization;

5 (18) psychological services, medical supplies and
6 equipment, and Medicare premiums, coinsurance and deductible
7 payments;

8 (19) medical equipment not specifically listed in this 9 paragraph when the use of the equipment will prevent the need 10 for costlier services that are reimbursable under this 11 subdivision;

(20) services performed by a certified pediatric nurse 12 practitioner, a certified family nurse practitioner, a certified 13 adult nurse practitioner, a certified obstetric/gynecological 14 15 nurse practitioner, a certified neonatal nurse practitioner, or a certified geriatric nurse practitioner in independent 16 practice, if (1) the service is otherwise covered under this 17 chapter as a physician service, (2) the service provided on an 18 19 inpatient basis is not included as part of the cost for inpatient services included in the operating payment rate, and 20 (3) the service is within the scope of practice of the nurse 21 22 practitioner's license as a registered nurse, as defined in 23 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

30 (22) telemedicine consultations, to the extent they are
31 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

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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 6 services shall select vendors of medical care who can provide 7 the most economical care consistent with high medical standards 8 and shall where possible contract with organizations on a 9 prepaid capitation basis to provide these services. The 10 commissioner shall consider proposals by counties and vendors 11 for prepaid health plans, competitive bidding programs, block 12 grants, or other vendor payment mechanisms designed to provide 13 services in an economical manner or to control utilization, with 14 15 safeguards to ensure that necessary services are provided. Before implementing prepaid programs in counties with a county 16 operated or affiliated public teaching hospital or a hospital or 17 clinic operated by the University of Minnesota, the commissioner 18 19 shall consider the risks the prepaid program creates for the hospital and allow the county or hospital the opportunity to 20 21 participate in the program in a manner that reflects the risk of 22 adverse selection and the nature of the patients served by the hospital, provided the terms of participation in the program are 23 24 competitive with the terms of other participants considering the 25 nature of the population served. Payment for services provided pursuant to this subdivision shall be as provided to medical 26 27 assistance vendors of these services under sections 256B.02, subdivision 8, and 256B.0625. For payments made during fiscal 28 year 1990 and later years, the commissioner shall consult with 29 30 an independent actuary in establishing prepayment rates, but 31 shall retain final control over the rate methodology.

32 (d)-Recipients-eligible-under-subdivision-37-paragraph-(a)7
33 clause-(2)7-item-(i)7-shall-pay-the-following-co-payments-for
34 services-provided-on-or-after-October-17-2003:

35 (1)-\$3-per-nonpreventive-visit---For-purposes-of-this
 36 subdivision7-a-visit-means-an-episode-of-service-which-is

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.

1	required-because-of-a-recipient <sup>_</sup> s-symptoms,-diagnosis,-or
2	established-illness,-and-which-is-delivered-in-an-ambulatory
3	setting-by-a-physician-or-physician-ancillary7-chiropractor7
4	podiatrist7-nurse-midwife7-advanced-practice-nurse7-audiologist7
5	optician,-or-optometrist;
6	<del>(2)-\$25-for-eyeglasses;</del>
7	<del>(3)-\$25-for-nonemergency-visits-to-a-hospital-based</del>
8	emergency-room;
9	(4)-\$3-per-brand-name-drug-prescription-and-\$1-per-generic
10	drug-prescription,-subject-to-a-\$20-per-month-maximum-for
11	prescription-drug-co-paymentsNo-co-payments-shall-apply-to
12	antipsychotic-drugs-when-used-for-the-treatment-of-mental
13	illness;-and
14	(5)-50-percent-coinsurance-on-restorative-dental-services-
15	(e)-Co-payments-shall-be-limited-to-one-per-day-per
16	provider-for-nonpreventive-visits7-eyeglasses7-and-nonemergency
17	visits-to-a-hospital-based-emergency-roomRecipients-of
18	general-assistance-medical-care-are-responsible-for-all
19	co-payments-in-this-subdivisionThe-general-assistance-medical
20	care-reimbursement-to-the-provider-shall-be-reduced-by-the
21	amount-of-the-co-payment7-except-that-reimbursement-for
22	prescription-drugs-shall-not-be-reduced-once-a-recipient-has
23	reached-the-\$20-per-month-maximum-for-prescription-drug
24	co-paymentsThe-provider-collects-the-co-payment-from-the
25	recipientProviders-may-not-deny-services-to-recipients-who
26	are-unable-to-pay-the-co-payment7-except-as-provided-in
27	paragraph-(f)-
28	(f)-If-it-is-the-routine-business-practice-of-a-provider-to
29	refuse-service-to-an-individual-with-uncollected-debt7-the
30	provider-may-include-uncollected-co-payments-under-this
31	sectionA-provider-must-give-advance-notice-to-a-recipient
32	with-uncollected-debt-before-services-can-be-denied-
33	(g) (d) Any county may, from its own resources, provide
34	medical payments for which state payments are not made.
35	(h) (e) Chemical dependency services that are reimbursed
36	under chapter 254B must not be reimbursed under general

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1 assistance medical care.

2 (i) (f) The maximum payment for new vendors enrolled in the 3 general assistance medical care program after the base year 4 shall be determined from the average usual and customary charge 5 of the same vendor type enrolled in the base year.

(j) (g) 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.

10 (\*) (h) Inpatient and outpatient payments shall be reduced 11 by five percent, effective July 1, 2003. This reduction is in 12 addition to the five percent reduction effective July 1, 2003, 13 and incorporated by reference in paragraph (±) (f).

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

17 (m) (j) Payments to managed care plans shall be reduced by 18 five percent for services provided on or after October 1, 2003.

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

[EFFECTIVE DATE.] This section is effective January 1, 2006.
 Sec. 27. Minnesota Statutes 2004, section 256D.045, is
 amended to read:

25 256D.045 [SOCIAL SECURITY NUMBER REQUIRED.]

To be eligible for general assistance under sections 26 27 256D.01 to 256D.21, an individual must provide the individual's Social Security number to the county agency or submit proof that 28 29 an application has been made. An individual who refuses to 30 provide a Social Security number because of a well-established 31 religious objection as described in Code of Federal Regulations, 32 title 42, section 435.910, may be eligible for general assistance medical care under section 256D.03. The provisions 33 of this section do not apply to the determination of eligibility 34 for emergency general assistance under section 256D.06, 35 subdivision 2. This provision applies to eligible children 36

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1 under the age of 18 effective July 1, 1997.

[EFFECTIVE DATE.] This section is effective August 1, 2006,
or upon HealthMatch implementation, whichever is later.

Sec. 28. Minnesota Statutes 2004, section 256L.01,
subdivision 4, is amended to read:

Subd. 4. [GROSS INDIVIDUAL OR GROSS FAMILY INCOME.] (a) 6 "Gross individual or gross family income" for nonfarm 7 self-employed means income calculated for the six-month period 8 of eligibility using as the baseline the adjusted gross income 9 reported on the applicant's federal income tax form for the 10 previous year and adding back in reported depreciation, 11 carryover loss, and net operating loss amounts that apply to the 12 business in which the family is currently engaged. 13

(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, 2006,

28 or upon HealthMatch implementation, whichever is later.

29 Sec. 29. Minnesota Statutes 2004, section 256L.03, 30 subdivision 1, is amended to read:

Subdivision 1. [COVERED HEALTH SERVICES.] For-individuals under-section-256b-047-subdivision-77-with-income-no-greater than-75-percent-of-the-federal-poverty-guidelines-or-for families-with-children-under-section-256b-047-subdivision-17-all subdivisions-of-this-section-apply- "Covered health services" means the health services reimbursed under chapter 256B, with

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the exception of inpatient hospital services, special education 1 services, private duty nursing services, adult dental care 2 services other than services covered under section 256B.0625, 3 subdivision 9, paragraph-{b}, orthodontic services, nonemergency 4 medical transportation services, personal care assistant and 5 case management services, nursing home or intermediate care 6 facilities services, inpatient mental health services, and 7 chemical dependency services. Outpatient mental health services 8 covered under the MinnesotaCare program are limited to 9 10 diagnostic assessments, psychological testing, explanation of findings, medication management by a physician, day treatment, 11 partial hospitalization, and individual, family, and group 12 psychotherapy. 13

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.

19 Covered health services shall be expanded as provided in 20 this section.

21 [EFFECTIVE DATE.] Notwithstanding section 256B.69, 22 subdivision 5a, paragraph (b), this section is effective July 1, 23 2005.

24 Sec. 30. Minnesota Statutes 2004, section 256L.03, 25 subdivision lb, is amended to read:

26 Subd. lb. [PREGNANT WOMEN; ELIGIBILITY FOR FULL MEDICAL ASSISTANCE SERVICES.] Beginning-January-17-19997 A pregnant 27 28 woman who-is enrolled in MinnesotaCare when-her-pregnancy-is 29 diagnosed is eligible for coverage of all services provided 30 under the medical assistance program according to chapter 256B 31 retroactive to the date the-pregnancy-is-medically-diagnosed of 32 conception. Co-payments totaling \$30 or more, paid after the date the-pregnancy-is-diagnosed of conception, shall be refunded. 33 34 Sec. 31. Minnesota Statutes 2004, section 256L.03, 35 subdivision 5, is amended to read:

36 Subd. 5. [CO-PAYMENTS AND COINSURANCE.] (a) Except as

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1 provided in paragraphs (b) and (c), the MinnesotaCare benefit 2 plan shall include the following co-payments and coinsurance 3 requirements for all enrollees:

4 (1) ten percent of the paid charges for inpatient hospital
5 services for adult enrollees, subject to an annual inpatient
6 out-of-pocket maximum of \$1,000 per individual and \$3,000 per
7 family;

8

(2) \$3 per prescription for adult enrollees;

9 (3) \$25 for eyeglasses for adult enrollees; and
10 (4) 50 percent of the fee-for-service rate for adult dental
11 care services other than preventive care services for persons
12 eligible under section 256L.04, subdivisions 1 to 7, with income
13 equal to or less greater than 175 190 percent of the federal
14 poverty guidelines.

(b) Paragraph (a), clause (1), does not apply to parents 15 and relative caretakers of children under the age of 21 in 16 households with family income equal to or less than 175 percent 17 of the federal poverty guidelines. Paragraph (a), clause (1), 18 19 does not apply to parents and relative caretakers of children under the age of 21 in households with family income greater 20 21 than 175 percent of the federal poverty guidelines for inpatient hospital admissions occurring on or after January 1, 2001. 22

23 (c) Paragraph (a), clauses (l) to (4), do not apply to
24 pregnant women and children under the age of 21.

(d) Adult enrollees with family gross income that exceeds Adult enrollees with family gross income that exceeds 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.

30 (e) When a MinnesotaCare enrollee becomes a member of a
31 prepaid health plan, or changes from one prepaid health plan to
32 another during a calendar year, any charges submitted towards
33 the \$10,000 annual inpatient benefit limit, and any
34 out-of-pocket expenses incurred by the enrollee for inpatient
35 services, that were submitted or incurred prior to enrollment,
36 or prior to the change in health plans, shall be disregarded.

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Section 31

[REVISOR ] \_\_\_\_\_S/MD 05-4117 04/28/05 [EFFECTIVE DATE.] This section is effective August 1, 2006, 1 or upon HealthMatch implementation, whichever is later. 2 Sec. 32. Minnesota Statutes 2004, section 256L.04, is 3 amended by adding a subdivision to read: 4 Subd. 1a. [SOCIAL SECURITY NUMBER REQUIRED.] (a) 5 Individuals and families applying for MinnesotaCare coverage 6 must provide a Social Security number. 7 (b) The commissioner shall not deny eligibility to an 8 otherwise eligible applicant who has applied for a Social 9 Security number and is awaiting issuance of that Social Security 10 number. 11 (c) Newborns enrolled under section 256L.05, subdivision 3, 12 are exempt from the requirements of this subdivision. 13 (d) Individuals who refuse to provide a Social Security 14 15 number because of well-established religious objections are 16 exempt from the requirements of this subdivision. The term "well-established religious objections" has the meaning given in 17 Code of Federal Regulations, title 42, section 435.910. 18 [EFFECTIVE DATE.] This section is effective August 1, 2006, 19 20 or upon HealthMatch implementation, whichever is later. Sec. 33. Minnesota Statutes 2004, section 256L.04, 21 subdivision 2, is amended to read: 22 Subd. 2. [COOPERATION IN ESTABLISHING THIRD-PARTY 23 LIABILITY, PATERNITY, AND OTHER MEDICAL SUPPORT.] (a) To be 24 eligible for MinnesotaCare, individuals and families must 25 26 cooperate with the state agency to identify potentially liable 27 third-party payers and assist the state in obtaining third-party payments. "Cooperation" includes, but is not limited 28 29 to, complying with the notice requirements in section 256B.056, subdivision 9, identifying any third party who may be liable for 30 care and services provided under MinnesotaCare to the enrollee, 31 32 providing relevant information to assist the state in pursuing a 33 potentially liable third party, and completing forms necessary 34 to recover third-party payments. 35 (b) A parent, guardian, relative caretaker, or child 36 enrolled in the MinnesotaCare program must cooperate with the

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1 Department of Human Services and the local agency in establishing the paternity of an enrolled child and in obtaining 2 3 medical care support and payments for the child and any other person for whom the person can legally assign rights, in 4 5 accordance with applicable laws and rules governing the medical assistance program. A child shall not be ineligible for or 6 disenrolled from the MinnesotaCare program solely because the 7 child's parent, relative caretaker, or guardian fails to 8 cooperate in establishing paternity or obtaining medical support. 9 Sec. 34. Minnesota Statutes 2004, section 256L.04, is 10 11 amended by adding a subdivision to read: 12 Subd. 2a. [APPLICATIONS FOR OTHER BENEFITS.] To be eligible for MinnesotaCare, individuals and families must take 13 all necessary steps to obtain other benefits as described in 14 Code of Federal Regulations, title 42, section 435.608. 15 Applicants and enrollees must apply for other benefits within 30 16 17 days. [EFFECTIVE DATE.] This section is effective August 1, 2006, 18 or upon HealthMatch implementation, whichever is later. 19 20 Sec. 35. Minnesota Statutes 2004, section 256L.04, subdivision 7, is amended to read: 21 22 Subd. 7. [SINGLE ADULTS AND HOUSEHOLDS WITH NO CHILDREN.] The definition of eligible persons includes all individuals and 23 24 households with no children who have gross family incomes that are equal to or less than  $\frac{1}{175}$  <u>190</u> percent of the federal poverty 25 26 guidelines. [EFFECTIVE DATE.] This section is effective August 1, 2006, 27 28 or upon HealthMatch implementation, whichever is later. 29 Sec. 36. Minnesota Statutes 2004, section 256L.05, subdivision 3, is amended to read: 30 Subd. 3. [EFFECTIVE DATE OF COVERAGE.] (a) The effective 31 32 date of coverage is the first day of the month following the 33 month in which eligibility is approved and the first premium payment has been received. As provided in section 256B.057, 34 35 coverage for newborns is automatic from the date of birth and 36 must be coordinated with other health coverage. The effective

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date of coverage for eligible newly adoptive children added to a 1 family receiving covered health services is the date-of-entry 2 into-the-family month of placement. The effective date of 3 coverage for other new recipients members added to the family 4 receiving-covered-health-services is the first day of the month 5 following the month in which eligibility-is-approved-or-at 6 renewal7-whichever-the-family-receiving-covered-health-services 7 prefers the change is reported. All eligibility criteria must 8 be met by the family at the time the new family member is 9 added. The income of the new family member is included with the 10 family's gross income and the adjusted premium begins in the 11 month the new family member is added. 12

(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.

16 (c) Benefits are not available until the day following 17 discharge if an enrollee is hospitalized on the first day of 18 coverage.

(d) Notwithstanding any other law to the contrary, benefits 19 20 under sections 256L.01 to 256L.18 are secondary to a plan of insurance or benefit program under which an eligible person may 21 have coverage and the commissioner shall use cost avoidance 22 23 techniques to ensure coordination of any other health coverage for eligible persons. The commissioner shall identify eligible 24 25 persons who may have coverage or benefits under other plans of 26 insurance or who become eligible for medical assistance.

27 [EFFECTIVE DATE.] This section is effective August 1, 2006,
28 or upon HealthMatch implementation, whichever is later.

Sec. 37. Minnesota Statutes 2004, section 256L.05,
subdivision 3a, is amended to read:

31 Subd. 3a. [RENEWAL OF ELIGIBILITY.] (a) Beginning January 32 1, 1999, an enrollee's eligibility must be renewed every 12 33 months. The 12-month period begins in the month after the month 34 the application is approved.

35 (b) Beginning October 1, 2004, an enrollee's eligibility
36 must be renewed every six months. The first six-month period of

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eligibility begins in-the-month-after the month the application 1 is approved received by the commissioner. The effective date of 2 coverage within the first six-month period of eligibility is as 3 provided in subdivision 3. Each new period of eligibility must 4 take into account any changes in circumstances that impact 5 eligibility and premium amount. An enrollee must provide all 6 the information needed to redetermine eligibility by the first 7 day of the month that ends the eligibility period. The premium 8 for the new period of eligibility must be received as provided 9 in section 256L.06 in order for eligibility to continue. 10

11 [EFFECTIVE DATE.] This section is effective August 1, 2006, or upon HealthMatch implementation, whichever is later. 12

13 Sec. 38. Minnesota Statutes 2004, section 256L.07, subdivision 1, is amended to read: 14

Subdivision 1. [GENERAL REQUIREMENTS.] (a) Children 15 enrolled in the original children's health plan as of September 16 30, 1992, children who enrolled in the MinnesotaCare program 17 after September 30, 1992, pursuant to Laws 1992, chapter 549, 18 19 article 4, section 17, and children who have family gross incomes that are equal to or less than 150 percent of the 20 federal poverty guidelines are eligible without meeting the 21 22 requirements of subdivision 2 and the four-month requirement in 23 subdivision 3, as long as they maintain continuous coverage in the MinnesotaCare program or medical assistance. Children who 24 25 apply for MinnesotaCare on or after the implementation date of the employer-subsidized health coverage program as described in 26 27 Laws 1998, chapter 407, article 5, section 45, who have family 28 gross incomes that are equal to or less than 150 percent of the federal poverty guidelines, must meet the requirements of 29 30 subdivision 2 to be eligible for MinnesotaCare.

31 (b) Families enrolled in MinnesotaCare under section 256L.04, subdivision 1, whose income increases above 275 percent 32 of the federal poverty guidelines, are no longer eligible for 33 34 the program and shall be disenrolled by the commissioner. 35 Individuals enrolled in MinnesotaCare under section 256L.04, 36 subdivision 7, whose income increases above 175 percent of the

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1 federal poverty guidelines are no longer eligible for the 2 program and shall be disenrolled by the commissioner. For 3 persons disenrolled under this subdivision, MinnesotaCare 4 coverage terminates the last day of the calendar month following 5 the month in which the commissioner determines that the income 6 of a family or individual exceeds program income limits.

(c)(1) Notwithstanding paragraph (b), families enrolled in 7 MinnesotaCare under section 256L.04, subdivision 1, may remain 8 enrolled in MinnesotaCare if ten percent of their annual income 9 is less than the annual premium for a policy with a \$500 10 deductible available through the Minnesota Comprehensive Health 11 Association. Families who are no longer eligible for 12 MinnesotaCare under this subdivision shall be given an 18-month 13 notice period from the date that ineligibility is determined 14 before disenrollment. This clause expires February 1, 2004. 15

(2) Effective February 1, 2004, notwithstanding paragraph 16 17 (b), children may remain enrolled in MinnesotaCare if ten percent of their annual gross individual or gross family income 18 as defined in section 256L.01, subdivision 4, is less than the 19 20 annual premium for a six-month policy with a \$500 deductible 21 available through the Minnesota Comprehensive Health 22 Association. Children who are no longer eligible for MinnesotaCare under this clause shall be given a 12-month notice 23 period from the date that ineligibility is determined before 24 25 disenrollment. The premium for children remaining eligible under this clause shall be the maximum premium determined under 26 section 256L.15, subdivision 2, paragraph (b). 27

(d) Effective July 1, 2003, notwithstanding paragraphs (b)
and (c), parents are no longer eligible for MinnesotaCare if
gross household income exceeds \$50,000 for the six-month
period of eligibility.

32 [EFFECTIVE DATE.] This section is effective August 1, 2006,
 33 or upon HealthMatch implementation, whichever is later.
 34 Sec. 39. Minnesota Statutes 2004, section 256L.07,
 35 subdivision 3, is amended to read:

36 Subd. 3. [OTHER HEALTH COVERAGE.] (a) Families and

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1 individuals enrolled in the MinnesotaCare program must have no
2 health coverage while enrolled or for at least four months prior
3 to application and renewal. Children enrolled in the original
4 children's health plan and children in families with income
5 equal to or less than 150 percent of the federal poverty
6 guidelines, who have other health insurance, are eligible if the
7 coverage:

8 (1) lacks two or more of the following:

9 (i) basic hospital insurance;

10 (ii) medical-surgical insurance;

11 (iii) prescription drug coverage;

12 (iv) dental coverage; or

13 (v) vision coverage;

14 (2) requires a deductible of \$100 or more per person per 15 year; or

16 (3) lacks coverage because the child has exceeded the
17 maximum coverage for a particular diagnosis or the policy
18 excludes a particular diagnosis.

19 The commissioner may change this eligibility criterion for 20 sliding scale premiums in order to remain within the limits of 21 available appropriations. The requirement of no health coverage 22 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, Medicare Part A or B
coverage under title XVIII of the Social Security Act, United
States Code, title 42, sections 1395c to 1395w-4, is considered
health coverage. An applicant or enrollee may not refuse
Medicare coverage to establish eligibility for MinnesotaCare.

34 (d) Applicants who were recipients of medical assistance or
35 general assistance medical care within one month of application
36 must meet the provisions of this subdivision and subdivision 2.

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1 (e) Effective-October-17-20037-applicants-who-were recipients-of-medical-assistance-and-had Cost-effective health 2 insurance which that was paid for by medical assistance are 3 exempt-from is not considered health coverage for purposes of 4 the four-month requirement under this section, except if the 5 insurance continued after medical assistance no longer 6 considered it cost-effective or after medical assistance closed. 7 Sec. 40. Minnesota Statutes 2004, section 256L.07, is 8 amended by adding a subdivision to read: 9 Subd. 5. [VOLUNTARY DISENROLLMENT FOR MEMBERS OF 10 MILITARY.] Notwithstanding section 256L.05, subdivision 3b, 11 MinnesotaCare enrollees who are members of the military and 12 their families, who choose to voluntarily disenroll from the 13 program when one or more family members are called to active 14 duty, may reenroll during or following that member's tour of 15 active duty. Those individuals and families shall be considered 16 to have good cause for voluntary termination under section 17 18 256L.06, subdivision 3, paragraph (d). Income and asset increases reported at the time of reenrollment shall be 19 20 disregarded. All provisions of sections 256L.01 to 256L.18, 21 shall apply to individuals and families enrolled under this subdivision upon six-month renewal. 22 23 Sec. 41. Minnesota Statutes 2004, section 256L.12, subdivision 6, is amended to read: 24 25 Subd. 6. [CO-PAYMENTS AND BENEFIT LIMITS.] Enrollees are

responsible for all co-payments in sections section 256L.03, subdivision 5, and-256b.0357 and shall pay co-payments to the managed care plan or to its participating providers. The enrollee is also responsible for payment of inpatient hospital charges which exceed the MinnesotaCare benefit limit.

31 Sec. 42. Minnesota Statutes 2004, section 256L.15,
32 subdivision 2, is amended to read:

33 Subd. 2. [SLIDING FEE SCALE TO DETERMINE PERCENTAGE OF 34 <u>MONTHLY</u> GROSS INDIVIDUAL OR FAMILY INCOME.] (a) The commissioner 35 shall establish a sliding fee scale to determine the percentage 36 of <u>monthly</u> gross individual or family income that households at

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different income levels must pay to obtain coverage through the 1 MinnesotaCare program. The sliding fee scale must be based on 2 the enrollee's monthly gross individual or family income. The 3 sliding fee scale must contain separate tables based on 4 enrollment of one, two, or three or more persons. The sliding 5 fee scale begins with a premium of 1.5 percent of monthly gross 6 individual or family income for individuals or families with 7 incomes below the limits for the medical assistance program for 8 families and children in effect on January 1, 1999, and proceeds 9 through the following evenly spaced steps: 1.8, 2.3, 3.1, 3.8, 10 4.8, 5.9, 7.4, and 8.8 percent. These percentages are matched 11 to evenly spaced income steps ranging from the medical 12 assistance income limit for families and children in effect on 13 January 1, 1999, to 275 percent of the federal poverty 14 guidelines for the applicable family size, up to a family size 15 of five. The sliding fee scale for a family of five must be 16 used for families of more than five. Effective October 1, 2003, 17 the commissioner shall increase each percentage by 0.5 18 19 percentage points for enrollees with income greater than 100 20 percent but not exceeding 200 percent of the federal poverty 21 guidelines and shall increase each percentage by 1.0 percentage points for families and children with incomes greater than 200 22 percent of the federal poverty guidelines. The sliding fee 23 24 scale and percentages are not subject to the provisions of chapter 14. If a family or individual reports increased income 25 26 after enrollment, premiums shall not be adjusted until 27 eligibility renewal.

(b)(1) Enrolled families whose gross annual income
increases above 275 percent of the federal poverty guideline
shall pay the maximum premium. This clause expires effective
February 1, 2004.

32 (2) Effective February 1, 2004, children in families whose
33 gross income is above 275 percent of the federal poverty
34 guidelines shall pay the maximum premium.

35 (3) The maximum premium is defined as a base charge for36 one, two, or three or more enrollees so that if all

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1 MinnesotaCare cases paid the maximum premium, the total revenue would equal the total cost of MinnesotaCare medical coverage and 2 administration. In this calculation, administrative costs shall 3 be assumed to equal ten percent of the total. The costs of 4 medical coverage for pregnant women and children under age two 5 and the enrollees in these groups shall be excluded from the 6 The maximum premium for two enrollees shall be twice the 7 total. maximum premium for one, and the maximum premium for three or 8 more enrollees shall be three times the maximum premium for one. 9 [EFFECTIVE DATE.] This section is effective August 1, 2006, 10 or upon HealthMatch implementation, whichever is later. 11 Sec. 43. Minnesota Statutes 2004, section 256L.15, 12 13 subdivision 3, is amended to read: [EXCEPTIONS TO SLIDING SCALE.] An-annual-premium 14 Subd. 3. of-\$48-is-required-for-all Children in families with income at 15 or less-than below 150 percent of the federal poverty guidelines 16 pay a monthly premium of \$4. 17 18 [EFFECTIVE DATE.] This section is effective August 1, 2006, or upon HealthMatch implementation, whichever is later. 19 Sec. 44. [256L.20] [MINNESOTACARE OPTION FOR SMALL 20 21 EMPLOYERS.] 22 Subdivision 1. [DEFINITIONS.] (a) For the purpose of this 23 section, the terms used have the meanings given them. 24 (b) "Dependent" means an unmarried child under 21 years of 25 age. 26 (c) "Eligible employer" means a business that employs at 27 least two, but not more than 50, eligible employees, the majority of whom are employed in the state, and includes a 28 29 municipality that has 50 or fewer employees. 30 (d) "Eligible employee" means an employee who works at 31 least 20 hours per week for an eligible employer. Eligible 32 employee does not include an employee who works on a temporary 33 or substitute basis or who does not work more than 26 weeks annually. 34 35 (e) "Maximum premium" has the meaning given under section 256L.15, subdivision 2, paragraph (b), clause (3). 36

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l	(f) _ "Participating employer" means an eligible employer who
2	meets the requirements in subdivision 3 and applies to the
3	commissioner to enroll its eligible employees and their
4	dependents in the MinnesotaCare program.
5	(g) "Program" means the MinnesotaCare program.
6	Subd. 2. [OPTION.] Eligible employees and their dependents
7	may enroll in MinnesotaCare if the eligible employer meets the
8	requirements of subdivision 3. The effective date of coverage
9	is according to section 256L.05, subdivision 3.
10	Subd. 3. [EMPLOYER REQUIREMENTS.] The commissioner shall
11	establish procedures for an eligible employer to apply for
12	coverage through the program. In order to participate, an
13	eligible employer must meet the following requirements:
14	(1) agrees to contribute toward the cost of the premium for
15	the employee and the employee's dependents according to
16	subdivision 4;
17	(2) certifies that at least 75 percent of its eligible
18	employees who do not have other creditable health coverage are
19	enrolled in the program;
20	(3) offers coverage to all eligible employees and the
21	dependents of eligible employees; and
22	(4) has not provided employer-subsidized health coverage as
23	an employee benefit during the previous 12 months, as defined in
24	section 256L.07, subdivision 2, paragraph (c).
25	Subd. 4. [PREMIUMS.] (a) The premium for MinnesotaCare
26	coverage provided under this section is equal to the maximum
27	premium regardless of the income of the eligible employee.
28	(b) For eligible employees without dependents with income
29	equal to or less than 175 percent of the federal poverty
30	guidelines and for eligible employees with dependents with
31	income equal to or less than 275 percent of the federal poverty
32	guidelines, the participating employer shall pay 50 percent of
33	the maximum premium for the eligible employee and any
34	dependents, if applicable.
35	(c) For eligible employees without dependents with income
36	over 175 percent of the federal poverty guidelines and for

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l	eligible employees with dependents with income over 275 percent
2	of the federal poverty guidelines, the participating employer
3	shall pay the full cost of the maximum premium for the eligible
4	employee and any dependents, if applicable. The participating
5	employer may require the employee to pay a portion of the cost
6	of the premium so long as the employer pays 50 percent of the
7	cost. If the employer requires the employee to pay a portion of
8	the premium, the employee shall pay the portion of the cost to
9	the employer.
10	(d) The commissioner shall collect premium payments from
11	participating employers for eligible employees and their
12	dependents who are covered by the program as provided under this
13	section. All premiums collected shall be deposited in the
14	health care access fund.
15	Subd. 5. [COVERAGE.] The coverage offered to those
16	enrolled in the program under this section must include all
17	health services described under section 256L.03 and all
18	co-payments and coinsurance requirements under section 256L.03,
19	subdivision 5, apply.
20	Subd. 6. [ENROLLMENT.] Upon payment of the premium, in
21	accordance with this section and section 256L.06, eligible
22	employees and their dependents shall be enrolled in
23	MinnesotaCare. For purposes of enrollment under this section,
24	income eligibility limits established under sections 256L.04 and
25	256L.07, subdivision 1, and asset limits established under
26	section 256L.17 do not apply. The barriers established under
27	section 256L.07, subdivision 2 or 3, do not apply to enrollees
28	eligible under this section. The commissioner may require
29	eligible employees to provide income verification to determine
30	premiums.
31	[EFFECTIVE DATE.] This section is effective August 1, 2006,
32	or upon HealthMatch implementation, whichever is later.
33	Sec. 45. Minnesota Statutes 2004, section 549.02, is
34	amended by adding a subdivision to read:
35	Subd. 3. [LIMITATION.] Notwithstanding subdivisions 1 and
36	2, where the state agency is named or intervenes as a party to

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[REVISOR ] \_ 35/MD 05-4117 04/28/05 enforce the agency's rights under section 256B.056, the agency 1 shall not be liable for costs to any prevailing defendant. 2 Sec. 46. Minnesota Statutes 2004, section 549.04, is 3 amended to read: 4 549.04 [DISBURSEMENTS; TAXATION AND ALLOWANCE.] 5 Subdivision 1. [GENERALLY.] In every action in a district 6 court, the prevailing party, including any public employee who 7 prevails in an action for wrongfully denied or withheld 8 employment benefits or rights, shall be allowed reasonable 9 disbursements paid or incurred, including fees and mileage paid 10 for service of process by the sheriff or by a private person. 11 Subd. 2. [LIMITATION.] Notwithstanding subdivision 1, 12 where the state agency is named or intervenes as a party to 13 enforce the agency's rights under section 256B.056, the agency 14 shall not be liable for disbursements to any prevailing 15 defendant. 16 Sec. 47. [EMPLOYER DISCLOSURE FOR MINNESOTA HEALTH CARE 17 PROGRAM.] 18 Subdivision 1. [DEFINITIONS.] (a) For purposes of this 19 20 section, the following definitions apply. 21 (b) "Commissioner" means the commissioner of human services. (c) "Minnesota health care program" means the prescription 22 23 drug program under section 256.955, medical assistance under 24 chapter 256B, general assistance medical care under section 256D.03, subdivision 3, and MinnesotaCare under chapter 256L. 25 26 Subd. 2. [REPORT.] (a) By January 15, 2007, for the previous fiscal year, the commissioner shall submit to the 27 28 legislature a report identifying all employers that employ 50 or 29 more employees who are Minnesota health care program recipients. In determining whether the 50-employee threshold is 30 met, the commissioner shall include all employees employed by an 31 employer and its subsidiaries at all locations within the 32 state. The report shall include the following information: 33 34 (1) the name of the employer and, as appropriate, the names of its subsidiaries that employ Minnesota health care program 35 recipients; 36

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1	(2) the number of Minnesota health care program recipients
2	who are employees of the employer;
3	(3) the number of Minnesota health care program recipients
4	who are spouses or dependents of employees of the employer; and
5	(4) the cost to the state of providing health care benefits
6	for these employers' employees and enrolled dependents.
7	(b) In preparing and publishing the report, the
8	commissioner shall take reasonable precautions to protect the
9	identity of Minnesota health care program recipients:
10	(1) the report shall include only nonindividually
11	identifiable summary data as defined in section 13.02,
12	subdivision 19;
13	(2) the commissioner shall employ generally accepted
14	statistical and scientific principles and methods for rendering
15	information as not individually identifiable. The commissioner
16	must determine that there is an insignificant risk that
17	information in the report could be used, alone or in combination
18	with other reasonably available information, to identify any
19	Minnesota health care program recipient; and
20	(3) the commissioner shall comply with all other applicable
21	privacy and security provisions of the Health Insurance
22	Portability and Accountability Act of 1996, Public Law 104-191,
23	and its corresponding regulations, Code of Federal Regulations,
24	title 45, sections 160, 162, and 164; Minnesota Statutes,
25	chapter 13; section 144.335; and any other applicable state and
26	federal law.
27	(c) The commissioner shall make the report available to the
28	public on the Department of Human Services' Web site, and shall
29	provide a copy of the report to any member of the public upon
30	request.
31	Sec. 48. [LIMITING COVERAGE OF HEALTH CARE SERVICES FOR
32	MEDICAL ASSISTANCE, GENERAL ASSISTANCE MEDICAL CARE, AND
33	MINNESOTACARE PROGRAMS.]
34	Subdivision 1. [PRIOR AUTHORIZATION OF SERVICES.] (a)
35	Effective July 1, 2005, prior authorization is required for the
36	services described in subdivision 2 for reimbursement under
Art	ticle 2 Section 48 106

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	1	chapters_256B, 256D, and 256L.
~	2	(b) Prior authorization shall be conducted under the
1	3	direction of the medical director of the Department of Human
	4	Services in conjunction with a medical policy advisory council.
	5	To the extent available, the medical director shall use publicly
	6	available evidence-based guidelines developed by an independent,
	7	nonprofit organization or by the professional association of the
	8	specialty that typically provides the service or by a multistate
	9	Medicaid evidence-based practice center. If the commissioner
	10	does not have a medical director and medical policy director in
	11	place, the commissioner shall contract prior authorization to a
	12	Minnesota-licensed utilization review organization or to another
·~~, .	13	entity such as a peer review organization eligible to operate in
	14	Minnesota.
	15	(c) A prepaid health plan shall use prior authorization for
	16	the services described in subdivision 2 unless the prepaid
	17	health plan is otherwise using evidence-based practices to
	18	address these services.
	19	(d) This section expires July 1, 2007, or when a list is
	20	established according to Minnesota Statutes, section 256B.0625,
	21	subdivision 46, whichever is earlier.
	22	Subd. 2. [SERVICES REQUIRING PRIOR AUTHORIZATION.] The
and the second	23	following services require prior authorization:
	24	(1) elective outpatient high-technology imaging to include
	25	positive emission tomography (PET) scans, magnetic resonance
	26	imaging (MRI), computed tomography (CT), and nuclear cardiology;
	27	(2) spinal fusion, unless in an emergency situation related
	28	to trauma;
	29	(3) bariatric surgery;
	30	(4) chiropractic visits beyond ten visits;
	31	(5) circumcision; and
	32	(6) orthodontia.
	33	Subd. 3. [RATE REDUCTION.] (a) Effective for the services
	34	identified in subdivision 2, rendered on or after July 1, 2005,
	35	the payment rate shall be reduced by ten percent from the rate
	36	in effect on June 30, 2005.

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1	(b) This subdivision shall expire on June 30, 2006, or upon
2	the completion of the prior authorization system required under
3	subdivision 1, paragraph (b), whichever is later.
4	Sec. 49. [ORAL HEALTH CARE SYSTEM PILOT PROJECT START-UP
5	GRANT.]
6	The commissioner of human services shall issue a request
7	for proposal for a two-year pilot project that shall provide
8	dental services for Minnesota health care program recipients
9	through a new oral health care delivery system. The request for
10	proposal shall be based upon the model designed by the Oral
11	HealthCare Solutions Project. The proposal must demonstrate the
12	capacity to obtain broad community support and to leverage the
13	state's start-up funding by attracting additional public and
14	private funding. The pilot project must include both urban and
15	rural regions of the state, and adhere to the financial and
16	delivery system requirements specified by the commissioner in
17	accordance with the Oral HealthCare Solutions Project design.
18	Sec. 50. [PLANNING PROCESS FOR MANAGED CARE.]
19	The commissioner of human services shall develop a planning
20	process for the purposes of implementing at least one additional
21	managed care arrangement to provide medical assistance services,
22	excluding continuing care services, to recipients enrolled in
23	the medical assistance fee-for-service program, effective
24	January 1, 2007. This planning process shall include an
25	advisory committee composed of current fee-for-service
26	consumers, consumer advocates, and providers, as well as
27	representatives of health plans and other provider organizations
28	qualified to provide basic health care services to persons with
29	disabilities. The commissioner shall seek any additional
30	federal authority necessary to provide basic health care
31	services through contracted managed care arrangements.
32	Sec. 51. [REPEALER.]
33	(a) Notwithstanding Minnesota Statutes, section 256B.69,
34	subdivision 5a, paragraph (b), Minnesota Statutes 2004, section
35	256L.035, is repealed effective July 1, 2005.
36	(b) Minnesota Statutes 2004, section 256B.0631, is repealed

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	1	effective January 1, 2006.
	2	ARTICLE 3
	3	HEALTH CARE COST CONTAINMENT
	4	Section 1. Minnesota Statutes 2004, section 62A.65,
	5	subdivision 3, is amended to read:
	6	Subd. 3. [PREMIUM RATE RESTRICTIONS.] No individual health
	7	plan may be offered, sold, issued, or renewed to a Minnesota
	8	resident unless the premium rate charged is determined in
	9	accordance with the following requirements:
	10	(a) Premium rates must be no more than 25 percent above and
	11	no more than 25 percent below the index rate charged to
	12	individuals for the same or similar coverage, adjusted pro rata
	13	for rating periods of less than one year. The premium
	14	variations permitted by this paragraph must be based only upon
	15	health status, claims experience, and occupation. For purposes
	16	of this paragraph, health status includes refraining from
	17	tobacco use or other actuarially valid lifestyle factors
	18	associated with good health, provided that the lifestyle factor
	19	and its effect upon premium rates have been determined by the
	20	commissioner to be actuarially valid and have been approved by
	21	the commissioner. Variations permitted under this paragraph
	22	must not be based upon age or applied differently at different
	23	ages. This paragraph does not prohibit use of a constant
	24	percentage adjustment for factors permitted to be used under
	25	this paragraph.
	26	(b) Premium rates may vary based upon the ages of covered
	27	persons only as provided in this paragraph. In addition to the
	28	variation permitted under paragraph (a), each health carrier may
	29	use an additional premium variation based upon age of up to plus
	30	or minus 50 percent of the index rate.
	31	(c) A health carrier may request approval by the
	32	commissioner to establish no more than three geographic regions
	33	and to establish separate index rates for each region, provided
-	34	that the index rates do not vary between any two regions by more

35 than 20 percent. Health carriers that do not do business in the 36 Minneapolis/St. Paul metropolitan area may request approval for

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1 no more than two geographic regions, and clauses (2) and (3) do 2 not apply to approval of requests made by those health 3 carriers. The commissioner may grant approval if the following 4 conditions are met:

5 (1) the geographic regions must be applied uniformly by the6 health carrier;

7 (2) one geographic region must be based on the8 Minneapolis/St. Paul metropolitan area;

9 (3) for each geographic region that is rural, the index 10 rate for that region must not exceed the index rate for the 11 Minneapolis/St. Paul metropolitan area; and

12 (4) the health carrier provides actuarial justification 13 acceptable to the commissioner for the proposed geographic 14 variations in index rates, establishing that the variations are 15 based upon differences in the cost to the health carrier of 16 providing coverage.

(d) Health carriers may use rate cells and must file with the commissioner the rate cells they use. Rate cells must be based upon the number of adults or children covered under the policy and may reflect the availability of Medicare coverage. The rates for different rate cells must not in any way reflect generalized differences in expected costs between principal insureds and their spouses.

(e) In developing its index rates and premiums for a health
plan, a health carrier shall take into account only the
following factors:

27 (1) actuarially valid differences in rating factors28 permitted under paragraphs (a) and (b); and

29 (2) actuarially valid geographic variations if approved by30 the commissioner as provided in paragraph (c).

31 (f) All premium variations must be justified in initial 32 rate filings and upon request of the commissioner in rate 33 revision filings. All rate variations are subject to approval 34 by the commissioner.

35 (g) The loss ratio must comply with the section 62A.02136 requirements for individual health plans.

	1	(h) <u>Notwithstanding paragraphs (a) to (g)</u> , the rates must
	2	not be approved, unless the commissioner has determined that the
	3	rates are reasonable. In determining reasonableness, the
	4	commissioner shall consider-the-growth-rates-applied-under
	5	section-623-04,-subdivision-1,-paragraph-(b) apply the premium
	6	growth limits established under section 62J.04, subdivision 1b,
	7	to the calendar year or years that the proposed premium rate
	8	would be in effect, and shall consider actuarially valid changes
	9	in risks associated with the enrollee populations, and
	10	actuarially valid changes as a result of statutory changes in
	11	Laws 1992, chapter 549.
	12	Sec. 2. Minnesota Statutes 2004, section 62J.04, is
~	13	amended by adding a subdivision to read:
	14	Subd. 1b. [PREMIUM GROWTH LIMITS.] (a) For calendar year
	15	2005 and each year thereafter, the commissioner shall set annual
	16	premium growth limits for health plan companies. The premium
	17	limits set by the commissioner for calendar years 2005 to 2010
	18	shall not exceed the regional Consumer Price Index for urban
	19	consumers for the preceding calendar year plus two percentage
	20	points and an additional one percentage point to be used to
	21	finance the implementation of the electronic medical record
	22	system. The commissioner shall ensure that the additional
	23	percentage point is being used to provide financial assistance
mary.	24	to health care providers to implement electronic medical record
	25	systems either directly or through an increase in reimbursement.
	26	(b) For the calendar years beyond 2010, the rate of premium
	27	growth shall be limited to the change in the Consumer Price
	28	Index for urban consumers for the previous calendar year plus
	29	two percentage points. The commissioners of health and commerce
	30	shall make a recommendation to the legislature by January 15,
	31	2009, regarding the continuation of the additional percentage
	<b>32</b> ·	point to the growth limit described in paragraph (a). The
	33	recommendation shall be based on the progress made by health
	34	care providers in instituting an electronic medical record
	35	system and in creating a statewide interactive electronic health
	36	record system.

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l	(c) -The commissioner may add additional percentage points
2	as needed to the premium limit for a calendar year if a major
3	disaster, bioterrorism, or a public health emergency occurs that
4	results in higher health care costs. Any additional percentage
5	points must reflect the additional cost to the health care
6	system directly attributed to the disaster or emergency.
7	(d) The commissioner shall publish the annual premium
8	growth limits in the State Register by January 31 of the year
9	that the limits are to be in effect.
10	(e) For the purpose of this subdivision, premium growth is
11	measured as the percentage change in per member, per month
12	premium revenue from the current year to the previous year.
13	Premium growth rates shall be calculated for the following lines
14	of business: individual, small group, and large group. Data
15	used for premium growth rate calculations shall be submitted as
16	part of the cost containment filing under section 62J.38.
17	(f) For purposes of this subdivision, "health plan company"
18	has the meaning given in section 62J.041.
19	(g) A health plan company may reduce reimbursement to
20	providers in order to meet the premium growth limitations
21	required by this section.
22	Sec. 3. Minnesota Statutes 2004, section 62J.04,
23	subdivision 3, is amended to read:
24	Subd. 3. [COST CONTAINMENT DUTIES.] The commissioner shall:
25	(1) establish statewide and regional cost containment goals
26	for total health care spending under this section and collect
27	data as described in sections 62J.38 to 62J.41 to monitor
28	statewide achievement of the cost containment goals and premium
29	growth limits;
30	(2) divide the state into no fewer than four regions, with
31	one of those regions being the Minneapolis/St. Paul metropolitan
32	statistical area but excluding Chisago, Isanti, Wright, and
33	Sherburne Counties, for purposes of fostering the development of
34	regional health planning and coordination of health care
35	delivery among regional health care systems and working to
36	achieve the cost containment goals;

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(3) monitor the quality of health care throughout the state
 and take action as necessary to ensure an appropriate level of
 quality;

(4) issue recommendations regarding uniform billing forms, 4 uniform electronic billing procedures and data interchanges, 5 patient identification cards, and other uniform claims and 6 7 administrative procedures for health care providers and private 8 and public sector payers. In developing the recommendations, the commissioner shall review the work of the work group on -9 electronic data interchange (WEDI) and the American National 10 Standards Institute (ANSI) at the national level, and the work 11 12 being done at the state and local level. The commissioner may adopt rules requiring the use of the Uniform Bill 82/92 form, 13 the National Council of Prescription Drug Providers (NCPDP) 3.2 14 15 electronic version, the Centers for Medicare and Medicaid Services 1500 form, or other standardized forms or procedures; 16

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(5) undertake health planning responsibilities;(6) authorize, fund, or promote research and

(6) authorize, fund, or promote research and
experimentation on new technologies and health care procedures;

20 (7) within the limits of appropriations for these purposes, administer or contract for statewide consumer education and 21 22 wellness programs that will improve the health of Minnesotans and increase individual responsibility relating to personal 23 health and the delivery of health care services, undertake 24 25 prevention programs including initiatives to improve birth outcomes, expand childhood immunization efforts, and provide 26 start-up grants for worksite wellness programs; 27

(8) undertake other activities to monitor and oversee the
delivery of health care services in Minnesota with the goal of
improving affordability, quality, and accessibility of health
care for all Minnesotans; and

(9) make the cost containment goal <u>and premium growth limit</u>
data available to the public in a consumer-oriented manner.
Sec. 4. Minnesota Statutes 2004, section 62J.041, is
amended to read:

36 62J.041 [INTERIM HEALTH PLAN COMPANY COST-CONTAINMENT-GOALS

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HEALTH CARE EXPENDITURE LIMITS.] 1 Subdivision 1. [DEFINITIONS.] (a) For purposes of this 2 section, the following definitions apply. 3 (b) "Health plan company" has the definition provided in 4 5 section 620.01. This definition does not include the state employee health plan offered under chapter 43A. 6 (c) "Total Health care expenditures" means incurred claims 7 8 or expenditures on health care services7-administrative 9 expenses7-charitable-contributions7-and-all-other-payments made 10 by health plan companies out-of-premium-revenues. (d) "Net-expenditures"-means-total-expenditures-minus 11 12 exempted-taxes-and-assessments-and-payments-or-allocations-made 13 to-establish-or-maintain-reserves-14 (e)-"Exempted-taxes-and-assessments"-means-direct-payments 15 for-taxes-to-government-agencies7-contributions-to-the-Minnesota Comprehensive-Health-Association7-the-medical-assistance 16 provider's-surcharge-under-section-256-96577-the-MinnesotaCare 17 18 provider-tax-under-section-295.527-assessments-by-the-Health 19 Coverage-Reinsurance-Association7-assessments-by-the-Minnesota 20 bife-and-Health-Insurance-Guaranty-Association-assessments-by 21 the-Minnesota-Risk-Adjustment-Association,-and-any-new 22 assessments-imposed-by-federal-or-state-law-23 (f) "Consumer cost-sharing or subscriber liability" means 24 enrollee coinsurance, co-payment, deductible payments, and 25 amounts in excess of benefit plan maximums. Subd. 2. [ESTABLISHMENT.] The commissioner of health shall 26 27 establish cost-containment-goals health care expenditure limits 28 for the increase in net calendar year 2006, and each year 29 thereafter, for health care expenditures by each health plan company for-calendar-years-19947-19957-19967-and-1997---The-cost 30 31 containment-goals-must-be-the-same-as-the-annual-cost 32 containment-goals-for-health-care-spending-established-under section-62J-04,-subdivision-1,-paragraph-(b). Health plan 33 companies that are affiliates may elect to meet one 34 combined cost-containment-goal health care expenditure limit. 35 The limits set by the commissioner shall not exceed the premium 36

limits established in section 62J.04, subdivision 1b. 1 2

Subd. 3. [DETERMINATION OF EXPENDITURES.] Health plan companies shall submit to the commissioner of health, by April 3 17-19947-for-calendar-year-19937-April-17-19957-for-calendar 4 5 year-1994;-April-1;-1996;-for-calendar-year-1995;-April-1;-1997; for-calendar-year-1996;-and-April-1;-1998;-for-calendar-year 6 7 1997 of each year beginning 2006, all information the 8 commissioner determines to be necessary to implement this section. The information must be submitted in the form 9 specified by the commissioner. The information must include, 10 but is not limited to, health care expenditures per member per 11 12 month or cost per employee per month, and detailed information 13 on revenues and reserves. The commissioner, to the extent possible, shall coordinate the submittal of the information 14 required under this section with the submittal of the financial 15 16 data required under chapter 62J, to minimize the administrative 17 burden on health plan companies. The commissioner may adjust final expenditure figures for demographic changes, risk 18 19 selection, changes in basic benefits, and legislative initiatives that materially change health care costs, as long as 20 21 these adjustments are consistent with the methodology submitted by the health plan company to the commissioner, and approved by 22 23 the commissioner as actuarially justified. The-methodology-to be-used-for-adjustments-and-the-election-to-meet-one-cost 24 25 containment-goal-for-affiliated-health-plan-companies-must-be submitted-to-the-commissioner-by-September-17-1994---Community 26 integrated-service-networks-may-submit-the-information-with 27 their-application-for-licensure---The-commissioner-shall-also 28 accept-changes-to-methodologies-already-submitted---The 29 30 adjustment-methodology-submitted-and-approved-by-the commissioner-must-apply-to-the-data-submitted-for-calendar-years 31 1994-and-1995---The-commissioner-may-allow-changes-to-accepted 32 adjustment-methodologies-for-data-submitted-for-calendar-years 33 1996-and-1997---Changes-to-the-adjustment-methodology-must-be 34 received-by-September-17-19967-and-must-be-approved-by-the 35 commissioner. 36

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1 Subd. 4. [MONITORING OF RESERVES.] (a) The commissioners 2 of health and commerce shall monitor health plan company reserves and net worth as established under chapters 60A, 62C, 3 62D, 62H, and 64B, with respect to the health plan companies 4 5 that each commissioner respectively regulates to assess the 6 degree to which savings resulting from the establishment of cost containment goals are passed on to consumers in the form of 7 8 lower premium rates.

(b) Health plan companies shall fully reflect in the 9 premium rates the savings generated by the cost containment 10 goals. No premium rate, currently reviewed by the Department of 11 · 12 Health or Commerce, may be approved for those health plan 13 companies unless the health plan company establishes to the satisfaction of the commissioner of commerce or the commissioner 14 15 of health, as appropriate, that the proposed new rate would comply with this paragraph. 16

(c) Health plan companies, except those licensed under 17 18 chapter 60A to sell accident and sickness insurance under chapter 62A, shall annually before the end of the fourth fiscal 19 20 quarter provide to the commissioner of health or commerce, as applicable, a projection of the level of reserves the company 21 expects to attain during each quarter of the following fiscal 22 year. These health plan companies shall submit with required 23 24 quarterly financial statements a calculation of the actual reserve level attained by the company at the end of each quarter 25 26 including identification of the sources of any significant 27 changes in the reserve level and an updated projection of the level of reserves the health plan company expects to attain by 28 29 the end of the fiscal year. In cases where the health plan company has been given a certificate to operate a new health 30 maintenance organization under chapter 62D, or been licensed as 31 a community integrated service network under chapter 62N, or 32 formed an affiliation with one of these organizations, the 33 health plan company shall also submit with its quarterly 34 financial statement, total enrollment at the beginning and end 35 of the quarter and enrollment changes within each service area 36

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of the new organization. The reserve calculations shall be
 maintained by the commissioners as trade secret information,
 except to the extent that such information is also required to
 be filed by another provision of state law and is not treated as
 trade secret information under such other provisions.

6 (d) Health plan companies in paragraph (c) whose reserves 7 are less than the required minimum or more than the required 8 maximum at the end of the fiscal year shall submit a plan of 9 corrective action to the commissioner of health or commerce 10 under subdivision 7.

(e) The commissioner of commerce, in consultation with the commissioner of health, shall report to the legislature no later than January 15, 1995, as to whether the concept of a reserve corridor or other mechanism for purposes of monitoring reserves is adaptable for use with indemnity health insurers that do business in multiple states and that must comply with their domiciliary state's reserves requirements.

18 Subd. 5. [NOTICE.] The commissioner of health shall 19 publish in the State Register and make available to the public by July 1, 1995 2007, and each year thereafter, a list of all 20 21 health plan companies that exceeded their cost-containment-goal health care expenditure limit for the ±994 previous calendar 22 23 year. The-commissioner-shall-publish-in-the-State-Register-and 24 make-available-to-the-public-by-July-1,-1996,-a-list-of-all health-plan-companies-that-exceeded-their-combined-cost 25 containment-goal-for-calendar-years-1994-and-1995. The 26 commissioner shall notify each health plan company that the 27 commissioner has determined that the health plan company 28 exceeded its cost-containment-goal, health care expenditure 29 limit at least 30 days before publishing the list, and shall 30 provide each health plan company with ten days to provide an 31 explanation for exceeding the cost-containment-goal health care 32 expenditure limit. The commissioner shall review the 33 explanation and may change a determination if the commissioner 34 determines the explanation to be valid. 35

36 Subd. 6. [ASSISTANCE BY THE COMMISSIONER OF COMMERCE.] The

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1	commissioner of commerce shall provide assistance to the
2	commissioner of health in monitoring health plan companies
3	regulated by the commissioner of commerce.
4	Sec. 5. [62J.255] [HEALTH RISK INFORMATION SHEET.]
5	(a) A health plan company shall provide to each enrollee on
6	an annual basis information on the increased personal health
7	risks and the additional costs to the health care system due to
8	obesity and to the use of tobacco.
9	(b) The commissioner, in consultation with the Minnesota
10	Medical Association, shall develop an information sheet on the
11	personal health risks of obesity and smoking and on the
12	additional costs to the health care system due to obesity and
13	due to smoking. The information sheet shall be posted on the
14	Minnesota Department of Health's Web site.
15	(c) When providing the information required in paragraph
16	(a), the health plan company must also provide each enrollee
17	with information on the best practices care guidelines and
18	quality of care measurement criteria identified in section
19	62J.43 as well as the availability of this information on the
20	department's Web site.
21	(d) This section does not apply to health plan companies
22	offering only limited dental or vision plans.
23	Sec. 6. Minnesota Statutes 2004, section 62J.301,
24	subdivision 3, is amended to read:
25	Subd. 3. [GENERAL DUTIES.] The commissioner shall:
26	(1) collect and maintain data which enable population-based
27	monitoring and trending of the access, utilization, quality, and
28	cost of health care services within Minnesota;
29	(2) collect and maintain data for the purpose of estimating
30	total Minnesota health care expenditures and trends;
31	(3) collect and maintain data for the purposes of setting
32	cost containment goals and premium growth limits under section
33	62J.04, and measuring cost containment goal and premium growth
34	<u>limit</u> compliance;
35	(4) conduct applied research using existing and new data
36	and promote applications based on existing research;
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(5) develop and implement data collection procedures to
 ensure a high level of cooperation from health care providers
 and health plan companies, as defined in section 62Q.01,
 subdivision 4;

(6) work closely with health plan companies and health care
providers to promote improvements in health care efficiency and
effectiveness; and

8 (7) participate as a partner or sponsor of private sector 9 initiatives that promote publicly disseminated applied research 10 on health care delivery, outcomes, costs, quality, and 11 management.

Sec. 7. Minnesota Statutes 2004, section 62J.38, is amended to read:

62J.38 [COST CONTAINMENT DATA FROM GROUP PURCHASERS.]
(a) The commissioner shall require group purchasers to
submit detailed data on total health care spending for each
calendar year. Group purchasers shall submit data for the 1993
calendar year by April 1, 1994, and each April 1 thereafter
shall submit data for the preceding calendar year.

20 (b) The commissioner shall require each group purchaser to 21 submit data on revenue, expenses, and member months, as applicable. Revenue data must distinguish between premium 22 23 revenue and revenue from other sources and must also include information on the amount of revenue in reserves and changes in 24 25 reserves. Premium revenue data, information on aggregate 26 enrollment, and data on member months must be broken down to distinguish between individual market, small group market, and 27 28 large group market. Filings under this section for calendar 29 year 2005 must also include information broken down by 30 individual market, small group market, and large group market for calendar year 2004. Expenditure data must distinguish 31 between costs incurred for patient care and administrative 32 33 costs. Patient care and administrative costs must include only expenses incurred on behalf of health plan members and must not 34 include the cost of providing health care services for 35 36 nonmembers at facilities owned by the group purchaser or

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1 affiliate. Expenditure data must be provided separately for the following categories and for other categories required by the 2 3 commissioner: physician services, dental services, other professional services, inpatient hospital services, outpatient 4 5 hospital services, emergency, pharmacy services and other nondurable medical goods, mental health, and chemical dependency 6 services, other expenditures, subscriber liability, and 7 administrative costs. Administrative costs must include costs 8 for marketing; advertising; overhead; salaries and benefits of 9 10 central office staff who do not provide direct patient care; 11 underwriting; lobbying; claims processing; provider contracting 12 and credentialing; detection and prevention of payment for 13 fraudulent or unjustified requests for reimbursement or services; clinical quality assurance and other types of medical 14 15 care quality improvement efforts; concurrent or prospective utilization review as defined in section 62M.02; costs incurred 16 to acquire a hospital, clinic, or health care facility, or the 17 18 assets thereof; capital costs incurred on behalf of a hospital 19 or clinic; lease payments; or any other costs incurred pursuant 20 to a partnership, joint venture, integration, or affiliation 21 agreement with a hospital, clinic, or other health care 22 provider. Capital costs and costs incurred must be recorded 23 according to standard accounting principles. The reports of this data must also separately identify expenses for local, 24 state, and federal taxes, fees, and assessments. 25 The 26 commissioner may require each group purchaser to submit any other data, including data in unaggregated form, for the 27 purposes of developing spending estimates, setting spending 28 limits, and monitoring actual spending and costs. 29 In addition to reporting administrative costs incurred to acquire a 30 31 hospital, clinic, or health care facility, or the assets thereof; or any other costs incurred pursuant to a partnership, 32 33 joint venture, integration, or affiliation agreement with a hospital, clinic, or other health care provider; reports 34 submitted under this section also must include the payments made 35 during the calendar year for these purposes. The commissioner 36

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1 shall make public, by group purchaser data collected under this 2 paragraph in accordance with section 62J.321, subdivision 5. 3 Workers' compensation insurance plans and automobile insurance 4 plans are exempt from complying with this paragraph as it 5 relates to the submission of administrative costs. 6 (c) The commissioner may collect information on: 7 (1) premiums, benefit levels, managed care procedures, and other features of health plan companies; 8 9 (2) prices, provider experience, and other information for 10 services less commonly covered by insurance or for which 11 patients commonly face significant out-of-pocket expenses; and 12 (3) information on health care services not provided 13 through health plan companies, including information on prices, 14 costs, expenditures, and utilization. 15 (d) All group purchasers shall provide the required data 16 using a uniform format and uniform definitions, as prescribed by the commissioner. 17 18 Sec. 8. [62J.82] [CHARGES TO UNINSURED; PROVIDER 19 RECOURSE.] 20 Subdivision 1. [DEFINITIONS.] (a) For purposes of this 21 section, the terms defined in this subdivision have the meanings 22 given them. 23 (b) "Covered individual" means an individual who has health plan company or public health care program coverage for health 24 25 care services. (c) "CPT code" means a code contained in the most current 26 27 edition of the Physician's Current Procedural Terminology (CPT) manual published by the American Medical Association. 28 29 (d) "Dependent" has the meaning given under section 62L.02, subdivision 11. 30 (e) "Health care service" has the meaning given under 31 section 62J.17, subdivision 2. 32 (f) "Health plan company" has the meaning given under 33 34 section 62Q.01, subdivision 4. (g) "Person" means an individual, corporation, firm, 35 partnership, incorporated or unincorporated association, or any 36

04/28/05 [REVISOR ] \_GS/MD 05-4117 1 other legal or commercial entity. 2 (h) "Provider" means a hospital or outpatient surgical 3 center licensed under chapter 144. 4 (i) "Third-party payer" means a health plan company or a public health care plan or program. 5 6 (j) "Uninsured individual" means a person or dependent who 7 does not have health plan company coverage or who is not 8 otherwise covered by a third-party payer. 9 Subd. 2. [NOTICE TO UNINSURED.] (a) A provider may attempt 10 to obtain from a person or the person's representative information about whether any third-party payer may fully or 11 partially cover the charges for health care services rendered by 12 the provider to the person. 13 (b) A provider shall inform each person, both orally and in 14 15 writing, immediately upon first meeting with that person, or as soon as practicable thereafter, that uninsured individuals will 16 17 be charged or billed for health care services in amounts that do not exceed the amounts described in subdivision 3. 18 19 (c) If, at the time health care services are provided, a 20 person has not provided proof of coverage by a third-party payer 21 or a provider otherwise determines that the person is an 22 uninsured individual, the provider, as part of any billing to the person, shall provide the person with a clear and ·23 24 conspicuous notice that includes: 25 (1) a statement of charges for health care services rendered by the provider; and 26 27 (2) a statement that uninsured individuals will be charged 28 or billed for health care services in amounts that do not exceed the amounts described in subdivision 3. 29 30 (d) For purposes of the notice required under paragraph (c), a provider may incorporate the items into the provider's 31 existing billing statements and is not required to develop a 32 separate notice. All communications to a person required by 33 34 this subdivision must be language appropriate. 35 Subd. 3. [PROVIDER CHARGES TO UNINSURED.] In billing or charging an uninsured individual or the individual's 36

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	l	representative for medically necessary health care services, a
	2	provider must bill by CPT code, or other billing identifier as
	3	may be routinely used for billing that health care service. A
	4	provider shall not bill or charge an uninsured individual or the
	5	individual's representative more than the amount the provider is
	6	paid for that service by the nongovernmental third-party payer
	7	that provided the most revenue to the provider during the
	8	previous calendar year, plus any applicable cost sharing
	9	payments payable by an individual covered by that provider's
	10	highest volume plan. After a bill or charge is issued under
	11	this subdivision, a provider may not increase the bill or charge.
	12	Subd. 4. [LIMITATIONS.] Notwithstanding any other
	13	provision of law, the amounts paid by uninsured individuals for
	14	health care services according to subdivision 3 does not
	15	constitute a provider's uniform, published, prevailing, or
	16	customary charges, or its usual fees to the general public, for
	17	purposes of any payment limit under the Medicare or medical
	18	assistance programs or any other federal or state financed
	19	health care program.
	20	Subd. 5. [RECOURSE LIMITED.] (a) Providers under agreement
	21	with a health plan company or public health care plan or program
	22	to provide health care services shall not have recourse against
~~~	23	covered individuals, or persons acting on their behalf, for
	24	amounts above those specified in the evidence of coverage or
	25	other plan or program document as co-payments or coinsurance for
	26	health care services. This subdivision applies only to health
	27	plans that provide coverage equivalent to or greater than a
	28	number two qualified plan described under section 62E.08, and is
	29	not limited to the following events:
	30	(1) nonpayment by the health plan company;
	31	(2) insolvency of the health plan company; and
	32	(3) breach of the agreement between the health plan company
, and the second	33	and the provider.
	34	(b) This subdivision does not limit a provider's ability to
	35	seek payment from any person other than the covered individual,
	36	the covered individual's guardian or conservator, the covered
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1	individual's immediate family members, or the covered
2	individual's legal representative in the event of nonpayment by
3	a health plan company.
4	Subd. 6. [REMEDIES.] A person may file an action in
5	district court seeking injunctive relief and damages for
6	violations of this section. In any such action, a person may
7	also recover costs and disbursements and reasonable attorney
8	fees.
9	Subd. 7. [GROUNDS FOR DISCIPLINARY ACTION.] Violations of
10	this section may be grounds for disciplinary or regulatory
11	action against a provider by the appropriate licensing board or
12	agency.
13	Subd. 8. [AUTHORITY OF ATTORNEY GENERAL.] The attorney
14	general may investigate violations of this section under section
15	8.31. The attorney general may file an action for violations of
16	this section according to section 8.31 or may pursue other
17	remedies available to the attorney general.
18	Subd. 9. [INCOME AND ASSET LIMITATIONS.] The provisions of
19	this section shall not apply to uninsured individuals with an
20	annual family income above \$125,000.
21	Sec. 9. [62J.83] [PROVIDER COST DISCLOSURE.]
22	Subdivision 1. [REPORT; AVAILABILITY.] (a) Each health
23	care provider, as defined by section 62J.03, subdivision 8,
24	shall report annually to the commissioner of health, in a form
25	and manner specified by the commissioner, the following:
26	(1) the average and median allowable charge from private
27	third-party payers for the 20 services or procedures most
28	commonly performed;
29	(2) the average and median payment rates for those services
30	and procedures for medical assistance; and
31	(3) the average and median payment rates for private pay
32	individuals.
33	(b) This information shall be available to the public:
34	(1) through the health care provider; and
35	(2) through the commissioner on agency Web sites, including
36	minnesotahealthinfo.com.

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1	Subd. 2. [COMPARABILITY.] The commissioner may contract
2	with one or more private, nonprofit organizations to make this
3	information available in an easily understood format that
4	promotes comparisons by integrated health care systems,
5	individual practice groups, single-provider practices, specialty
6	groups, and hospitals.
7	Subd. 3. [DETERMINATION OF MOST COMMON PROCEDURES.] The
8	commissioner may specify the 20 most common procedures by
9	specialty, provider type, or other suitable categories.
10	Sec. 10. Minnesota Statutes 2004, section 62L.08,
11	subdivision 8, is amended to read:
12	Subd. 8. [FILING REQUIREMENT.] (a) No later than July 1,
13	1993, and each year thereafter, a health carrier that offers,
14	sells, issues, or renews a health benefit plan for small
15	employers shall file with the commissioner the index rates and
16	must demonstrate that all rates shall be within the rating
17	restrictions defined in this chapter. Such demonstration must
18	include the allowable range of rates from the index rates and a
19	description of how the health carrier intends to use demographic
20	factors including case characteristics in calculating the
21	premium rates.
22	(b) Notwithstanding paragraph (a), the rates shall not be
23	approved, unless the commissioner has determined that the rates
24	are reasonable. In determining reasonableness, the commissioner
25	shall consider-the-growth-rates-applied-under-section-625-047
26	subdivision-17-paragraph-(b) apply the premium growth limits
27	established under section 62J.04, subdivision lb, to the
28	calendar year or years that the proposed premium rate would be
29	in effect, and shall consider actuarially valid changes in risk
30	associated with the enrollee population, and actuarially valid
31	changes as a result of statutory changes in Laws 1992, chapter
32	549. For-premium-rates-proposed-to-go-into-effect-between-July
33	17-1993-and-December-317-19937-the-pertinent-growth-rate-is-the
34	growth-rate-applied-under-section-62J.047-subdivision-17
35	paragraph-{b};-to-calendar-year-1994.
36	Sec. 11. Minnesota Statutes 2004, section 620.37,

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1	subdivision 7, is amended to read:
2	Subd. 7. [HUMAN SERVICES.] (a) The commissioner of human
- 3	services shall implement this section in a manner that is
4	consistent with applicable federal laws and regulations and that
5	avoids the duplication of review activities performed by a
6	nationally recognized independent organization.
7	(b) By December 31 of each year, the commissioner shall
8	submit to the legislature a written report identifying the
9	number of audits performed by a nationally recognized
10	independent organization that were accepted, partially accepted,
11	or rejected by the commissioner under this section. The
12	commissioner shall provide the rationale for partial acceptance
13	or rejection. If the rationale for the partial acceptance or
14	rejection was based on the commissioner's determination that the
15	standards used in the audit were not equivalent to state law,
16	regulation, or contract requirement, the report must document
17	the variances between the audit standards and the applicable
18	state requirements.
19	ARTICLE 4
19 20	
20	LONG-TERM CARE AND CONTINUING CARE
20 21	LONG-TERM CARE AND CONTINUING CARE Section 1. Minnesota Statutes 2004, section 144A.073, is
20 21 22	LONG-TERM CARE AND CONTINUING CARE Section 1. Minnesota Statutes 2004, section 144A.073, is amended by adding a subdivision to read:
20 21 22 23	LONG-TERM CARE AND CONTINUING CARE Section 1. Minnesota Statutes 2004, section 144A.073, is amended by adding a subdivision to read: <u>Subd. 3d.</u> [PROJECT AMENDMENT AUTHORIZED.] <u>Notwithstanding</u>
20 21 22 23 24	LONG-TERM CARE AND CONTINUING CARE Section 1. Minnesota Statutes 2004, section 144A.073, is amended by adding a subdivision to read: <u>Subd. 3d.</u> [PROJECT AMENDMENT AUTHORIZED.] Notwithstanding the provisions of subdivision 3b:
20 21 22 23 24 25	LONG-TERM CARE AND CONTINUING CARE Section 1. Minnesota Statutes 2004, section 144A.073, is amended by adding a subdivision to read: <u>Subd. 3d.</u> [PROJECT AMENDMENT AUTHORIZED.] <u>Notwithstanding</u> the provisions of subdivision 3b: <u>(1) a nursing facility located in the city of Duluth with</u>
20 21 22 23 24 25 26	LONG-TERM CARE AND CONTINUING CARE Section 1. Minnesota Statutes 2004, section 144A.073, is amended by adding a subdivision to read: <u>Subd. 3d.</u> [PROJECT AMENDMENT AUTHORIZED.] Notwithstanding the provisions of subdivision 3b: (1) a nursing facility located in the city of Duluth with 42 licensed beds as of January 1, 2005, that received approval
20 21 22 23 24 25 26 27	LONG-TERM CARE AND CONTINUING CARE Section 1. Minnesota Statutes 2004, section 144A.073, is amended by adding a subdivision to read: <u>Subd. 3d.</u> [PROJECT AMENDMENT AUTHORIZED.] Notwithstanding the provisions of subdivision 3b: <u>(1) a nursing facility located in the city of Duluth with</u> 42 licensed beds as of January 1, 2005, that received approval under this section in 2002 for a moratorium exception project
20 21 22 23 24 25 26 27 28	LONG-TERM CARE AND CONTINUING CARE Section 1. Minnesota Statutes 2004, section 144A.073, is amended by adding a subdivision to read: <u>Subd. 3d.</u> [PROJECT AMENDMENT AUTHORIZED.] <u>Notwithstanding</u> the provisions of subdivision 3b: <u>(1) a nursing facility located in the city of Duluth with</u> 42 licensed beds as of January 1, 2005, that received approval under this section in 2002 for a moratorium exception project may reduce the number of resident rooms in the new addition from
20 21 22 23 24 25 26 27 28 29	LONG-TERM CARE AND CONTINUING CARE Section 1. Minnesota Statutes 2004, section 144A.073, is amended by adding a subdivision to read: <u>Subd. 3d.</u> [PROJECT AMENDMENT AUTHORIZED.] Notwithstanding the provisions of subdivision 3b: (1) a nursing facility located in the city of Duluth with 42 licensed beds as of January 1, 2005, that received approval under this section in 2002 for a moratorium exception project may reduce the number of resident rooms in the new addition from 13 to nine and may reduce the common space by more than five
20 21 22 23 24 25 26 27 28 29 30	LONG-TERM CARE AND CONTINUING CARE Section 1. Minnesota Statutes 2004, section 144A.073, is amended by adding a subdivision to read: <u>Subd. 3d.</u> [PROJECT AMENDMENT AUTHORIZED.] Notwithstanding the provisions of subdivision 3b: (1) a nursing facility located in the city of Duluth with 42 licensed beds as of January 1, 2005, that received approval under this section in 2002 for a moratorium exception project may reduce the number of resident rooms in the new addition from 13 to nine and may reduce the common space by more than five percent; and
20 21 22 23 24 25 26 27 28 29 30 31	LONG-TERM CARE AND CONTINUING CARE Section 1. Minnesota Statutes 2004, section 144A.073, is amended by adding a subdivision to read: <u>Subd. 3d.</u> [PROJECT AMENDMENT AUTHORIZED.] <u>Notwithstanding</u> the provisions of subdivision 3b: <u>(1) a nursing facility located in the city of Duluth with</u> 42 licensed beds as of January 1, 2005, that received approval under this section in 2002 for a moratorium exception project may reduce the number of resident rooms in the new addition from 13 to nine and may reduce the common space by more than five <u>percent; and</u> <u>(2) a nursing facility located in the city of Duluth with</u>
20 21 22 23 24 25 26 27 28 29 30 31 32	LONG-TERM CARE AND CONTINUING CARE Section 1. Minnesota Statutes 2004, section 144A.073, is amended by adding a subdivision to read: <u>Subd. 3d.</u> [PROJECT AMENDMENT AUTHORIZED.] Notwithstanding the provisions of subdivision 3b: (1) a nursing facility located in the city of Duluth with 42 licensed beds as of January 1, 2005, that received approval under this section in 2002 for a moratorium exception project may reduce the number of resident rooms in the new addition from 13 to nine and may reduce the common space by more than five percent; and (2) a nursing facility located in the city of Duluth with 127 licensed beds as of January 1, 2005, that received approval
20 21 22 23 24 25 26 27 28 29 30 31 32 33	LONG-TERM CARE AND CONTINUING CARE Section 1. Minnesota Statutes 2004, section 144A.073, is amended by adding a subdivision to read: <u>Subd. 3d. [PROJECT AMENDMENT AUTHORIZED.] Notwithstanding</u> the provisions of subdivision 3b: <u>(1) a nursing facility located in the city of Duluth with</u> 42 licensed beds as of January 1, 2005, that received approval under this section in 2002 for a moratorium exception project may reduce the number of resident rooms in the new addition from 13 to nine and may reduce the common space by more than five percent; and <u>(2) a nursing facility located in the city of Duluth with</u> 127 licensed beds as of January 1, 2005, that received approval under this section in 2002 for a moratorium exception project

1 subdivision 10, is amended to read: Subd. 10. [EXTENSION OF APPROVAL OF MORATORIUM EXCEPTION.] 2 3 Notwithstanding subdivision 3, the commissioner of health shall 4 extend project approval for an additional 18 36 months for any 5 proposed exception to the nursing home licensure and 6 certification moratorium if the proposal was approved under this section between July 1, 2001, and June 30, 2003. 7 Sec. 3. Minnesota Statutes 2004, section 252.291, is 8 1 amended by adding a subdivision to read: 9 10 Subd. 2b. [EXCEPTION FOR BROWN COUNTY FACILITY.] (a) The commissioner shall authorize and grant a new license under 11 12 chapter 245A to a new intermediate care facility for persons 13 with mental retardation under the following circumstances: 14 (1) the new facility replaces an existing six-bed intermediate care facility for the mentally retarded located in 15 16 Brown County that has been operating since June 1982; (2) the new facility is located on an already purchased 17 parcel of land; and 18 19 (3) the new facility is handicapped accessible. 20 (b) The medical assistance payment rate for the new 21 facility shall be the higher of the rate specified in paragraph 22 (c) or as otherwise provided by law. 23 (c) The new facility shall be considered a newly 24 established facility for rate-setting purposes and shall be eligible for the investment per bed limit specified in section 25 256B.501, subdivision 11, paragraph (c), and the interest 26 expense limitation specified in section 256B.501, subdivision 27 11, paragraph (d). Notwithstanding section 256B.5011, the newly 28 established facility's initial payment rate shall be set 29 according to Minnesota Rules, part 9553.0075, and shall not be 30 subject to the provisions of section 256B.501, subdivision 5b. 31 (d) During the construction of the new facility, Brown 32 County shall work with residents, families, and service 33 providers to explore all service options open to current 34 residents of the facility. 35 36 Sec. 4. Minnesota Statutes 2004, section 256B.0621,

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1 subdivision 2, is amended to read:

2 Subd. 2. [TARGETED CASE MANAGEMENT; DEFINITIONS.] For 3 purposes of subdivisions 3 to 10, the following terms have the 4 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;

10 (2) "home care targeted case management" means the 11 provision of targeted case management services for the purpose 12 of assisting home care service recipients to gain access to 13 needed services and supports so that they may remain in the 14 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 20 the provision of both county targeted case management and public 21 or private vendor service coordination services for the purpose 22 23 of assisting recipients to gain access to needed services and supports if they choose to move from an institution to the 24 25 community. Relocation targeted case management may be provided 26 during the last 180 consecutive days of an eligible recipient's institutional stay; and 27

(5) "targeted case management" means case management
services provided to help recipients gain access to needed
medical, social, educational, and other services and supports.

31 Sec. 5. Minnesota Statutes 2004, section 256B.0621, 32 subdivision 3, is amended to read:

33 Subd. 3. [ELIGIBILITY.] The following persons are eligible 34 for relocation targeted case management or home care-targeted 35 <u>care targeted</u> case management:

36 (1) medical assistance eligible persons residing in

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institutions who choose to move into the community are eligible
 for relocation targeted case management services; and

3 (2) medical assistance eligible persons receiving home care
4 services, who are not eligible for any other medical assistance
5 reimbursable case management service, are eligible for home
6 care-targeted care targeted case management services beginning
7 January-17-2003 July 1, 2005.

8 Sec. 6. Minnesota Statutes 2004, section 256B.0621,
9 subdivision 4, is amended to read:

Subd. 4. [RELOCATION TARGETED <u>COUNTY</u> CASE MANAGEMENT
PROVIDER QUALIFICATIONS.] (a) A relocation targeted <u>county</u> 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;

(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

31 (6) the capacity to document and maintain individual case32 records under state and federal requirements.

33 (b) A provider of targeted case management under section
34 256B.0625, subdivision 20, may be deemed a certified provider of
35 relocation targeted case management.

36 (c) A relocation targeted <u>county</u> case management provider

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may subcontract with another provider to deliver relocation 1 targeted case management services. Subcontracted providers must 2 demonstrate the ability to provide the services outlined in 3 subdivision 6, and have a procedure in place that notifies the 4 recipient and the recipient's legal representative of any 5 conflict of interest if the contracted targeted case management 6 provider also provides, or will provide, the recipient's 7 8 services and supports. Counties must require that contracted providers must provide information on all conflicts of interest 9 and obtain the recipient's informed consent or provide the 10 recipient with alternatives. 11

Sec. 7. Minnesota Statutes 2004, section 256B.0621,
subdivision 5, is amended to read:

14 Subd. 5. [HOME CARE TARGETED CASE MANAGEMENT AND RELOCATION SERVICE COORDINATION PROVIDER QUALIFICATIONS.] The 15 following-qualifications-and-certification-standards-must-be-met 16 by Providers of home care targeted case management and 17 18 relocation service coordination must meet the qualifications 19 under subdivision 4 for county vendors or the following 20 qualifications and certification standards for private vendors. 21 (a) The commissioner must certify each provider of home care targeted case management and relocation service 22 coordination before enrollment. The certification process shall 23 examine the provider's ability to meet the requirements in this 24 25 subdivision and other state and federal requirements of this 26 service.

(b) A Both home care targeted case management provider-is 27 an providers and relocation service coordination providers are 28 29 enrolled medical assistance provider providers who has have a minimum of a bachelor's degree or a license in a health or human 30 services field, or comparable training and two years of 31 32 experience in human services, and is have been determined by the commissioner to have all of the following characteristics: 33 (1) the demonstrated capacity and experience to provide the 34

35 components of case management to coordinate and link community 36 resources needed by the eligible population;

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	1	(2) -the administrative capacity and experience to serve the
	2	target population for whom it will provide services and ensure
	3	quality of services under state and federal requirements;
	4	(3) a financial management system that provides accurate
	5	documentation of services and costs under state and federal
	6	requirements;
	7	(4) the capacity to document and maintain individual case
	8	records under state and federal requirements; and
	9	(5) the capacity to coordinate with county administrative
	10	functions;
	11	(6) have no financial interest in the provision of
	12	out-of-home residential services to persons for whom targeted
	13	case management or relocation service coordination is provided;
	14	and
	15	(7) if a provider has a financial interest in services
	16	other than out-of-home residential services provided to persons
	17	for whom targeted case management or relocation service
	18	coordination is also provided, the county must determine each
	19	year that:
	20	(i) any possible conflict of interest is explained annually
	21	at a face-to-face meeting and in writing and the person provides
and the second of	22	written informed consent consistent with section 256B.77,
	23	subdivision 2, paragraph (p); and
	24	(ii) information on a range of other feasible service
	25	provider options has been provided.
	26	(c) The State of Minnesota, a county board, or agency
	27	acting on behalf of a county board shall not be liable for
	28	damages, injuries, or liabilities sustained because of services
	29	provided to a client by a private service coordination vendor.
	30	Sec. 8. Minnesota Statutes 2004, section 256B.0621,
	31	subdivision 6, is amended to read:
	32	Subd. 6. [ELIGIBLE SERVICES.] (a) Services eligible for
	33	medical assistance reimbursement as targeted case management
	34	include:
	35	(1) assessment of the recipient's need for targeted case
	36	management services and for persons choosing to relocate, the
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1 county must provide service coordination provider options at the
2 first contact and upon request;

3 (2) development, completion, and regular review of a
4 written individual service plan, which is based upon the
5 assessment of the recipient's needs and choices, and which will
6 ensure access to medical, social, educational, and other related
7 services and supports;

8 (3) routine contact or communication with the recipient, 9 recipient's family, primary caregiver, legal representative, 10 substitute care provider, service providers, or other relevant 11 persons identified as necessary to the development or 12 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 <u>and engaging in advocacy as needed</u> to ensure quality of services, appropriateness, and continued need;

20 (6) completing and maintaining necessary documentation that
21 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

26 (8) coordinating with the institution discharge planner in
27 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).

34 Sec. 9. Minnesota Statutes 2004, section 256B.0621, 35 subdivision 7, is amended to read:

36 Subd. 7. [TIME LINES.] The following time lines must be

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met for assigning a case manager: 1

2 (a) For relocation targeted case management, an eligible recipient must be assigned a county case manager who visits the 3 person within 20 working days of requesting a case manager from 4 their county of financial responsibility as determined under 5 chapter 256G. 6

(1) If a county agency, its contractor, or federally 7 recognized tribe does not provide case management services as . 8 required, the recipient may obtain targeted-relocation-case 9 management-services relocation service coordination from an 10 11 alternative a provider of-targeted-case-management-services 12 enrolled-by-the-commissioner qualified under subdivision 5.

13 (2) The commissioner may waive the provider requirements in subdivision 4, paragraph (a), clauses (1) and (4), to ensure 14 recipient access to the assistance necessary to move from an 15 institution to the community. The recipient or the recipient's 16 legal guardian shall provide written notice to the county or 17 tribe of the decision to obtain services from an alternative 18 provider. 19

(3) Providers of relocation targeted case management 20 enrolled under this subdivision shall: 21

22 (i) meet the provider requirements under subdivision 4 that are not waived by the commissioner; 23

(ii) be qualified to provide the services specified in 24 25 subdivision 6;

(iii) coordinate efforts with local social service agencies 26 and tribes; and 27

(iv) comply with the conflict of interest provisions 28 established under subdivision 4, paragraph (c). 29 30

(4) Local social service agencies and federally recognized tribes shall cooperate with providers certified by the 31 commissioner under this subdivision to facilitate the 32 recipient's successful relocation from an institution to the 33 34 community.

(b) For home care targeted case management, an eligible 35 recipient must be assigned a case manager within 20 working days 36

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of requesting a case manager from a home care targeted case
 management provider, as defined in subdivision 5.

3 Sec. 10. Minnesota Statutes 2004, section 256B.0625,
4 subdivision 2, is amended to read:

Subd. 2. [SKILLED AND INTERMEDIATE NURSING CARE.] Medical 5 assistance covers skilled nursing home services and services of 6 intermediate care facilities, including training and 7 habilitation services, as defined in section 252.41, subdivision 8 3, for persons with mental retardation or related conditions who 9 are residing in intermediate care facilities for persons with 10 mental retardation or related conditions. Medical assistance 11 12 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) 13 the facility in which the swing bed is located is eligible as a 14 sole community provider, as defined in Code of Federal 15 Regulations, title 42, section 412.92, or the facility is a 16 public hospital owned by a governmental entity with 15 or fewer 17 licensed acute care beds; (b) the Centers for Medicare and 18 Medicaid Services approves the necessary state plan amendments; 19 20 (c) the patient was screened as provided by law; (d) the patient 21 no longer requires acute care services; and (e) no nursing home beds are available within 25 miles of the facility. 22 The commissioner shall exempt a facility from compliance with the 23 sole community provider requirement in clause (a) if, as of 24 25 January 1, 2004, the facility had an agreement with the commissioner to provide medical assistance swing bed services. 26 Medical assistance also covers up to ten days of nursing care 27 provided to a patient in a swing bed if: (1) the patient's 28 physician certifies that the patient has a terminal illness or 29 condition that is likely to result in death within 30 days and 30 that moving the patient would not be in the best interests of 31 the patient and patient's family; (2) no open nursing home beds 32 33 are available within 25 miles of the facility; and (3) no open beds are available in any Medicare hospice program within 50 34 35 miles of the facility. The daily medical assistance payment for nursing care for the patient in the swing bed is the statewide 36

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

4 <u>following final enactment and applies to medical assistance</u>
5 <u>payments for swing bed services provided on or after March 5,</u>
6 2005.

Sec. 11. Minnesota Statutes 2004, section 256B.0625,
8 subdivision 19c, is amended to read:

9 Subd. 19c. [PERSONAL CARE.] Medical assistance covers personal care assistant services provided by an individual who 10 11 is qualified to provide the services according to subdivision 12 19a and section 256B.0627, where the services are prescribed determined to be medically necessary by a physician, provided in 13 14 accordance with a service plan of-treatment, and are supervised by the recipient or a qualified professional. The physician's 15 16 determination of medical necessity for personal care assistant 17 services shall be documented on a form approved by the commissioner and include the diagnosis or condition of the 18 person that results in a need for personal care assistant 19 services and be updated either when the person's medical 20 21 condition requires a change or at least annually if the medical need for personal care services is ongoing. 22 23 "Qualified professional" means a mental health professional as defined in section 245.462, subdivision 18, or 245.4871, 24 25 subdivision 27; or a registered nurse as defined in sections 148.171 to 148.285, or a licensed social worker as defined in 26

27 section 148B.21. As part of the assessment, the county public 28 health nurse will assist the recipient or responsible party to 29 identify the most appropriate person to provide supervision of 30 the personal care assistant. The qualified professional shall 31 perform the duties described in Minnesota Rules, part 9505.0335, 32 subpart 4.

33 Sec. 12. Minnesota Statutes 2004, section 256B.0627,
34 subdivision 1, is amended to read:

35 Subdivision 1. [DEFINITION.] (a) "Activities of daily
36 living" includes eating, toileting, grooming, dressing, bathing,

1 transferring, mobility, and positioning.

(b) "Assessment" means a review and evaluation of a 2 recipient's need for home care services conducted in person. 3 Assessments for private duty nursing shall be conducted by a 4 5 registered private duty nurse. Assessments for home health agency services shall be conducted by a home health agency 6 nurse. Assessments for personal care assistant services shall 7 be conducted by the county public health nurse or a certified 8 9 public health nurse under contract with the county. A face-to-face assessment must include: documentation of health 10 status, determination of need, evaluation of service 11 effectiveness, identification of appropriate services, service 12 plan development or modification, coordination of services, 13 14 referrals and follow-up to appropriate payers and community resources, completion of required reports, recommendation of 15 service authorization, and consumer education. Once the need 16 for personal care assistant services is determined under this 17 section, the county public health nurse or certified public 18 health nurse under contract with the county is responsible for 19 communicating this recommendation to the commissioner and the 20 recipient. A face-to-face assessment for personal care 21 assistant services is conducted on those recipients who have 22 23 never had a county public health nurse assessment. A face-to-face assessment must occur at least annually or when 24 there is a significant change in the recipient's condition or 25 when there is a change in the need for personal care assistant 26 27 services. A service update may substitute for the annual face-to-face assessment when there is not a significant change 28 in recipient condition or a change in the need for personal care 29 assistant service. A service update or review for temporary 30 increase includes a review of initial baseline data, evaluation 31 of service effectiveness, redetermination of service need, 32 modification of service plan and appropriate referrals, update 33 34 of initial forms, obtaining service authorization, and on going consumer education. Assessments for medical assistance home 35 care services for mental retardation or related conditions and 36

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1 alternative care services for developmentally disabled home and 2 community-based waivered recipients may be conducted by the 3 county public health nurse to ensure coordination and avoid 4 duplication. Assessments must be completed on forms provided by 5 the commissioner within 30 days of a request for home care 6 services by a recipient or responsible party.

7 (c) "Care plan" means a written description of personal 8 care assistant services developed by the qualified professional 9 or the recipient's physician with the recipient or responsible 10 party to be used by the personal care assistant with a copy 11 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

18 (2) regular care is private duty nursing provided to all19 other recipients.

20 (e) "Health-related functions" means functions that can be
21 delegated or assigned by a licensed health care professional
22 under state law to be performed by a personal care attendant.

(f) "Home care services" means a health service, determined 23 by the commissioner as medically necessary, that is ordered by a 24 physician and documented in a service plan that is reviewed by 25 the physician at least once every 60 days for the provision of 26 home health services, or private duty nursing, or at least once 27 28 every 365 days for personal care. Home care services are provided to the recipient at the recipient's residence that is a 29 place other than a hospital or long-term care facility or as 30 specified in section 256B.0625. 31

(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.

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(h) - "Medically necessary" has the meaning given in 1 Minnesota Rules, parts 9505.0170 to 9505.0475. 2 (i) "Personal care assistant" means a person who: 3 (1) is at least 18 years old, except for persons 16 to 18 4 5 years of age who participated in a related school-based job training program or have completed a certified home health aide 6 competency evaluation; 7 (2) is able to effectively communicate with the recipient 8 and personal care provider organization; 9 (3) effective July 1, 1996, has completed one of the 10 training requirements as specified in Minnesota Rules, part 11 9505.0335, subpart 3, items A to D; 12 (4) has the ability to, and provides covered personal care 13 assistant services according to the recipient's care plan, 14 responds appropriately to recipient needs, and reports changes 15 in the recipient's condition to the supervising qualified 16 professional or physician; 17 (5) is not a consumer of personal care assistant services; 18 19 and 20 (6) maintains daily written records detailing: (i) the actual services provided to the recipient; and 21 22 (ii) the amount of time spent providing the services; and 23 (7) is subject to criminal background checks and procedures specified in chapter 245C. 24 25 (j) "Personal care provider organization" means an 26 organization enrolled to provide personal care assistant 27 services under the medical assistance program that complies with 28 the following: 29 (1) owners who have a five percent interest or more, and 30 managerial officials are subject to a background study as provided in chapter 245C. This applies to currently enrolled 31 32 personal care provider organizations and those agencies seeking 33 enrollment as a personal care provider organization. An 34 organization will be barred from enrollment if an owner or 35 managerial official of the organization has been convicted of a crime specified in chapter 245C, or a comparable crime in 36

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another jurisdiction, unless the owner or managerial official
 meets the reconsideration criteria specified in chapter 245C;

3 (2) the organization must maintain a surety bond and liability insurance throughout the duration of enrollment and 4 5 provides proof thereof. The insurer must notify the Department of Human Services of the cancellation or lapse of policy; and 6 7 (3)-the-organization must maintain documentation of services as 8 specified in Minnesota Rules, part 9505.2175, subpart 7, as well 9 as evidence of compliance with personal care assistant training requirements; 10

11 (3) the organization must maintain documentation and a 12 recipient file and satisfy communication requirements in 13 subdivision 4, paragraph (f); and

14 (4) the organization must comply with all laws and rules
15 governing the provision of personal care services.

(k) "Responsible party" means an individual who is capable 16 17 of providing the support necessary to assist the recipient to live in the community, is at least 18 years old, actively 18 19 participates in planning and directing of personal care 20 assistant services, and is not the personal care assistant. The 21 responsible party must be accessible to the recipient and the personal care assistant when personal care services are being 22 23 provided and monitor the services at least weekly according to the plan of care. The responsible party must be identified at 24 25 the time of assessment and listed on the recipient's service agreement and care plan. Responsible parties who are parents of 26 27 minors or guardians of minors or incapacitated persons may delegate the responsibility to another adult who is not the 28 personal care assistant during a temporary absence of at least 29 24 hours but not more than six months. The person delegated as 30 31 a responsible party must be able to meet the definition of 32 responsible party, except that the delegated responsible party is required to reside with the recipient only while serving as 33 the responsible party. The delegated responsible party is not 34 35 required to reside with the recipient while serving as the responsible party if adequate supervision and monitoring are 36

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provided for as part of the person's individual service plan 1 2 under a home and community-based waiver program or in 3 conjunction with a home care targeted case management service provider or other case manager. The responsible party must 4 5 assure that the delegate performs the functions of the 6 responsible party, is identified at the time of the assessment, 7 and is listed on the service agreement and the care plan. 8 Foster care license holders may be designated the responsible party for residents of the foster care home if case management 9 10 is provided as required in section 256B.0625, subdivision 19a. For persons who, as of April 1, 1992, are sharing personal care 11 assistant services in order to obtain the availability of 12 24-hour coverage, an employee of the personal care provider 13 organization may be designated as the responsible party if case 14 management is provided as required in section 256B.0625, 15 subdivision 19a. 16

(1) "Service plan" means a written description of the 17 services needed based on the assessment developed by the nurse 18 19 who conducts the assessment together with the recipient or 20 responsible party. The service plan shall include a description of the covered home care services, frequency and duration of 21 services, and expected outcomes and goals. The recipient and 22 23 the provider chosen by the recipient or responsible party must be given a copy of the completed service plan within 30 calendar 24 25 days of the request for home care services by the recipient or 26 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;

34 (2) services which due to the recipient's medical condition
35 may only be safely and effectively provided by a registered
36 nurse or a licensed practical nurse;

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(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.

5 (n) "Telehomecare" means the use of telecommunications 6 technology by a home health care professional to deliver home 7 health care services, within the professional's scope of 8 practice, to a patient located at a site other than the site 9 where the practitioner is located.

10 Sec. 13. Minnesota Statutes 2004, section 256B.0627, 11 subdivision 4, is amended to read:

Subd. 4. [PERSONAL CARE ASSISTANT SERVICES.] (a) The 12 personal care assistant services that are eligible for payment 13 14 are services and supports furnished to an individual, as needed, 15 to assist in accomplishing activities of daily living; instrumental activities of daily living; health-related 16 17 functions through hands-on assistance, supervision, and cuing; 18 and redirection and intervention for behavior including observation and monitoring. 19

(b) Payment for services will be made within the limits
approved using the prior authorized process established in
subdivision 5.

23 (c) The amount and type of services authorized shall be
24 based on an assessment of the recipient's needs in these areas:
25 (1) bowel and bladder care;

26 (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;

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(4) respiratory assistance;

31 (5) transfers and ambulation;

32 (6) bathing, grooming, and hairwashing necessary for
33 personal hygiene;

34 (7) turning and positioning;

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35 (8) assistance with furnishing medication that is 36 self-administered;

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(9) application and maintenance of prosthetics and
 orthotics;

3 (10) cleaning medical equipment;

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(11) dressing or undressing;

5 (12) assistance with eating and meal preparation and
6 necessary grocery shopping;

7 (13) accompanying a recipient to obtain medical diagnosis8 or treatment;

9 (14) assisting, monitoring, or prompting the recipient to
10 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, includingobservation 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 27 part of a personal care service described in clauses (1) to (18). 28 For purposes of this subdivision, monitoring and observation 29 means watching for outward visible signs that are likely to 30 occur and for which there is a covered personal care service or 31 an appropriate personal care intervention. For purposes of this 32 subdivision, a clean procedure refers to a procedure that 33 reduces the numbers of microorganisms or prevents or reduces the 34 transmission of microorganisms from one person or place to 35 another. A clean procedure may be used beginning 14 days after 36

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04/28/05 [REVISOR ] JGS/MD 05-4117 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 determination of medical necessity as required by section 256B.0625, subdivision 19c. The determination must be in the recipient's file at the time claims are submitted for payment; (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 31 commissioner's designee.

(e) The recipient or responsible party may choose to 32 supervise the personal care assistant or to have a qualified 33 professional, as defined in section 256B.0625, subdivision 19c, 34 provide the supervision. As required under section 256B.0625, 35 subdivision 19c, the county public health nurse, as a part of 36

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1 the assessment, will assist the recipient or responsible party to identify the most appropriate person to provide supervision 2 of the personal care assistant. Health-related delegated tasks 3 performed by the personal care assistant will be under the 4 supervision of a qualified professional or the direction of the 5 recipient's physician. If the recipient has a qualified 6 professional, Minnesota Rules, part 9505.0335, subpart 4, 7 8 applies. 9 (f) In order to be paid for personal care services, personal care provider organizations, and personal care choice 10 11 providers are required: (1) to maintain a recipient file for each recipient for 12 13 whom services are being billed that contains: 14 (i) the current physician's determination of medical necessity as required by section 256B.0625, subdivision 19c; 15 (ii) the service plan, including the monthly authorized 16 hours, or flexible use plan; 17 (iii) the care plan, signed by the recipient and the 18 qualified professional, if required or designated, detailing the 19 20 personal care services to be provided; 21 (iv) documentation, on a form approved by the commissioner 22 and signed by the personal care assistant, specifying the day, 23 month, year, arrival, and departure times, with AM and PM notation, for all services provided to the recipient. The form 24 must include a notice that it is a federal crime to provide 25 false information on personal care service billings for medical 26 27 assistance payment; and (v) all notices to the recipient regarding personal care 28 29 service use exceeding authorized hours; and (2) to communicate, by telephone if available, and in 30 31 writing, with the recipient or the responsible party about the 32 schedule for use of authorized hours and to notify the recipient and the county public health nurse in advance and as soon as 33 possible, on a form approved by the commissioner, if the monthly 34 number of hours authorized is likely to be exceeded for the 35 36 month.

	1	(g)_The commissioner shall establish an ongoing audit
and and	2	process for potential fraud and abuse for personal care
	3	assistant services. The audit process must include, at a
	4	minimum, a requirement that the documentation of hours of care
	5	provided be on a form approved by the commissioner and include
	6	the personal care assistant's signature attesting that the hours
	7	shown on each bill were provided by the personal care assistant
	8	on the dates and the times specified.
	9	Sec. 14. Minnesota Statutes 2004, section 256B.0627,
	10	subdivision 5, is amended to read:
	11	Subd. 5. [LIMITATION ON PAYMENTS.] Medical assistance
	1 <b>2</b>	payments for home care services shall be limited according to
	13	this subdivision.
	14	(a) [LIMITS ON SERVICES WITHOUT PRIOR AUTHORIZATION.] A
	15	recipient may receive the following home care services during a
	16	calendar year:
	17	(1) up to two face-to-face assessments to determine a
	18	recipient's need for personal care assistant services;
	19	(2) one service update done to determine a recipient's need
	20	for personal care assistant services; and
	21	(3) up to nine skilled nurse visits.
~	22	(b) [PRIOR AUTHORIZATION; EXCEPTIONS.] All home care
1910 augus	23	services above the limits in paragraph (a) must receive the
	24	commissioner's prior authorization, except when:
	25	(1) the home care services were required to treat an
	26	emergency medical condition that if not immediately treated
	27	could cause a recipient serious physical or mental disability,
	28	continuation of severe pain, or death. The provider must
	29	request retroactive authorization no later than five working
	30	days after giving the initial service. The provider must be
	31	able to substantiate the emergency by documentation such as
	32	reports, notes, and admission or discharge histories;
	33	(2) the home care services were provided on or after the
	34	date on which the recipient's eligibility began, but before the
	35	date on which the recipient was notified that the case was
	36	opened. Authorization will be considered if the request is

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submitted by the provider within 20 working days of the date the
 recipient was notified that the case was opened;

3 (3) a third-party payor for home care services has denied 4 or adjusted a payment. Authorization requests must be submitted 5 by the provider within 20 working days of the notice of denial 6 or adjustment. A copy of the notice must be included with the 7 request;

8 (4) the commissioner has determined that a county or state 9 human services agency has made an error; or

10 (5) the professional nurse determines an immediate need for 11 up to 40 skilled nursing or home health aide visits per calendar 12 year and submits a request for authorization within 20 working 13 days of the initial service date, and medical assistance is 14 determined to be the appropriate payer.

15 (c) [RETROACTIVE AUTHORIZATION.] A request for retroactive 16 authorization will be evaluated according to the same criteria 17 applied to prior authorization requests.

[ASSESSMENT AND SERVICE PLAN.] Assessments under 18 (d) 19 section 256B.0627, subdivision 1, paragraph (a), shall be 20 conducted initially, and at least annually thereafter, in person with the recipient and result in a completed service plan using 21 22 forms specified by the commissioner. Within 30 days of 23 recipient or responsible party request for home care services, the assessment, the service plan, and other information 24 25 necessary to determine medical necessity such as diagnostic or testing information, social or medical histories, and hospital 26 27 or facility discharge summaries shall be submitted to the 28 commissioner. Notwithstanding the provisions of section 256B.0627, subdivision 12, the commissioner shall maximize 29 30 federal financial participation to pay for public health nurse 31 assessments for personal care services. For personal care assistant services: 32

(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.

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6 (2) If the recipient's medical need changes, the

recipient's provider may assess the need for a change in service 1 authorization and request the change from the county public 2 health nurse. Within 30 days of the request, the public health 3 nurse will determine whether to request the change in services 4 5 based upon the provider assessment, or conduct a home visit to assess the need and determine whether the change is 6 7 appropriate. If the change in service need is due to a change 8 in medical condition, a new physician's determination of medical 9 necessity, required by section 256B.0625, subdivision 19c, must 10 be obtained.

11 (3) To continue to receive personal care assistant services 12 after the first year, the recipient or the responsible party, in 13 conjunction with the public health nurse, may complete a service 14 update on forms developed by the commissioner according to 15 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
<u>option</u>, 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:

23 [HOME HEALTH SERVICES.] All home health services (1) 24 provided by a home health aide must be prior authorized by the 25 commissioner or the commissioner's designee. Prior 26 authorization must be based on medical necessity and cost-effectiveness when compared with other care options. When 27 home health services are used in combination with personal care 28 and private duty nursing, the cost of all home care services 29 shall be considered for cost-effectiveness. The commissioner 30 shall limit home health aide visits to no more than one visit 31 each per day. The commissioner, or the commissioner's designee, 32 may authorize up to two skilled nurse visits per day. 33

34 (2) [PERSONAL CARE ASSISTANT SERVICES.] (i) All personal
35 care assistant services and supervision by a qualified
36 professional, if requested by the recipient, must be prior

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authorized by the commissioner or the commissioner's designee 1 except for the assessments established in paragraph (a). 2 The amount of personal care assistant services authorized must be 3 based on the recipient's home care rating. A child may not be 4 5 found to be dependent in an activity of daily living if because of the child's age an adult would either perform the activity 6 for the child or assist the child with the activity and the 7 amount of assistance needed is similar to the assistance 8 appropriate for a typical child of the same age. Based on 9 10 medical necessity, the commissioner may authorize:

11 (A) up to two times the average number of direct care hours 12 provided in nursing facilities for the recipient's comparable 13 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

24 (D) up to the amount the commissioner would pay, as of July 25 1, 1991, plus any inflation adjustment provided for home care 26 services, for care provided in a regional treatment center for 27 recipients referred to the commissioner by a regional treatment 28 center preadmission evaluation team. For purposes of this 29 clause, home care services means all services provided in the 30 home or community that would be included in the payment to a 31 regional treatment center; or

32 (E) up to the amount medical assistance would reimburse for 33 facility care for recipients referred to the commissioner by a 34 preadmission screening team established under section 256B.0911 35 or 256B.092; and

36 (F) a reasonable amount of time for the provision of

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supervision by a qualified professional of personal care
 assistant services, if a qualified professional is requested by
 the recipient or responsible party.

4 (ii) The number of direct care hours shall be determined
5 according to the annual cost report submitted to the department
6 by nursing facilities. The average number of direct care hours,
7 as established by May 1, 1992, shall be calculated and
8 incorporated into the home care limits on July 1, 1992. These
9 limits shall be calculated to the nearest quarter hour.

(iii) The home care rating shall be determined by the 10 commissioner or the commissioner's designee based on information 11 12 submitted to the commissioner by the county public health nurse 13 on forms specified by the commissioner. The home care rating shall be a combination of current assessment tools developed 14 under sections 256B.0911 and 256B.501 with an addition for 15 16 seizure activity that will assess the frequency and severity of seizure activity and with adjustments, additions, and 17 clarifications that are necessary to reflect the needs and 18 19 conditions of recipients who need home care including children and adults under 65 years of age. The commissioner shall 20 establish these forms and protocols under this section and shall 21 use an advisory group, including representatives of recipients, 22 providers, and counties, for consultation in establishing and 23 revising the forms and protocols. 24

(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:

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(A) daily tube feedings;

32 (B) daily parenteral therapy;

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(C) wound or decubiti care;

34 (D) postural drainage, percussion, nebulizer treatments,
35 suctioning, tracheotomy care, oxygen, mechanical ventilation;
36 (E) catheterization;

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1 (F) -ostomy care;

(G) quadriplegia; or

3 (H) other comparable medical conditions or treatments the
4 commissioner determines would otherwise require institutional
5 care.

6 (v) A recipient shall qualify as having Level I behavior if 7 there is reasonable supporting evidence that the recipient 8 exhibits, or that without supervision, observation, or 9 redirection would exhibit, one or more of the following 10 behaviors that cause, or have the potential to cause:

11 (A)

(A) injury to the recipient's own body;

12 (B) physical injury to other people; or

13 (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):

23 (A) unusual or repetitive habits;

24 (B) withdrawn behavior; or

25 (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

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cost-effectiveness when compared with alternative care options.
 The commissioner may authorize medically necessary private duty
 nursing services in quarter-hour units when:

4 (i) the recipient requires more individual and continuous5 care than can be provided during a nurse visit; or

6 (ii) the cares are outside of the scope of services that
7 can be provided by a home health aide or personal care assistant.
8 The commissioner may authorize:

9 (A) up to two times the average amount of direct care hours 10 provided in nursing facilities statewide for case mix 11 classification "K" as established by the annual cost report 12 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 meets the hospital admission criteria established under Minnesota Rules, parts 9505.0501 to 9505.0540.

20 The commissioner may authorize up to 16 hours per day of 21 medically necessary private duty nursing services or up to 24 hours per day of medically necessary private duty nursing 22 services until such time as the commissioner is able to make a 23 determination of eligibility for recipients who are 24 25 cooperatively applying for home care services under the community alternative care program developed under section 26 256B.49, or until it is determined by the appropriate regulatory 27 agency that a health benefit plan is or is not required to pay 28 29 for appropriate medically necessary health care services. Recipients or their representatives must cooperatively assist 30 the commissioner in obtaining this determination. Recipients 31 32 who are eligible for the community alternative care program may not receive more hours of nursing under this section than would 33 34 otherwise be authorized under section 256B.49.

35 (4) [VENTILATOR-DEPENDENT RECIPIENTS.] If the recipient is
36 ventilator-dependent, the monthly medical assistance

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1 authorization for home care services shall not exceed what the 2 commissioner would pay for care at the highest cost hospital 3 designated as a long-term hospital under the Medicare program. 4 For purposes of this clause, home care services means all 5 services provided in the home that would be included in the 6 payment for care at the long-term hospital.

7 "Ventilator-dependent" means an individual who receives 8 mechanical ventilation for life support at least six hours per 9 day and is expected to be or has been dependent for at least 30 10 consecutive days.

[PRIOR AUTHORIZATION; TIME LIMITS.] The commissioner 11 (f) or the commissioner's designee shall determine the time period 12 13 for which a prior authorization shall be effective and, if 14 flexible use has been requested, whether to allow the flexible 15 If the recipient continues to require home care use option. 16 services beyond the duration of the prior authorization, the 17 home care provider must request a new prior authorization. Under no circumstances, other than the exceptions in paragraph 18 (b), shall a prior authorization be valid prior to the date the 19 20 commissioner receives the request or for more than 12 months. A recipient who appeals a reduction in previously authorized home 21 care services may continue previously authorized services, other 22 than temporary services under paragraph (h), pending an appeal 23 under section 256.045. The commissioner must provide a detailed 24 explanation of why the authorized services are reduced in amount 25 26 from those requested by the home care provider.

27 [APPROVAL OF HOME CARE SERVICES.] The commissioner or (g) the commissioner's designee shall determine the medical 28 necessity of home care services, the level of caregiver 29 according to subdivision 2, and the institutional comparison 30 according to this subdivision, the cost-effectiveness of 31 services, and the amount, scope, and duration of home care 32 services reimbursable by medical assistance, based on the 33 assessment, primary payer coverage determination information as 34 required, the service plan, the recipient's age, the cost of 35 services, the recipient's medical condition, and diagnosis or 36

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disability. The commissioner may publish additional criteria 1 for determining medical necessity according to section 256B.04. 2 [PRIOR AUTHORIZATION REQUESTS; TEMPORARY SERVICES.] 3 (h) The agency nurse, the independently enrolled private duty nurse, 4 5 or county public health nurse may request a temporary authorization for home care services by telephone. The 6 commissioner may approve a temporary level of home care services 7 8 based on the assessment, and service or care plan information, and primary payer coverage determination information as required. 9 Authorization for a temporary level of home care services 10 including nurse supervision is limited to the time specified by 11 the commissioner, but shall not exceed 45 days, unless extended 12 13 because the county public health nurse has not completed the required assessment and service plan, or the commissioner's 14 15 determination has not been made. The level of services authorized under this provision shall have no bearing on a 16 future prior authorization. 17

(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).

, particular,

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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

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1 services when the number of foster care residents is greater 2 than four unless the county responsible for the recipient's 3 foster placement made the placement prior to April 1, 1992, 4 requests that personal care assistant and private duty nursing 5 services be provided, and case management is provided as 6 required in section 256B.0625, subdivision 19a.

Sec. 15. Minnesota Statutes 2004, section 256B.0627,
8 subdivision 9, is amended to read:

9 Subd. 9. [OPTION FOR FLEXIBLE USE OF PERSONAL CARE ASSISTANT HOURS.] (a) "Flexible use option" means the scheduled 10 11 use of authorized hours of personal care assistant services, which vary within the-length-of-the a service authorization 12 period covering no more than six months, in order to more 13 14 effectively meet the needs and schedule of the recipient. Authorized hours not used within the six-month 15 period may not be carried over to another time period. The 16 flexible use of personal care assistant hours for a six-month 17 period must be prior authorized by the commissioner, based on a 18 19 request submitted on a form approved by the commissioner. The 20 request must include the assessment and the annual service plan 21 prepared by the county public health nurse.

22 (b) The recipient or responsible party, together with the 23 case manager, if the recipient has case management services, and 24 the county public health nurse, shall determine whether flexible 25 use is an appropriate option based on the needs, abilities, preferences, and history of service use of the recipient or 26 responsible party, and if appropriate, must ensure that the 27 allocation of hours covers the ongoing needs of the recipient 28 over an entire year divided into two six-month periods of 29 30 flexible use.

31 (c) If prior authorized, recipients may use their approved 32 hours flexibly within the service authorization period for 33 medically necessary covered services specified in the assessment 34 required in subdivision 1. The flexible use of authorized hours 35 does not increase the total amount of authorized hours available 36 to a recipient as determined under subdivision 5. The

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commissioner shall not authorize additional personal care 1 assistant services to supplement a service authorization that is 2 exhausted before the end date under a flexible service use plan, 3 unless the county public health nurse determines a change in 4 condition and a need for increased services is established. 5 (b) (d) The personal care provider organization and the 6 recipient or responsible party7-together-with-the-provider7 must 7 8 work-to-monitor-and-document-the-use-of-authorized-hours-and ensure-that-a-recipient-is-able-to-manage-services-effectively 9 throughout-the-authorized-period---Upon-request-of-the-recipient 10 11 or-responsible-party7-the-provider-must-furnish-regular-updates to-the-recipient-or-responsible-party-on-the-amount-of-personal 12 care-assistant-services-used develop a written month-to-month 13 plan of the projected use of personal care assistant services 14 that is part of the care plan and ensures: 15 16 (1) that the health and safety needs of the recipient will 17 be met; (2) that the total annual authorization will not be used 18 19 before the end of the authorization period; and (3) monthly monitoring will be conducted of hours used as a 20 percentage of the authorized amount. 21 22 (e) The provider shall notify the recipient, the case manager, if the recipient has case management services, and the 23 24 county public health nurse in advance and as soon as possible, on a form approved by the commissioner, if the monthly amount of 25 26 hours authorized is likely to be exceeded for the month. 27 (f) The commissioner shall provide written notice to the 28 provider, the recipient or responsible party, the county case 29 manager, if the recipient has case management services, and the 30 county public health nurse, when a flexible use recipient 31 exceeds the personal care service authorization for the month by an amount determined by the commissioner. If the use of hours 32 33 exceeds the monthly service authorization by the amount 34 determined by the commissioner for two months during any 35 three-month period, the commissioner shall notify the recipient and the county public health nurse that the flexible use 36 Article 4 Section 15 155

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authorization will be revoked beginning the following month. 1 The revocation will not become effective if, within ten working 2 days of the commissioner's notice of flexible use revocation, 3 the county public health nurse requests prior authorization for 4 an increase in the service authorization and continuation of the 5 flexible use option, or the recipient appeals and assistance 6 pending appeal is ordered. The commissioner shall determine 7 8 whether to approve the increase and continued flexible use. (g) The recipient or responsible party may stop the 9 flexible use of hours by notifying the provider and county 10 public health nurse in writing. 11 12 (h) The recipient or responsible party may appeal the 13 commissioner's action according to section 256.045. The denial or revocation of the flexible use option shall not affect the 14 recipient's authorized level of personal care assistant services 15 16 as determined under subdivision 5. Sec. 16. Minnesota Statutes 2004, section 256B.0627, is 17 amended by adding a subdivision to read: 18 Subd. 18. [OVERSIGHT OF ENROLLED PERSONAL CARE ASSISTANT 19 20 SERVICES PROVIDERS.] The commissioner may request from providers documentation of compliance with laws, rules, and policies 21 22 governing the provision of personal care assistant services. A personal care assistant service provider must provide the 23 24 requested documentation to the commissioner within ten business 25 days of the request. Failure to provide information to demonstrate substantial compliance with laws, rules, or policies 26 may result in suspension, denial, or termination of the provider 27 28 agreement. 29 Sec. 17. Minnesota Statutes 2004, section 256B.15, subdivision 1, is amended to read: 30 Subdivision 1. [POLICY, APPLICABILITY, PURPOSE, AND 31 32 CONSTRUCTION; DEFINITION.] (a) It is the policy of this state that individuals or couples, either or both of whom participate 33 in the medical assistance program, use their own assets to pay 34 their share of the total cost of their care during or after 35 36 their enrollment in the program according to applicable federal

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law and the laws of this state. The following provisions apply:
 (1) subdivisions lc to lk shall not apply to claims arising

under this section which are presented under section 525.313;

4 (2) the provisions of subdivisions lc to lk expanding the
5 interests included in an estate for purposes of recovery under
6 this section give effect to the provisions of United States
7 Code, title 42, section 1396p, governing recoveries, but do not
8 give rise to any express or implied liens in favor of any other
9 parties not named in these provisions;

10 (3) the continuation of a recipient's life estate or joint 11 tenancy interest in real property after the recipient's death 12 for the purpose of recovering medical assistance under this 13 section modifies common law principles holding that these 14 interests terminate on the death of the holder;

15 (4) all laws, rules, and regulations governing or involved 16 with a recovery of medical assistance shall be liberally 17 construed to accomplish their intended purposes;

(5) a deceased recipient's life estate and joint tenancy 18 19 interests continued under this section shall be owned by the remaindermen or surviving joint tenants as their interests may 20 appear on the date of the recipient's death. They shall not be 21 22 merged into the remainder interest or the interests of the surviving joint tenants by reason of ownership. They shall be 23 subject to the provisions of this section. Any conveyance, 24 transfer, sale, assignment, or encumbrance by a remainderman, a 25 surviving joint tenant, or their heirs, successors, and assigns 26 shall be deemed to include all of their interest in the deceased 27 recipient's life estate or joint tenancy interest continued 28 under this section; and 29

30 (6) the provisions of subdivisions lc to lk continuing a 31 recipient's joint tenancy interests in real property after the 32 recipient's death do not apply to a homestead owned of record, 33 on the date the recipient dies, by the recipient and the 34 recipient's spouse as joint tenants with a right of 35 survivorship. Homestead means the real property occupied by the 36 surviving joint tenant spouse as their sole residence on the

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date the recipient dies and classified and taxed to the 1 recipient and surviving joint tenant spouse as homestead 2 property for property tax purposes in the calendar year in which 3 the recipient dies. For purposes of this exemption, real 4 property the recipient and their surviving joint tenant spouse 5 purchase solely with the proceeds from the sale of their prior 6 homestead, own of record as joint tenants, and qualify as 7 homestead property under section 273.124 in the calendar year in 8 which the recipient dies and prior to the recipient's death 9 shall be deemed to be real property classified and taxed to the 10 recipient and their surviving joint tenant spouse as homestead 11 property in the calendar year in which the recipient dies. The 12 surviving spouse, or any person with personal knowledge of the 13 facts, may provide an affidavit describing the homestead 14 property affected by this clause and stating facts showing 15 compliance with this clause. The affidavit shall be prima facie 16 evidence of the facts it states. 17

(b) <u>The commissioner shall release liens arising under</u>
<u>notices of potential claims under this section and medical</u>
<u>assistance liens under sections 514.980 to 514.985, against life</u>
<u>estates and jointly owned interests a remainderman or surviving</u>
<u>joint tenant has in farm and income-producing property the</u>
<u>deceased recipient owned of record on the date of the</u>
<u>recipient's death under the following conditions:</u>

(1) the farm property is real property for which all of the
following apply continuously for a period beginning at least
three years before the calendar year in which the recipient
first received long-term care medical assistance through the
date of the recipient's death:

30 (i) the remainderman or surviving joint tenant is a farmer, 31 as defined in section 500.24, subdivision 2, paragraph (n), and 32 is engaged in farming, as defined in section 500.24, subdivision 33 2, paragraph (a);

34 (ii) all of the land is a family farm as defined in section
35 500.24, subdivision 2, paragraph (b); and

36 (iii) all of the land is classified and taxed as class 2a

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agricultural land under section 273.13, subdivision 23, 1 paragraph (a), for property tax purposes; and 2 3 (2) the income-producing property is real property for which all of the following apply continuously for a period 4 beginning at least three years before the calendar year in which 5 the recipient first received long-term care medical assistance 6 through the date of the recipient's death: 7 8 -(i) no part of the property is classified or taxed as 9 homestead property for property tax purposes, provided that if the property is classified and taxed as both homestead and 10 nonhomestead property, the portion of the property classified 11 12 and taxed as nonhomestead property shall be considered to satisfy this requirement; 13 (ii) all of the property is classified and taxed as class 14 15 lc property under section 273.13, subdivision 22, paragraph (c), 16 except that part of the class 1c property that is a dwelling occupied as a homestead; class 3a or 3b commercial or industrial 17 18 property under section 273.13, subdivision 24; or as class 4a or 4c property classified under section 273.13, subdivision 25, 19 20 paragraphs (a) and (d), for property tax purposes; and (iii) the business, profession, or occupation in which the 21 22 real property is used is the primary business, profession, or 23 occupation of the remainderman or surviving joint tenant and the real property is used solely for that business, profession, or 24 occupation. A primary business, profession, or occupation is 25 one the ongoing operation of which provides at least 65 percent 26 27 of a person's gross income for federal income tax purposes for the calendar year. 28 (c) For purposes of this section, "medical assistance" 29 includes the medical assistance program under this chapter and 30 the general assistance medical care program under chapter 256D 31 and but does not include the alternative care program for 32 nonmedical assistance recipients under section 256B.0913. 33 [EFFECTIVE DATE.] The amendments in this section relating 34 to the alternative care program are effective retroactively from 35 July 1, 2003, and apply to the estates of decedents who die on 36

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1 or after that date. The remaining amendments in this section are effective July 1, 2005, and apply to the estates of 2 decedents who die on or after that date. 3 4 Sec. 18. Minnesota Statutes 2004, section 256B.15, subdivision la, is amended to read: 5 Subd. la. [ESTATES SUBJECT TO CLAIMS.] If a person 6 7 receives any medical assistance hereunder, on the person's death, if single, or on the death of the survivor of a married 8 9 couple, either or both of whom received medical assistance, or as otherwise provided for in this section, the total amount paid 10 11 for medical assistance rendered for the person and spouse shall 12 be filed as a claim against the estate of the person or the 13 estate of the surviving spouse in the court having jurisdiction 14 to probate the estate or to issue a decree of descent according to sections 525.31 to 525.313. 15

16 A claim shall be filed if medical assistance was rendered 17 for either or both persons under one of the following 18 circumstances:

(a) the person was over 55 years of age, and received
services under this chapter, excluding alternative care;

21 (b) the person resided in a medical institution for six months or longer, received services under this chapter, 22 23 excluding alternative care, and, at the time of 24 institutionalization or application for medical assistance, 25 whichever is later, the person could not have reasonably been 26 expected to be discharged and returned home, as certified in 27 writing by the person's treating physician. For purposes of this section only, a "medical institution" means a skilled 28 29 nursing facility, intermediate care facility, intermediate care 30 facility for persons with mental retardation, nursing facility, 31 or inpatient hospital; or

32 (c) the person received general assistance medical care33 services under chapter 256D.

The claim shall be considered an expense of the last illness of the decedent for the purpose of section 524.3-805. Any statute of limitations that purports to limit any county

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agency or the state agency, or both, to recover for medical 1 assistance granted hereunder shall not apply to any claim made 2 hereunder for reimbursement for any medical assistance granted 3 4 hereunder. Notice of the claim shall be given to all heirs and devisees of the decedent whose identity can be ascertained with 5 reasonable diligence. The notice must include procedures and 6 7 instructions for making an application for a hardship waiver under subdivision 5; time frames for submitting an application 8 and determination; and information regarding appeal rights and 9 procedures. Counties are entitled to one-half of the nonfederal 10 11 share of medical assistance collections from estates that are 12 directly attributable to county effort. Counties-are-entitled to-ten-percent-of-the-collections-for-alternative-care-directly 13 14 attributable-to-county-effort.

15 [EFFECTIVE DATE.] The amendments in this section relating 16 to the alternative care program are effective retroactively from 17 July 1, 2003, and apply to the estates of decedents who die on or after that date. 18

Sec. 19. Minnesota Statutes 2004, section 256B.15, 19 subdivision 2, is amended to read: 20

21 Subd. 2. [LIMITATIONS ON CLAIMS.] The claim shall include only the total amount of medical assistance rendered after age 22 23 55 or during a period of institutionalization described in 24 subdivision la, clause (b), and the total amount of general 25 assistance medical care rendered, and shall not include interest. Claims that have been allowed but not paid shall bear 26 27 interest according to section 524.3-806, paragraph (d). A claim against the estate of a surviving spouse who did not receive 28 29 medical assistance, for medical assistance rendered for the 30 predeceased spouse, is limited to the value of the assets of the 31 estate that were marital property or jointly owned property at 32 any time during the marriage. Claims-for-alternative-care-shall 33 be-net-of-all-premiums-paid-under-section-256B-09137-subdivision 127-on-or-after-July-17-20037-and-shall-be-limited-to-services 34 35 provided-on-or-after-July-17-2003. [EFFECTIVE DATE.] This section is effective retroactively

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from July 1, 2003, for decedents dying on or after that date. 1 Sec. 20. Minnesota Statutes 2004, section 256B.431, is 2 3 amended by adding a subdivision to read: Subd. 41. [NURSING FACILITY RATE INCREASES FOR SEPTEMBER 4 1, 2005, AND JULY 1, 2006.] (a) For the rate period beginning 5 September 1, 2005, and the rate year beginning July 1, 2006, the 6 7 commissioner shall make available to each nursing facility reimbursed under this section or section 256B.434 an adjustment 8 9 equal to two percent of the total operating payment rate. (b) Money resulting from the rate adjustment under 10 11 paragraph (a) must be used to increase wages and benefits and pay associated costs for employees, except management fees, the 12 administrator, and central office staff. Except as provided in 13 14 paragraph (c), money received by a facility as a result of the 15 rate adjustment provided in paragraph (a) must be used only for 16 wage, benefit, and staff increases implemented on or after the effective date of the rate increase each year, and must not be 17 18 used for increases implemented prior to that date. 19 (c) With respect only to the September 1, 2005, rate 20 increase, a hospital-attached nursing facility that incurred costs for salary and employee benefit increases first provided 21 22 after July 1, 2003, may count those costs towards the amount 23 required to be spent on salaries and benefits under paragraph 24 (b). These costs must be reported to the commissioner in the 25 form and manner specified by the commissioner. 26 (d) Nursing facilities may apply for the rate adjustment 27 under paragraph (a). The application must be made to the 28 commissioner and contain a plan by which the nursing facility 29 will distribute the funds according to paragraph (b). For 30 nursing facilities in which the employees are represented by an 31 exclusive bargaining representative, an agreement negotiated and 32 agreed to by the employer and the exclusive bargaining 33 representative constitutes the plan. A negotiated agreement may 34 constitute the plan only if the agreement is finalized after the date of enactment of all increases for the rate year and signed 35 36 by both parties prior to submission to the commissioner. The

•	1	commissioner shall review the plan to ensure that the rate
~	2	adjustments are used as provided in paragraph (b). To be
	3	eligible, a facility must submit its distribution plan by
	4	December 31 each year. If a facility's distribution plan is
	5	effective after the first day of the applicable rate period that
	6	the funds are available, the rate adjustments are effective the
	7	same date as the facility's plan.
	8	(e) A copy of the approved distribution plan must be made
	9	available to all employees by giving each employee a copy or by
	10	posting a copy in an area of the nursing facility to which all
	11	employees have access. If an employee does not receive the wage
	12	and benefit adjustment described in the facility's approved plan
	13	and is unable to resolve the problem with the facility's
	14	management or through the employee's union representative, the
	15	employee may contact the commissioner at an address or telephone
	16	number provided by the commissioner and included in the approved
	17	plan.
	18	Sec. 21. Minnesota Statutes 2004, section 256B.431, is
	19	amended by adding a subdivision to read:
	20	Subd. 42. [SINGLE-BED ROOM PAYMENT RATE.] (a) Beginning
	21	July 1, 2005, the operating payment rate for nursing facilities
1977 Mary	22	reimbursed under this section or section 256B.434 shall be
	23	increased by five percent multiplied by the ratio of the number
	24	of new single-bed rooms created divided by the number of active
	25	beds on July 1, 2005, for each bed closure that results in the
	26	creation of a single-bed room after July 1, 2005.
	27	(b) A nursing facility is prohibited from discharging
	28	residents for purposes of establishing single-bed rooms. A
	29	nursing facility must retain a statement from any resident.
	30	discharged to another nursing facility between July 1, 2005, and
	31	December 31, 2007, signed by the resident or the resident's
	32	designated responsible party, certifying the resident requests
	33	to move and is under no coercion to be discharged. This signed
	34	statement must be witnessed and signed by the local ombudsman.
	35	The commissioner shall assess a monetary penalty of \$5,000 per
	36	occurrence against any nursing facility determined to have
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discharged a resident for purposes of establishing single-bed 1 2 rooms. (c) If after the date of enactment of this section and 3 before December 31, 2007, more than 4,000 nursing home beds are 4 removed from service, a portion of the appropriation for nursing 5 homes shall be transferred to the alternative care program. 6 The 7 amount of this transfer shall equal the number of beds removed from service less 4,000, multiplied by the average monthly 8 per-person cost for alternative care, multiplied by 12, and 9 further multiplied by 0.3. 10 11 (d) Savings that result from bed closures on or after July 12 1, 2005, that do not result in the establishment of single-bed rooms and exceed the number of closures included in the February 13 2005 forecast shall not cancel to the general fund but are 14 appropriated to the commissioner for the medical assistance 15 16 costs of nursing home moratorium exceptions approved by the commissioner of health under section 144A.073. The commissioner 17 18 of health, in consultation with the commissioner of human services, shall publish a request for proposals under section 19 20 144A.073, subdivision 2, when, in the determination of the commissioner of health, sufficient funds are available under 21 this paragraph. Money appropriated to the commissioner of human 22 23 services under this paragraph shall not cancel and shall be available until expended. 24 25 (e) For the rate year beginning July 1, 2005, the amount 26 nursing facilities receive for medically necessary single-bed 27 rooms under Minnesota Rules, part 9549.0070, subpart 3, shall be up to 114.365 percent of the established total payment rate for 28 29 the resident. For the rate year beginning July 1, 2006, the 30 amount nursing facilities receive for medically necessary 31 single-bed rooms under Minnesota Rules, part 9549.0070, subpart 32 3, shall be up to 114.75 percent of the established total payment rate for the resident. For the rate years beginning on 33 or after July 1, 2007, the single-bed payment rate shall be up 34 35 to 115 percent of the established total payment rate for the 36 resident.

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Sec. 22. Minnesota Statutes 2004, section 256B.434,
 subdivision 4, is amended to read:

3 Subd. 4. [ALTERNATE RATES FOR NURSING FACILITIES.] (a) For 4 nursing facilities which have their payment rates determined 5 under this section rather than section 256B.431, the 6 commissioner shall establish a rate under this subdivision. The 7 nursing facility must enter into a written contract with the 8 commissioner.

9 (b) A nursing facility's case mix payment rate for the 10 first rate year of a facility's contract under this section is 11 the payment rate the facility would have received under section 12 256B.431.

(C) A nursing facility's case mix payment rates for the 13 14 second and subsequent years of a facility's contract under this 15 section are the previous rate year's contract payment rates plus an inflation adjustment and, for facilities reimbursed under 16 17 this section or section 256B.431, an adjustment to include the cost of any increase in Health Department licensing fees for the 18 facility taking effect on or after July 1, 2001. The index for 19 20 the inflation adjustment must be based on the change in the Consumer Price Index-All Items (United States City average) 21 (CPI-U) forecasted by the commissioner of finance's national 22 economic consultant, as forecasted in the fourth quarter of the 23 calendar year preceding the rate year. The inflation adjustment 24 25 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 26 27 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, 28 2003, and July 1, 2004, July 1, 2005, and July 1, 2006, this 29 paragraph shall apply only to the property-related payment rate, 30 except that adjustments to include the cost of any increase in 31 Health Department licensing fees taking effect on or after July 32 1, 2001, shall be provided. In determining the amount of the 33 property-related payment rate adjustment under this paragraph, 34 the commissioner shall determine the proportion of the 35 facility's rates that are property-related based on the 36

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1 facility'-s most recent cost report. 2 (d) The commissioner shall develop additional incentive-based payments of up to five percent above the 3 standard contract rate for achieving outcomes specified in each 4 contract. The specified facility-specific outcomes must be 5 6 measurable and approved by the commissioner. The commissioner 7 may establish, for each contract, various levels of achievement 8 within an outcome. After the outcomes have been specified the 9 commissioner shall assign various levels of payment associated 10 with achieving the outcome. Any incentive-based payment cancels 11 if there is a termination of the contract. In establishing the specified outcomes and related criteria the commissioner shall 12 13 consider the following state policy objectives: 14 (1) improved cost effectiveness and quality of life as measured by improved clinical outcomes; 15 16 (2) successful diversion or discharge to community 17 alternatives; (3) decreased acute care costs; 18 19 (4) improved consumer satisfaction; (5) the achievement of quality; or 20 21 (6) any additional outcomes proposed by a nursing facility 22 that the commissioner finds desirable. Sec. 23. Minnesota Statutes 2004, section 256B.434, is 23 amended by adding a subdivision to read: 24 25 Subd. 4f. [RATE INCREASE EFFECTIVE JULY 1, 2005.] For the rate year beginning July 1, 2005, a facility in Ramsey County 26 27 licensed for 180 beds shall have its operating payment rate as determined under this section and in effect on June 30, 2005, 28 29 increased by \$2.49. The increase under this subdivision shall be included in the facility's total payment rates for the 30 31 purposes of determining future rates under this section or any 32 other section. 33 Sec. 24. Minnesota Statutes 2004, section 256B.440, is amended by adding a subdivision to read: 34 Subd. 4. [CONTINUED SYSTEM DEVELOPMENT.] (a) The 35 commissioner shall continue developmental work on a new nursing 36

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home reimbursement system and present recommendations for a new 1 system to the legislature by January 15, 2006. The new system 2 shall comply with subdivisions 1 and 2. 3 (b) Nursing facilities shall continue to file, and the 4 5 commissioner shall continue to collect and audit, annual cost reports under the conditions specified in subdivision 3. 6 7 (c) Notwithstanding any contrary provisions of chapter 16C, the commissioner may, within the limits of appropriations 8 9 specifically available for this purpose, extend contracts 10 previously negotiated for consulting work on development of the new reimbursement system. 11 Sec. 25. Minnesota Statutes 2004, section 256B.5012, is 12 13 amended by adding a subdivision to read: 14 Subd. 6. [ICF/MR RATE INCREASES BEGINNING SEPTEMBER 1, 2005, AND JULY 1, 2006.] (a) For the rate periods beginning 15 16 September 1, 2005, and July 1, 2006, the commissioner shall make 17 available to each facility reimbursed under this section an 18 adjustment to the total operating payment rate of two percent. (b) Money resulting from the rate adjustment under 19 20 paragraph (a) must be used to increase wages and benefits and 21 pay associated costs for employees, except for administrative and central office employees. Money received by a facility as a 22 result of the rate adjustment provided in paragraph (a) must be 23 used only for wage, benefit, and staff increases implemented on 24 or after the effective date of the rate increase each year, and 25 must not be used for increases implemented prior to that date. 26 27 (c) For each facility, the commissioner shall make available an adjustment using the percentage specified in 28 paragraph (a) multiplied by the total payment rate, excluding 29 the property-related payment rate, in effect on the preceding 30 day. The total payment rate shall include the adjustment 31 provided in section 256B.501, subdivision 12. 32 (d) A facility whose payment rates are governed by closure 33 34 agreements, receivership agreements, or Minnesota Rules, part 9553.0075, is not eligible for an adjustment otherwise granted 35 under this subdivision. 36

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1	(e) -A facility may apply for the payment rate adjustment
2	provided under paragraph (a). The application must be made to
3	the commissioner and contain a plan by which the facility will
4	distribute the funds according to paragraph (b). For facilities
5	in which the employees are represented by an exclusive
6	bargaining representative, an agreement negotiated and agreed to
7	by the employer and the exclusive bargaining representative
8	constitutes the plan. A negotiated agreement may constitute the
9	plan only if the agreement is finalized after the date of
10	enactment of all rate increases for the rate year. The
11	commissioner shall review the plan to ensure that the payment
12	rate adjustment per diem is used as provided in this
13	subdivision. To be eligible, a facility must submit its plan by
14	December 31 each year. If a facility's plan is effective for
15	its employees after the first day of the applicable rate period
16	that the funds are available, the payment rate adjustment per
17	diem is effective the same date as its plan.
18	(f) A copy of the approved distribution plan must be made
19	available to all employees by giving each employee a copy or by
20	posting it in an area of the facility to which all employees
21	have access. If an employee does not receive the wage and
22	benefit adjustment described in the facility's approved plan and
23	is unable to resolve the problem with the facility's management
24	or through the employee's union representative, the employee may
25	contact the commissioner at an address or telephone number
26	provided by the commissioner and included in the approved plan.
27	Sec. 26. Minnesota Statutes 2004, section 256B.69,
28	subdivision 23, is amended to read:
29	Subd. 23. [ALTERNATIVE INTEGRATED LONG-TERM CARE SERVICES;
30	ELDERLY AND DISABLED PERSONS.] (a) The commissioner may
31	implement demonstration projects to create alternative
32	integrated delivery systems for acute and long-term care
33	services to elderly persons and persons with disabilities as
34	defined in section 256B.77, subdivision 7a, that provide
35	increased coordination, improve access to quality services, and
36	mitigate future cost increases. The commissioner may seek

federal authority to combine Medicare and Medicaid capitation 1 payments for the purpose of such demonstrations. Medicare funds 2 3 and services shall be administered according to the terms and conditions of the federal waiver and demonstration provisions. 4 5 For the purpose of administering medical assistance funds, 6 demonstrations under this subdivision are subject to subdivisions 1 to 22. The provisions of Minnesota Rules, parts 7 9500.1450 to 9500.1464, apply to these demonstrations, with the 8 exceptions of parts 9500.1452, subpart 2, item B; and 9500.1457, 9 10 subpart 1, items B and C, which do not apply to persons enrolling in demonstrations under this section. An initial open 11 enrollment period may be provided. Persons who disenroll from 12 demonstrations under this subdivision remain subject to 13 14 Minnesota Rules, parts 9500.1450 to 9500.1464. When a person is 15 enrolled in a health plan under these demonstrations and the health plan's participation is subsequently terminated for any 16 reason, the person shall be provided an opportunity to select a 17 18 new health plan and shall have the right to change health plans within the first 60 days of enrollment in the second health 19 20 plan. Persons required to participate in health plans under 21 this section who fail to make a choice of health plan shall not be randomly assigned to health plans under these demonstrations. 22 23 Notwithstanding section 256L.12, subdivision 5, and Minnesota Rules, part 9505.5220, subpart 1, item A, if adopted, for the 24 purpose of demonstrations under this subdivision, the 25 commissioner may contract with managed care organizations, 26 including counties, to serve only elderly persons eligible for 27 medical assistance, elderly and disabled persons, or disabled 28 persons only. For persons with primary diagnoses of mental 29 retardation or a related condition, serious and persistent 30 mental illness, or serious emotional disturbance, the 31 commissioner must ensure that the county authority has approved 32 the demonstration and contracting design. Enrollment in these 33 projects for persons with disabilities shall be voluntary. The 34 commissioner shall not implement any demonstration project under 35 36 this subdivision for persons with primary diagnoses of mental

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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.

5 (b) Notwithstanding chapter 245B, sections 252.40 to 252.46, 256B.092, 256B.501 to 256B.5015, and Minnesota Rules, 6 parts 9525.0004 to 9525.0036, 9525.1200 to 9525.1330, 9525.1580, 7 and 9525.1800 to 9525.1930, the commissioner may implement under 8 this section projects for persons with developmental 9 10 disabilities. The commissioner may capitate payments for ICF/MR services, waivered services for mental retardation or related 11 12 conditions, including case management services, day training and habilitation and alternative active treatment services, and 13 other services as approved by the state and by the federal 14 government. Case management and active treatment must be 15 16 individualized and developed in accordance with a 17 person-centered plan. Costs under these projects may not exceed costs that would have been incurred under fee-for-service. 18 Beginning July 1, 2003, and until two years after the pilot 19 20 project implementation date, subcontractor participation in the 21 long-term care developmental disability pilot is limited to a nonprofit long-term care system providing ICF/MR services, home 22 23 and community-based waiver services, and in-home services to no 24 more than 120 consumers with developmental disabilities in Carver, Hennepin, and Scott Counties. The commissioner shall 25 26 report to the legislature prior to expansion of the 27 developmental disability pilot project. This paragraph expires 28 two years after the implementation date of the pilot project. 29 (c) Before implementation of a demonstration project for disabled persons, the commissioner must provide information to 30 appropriate committees of the house of representatives and 31 32 senate and must involve representatives of affected disability

33 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 1 shall amend the state plan and seek any federal waivers 2 necessary to implement this paragraph. 3 4 (e) Notwithstanding section 256B.0621, health plans 5 providing services under this section are responsible for home care targeted case management and relocation targeted case 6 7 management. Services must be provided according to the terms of 8 the waivers and contracts approved by the federal government. 9 Sec. 27. [501B.895] [PUBLIC HEALTH CARE PROGRAMS AND CERTAIN TRUSTS.] 10 (a) It is the public policy of this state that individuals 11 12 use all available resources to pay for the cost of long-term care services, as defined in section 256B.0595, before turning 13 to Minnesota health care program funds, and that trust 14 instruments should not be permitted to shield available 15 16 resources of an individual or an individual's spouse from such use. Any irrevocable inter vivos trust or any legal instrument, 17 device, or arrangement similar to an irrevocable inter vivos 18 trust created on or after July 1, 2005, containing assets or 19 income of an individual or an individual's spouse, including 20 those created by a person, court, or administrative body with 21 legal authority to act in place of, at the direction of, upon 22 the request of, or on behalf of the individual or individual's 23 spouse, becomes revocable by operation of law for the sole 24 purpose of a state or local human services agency determination 25 on an application by the individual or the individual's spouse 26 for payment of long-term care services through a Minnesota 27 public health care program under chapter 256. For purposes of 28 this section, any inter vivos trust and any legal instrument, 29 device, or arrangement similar to an inter vivos trust: 30 (1) shall be deemed to be located in and subject to the 31 laws of this state; and 32 (2) is created as of the date it is fully executed by or on 33 34 behalf of all of the settlors or others. (b) For purposes of this section, a legal instrument, 35 device, or arrangement similar to an irrevocable inter vivos 36

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1 trust means any instrument, device, or arrangement which involves a grantor who transfers or whose property is 2 transferred by another including, but not limited to, any court, 3 4 administrative body, or anyone else with authority to act on 5 their behalf or at their direction, to an individual or entity with fiduciary, contractual, or legal obligations to the grantor 6 7 or others to be held, managed, or administered by the individual or entity for the benefit of the grantor or others. These legal 8 instruments, devices, or other arrangements are irrevocable 9 inter vivos trusts for purposes of this section. 10 11 (c) In the event of a conflict between this section and the 12 provisions of an irrevocable trust created on or after July 1, 13 2005, this section shall control. 14 (d) This section does not apply to trusts that qualify as supplemental needs trusts under section 501B.89 or to trusts 15 16 meeting the criteria of United States Code, title 42, section 17 1396p (d)(4)(a) and (c) for purposes of eligibility for medical 18 assistance. 19 (e) This section applies to all trusts first created on or 20 after July 1, 2005, and to all interests in real or personal 21 property regardless of the date on which the interest was 22 created, reserved, or acquired. 23 Sec. 28. Minnesota Statutes 2004, section 514.981, subdivision 6, is amended to read: 24 25 Subd. 6. [TIME LIMITS; CLAIM LIMITS; LIENS ON LIFE ESTATES AND JOINT TENANCIES.] (a) A medical assistance lien is a lien on 26 27 the real property it describes for a period of ten years from 28 the date it attaches according to section 514.981, subdivision 2, paragraph (a), except as otherwise provided for in sections 29 514.980 to 514.985. The agency may renew a medical assistance 30 31 lien for an additional ten years from the date it would otherwise expire by recording or filing a certificate of renewal 32 before the lien expires. The certificate shall be recorded or 33 filed in the office of the county recorder or registrar of 34 35 titles for the county in which the lien is recorded or filed. 36 The certificate must refer to the recording or filing data for

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1 the medical assistance lien it renews. The certificate need not 2 be attested, certified, or acknowledged as a condition for 3 recording or filing. The registrar of titles or the recorder 4 shall file, record, index, and return the certificate of renewal 5 in the same manner as provided for medical assistance liens in 6 section 514.982, subdivision 2.

(b) A medical assistance lien is not enforceable against 7 8 the real property of an estate to the extent there is a 9 determination by a court of competent jurisdiction, or by an officer of the court designated for that purpose, that there are 10 insufficient assets in the estate to satisfy the agency's 11 medical assistance lien in whole or in part because of the 12 13 homestead exemption under section 256B.15, subdivision 4, the rights of the surviving spouse or minor children under section 14 524.2-403, paragraphs (a) and (b), or claims with a priority 15 16 under section 524.3-805, paragraph (a), clauses (1) to (4). For purposes of this section, the rights of the decedent's adult 17 18 children to exempt property under section 524.2-403, paragraph (b), shall not be considered costs of administration under 19 section 524.3-805, paragraph (a), clause (1). 20

(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 27 tenancy interest in the real property shall not end upon the 28 recipient's death but shall merge into the remainder interest or 29 other interest in real property the medical assistance recipient 30 owned in joint tenancy with others. The medical assistance lien 31 shall attach to and run with the remainder or other interest in 32 the real property to the extent of the medical assistance 33 recipient's interest in the property at the time of the 34 recipient's death as determined under this section. 35

36 (2) If the medical assistance recipient's interest was a

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1 life estate in real property, the lien shall be a lien against 2 the portion of the remainder equal to the percentage factor for 3 the life estate of a person the medical assistance recipient's 4 age on the date the life estate ended according to its terms or 5 the date of the medical assistance recipient's death as listed 6 in the Life Estate Mortality Table in the health care program's 7 manual.

8 (3) If the medical assistance recipient owned the interest 9 in real property in joint tenancy with others, the lien shall be a lien against the portion of that interest equal to the 10 11 fractional interest the medical assistance recipient would have 12 owned in the jointly owned interest had the medical assistance . recipient and the other owners held title to that interest as 13 14 tenants in common on the date the medical assistance recipient 15 died.

16 (4) The medical assistance lien shall remain a lien against 17 the remainder or other jointly owned interest for the length of 18 time and be renewable as provided in paragraph (a).

19 (5) Subdivision 5, paragraph (a), clause (4), paragraph 20 (b), clauses (1) and (2); and subdivision 6, paragraph (b), do 21 not apply to medical assistance liens which attach to interests 22 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.

35 (8) The provisions of clauses (1) to (7) do not apply to a
36 homestead owned of record, on the date the recipient dies, by

the recipient and the recipient's spouse as joint tenants with a 1 right of survivorship. Homestead means the real property 2 3 occupied by the surviving joint tenant spouse as their sole residence on the date the recipient dies and classified and 4 5 taxed to the recipient and surviving joint tenant spouse as 6 homestead property for property tax purposes in the calendar 7 year in which the recipient dies. For purposes of this exemption, real property the recipient and their surviving joint 8 9 tenant spouse purchase solely with the proceeds from the sale of 10 their prior homestead, own of record as joint tenants, and qualify as homestead property under section 273.124 in the 11 12 calendar year in which the recipient dies and prior to the recipient's death shall be deemed to be real property classified 13 14 and taxed to the recipient and their surviving joint tenant spouse as homestead property in the calendar year in which the 15 16 recipient dies. The surviving spouse, or any person with 17 personal knowledge of the facts, may provide an affidavit describing the homestead property affected by this clause and 18 stating facts showing compliance with this clause. 19 The 20 affidavit shall be prima facie evidence of the facts it states. 21 (d) The commissioner shall release liens arising under notices of potential claims under section 256B.15 and medical 22 assistance liens under sections 514.980 to 514.985, against life 23 24 estates and jointly owned interests a remainderman or surviving 25 tenant has in farm and income-producing property the deceased recipient owned of record on the date of the recipient's death 26 27 under the following conditions: (1) the farm property is real property for which all of the 28 29 following apply continuously for a period beginning at least three years before the calendar year in which the recipient 30 first received long-term care medical assistance through the 31 date of the recipient's death: 32 (i) the remainderman or surviving joint tenant is a farmer, 33 as defined in section 500.24, subdivision 2, paragraph (n), and 34

35 is engaged in farming, as defined in section 500.24, subdivision 36 2, paragraph (a);

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1	(ii) all of the land is a family farm as defined in section
2	500.24, subdivision 2, paragraph (b); and
3	(iii) all of the land is classified and taxed as class 2a
4	agricultural land under section 273.13, subdivision 23,
5	paragraph (a), for property tax purposes; and
6	(2) the income-producing property is real property for
7	which all of the following apply continuously for a period
8	beginning at least three years before the calendar year in which
9	the recipient first received long-term care medical assistance
10	through the date of the recipient's death:
11	(i) no part of the property is classified or taxed as
12	homestead property for property tax purposes, provided that if
13	the property is classified and taxed as both homestead and
14	nonhomestead property, the portion of the property classified
15	and taxed as nonhomestead property shall be considered to
16	satisfy this requirement;
17	(ii) all of the property is classified and taxed as class
18	<pre>lc property under section 273.13, subdivision 22, paragraph (c),</pre>
19	except that part of the class lc property that is a dwelling
20	occupied as a homestead; class 3a or 3b commercial or industrial
21	property under section 273.13, subdivision 24; or as class 4a or
22	4c property classified under section 273.13, subdivision 25,
23	paragraphs (a) and (d), for property tax purposes; and
24	(iii) the business, profession, or occupation in which the
25	real property is used is the primary business, profession, or
26	occupation of the remainderman or surviving joint tenant and the
27	real property is used solely for that business, profession, or
28	occupation. A primary business, profession, or occupation is
29	one the ongoing operation of which provides at least 65 percent
30	of a person's gross income for federal income tax purposes for
31	the calendar year.
32	[EFFECTIVE DATE.] This section is effective July 1, 2005,
33	and applies to the estates of decedents who die on or after that
34	date.
35	Sec. 29. Minnesota Statutes 2004, section 524.3-805, is
36	amended to read:

Article 4 Section 29 176

1

524.3-805 [CLASSIFICATION OF CLAIMS.]

2 (a) If the applicable assets of the estate are insufficient
3 to pay all claims in full, the personal representative shall
4 make payment in the following order:

5

costs and expenses of administration;

6

7

(2) reasonable funeral expenses;

(3) debts and taxes with preference under federal law;

8 (4) reasonable and necessary medical, hospital, or nursing 9 home expenses of the last illness of the decedent, including 10 compensation of persons attending the decedent, a-claim-filed 11 under-section-256B-15-for-recovery-of-expenditures-for 12 alternative-care-for-nonmedical-assistance-recipients-under 13 section-256B-09137 and including a claim filed pursuant to 14 section 256B.15;

15 (5) reasonable and necessary medical, hospital, and nursing 16 home expenses for the care of the decedent during the year 17 immediately preceding death;

18 (6) debts with preference under other laws of this state,19 and state taxes;

20

(7) all other claims.

21 (b) No preference shall be given in the payment of any 22 claim over any other claim of the same class, and a claim due 23 and payable shall not be entitled to a preference over claims not due, except that if claims for expenses of the last illness 24 involve only claims filed under section 256B-15-for-recovery-of 25 expenditures-for-alternative-care-for-nonmedical-assistance 26 27 recipients-under-section-256B-09137-section 246.53 for costs of state hospital care and claims filed under section 256B.157 28 claims-filed-to-recover-expenditures-for-alternative-care-for 29 nonmedical-assistance-recipients-under-section-256B-0913-shall 30 have-preference-over-claims-filed-under-both-sections-246.53-and 31 other-claims-filed-under-section-256B-157-and. Claims filed 32 under section 246.53 have preference over claims filed under 33 section 256B.15 for-recovery-of-amounts-other-than-those-for 34 expenditures-for-alternative-care-for-nonmedical-assistance 35 recipients-under-section-256B-0913. 36

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1	[EFFECTIVE DATE.] This section is effective retroactively
2	from July 1, 2003, for decedents dying on or after that date.
3	Sec. 30. [COMMUNITY SERVICES PROVIDER RATE INCREASES.]
4	(a) The commissioner of human services shall increase
5	reimbursement rates by two percent for the rate period beginning
6	September 1, 2005, and the rate year beginning July 1, 2006,
7	effective for services rendered on or after those dates.
8	(b) The two percent annual rate increase described in this
9	section must be provided to:
10	(1) home and community-based waivered services for persons
11	with mental retardation or related conditions under Minnesota
12	Statutes, section 256B.501;
13	(2) home and community-based waivered services for the
14	elderly under Minnesota Statutes, section 256B.0915;
15	(3) waivered services under community alternatives for
16	disabled individuals under Minnesota Statutes, section 256B.49;
17	(4) community alternative care waivered services under
18	Minnesota Statutes, section 256B.49;
19	(5) traumatic brain injury waivered services under
20	Minnesota Statutes, section 256B.49;
21	(6) nursing services and home health services under
22	Minnesota Statutes, section 256B.0625, subdivision 6a;
23	(7) personal care services and nursing supervision of
24	personal care services under Minnesota Statutes, section
25	256B.0625, subdivision 19a;
26	(8) private duty nursing services under Minnesota Statutes,
27	section 256B.0625, subdivision 7;
28	(9) day training and habilitation services for adults with
29	mental retardation or related conditions under Minnesota
30	Statutes, sections 252.40 to 252.46;
31	(10) alternative care services under Minnesota Statutes,
32	section 256B.0913;
33	(11) adult residential program grants under Minnesota
34	Rules, parts 9535.2000 to 9535.3000;
35	(12) adult and family community support grants under
36	Minnesota Rules, parts 9535.1700 to 9535.1760;

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	1	(13)- the group residential housing supplementary service
~~.	2	rate under Minnesota Statutes, section 2561.05, subdivision la;
	3	(14) adult mental health integrated fund grants under
	4	Minnesota Statutes, section 245.4661;
	5	(15) semi-independent living services under Minnesota
	6	Statutes, section 252.275, including SILS funding under county
	7	social services grants formerly funded under Minnesota Statutes,
	8	chapter 2561;
	9	(16) community support services for deaf and
	10	hard-of-hearing adults with mental illness who use or wish to
	11	use sign language as their primary means of communication; and
	12	(17) living skills training programs for persons with
	13	intractable epilepsy who need assistance in the transition to
	14	independent living.
	15	(c) Providers that receive a rate increase under this
	16	section shall use the additional revenue to increase wages and
	17	benefits and pay associated costs for employees, except for
	18	management fees, the administrator, and central office staffs.
	19	(d) For public employees, the increase for wages and
	20	benefits for certain staff is available and pay rates shall be
	21	increased only to the extent that they comply with laws
and the second second	22	governing public employees collective bargaining. Money
	23	received by a provider for pay increases under this section may
	24	be used only for increases implemented on or after the first day
	25	of the rate period in which the increase is available and must
	26	not be used for increases implemented prior to that date.
	27	(e) A copy of the provider's plan for complying with
	28	paragraph (c) must be made available to all employees by giving
	29	each employee a copy or by posting a copy in an area of the
	30 ·	provider's operation to which all employees have access. If an
	31	employee does not receive the adjustment, if any, described in
	32	the plan and is unable to resolve the problem with the provider,
~	33	the employee may contact the employee's union representative.
	34	If the employee is not covered by a collective bargaining
	35	agreement, the employee may contact the commissioner at a
	36	telephone number provided by the commissioner and included in
	Art	ticle 4 Section 30 179

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1 the provider's plan. Sec. 31. [CONSUMER-DIRECTED COMMUNITY SUPPORTS 2 3 METHODOLOGY.] For persons using the home and community-based waiver for 4 5 persons with developmental disabilities whose Consumer-Directed Community Supports budgets were reduced by the October 2004, 6 state-set budget methodology, the commissioner of human services 7 8 must allow exceptions to exceed the state-set budget formula up to the daily average cost during calendar year 2004 or for 9 10 persons who graduated from school during 2004, the average daily 11 cost during July through December 2004, less one-half of case 12 management and home modifications over \$5,000 when the individual's county of financial responsibility determines that: 13 14 (1) necessary alternative services will cost the same or 15 more than the person's current budget; and 16 (2) administrative expenses or provider rates will result 17 in fewer hours of needed staffing for the person than under the 18 Consumer-Directed Community Supports option. Any exceptions the 19 county grants must be within the county's allowable aggregate 20 amount for the home and community-based waiver for persons with developmental disabilities. 21 22 [EFFECTIVE DATE.] This section is effective upon federal 23 approval of the waiver amendment in section 33. Sec. 32. [COSTS ASSOCIATED WITH PHYSICAL ACTIVITIES.] 24 25 The expenses allowed for adults under the Consumer-Directed 26 Community Supports option shall include costs at the lowest rate 27 available, considering daily, monthly, semiannual, annual, or 28 membership rates, including transportation, associated with physical exercise or other physical activities to maintain or 29 improve the person's health and functioning. 30 [EFFECTIVE DATE.] This section is effective upon federal 31 approval of the waiver amendment in section 33. 32 33 Sec. 33. [WAIVER AMENDMENT.] 34 The commissioner of human services shall submit an amendment to the Centers for Medicare and Medicaid Services 35 36 consistent with sections 31 and 32 by August 1, 2005.

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a destruction of	1	Sec. 34. [INDEPENDENT EVALUATION AND REVIEW OF UNALLOWABLE
	2	ITEMS.]
	3	The commissioner of human services shall include in the
	4	independent evaluation of the Consumer-Directed Community
	5	Supports option provided through the home and community-based
	6	services waivers for persons with disabilities under 65 years of
	7	age:
	8	(1) provision for ongoing, regular participation by
	9	stakeholder representatives through June 30, 2007;
	10	(2) recommendations on whether changes to the unallowable
	11	items should be made to meet the health, safety, or welfare
	12	needs of participants in the Consumer-Directed Community
	13	Supports option within the allowed budget amounts. The
	14	recommendations on allowable items shall be provided to the
	15	senate and house of representatives committees with jurisdiction
	16	over human services policy and finance issues by January 15,
	17	2006; and
	18	(3) a review of the statewide caseload changes for the
	19	disability waiver programs for persons under 65 years of age
	20	that occurred since the state-set budget methodology
	21	implementation on October 1, 2004, and recommendations on the
	22	fiscal impact of the budget methodology on use of the
	23	Consumer-Directed Community Supports option.
	24	[EFFECTIVE DATE.] This section is effective the day
	25	following final enactment.
	26	Sec. 35. [IMMUNITY; REFUNDS BARRED.]
	27	(a) The commissioner of human services, county agencies,
	28	and elected officials and their employees are immune from all
	29	liability for any action taken implementing those portions of
	30	Laws 2003, First Special Session chapter 14, that extend medical
	31	assistance lien policies to include the alternative care
	32	program, as those laws existed at the time the action was taken.
	33	(b) The legislature expressly intends that none of the
	34	recoveries of alternative care payments the state or a local
÷	35	agency made under Minnesota Statutes, sections 514.991 to
	36	514.995, as they existed prior to the effective date of this
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	Ar	ticle 4 Section 35 181

04/28/05 [REVISOR ] \_\_\_\_\_S/MD 05-4117 1 amendment, shall be refunded or repaid. 2 [EFFECTIVE DATE.] This section is effective retroactively 3 from August 1, 2003. Sec. 36. [SKILLED NURSING FACILITIES IN FARIBAULT COUNTY.] 4 5 All skilled nursing facilities in Faribault County shall have the inspection required under Minnesota Statutes, section 6 7 144A.10, conducted by the Department of Health's Mankato survey 8 team. Sec. 37. [EXPIRATION DATE.] 9 10 Section 31 shall expire on the date the commissioner of human services implements a new consumer-directed community 11 supports budget methodology that is based on reliable and 12 accurate information about the services and supports intensity 13 14 needs of persons using the option and that adequately accounts 15 for the increased costs of adults who graduate from school and need services funded by the waiver during the day. 16 17 Sec. 38. [REPEALER.] Minnesota Statutes 2004, sections 514.991; 514.992; 18 19 514.993; 514.994; and 514.995, are repealed retroactively from 20 July 1, 2003. ARTICLE 5 21 MENTAL AND CHEMICAL HEALTH 22 23 Section 1. Minnesota Statutes 2004, section 62J.692, subdivision 3, is amended to read: 24 25 Subd. 3. [APPLICATION PROCESS.] (a) A clinical medical 26 education program conducted in Minnesota by a teaching institution to train physicians, doctor of pharmacy 27 28 practitioners, dentists, chiropractors, or physician assistants is eligible for funds under subdivision 4 if the program: 29 30 (1) is funded, in part, by patient care revenues; (2) occurs in patient care settings that face increased 31 financial pressure as a result of competition with nonteaching 32 patient care entities; and 33 34 (3) emphasizes primary care or specialties that are in 35 undersupply in Minnesota. A clinical medical education program that trains 36

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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.

5 (b) A clinical medical education program for advanced practice nursing is eligible for funds under subdivision 4 if 6 7 the program meets the eligibility requirements in paragraph (a), 8 clauses (1) to (3), and is sponsored by the University of 9 Minnesota Academic Health Center, the Mayo Foundation, or 10 institutions that are part of the Minnesota State Colleges and Universities system or members of the Minnesota Private College 11 12 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 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 (2) the name, title, and business address of those persons
 23 responsible for administering the funds;

(3) for each clinical medical education program for which 24 25 funds are being sought; the type and specialty orientation of trainees in the program; the name, site address, and medical 26 assistance provider number of each training site used in the 27 program; the total number of trainees at each training site; and 28 the total number of eligible trainee FTEs at each site. Only 29 those training sites that host 0.5 FTE or more eligible trainees 30 for a program may be included in the program's application; and 31 (4) other supporting information the commissioner deems 32 necessary to determine program eligibility based on the criteria `3 in paragraphs (a) and (b) and to ensure the equitable 4 distribution of funds. 35

36 (d) An application must include the information specified

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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) in the first year of each biennium:

5 (1) audited clinical training costs per trainee for each 6 clinical medical education program when available or estimates 7 of clinical training costs based on audited financial data;

8 (2) a description of current sources of funding for 9 clinical medical education costs, including a description and 10 dollar amount of all state and federal financial support, 11 including Medicare direct and indirect payments; and

12 (3) other revenue received for the purposes of clinical13 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 244.054, is amended to read:

19 244.054 [DISCHARGE PLANS; OFFENDERS WITH SERIOUS AND
20 PERSISTENT MENTAL ILLNESS.]

Subdivision 1. [OFFER TO DEVELOP PLAN.] The commissioner 21 22 of human services, in collaboration with the commissioner of 23 corrections, shall offer to develop a discharge plan for 24 community-based services for every offender with serious and persistent mental illness, as defined in section 245.462, 25 26 subdivision 20, paragraph (c), and every offender who has had a 27 diagnosis of mental illness and would otherwise be eligible for case management services under section 245.462, subdivision 20, 28 29 paragraph (c), but for the requirement that the offender be 30 hospitalized or in residential treatment, who is being released from a correctional facility. If an offender is being released 31 32 pursuant to section 244.05, the offender may choose to have the discharge plan made one of the conditions of the offender's 33 supervised release and shall follow the conditions to the extent 34 that services are available and offered to the offender. 35

36 Subd. 2. [CONTENT OF PLAN.] If an offender chooses to have

a discharge plan developed, the commissioner of human services
 shall develop and implement a discharge plan, which must include
 at least the following:

4 (1) at least 90 days before the offender is due to be
5 discharged, the commissioner of human services shall designate
6 an-agent-of-the-Department-of-Human-Services a discharge planner
7 with mental health training to serve as the primary person
8 responsible for carrying out discharge planning activities;

9 (2) at least 75 days before the offender is due to be
10 discharged, the offender's designated-agent discharge planner
11 shall:

(i) obtain informed consent and releases of information from the offender that are needed for transition services, and forward them to the appropriate local entity;

(ii) contact the county human services department in the 15 16 community where the offender expects to reside following 17 discharge, and inform the department of the offender's impending discharge and the planned date of the offender's return to the 18 19 community; determine whether the county or a designated contracted provider will provide case management services to the 20 offender; refer the offender to the case management services 21 22 provider; and confirm that the case management services provider will have opened the offender's case prior to the offender's 23 discharge; and 24

25 (iii) refer-the-offender-to-appropriate-staff-in-the-county 26 human-services-department-in-the-community-where-the-offender 27 expects-to-reside-following-discharge;-for-enrollment-of-the 28 offender-if-eligible-in-medical-assistance-or-general-assistance 29 medical-care7-using-special-procedures-established-by-process and-Department-of-Human-Services-bulletin assist the offender in 30 filling out an application for medical assistance, general 31 32 assistance medical care, or MinnesotaCare and submit the <sup>-</sup>3 application for eligibility determination to the commissioner. The commissioner shall determine an offender's eligibility no 35 more than 45 days, or no more than 60 days if the offender's disability status must be determined, from the date that the 36

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1 application is received by the department. The effective date 2 of eligibility for the health care program shall be no earlier than the date of the offender's release. If eligibility is 3 approved, the commissioner shall mail a Minnesota health care 4 5 program membership card to the facility in which the offender resides and transfer the offender's case to MinnesotaCare 6 7 operations within the department or the appropriate county human services agency in the county where the offender expects to 8 reside following release for ongoing case management; 9

10 (3) at least 2-1/2 months before discharge, the offender's 11 designated-agent discharge planner shall secure timely 12 appointments for the offender with a psychiatrist no later than 13 30 days following discharge, and with other program staff at a 14 community mental health provider that is able to serve former 15 offenders with serious and persistent mental illness;

(4) at least 30 days before discharge, the offender's 16 designated-agent discharge planner shall convene a predischarge 17 18 assessment and planning meeting of key staff from the programs in which the offender has participated while in the correctional 19 facility, the offender, the supervising agent, and the mental 20 health case management services provider assigned to the 21 offender. At the meeting, attendees shall provide background 22 information and continuing care recommendations for the 23 offender, including information on the offender's risk for 24 relapse; current medications, including dosage and frequency; 25 therapy and behavioral goals; diagnostic and assessment 26 information, including results of a chemical dependency 27 28 evaluation; confirmation of appointments with a psychiatrist and other program staff in the community; a relapse prevention plan; 29 continuing care needs; needs for housing, employment, and 30 finance support and assistance; and recommendations for 31 successful community integration, including chemical dependency 32 treatment or support if chemical dependency is a risk factor. 33 Immediately following this meeting, the offender's designated 34 agent discharge planner shall summarize this background 35 information and continuing care recommendations in a written 36

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l report;

(5) immediately following the predischarge assessment and
planning meeting, the provider of mental health case management
services who will serve the offender following discharge shall
offer to make arrangements and referrals for housing, financial
support, benefits assistance, employment counseling, and other
services required in sections 245.461 to 245.486;

8 (6) at least ten days before the offender's first scheduled 9 postdischarge appointment with a mental health provider, the 10 offender's designated-agent discharge planner shall transfer the 11 following records to the offender's case management services provider and psychiatrist: the predischarge assessment and 12 13 planning report, medical records, and pharmacy records. These 14 records may be transferred only if the offender provides 15 informed consent for their release;

16 (7) upon discharge, the offender's designated-agent 17 <u>discharge planner</u> shall ensure that the offender leaves the 18 correctional facility with at least a ten-day supply of all 19 necessary medications; and

(8) upon discharge, the prescribing authority at the offender's correctional facility shall telephone in prescriptions for all necessary medications to a pharmacy in the community where the offender plans to reside. The prescriptions must provide at least a 30-day <u>60-day</u> supply of all necessary medications, and must be able to be refilled once for one additional 30-day supply.

27 [EFFECTIVE DATE.] Subdivision 2, clause (2), item (iii), is
28 effective August 1, 2006, or upon HealthMatch implementation,
29 whichever is later.

30 Sec. 3. Minnesota Statutes 2004, section 245.4661, is 31 amended by adding a subdivision to read:

<u>Subd. 8.</u> [SUPPORTIVE HOUSING AND OTHER COMMUNITY SERVICES
FOR INDIVIDUALS TRANSITIONING FROM ANOKA-METRO REGIONAL
TREATMENT CENTER.] <u>The commissioner, through agreements with</u>
<u>counties and in consultation with providers of supportive</u>
<u>housing with services and others, shall transition individuals</u>

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1	who are currently at Anoka-Metro Regional Treatment Center into
2	the community, who are ready to be discharged or who are at
3	imminent risk of admission. The commissioner shall expand the
4	adult mental health initiative pilot projects under section
5	245.4661 to provide appropriate, thorough, flexible, and
6	sufficient services that may include supportive housing with
7	services, assertive community treatment, case management, and
8	other community supports for individuals with a mental illness
9	who:
10	(1) are at imminent risk of being admitted to, or are ready
11	to be discharged or have recently been discharged from, a
12	regional treatment center, community hospital, or residential
13	treatment program; and
14	(2) have no appropriate housing available or lack the
15	resources necessary to access permanent housing.
16	Sec. 4. Minnesota Statutes 2004, section 245.4661, is
17	amended by adding a subdivision to read:
18	Subd. 9. [BED CLOSING.] The commissioner shall close 25
19	beds at the Anoka-Metro Regional Treatment Center by July 1,
20	2007, and an additional 25 beds by July 1, 2008, or after
21	sufficient alternative services have been developed. The
22	commissioner shall transfer state savings resulting from these
23	bed closures into appropriate accounts according to subdivision
24	10 to pay for the ongoing provision of the alternative services
25	in subdivision 8 and for expansion of contract beds under
26	section 256.9693. No individual will be involuntarily
27	discharged under this subdivision if appropriate community
28	services are not available to support the individual.
29	Sec. 5. Minnesota Statutes 2004, section 245.4661, is
30	amended by adding a subdivision to read:
31	Subd. 10. [BUDGET FLEXIBILITY.] The commissioner may make
32	budget transfers that do not increase the state share of costs
33	to effectively implement the restructuring of adult mental
34	health services.
35	Sec. 6. Minnesota Statutes 2004, section 245.4661, is
36	amended by adding a subdivision to read:

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1	Subd. 11. [COUNTY ELIGIBILITY.] The commissioner may
2	approve funding for services under subdivision 8 according to
3	subdivisions 9 and 10 for a county or group of counties that:
4	(1) agrees to outcome-based performance criteria that
5	includes a reduction in utilization of regional treatment center
6	inpatient services through provision of quality services that
7	meet individual needs;
8	(2) agrees to the collection and submission of data
9	necessary to measure progress towards the criteria in clause (1)
10	and measurement of any resulting state or county savings;
11	(3) agrees to reinvest in the services defined in
12	subdivision 8 an amount equal to the ten percent county share of
13	regional treatment center services for the fiscal year ending
14	June 30, 2004, applied against the bed utilization reduction in
15	clause (1); and
16	(4) agrees to develop a supportive housing program that
17	insures the delivery of employment services, supportive
18	services, housing and health care for eligible individuals, or
1 <b>9</b>	agrees to contract with an existing integrated program.
20	Sec. 7. Minnesota Statutes 2004, section 245.4885,
21	subdivision 1, is amended to read:
22	Subdivision 1. [SCREENING-REQUIRED ADMISSION CRITERIA.]
23	The county board shall, prior to admission, except in the case
24	of emergency admission, screen determine the needed level of
25	care for all children referred for treatment of severe emotional
26	disturbance to in a treatment foster care setting, residential
27	treatment facility, or informally admitted to a regional
28	treatment center if public funds are used to pay for the
29	services. The county board shall also screen determine the
30	needed level of care for all children admitted to an acute care
31	hospital for treatment of severe emotional disturbance if public
32	funds other than reimbursement under chapters 256B and 256D are
<u></u>	used to pay for the services. If-a-child-is-admitted-to-a
	residential-treatment-facility-or-acute-care-hospital-for
35	emergency-treatment-or-held-for-emergency-care-by-a-regional
36	treatment-center-under-section-253B-057-subdivision-17-screening
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1 must-occur-within-three-working-days-of-admission-Screening The level of care determination shall determine 2 3 whether the proposed treatment: 4 (1) is necessary; 5 (2) is appropriate to the child's individual treatment 6 needs; 7 (3) cannot be effectively provided in the child's home; and 8 (4) provides a length of stay as short as possible 9 consistent with the individual child's need. 10 When a screening level of care determination is conducted, 11 the county board may not determine that referral or admission to a treatment foster care setting, residential treatment facility, 12 13 or acute care hospital is not appropriate solely because 14 services were not first provided to the child in a less 15 restrictive setting and the child failed to make progress toward or meet treatment goals in the less restrictive 16 17 setting. Screening-shall-include-both The level of care 18 determination must be based on a diagnostic assessment and that includes a functional assessment which evaluates family, school, 19 and community living situations; and an assessment of the 20 child's need for care out of the home using a validated tool 21 22 which assesses a child's functional status and assigns an appropriate level of care. The validated tool must be approved 23 by the commissioner of human services. If a diagnostic 24 assessment or including a functional assessment has been 25 26 completed by a mental health professional within the past 180 days, a new diagnostic or-functional assessment need not be 27 completed unless in the opinion of the current treating mental 28 29 health professional the child's mental health status has changed 30 markedly since the assessment was completed. The child's parent shall be notified if an assessment will not be completed and of 31 the reasons. A copy of the notice shall be placed in the 32 33 child's file. Recommendations developed as part of 34 the screening level of care determination process shall include specific community services needed by the child and, if 35 36 appropriate, the child's family, and shall indicate whether or

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1 not these services are available and accessible to the child and 2 family.

3 During the screening level of care determination process, 4 the child, child's family, or child's legal representative, as 5 appropriate, must be informed of the child's eligibility for 6 case management services and family community support services 7 and that an individual family community support plan is being 8 developed by the case manager, if assigned.

9 Screening <u>The level of care determination</u> shall be-in 10 compliance <u>comply</u> with section 260C.212. Wherever possible, the 11 parent shall be consulted in the screening process, unless 12 clinically inappropriate.

13 The screening-process level of care determination, and 14 placement decision, and recommendations for mental health 15 services must be documented in the child's record.

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 j times of review, persons responsible for the review, and review criteria are comparable to the standards in clauses (1) to (4).

21 [EFFECTIVE DATE.] This section is effective July 1, 2006. 22 Sec. 8. Minnesota Statutes 2004, section 245.4885, is 23 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.

31 Sec. 9. Minnesota Statutes 2004, section 245.4885,
32 subdivision 2, is amended to read:

3 Subd. 2. [QUALIFICATIONS.] No-later-than-July-17-19917 4 Screening Level of care determination of children for treatment 35 <u>foster care</u>, residential, and inpatient services must be 36 conducted by a mental health professional. Where appropriate

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1 and available, culturally informed mental health consultants must participate in the screening level of care determination. 2 Mental health professionals providing screening level of care 3 determination for treatment foster care, inpatient, and 4 residential services must not be financially affiliated with any 5 acute-care-inpatient-hospital7-residential-treatment-facility7 6 or-regional-treatment-center nongovernment entity which may be 7 providing those services. The-commissioner-may-waive-this 8 9 requirement-for-mental-health-professional-participation-after 10 July-17-19917-if-the-county-documents-that: 11 (1)-mental-health-professionals-or-mental-health 12 practitioners-are-unavailable-to-provide-this-service;-and 13 (2)-services-are-provided-by-a-designated-person-with 14 training-in-human-services-who-receives-clinical-supervision

15 from-a-mental-health-professional.

16 [EFFECTIVE DATE.] This section is effective July 1, 2006.
17 Sec. 10. Minnesota Statutes 2004, section 254B.03,
18 subdivision 4, is amended to read:

Subd. 4. [DIVISION OF COSTS.] Except for services provided 19 by a county under section 254B.09, subdivision 1, or services 20 21 provided under section 256B.69 or 256D.03, subdivision 4, 22 paragraph (b), or when the primary drug problem is amphetamine 23 or methamphetamine abuse or dependence, the county shall, out of 24 local money, pay the state for 15 percent of the cost of 25 chemical dependency services, including those services provided to persons eligible for medical assistance under chapter 256B 26 and general assistance medical care under chapter 256D. 27 28 Counties may use the indigent hospitalization levy for treatment 29 and hospital payments made under this section. Fifteen percent of any state collections from private or third-party pay, less 30 15 percent of the cost of payment and collections, must be 31 32 distributed to the county that paid for a portion of the treatment under this section. If all funds allocated according 33 34 to section 254B.02 are exhausted by a county and, except for treatment provided for amphetamine or methamphetamine abuse or 35 36 dependence, the county has met or exceeded the base level of

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expenditures under section 254B.02, subdivision 3, the county 1 shall pay the state for 15 percent of the costs paid by the 2 3 state under this section, unless the payment is for treatment of 4 amphetamine or methamphetamine abuse of dependence. The 5 commissioner may refuse to pay state funds for services to persons not eligible under section 254B.04, subdivision 1, if 6 7 the county financially responsible for the persons has exhausted its allocation. 8 [EFFECTIVE DATE.] This section is effective January 1, 2006. 9 Sec. 11. Minnesota Statutes 2004, section 256B.0622, 10 subdivision 2, is amended to read: 11 12 Subd. 2. [DEFINITIONS.] For purposes of this section, the

14 (a) "Intensive nonresidential rehabilitative mental health 15 services" means adult rehabilitative mental health services as defined in section 256B.0623, subdivision 2, paragraph (a), 16 17 except that these services are provided by a multidisciplinary staff using a total team approach consistent with assertive 18 19 community treatment, the Fairweather Lodge treatment model, as 20 defined by the standards established by the National Coalition for Community Living, and other evidence-based practices, and 21 22 directed to recipients with a serious mental illness who require 23 intensive services.

following terms have the meanings given them.

(b) "Intensive residential rehabilitative mental health 24 services" means short-term, time-limited services provided in a 25 residential setting to recipients who are in need of more 26 restrictive settings and are at risk of significant functional 27 deterioration if they do not receive these services. Services 28 are designed to develop and enhance psychiatric stability, 29 personal and emotional adjustment, self-sufficiency, and skills 30 to live in a more independent setting. Services must be 31 directed toward a targeted discharge date with specified client 32 outcomes and must be consistent with the Fairweather Lodge 33 treatment model as defined in paragraph (a), and other 34 evidence-based practices. 35 36 (c) "Evidence-based practices" are nationally recognized

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mental health services that are proven by substantial research
 to be effective in helping individuals with serious mental
 illness obtain specific treatment goals.

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

7 (e) "Treatment team" means all staff who provide services 8 under this section to recipients. At a minimum, this includes 9 the clinical supervisor, mental health professionals, mental 10 health practitioners, and mental health rehabilitation workers.

Sec. 12. Minnesota Statutes 2004, section 256B.0625, is amended by adding a subdivision to read:

Subd. 46. [MENTAL HEALTH TELEMEDICINE.] Effective January 13 14 1, 2006, and subject to federal approval, mental health services that are otherwise covered by medical assistance as direct 15 16 face-to-face services may be provided via two-way interactive 17 video. Use of two-way interactive video must be medically 18 appropriate to the condition and needs of the person being 19 served. Reimbursement is at the same rates and under the same 20 conditions that would otherwise apply to the service. The 21 interactive video equipment and connection must comply with Medicare standards in effect at the time the service is provided. 22 23 Sec. 13. Minnesota Statutes 2004, section 256B.0625, is amended by adding a subdivision to read: 24

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.

29 Sec. 14. Minnesota Statutes 2004, section 256B.0625, is 30 amended by adding a subdivision to read:

31 <u>Subd. 48.</u> [PSYCHIATRIC CONSULTATION TO PRIMARY CARE 32 PRACTITIONERS.] <u>Effective January 1, 2006, medical assistance</u> 33 <u>covers consultation provided by a psychiatrist via telephone,</u> 34 <u>e-mail, facsimile, or other means of communication to primary</u> 35 <u>care practitioners, including pediatricians. The need for</u> 36 <u>consultation and the receipt of the consultation must be</u>

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	l	documented in the patient record maintained by the primary care
rines,	2	practitioner. If the patient consents, and subject to federal
	3	limitations and data privacy provisions, the consultation may be
	4	provided without the patient present.
	5	Sec. 15. [256B.0946] [TREATMENT FOSTER CARE.]
	6	Subdivision 1. [COVERED SERVICE.] (a) Effective July 1,
	7	2006, and subject to federal approval, medical assistance covers
	8	medically necessary services described under paragraph (b) that
	9	are provided by a provider entity eligible under subdivision 3
	10	to a client eligible under subdivision 2 who is placed in a
	11	treatment foster home licensed under Minnesota Rules, parts
and the second s	12	2960.3000 to 2960.3340.
	13	(b) Services to children with severe emotional disturbance
	14	residing in treatment foster care settings must meet the
	15	relevant standards for mental health services under sections
	16	245.487 to 245.4887. In addition, specific service components
	17	reimbursed by medical assistance must meet the following
	18	standards:
	19	(1) case management service component must meet the
	20	standards in Minnesota Rules, parts 9520.0900 to 9520.0926 and
	21	9505.0322, excluding subparts 6 and 10;
	22	(2) psychotherapy and skills training components must meet
office and	23	the standards for children's therapeutic services and supports
	24	in section 256B.0943; and
	25	(3) family psychoeducation services under supervision of a
	26	mental health professional.
	27	Subd. 2. [DETERMINATION OF CLIENT ELIGIBILITY.] A client's
	28	eligibility to receive treatment foster care under this section
	29	shall be determined by a diagnostic assessment, an evaluation of
	30	level of care needed, and development of an individual treatment
	31	plan, as defined in paragraphs (a) to (c).
	32	(a) The diagnostic assessment must:
and and a second second	33	(1) be conducted by a psychiatrist, licensed psychologist,
	34	or licensed independent clinical social worker that is performed
	35	within 180 days prior to the start of service;
	36	(2) include current diagnoses on all five axes of the

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1	client's current mental health status;
2	(3) determine whether or not a child meets the criteria for
3	severe emotional disturbance in section 245.4871, subdivision 6,
4	or for serious and persistent mental illness in section 245.462,
5	subdivision 20; and
6	(4) be completed annually until age 18. For individuals
7	between age 18 and 21, unless a client's mental health condition
8	has changed markedly since the client's most recent diagnostic
9	assessment, annual updating is necessary. For the purpose of
10	this section, "updating" means a written summary, including
11	current diagnoses on all five axes, by a mental health
12	professional of the client's current mental status and service
13	needs.
14	(b) The evaluation of level of care must be conducted by
15	the placing county with an instrument approved by the
16	commissioner of human services. The commissioner shall update
17	the list of approved level of care instruments annually.
18	(c) The individual treatment plan must be:
19	(1) based on the information in the client's diagnostic
20	assessment;
21	(2) developed through a child-centered, family driven
22	planning process that identifies service needs and
Ż3	individualized, planned, and culturally appropriate
24	interventions that contain specific measurable treatment goals
25	and objectives for the client and treatment strategies for the
26	client's family and foster family;
27	(3) reviewed at least once every 90 days and revised; and
28	(4) signed by the client or, if appropriate, by the
29	client's parent or other person authorized by statute to consent
30	to mental health services for the client.
31	Subd. 3. [ELIGIBLE PROVIDERS.] For purposes of this
32	section, a provider agency must have an individual placement
33	agreement for each recipient and must be a licensed child
34	placing agency, under Minnesota Rules, parts 9543.0010 to
35	9543.0150, and either:
36	(1) a county;

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~	l	(2) an Indian Health Services facility operated by a tribe
general,	2	or tribal organization under funding authorized by United States
	3	Code, title 25, sections 450f to 450n, or title 3 of the Indian
	4	Self-Determination Act, Public Law 93-638, section 638
	5	(facilities or providers); or
	6	(3) a noncounty entity under contract with a county board.
	7	Subd. 4. [ELIGIBLE PROVIDER RESPONSIBILITIES.] (a) To be
	8	an eligible provider under this section, a provider must develop
	9	written policies and procedures for treatment foster care
	10	services consistent with subdivision 1, paragraph (b), clauses
	11	(1), (2), and (3).
,	12	(b) In delivering services under this section, a treatment
	13	foster care provider must ensure that staff caseload size
	14	reasonably enables the provider to play an active role in
	15	service planning, monitoring, delivering, and reviewing for
	16	discharge planning to meet the needs of the client, the client's
	17	foster family, and the birth family, as specified in each
	18	<u>client's individual treatment plan.</u>
	19	Subd. 5. [SERVICE AUTHORIZATION.] The commissioner will
	20	administer authorizations for services under this section in
	21	compliance with section 256B.0625, subdivision 25.
1997 <sup>(100</sup> 00),	22	Subd. 6. [EXCLUDED SERVICES.] (a) Services in clauses (1)
~	23	to (4) are not eligible as components of treatment foster care
	24	services:
	25	(1) treatment foster care services provided in violation of
	26	medical assistance policy in Minnesota Rules, part 9505.0220;
	27	(2) service components of children's therapeutic services
	28	and supports simultaneously provided by more than one treatment
	29	foster care provider;
	30	(3) home and community-based waiver services; and
	31	(4) treatment foster care services provided to a child
	32	without a level of care determination according to section
	33	245.4885, subdivision 1.
	34	(b) Children receiving treatment foster care services are
	35	not eligible for medical assistance reimbursement for the
	36	following services while receiving treatment foster care:
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1	(1) mental health case management services under section
2	256B.0625, subdivision 20; and
3	(2) psychotherapy and skill training components of
4	children's therapeutic services and supports under section
5	256B.0625, subdivision 35b.
6	Sec. 16. [256B.0947] [TRANSITIONAL YOUTH INTENSIVE
7	REHABILITATIVE MENTAL HEALTH SERVICES.]
8	Subdivision 1. [SCOPE.] Subject to federal approval,
9	medical assistance covers medically necessary, intensive
10	nonresidential rehabilitative mental health services as defined
11	in subdivision 2, for recipients as defined in subdivision 3,
12	when the services are provided by an entity meeting the
13	standards in this section.
14	Subd. 2. [DEFINITIONS.] For purposes of this section, the
15	following terms have the meanings given them.
16	(a) "Intensive nonresidential rehabilitative mental health
17	services" means child rehabilitative mental health services as
18	defined in section 256B.0943, except that these services are
19	provided by a multidisciplinary staff using a total team
20	approach consistent with assertive community treatment, or other
21	evidence-based practices, and directed to recipients with a
22	serious mental illness who require intensive services.
23	(b) "Evidence-based practices" are nationally recognized
24	mental health services that are proven by substantial research
25	to be effective in helping individuals with serious mental
26	illness obtain specific treatment goals.
27	(c) "Treatment team" means all staff who provide services
28	to recipients under this section. At a minimum, this includes
29	the clinical supervisor, mental health professionals, mental
30	health practitioners, mental health behavioral aides, and a
31	school representative familiar with the recipient's individual
32	education plan (IEP) if applicable.
33	Subd. 3. [ELIGIBILITY FOR TRANSITIONAL YOUTH.] An eligible
34	recipient under the age of 18 is an individual who:
35	<u>(1) is age 16 or 17;</u>
36	(2) is diagnosed with a medical condition, such as an

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	l	emotional disturbance or traumatic brain injury, for which
99999 (m. 1	2	intensive nonresidential rehabilitative mental health services
	3	are needed;
	4	(3) has substantial disability and functional impairment in
	5	three or more of the areas listed in section 245.462,
	6	subdivision lla, so that self-sufficiency upon adulthood or
	7	emancipation is unlikely; and
	8	(4) has had a recent diagnostic assessment by a qualified
	9	professional that documents that intensive nonresidential
	10	rehabilitative mental health services are medically necessary to
	11	address identified disability and functional impairments and
	12	individual recipient goals.
	13	Subd. 4. [PROVIDER CERTIFICATION AND CONTRACT
	14	REQUIREMENTS.] (a) The intensive nonresidential rehabilitative
	15	mental health services provider must:
	16	(1) have a contract with the host county to provide
	17	intensive transition youth rehabilitative mental health
	18	services; and
	19	(2) be certified by the commissioner as being in compliance
	20	with this section and section 256B.0943.
	21	(b) The commissioner shall develop procedures for counties
	22	and providers to submit contracts and other documentation as
w	23	needed to allow the commissioner to determine whether the
	24	standards in this section are met.
	25	Subd. 5. [STANDARDS APPLICABLE TO NONRESIDENTIAL
	26	PROVIDERS.] (a) Services must be provided by a certified
	27	provider entity as defined in section 256B.0943, subdivision 4
	28	that meets the requirements in section 245B.0943, subdivisions 5
	29	and 6.
	30	(b) The clinical supervisor must be an active member of the
	31	treatment team. The treatment team must meet with the clinical
	32	supervisor at least weekly to discuss recipients' progress and
	33	make rapid adjustments to meet recipients' needs. The team
	34	meeting shall include recipient-specific case reviews and
	35	general treatment discussions among team members.
	36	Recipient-specific case reviews and planning must be documented

[REVISOR ] .S/MD 05-4117 04/28/05 1 in the individual recipient's treatment record. 2 (c) Treatment staff must have prompt access in person or by telephone to a mental health practitioner or mental health 3 professional. The provider must have the capacity to promptly 4 and appropriately respond to emergent needs and make any 5 necessary staffing adjustments to assure the health and safety 6 7 of recipients. 8 (d) The initial functional assessment must be completed within ten days of intake and updated at least every three 9 months or prior to discharge from the service, whichever comes 10 first. 11 12 (e) The initial individual treatment plan must be completed within ten days of intake and reviewed and updated at least 13 monthly with the recipient. 14 Subd. 6. [ADDITIONAL STANDARDS FOR NONRESIDENTIAL 15 16 SERVICES.] The standards in this subdivision apply to intensive nonresidential rehabilitative mental health services. 17 (1) The treatment team must use team treatment, not an 18 19 individual treatment model. 20 (2) The clinical supervisor must function as a practicing clinician at least on a part-time basis. 21 22 (3) The staffing ratio must not exceed ten recipients to one full-time equivalent treatment team position. 23 24 (4) Services must be available at times that meet client 25 needs. 26 (5) The treatment team must actively and assertively engage and reach out to the recipient's family members and significant 27 28 others, after obtaining the recipient's permission. 29 (6) The treatment team must establish ongoing communication 30 and collaboration between the team, family, and significant others and educate the family and significant others about 31 32 mental illness, symptom management, and the family's role in 33 treatment. 34 (7) The treatment team must provide interventions to promote positive interpersonal relationships. 35 Subd. 7. [MEDICAL ASSISTANCE PAYMENT FOR INTENSIVE 36

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	1	REHABILITATIVE MENTAL HEALTH SERVICES.] (a) Payment for
· •	2	nonresidential services in this section shall be based on one
	3	daily rate per provider inclusive of the following services
	4	received by an eligible recipient in a given calendar day: all
	5	rehabilitative services under this section, staff travel time to
	6	provide rehabilitative services under this section, and
	7	nonresidential crisis stabilization services under section
	8	256B.0944.
	9	(b) Except as indicated in paragraph (c), payment will not
	10	be made to more than one entity for each recipient for services
	11	provided under this section on a given day. If services under
····.	12	this section are provided by a team that includes staff from
	13	more than one entity, the team must determine how to distribute
	14	the payment among the members.
	15	(c) The host county shall recommend to the commissioner one
	16	rate for each entity that will bill medical assistance for
	17	nonresidential intensive rehabilitative mental health services.
	18	In developing these rates, the host county shall consider and
	19	document:
	20	(1) the cost for similar services in the local trade area;
	21	(2) actual costs incurred by entities providing the
· .	22	services;
~	23	(3) the intensity and frequency of services to be provided
	24	to each recipient;
	25	(4) the degree to which recipients will receive services
	26	other than services under this section; and
	27	(5) the costs of other services that will be separately
	28	reimbursed.
	29	(d) The rate for intensive rehabilitative mental health
	30	services must exclude medical assistance room and board rate, as
	31	defined in section 2561.03, subdivision 6, and services not
	32	covered under this section, such as partial hospitalization and
	33	inpatient services. Physician services are not a component of
	34	the treatment team and may be billed separately. The county's
	35	recommendation shall specify the period for which the rate will
	36	be applicable, not to exceed two years.

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(e) When services under this section are provided by an 1 assertive community team, case management functions must be an 2 3 integral part of the team. 4 (f) The rate for a provider must not exceed the rate 5 charged by that provider for the same service to other payors. 6 (g) The commissioner shall approve or reject the county's rate recommendation, based on the commissioner's own analysis of 7 the criteria in paragraph (c). 8 Subd. 9. [PROVIDER ENROLLMENT; RATE SETTING FOR 9 10 COUNTY-OPERATED ENTITIES.] Counties that employ their own staff 11 to provide services under this section shall apply directly to the commissioner for enrollment and rate setting. In this case, 12 a county contract is not required and the commissioner shall 13 perform the program review and rate setting duties which would 14 15 otherwise be required of counties under this section. [EFFECTIVE DATE.] This section is effective July 1, 2006. 16

Sec. 17. 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 percent state funds and 20 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

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(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; and
(5) beginning July 1, 2006, 50 percent state funds and 50

7 percent county funds for the cost of treatment foster care 8 services under section 256B.0946.

For counties that participate in a Medicaid demonstration 9 project under sections 256B.69 and 256B.71, the division of the 10 nonfederal share of medical assistance expenses for payments 11 made to prepaid health plans or for payments made to health 12 maintenance organizations in the form of prepaid capitation 13 payments, this division of medical assistance expenses shall be 14 95 percent by the state and five percent by the county of 15 16 financial responsibility.

17 In counties where prepaid health plans are under contract 18 to the commissioner to provide services to medical assistance 19 recipients, the cost of court ordered treatment ordered without 20 consulting the prepaid health plan that does not include 21 diagnostic evaluation, recommendation, and referral for 22 treatment by the prepaid health plan is the responsibility of 23 the county of financial responsibility.

24 Sec. 18. Minnesota Statutes 2004, section 256D.03, 25 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):

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inpatient hospital services;

31 (2) outpatient hospital services;

32 (3) services provided by Medicare certified rehabilitation33 agencies;

34 (4) prescription drugs and other products recommended
35 through the process established in section 256B.0625,
36 subdivision 13;

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1 (5) equipment necessary to administer insulin and diagnostic supplies and equipment for diabetics to monitor blood 2 3 sugar level; 4 (6) eyeglasses and eye examinations provided by a physician or optometrist; 5 6 (7) hearing aids; 7 (8) prosthetic devices; (9) laboratory and X-ray services; 8 9 (10) physician's services; 10 (11) medical transportation except special transportation; (12) chiropractic services as covered under the medical 11 assistance program; 12 13 (13) podiatric services; 14 (14) dental services and dentures, subject to the limitations specified in section 256B.0625, subdivision 9; 15 (15) outpatient services provided by a mental health center 16 or clinic that is under contract with the county board and is 17 established under section 245.62; 18 (16) day treatment services for mental illness provided 19 under contract with the county board; 20 (17) prescribed medications for persons who have been 21 diagnosed as mentally ill as necessary to prevent more 22 23 restrictive institutionalization; (18) psychological services, medical supplies and 24 25 equipment, and Medicare premiums, coinsurance and deductible 26 payments; (19) medical equipment not specifically listed in this 27 paragraph when the use of the equipment will prevent the need 28 for costlier services that are reimbursable under this 29 30 subdivision; (20) services performed by a certified pediatric nurse 31 32 practitioner, a certified family nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological 33 nurse practitioner, a certified neonatal nurse practitioner, or 34 a certified geriatric nurse practitioner in independent 35 practice, if (1) the service is otherwise covered under this 36

1 chapter as a physician service, (2) the service provided on an 2 inpatient basis is not included as part of the cost for 3 inpatient services included in the operating payment rate, and 4 (3) the service is within the scope of practice of the nurse 5 practitioner's license as a registered nurse, as defined in 6 section 148.171;

7 (21) services of a certified public health nurse or a 8 registered nurse practicing in a public health nursing clinic 9 that is a department of, or that operates under the direct 10 authority of, a unit of government, if the service is within the 11 scope of practice of the public health nurse's license as a 12 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

15 (23) mental health telemedicine and psychiatric
16 consultation as covered under section 256B.0625, subdivisions 46
17 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 28 services shall select vendors of medical care who can provide 29 the most economical care consistent with high medical standards 30 and shall where possible contract with organizations on a 31 prepaid capitation basis to provide these services. 32 The commissioner shall consider proposals by counties and vendors 33 for prepaid health plans, competitive bidding programs, block 34 grants, or other vendor payment mechanisms designed to provide 35 services in an economical manner or to control utilization, with 36

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safeguards to ensure that necessary services are provided. 1 Before implementing prepaid programs in counties with a county 2 operated or affiliated public teaching hospital or a hospital or 3 clinic operated by the University of Minnesota, the commissioner 4 shall consider the risks the prepaid program creates for the 5 hospital and allow the county or hospital the opportunity to 6 participate in the program in a manner that reflects the risk of 7 adverse selection and the nature of the patients served by the 8 hospital, provided the terms of participation in the program are 9 10 competitive with the terms of other participants considering the nature of the population served. Payment for services provided 11 pursuant to this subdivision shall be as provided to medical 12 assistance vendors of these services under sections 256B.02, 13 subdivision 8, and 256B.0625. For payments made during fiscal 14 year 1990 and later years, the commissioner shall consult with 15 an independent actuary in establishing prepayment rates, but 16 shall retain final control over the rate methodology. 17

(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;

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(2) \$25 for eyeglasses;

29 (3) \$25 for nonemergency visits to a hospital-based30 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

36 (5) 50 percent coinsurance on restorative dental services.

1 (e) Co-payments shall be limited to one per day per provider for nonpreventive visits, eyeglasses, and nonemergency 2 visits to a hospital-based emergency room. Recipients of 3 general assistance medical care are responsible for all 4 5 co-payments in this subdivision. The general assistance medical 6 care reimbursement to the provider shall be reduced by the 7 amount of the co-payment, except that reimbursement for prescription drugs shall not be reduced once a recipient has 8 reached the \$20 per month maximum for prescription drug 9 10 co-payments. The provider collects the co-payment from the recipient. Providers may not deny services to recipients who 11 12 are unable to pay the co-payment, except as provided in 13 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.

19 (g) Any county may, from its own resources, provide medical20 payments for which state payments are not made.

21 (h) Chemical dependency services that are reimbursed under
22 chapter 254B must not be reimbursed under general assistance
23 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.

32 (k) Inpatient and outpatient payments shall be reduced by 33 five percent, effective July 1, 2003. This reduction is in 34 addition to the five percent reduction effective July 1, 2003, 35 and incorporated by reference in paragraph (i).

36 (1) Payments for all other health services except

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inpatient, outpatient, and pharmacy services shall be reduced by
 five percent, effective July 1, 2003.

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

5 (n) A hospital receiving a reduced payment as a result of 6 this section may apply the unpaid balance toward satisfaction of 7 the hospital's bad debts.

8 [EFFECTIVE DATE.] This section is effective January 1, 2006.
9 Sec. 19. Minnesota Statutes 2004, section 256D.44,
10 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.

17 (a) The county agency shall pay a monthly allowance for 18 medically prescribed diets if the cost of those additional 19 dietary needs cannot be met through some other maintenance 20 benefit. The need for special diets or dietary items must be prescribed by a licensed physician. Costs for special diets 21 22 shall be determined as percentages of the allotment for a 23 one-person household under the thrifty food plan as defined by the United States Department of Agriculture. The types of diets 24 and the percentages of the thrifty food plan that are covered 25 are as follows: 26

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

29 (2) controlled protein diet, 40 to 60 grams and requires special products, 100 percent of thrifty food plan; 30 31 (3) controlled protein diet, less than 40 grams and requires special products, 125 percent of thrifty food plan; 32 33 (4) low cholesterol diet, 25 percent of thrifty food plan; (5) high residue diet, 20 percent of thrifty food plan; 34 (6) pregnancy and lactation diet, 35 percent of thrifty 35 food plan; 36<sup>.</sup>

1 (7) gluten-free diet, 25 percent of thrifty food plan; (8) lactose-free diet, 25 percent of thrifty food plan; 2 3 (9) antidumping diet, 15 percent of thrifty food plan; (10) hypoglycemic diet, 15 percent of thrifty food plan; or 4 (11) ketogenic diet, 25 percent of thrifty food plan. 5 6 (b) Payment for nonrecurring special needs must be allowed 7 for necessary home repairs or necessary repairs or replacement of household furniture and appliances using the payment standard 8 of the AFDC program in effect on July 16, 1996, for these 9 expenses, as long as other funding sources are not available. 10

(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.

17 (d) The county agency shall continue to pay a monthly allowance of \$68 for restaurant meals for a person who was 18 19 receiving a restaurant meal allowance on June 1, 1990, and who eats two or more meals in a restaurant daily. The allowance 20 must continue until the person has not received Minnesota 21 supplemental aid for one full calendar month or until the 22 person's living arrangement changes and the person no longer 23 meets the criteria for the restaurant meal allowance, whichever 24 occurs first. 25

(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

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1 the standards of assistance established in subdivisions 1 to 4
2 for individuals under the age of 65 who are relocating from an
3 institution, or an adult mental health residential treatment
4 program under section 256B.0622, and who are shelter needy. An
5 eligible individual who receives this benefit prior to age 65
6 may continue to receive the benefit after the age of 65.

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7 "Shelter needy" means that the assistance unit incurs monthly shelter costs that exceed 40 percent of the assistance 8 9 unit's gross income before the application of this special needs standard. "Gross income" for the purposes of this section is 10 the applicant's or recipient's income as defined in section 11 256D.35, subdivision 10, or the standard specified in 12 13 subdivision 3, whichever is greater. A recipient of a federal or state housing subsidy, that limits shelter costs to a 14 15 percentage of gross income, shall not be considered shelter 16 needy for purposes of this paragraph.

Sec. 20. Minnesota Statutes 2004, section 256L.03,subdivision 1, is amended to read:

Subdivision 1. [COVERED HEALTH SERVICES.] For individuals 19 20 under section 256L.04, subdivision 7, with income no greater 21 than 75 percent of the federal poverty guidelines or for families with children under section 256L.04, subdivision 1, all 22 23 subdivisions of this section apply. "Covered health services" 24 means the health services reimbursed under chapter 256B, with 25 the exception of inpatient hospital services, special education 26 services, private duty nursing services, adult dental care 27 services other than services covered under section 256B.0625, 28 subdivision 9, paragraph (b), orthodontic services, nonemergency 29 medical transportation services, personal care assistant and 30 case management services, nursing home or intermediate care facilities services, inpatient mental health services, and 31 32 chemical dependency services. Outpatient mental health services covered under the MinnesotaCare program are limited to 33 34 diagnostic assessments, psychological testing, explanation of 35 findings, mental health telemedicine, psychiatric consultation, 36 medication management by a physician, day treatment, partial

04/28/05 [REVISOR ] ,S/MD 05-4117 1 hospitalization, and individual, family, and group psychotherapy. No public funds shall be used for coverage of abortion 2 under MinnesotaCare except where the life of the female would be 3 endangered or substantial and irreversible impairment of a major 4 bodily function would result if the fetus were carried to term; 5 or where the pregnancy is the result of rape or incest. 6 7 Covered health services shall be expanded as provided in 8 this section. [EFFECTIVE DATE.] This section is effective January 1, 2006. 9 10 Sec. 21. [641.155] [DISCHARGE PLANS; OFFENDERS WITH SERIOUS AND PERSISTENT MENTAL ILLNESS.] 11 12 The commissioner of corrections shall develop a model discharge planning process for every offender with a serious and 13 14 persistent mental illness, as defined in section 245.462, 15 subdivision 20, paragraph (c), who has been convicted and sentenced to serve three or more months and is being released 16 from a county jail or county regional jail. 17 18 An offender with a serious and persistent mental illness, as defined in section 245.462, subdivision 20, paragraph (c), 19 20 who has been convicted and sentenced to serve three or more 21 months and is being released from a county jail or county regional jail shall be referred to the appropriate staff in the 22 23 county human services department at least 60 days before being 24 released. The county human services department may carry out provisions of the model discharge planning process such as: 25 (1) providing assistance in filling out an application for 26 27 medical assistance, general assistance medical care, or MinnesotaCare; 28 (2) making a referral for case management as outlined under 29 section 245.467, subdivision 4; 30 (3) providing assistance in obtaining a state photo 31 identification; 32 33 (4) securing a timely appointment with a psychiatrist or other appropriate community mental health providers; and 34 (5) providing prescriptions for a 30-day supply of all 35 36 necessary medications.

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1	Sec. 22. [PRIORITY IN JANITORIAL CONTRACTS.]
2	When awarding contracts to provide the janitorial services
3	for the new Department of Human Services and Department of
4	Health buildings, the commissioner of administration shall give
5	priority to supported work vendors.
6	ARTICLE 6
7	FAMILY SUPPORT
8	Section 1. Minnesota Statutes 2004, section 119B.011, is
9	amended by adding a subdivision to read:
10	Subd. 23. [WORK PARTICIPATION RATE ENHANCEMENT
11	PROGRAM.] "Work participation rate enhancement program" means
12	the program established under section 256J.575.
13	Sec. 2. Minnesota Statutes 2004, section 119B.05,
14	subdivision 1, is amended to read:
15	Subdivision 1. [ELIGIBLE PARTICIPANTS.] Families eligible
16	for child care assistance under the MFIP child care program are:
17	(1) MFIP participants who are employed or in job search and
18	meet the requirements of section 119B.10;
19	(2) persons who are members of transition year families
20	under section 119B.011, subdivision 20, and meet the
21	requirements of section 119B.10;
22	(3) families who are participating in employment
23	orientation or job search, or other employment or training
24	activities that are included in an approved employability
25	development plan under section 256J.95;
26	(4) MFIP families who are participating in work job search,
27	job support, employment, or training activities as required in
28	their employment plan, or in appeals, hearings, assessments, or
29	orientations according to chapter 256J;
30	(5) MFIP families who are participating in social services
31	activities under chapter 256J as required in their employment
32	plan approved according to chapter 256J;
33	(6) families who are participating in services or
34	activities that are included in an approved family stabilization
35	plan under section 256J.575;
36	(7) families who are participating in programs as required

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1 in tribal\_contracts under section ll9B.02, subdivision 2, or 2 256.01, subdivision 2; and

3 (7) (8) families who are participating in the transition
4 year extension under section 119B.011, subdivision 20a.

5 Sec. 3. Minnesota Statutes 2004, section 252.27,
6 subdivision 2a, is amended to read:

Subd. 2a. [CONTRIBUTION AMOUNT.] (a) The natural or 7 8 adoptive parents of a minor child, including a child determined 9 eligible for medical assistance without consideration of parental income, must contribute to the cost of services used by 10 making monthly payments on a sliding scale based on income, 11 unless the child is married or has been married, parental rights 12 have been terminated, or the child's adoption is subsidized 13 according to section 259.67 or through title IV-E of the Social 14 15 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;

25 (2) if the adjusted gross income is equal to or greater than 175 percent of federal poverty guidelines and less than or 26 equal to 375 percent of federal poverty guidelines, the parental 27 contribution shall be determined using a sliding fee scale 28 established by the commissioner of human services which begins 29 at one percent of adjusted gross income at 175 percent of 30 federal poverty guidelines and increases to 7.5 percent of 31 adjusted gross income for those with adjusted gross income up to 32 375 percent of federal poverty guidelines; 33

34 (3) if the adjusted gross income is greater than 375
35 percent of federal poverty guidelines and less than 675 percent
36 of federal poverty guidelines, the parental contribution shall

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1 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 ten percent of adjusted gross income; and

6 (5) if the adjusted gross income is equal to or greater 7 than 975 percent of federal poverty guidelines, the parental 8 contribution shall be 12.5 percent of adjusted gross income.

If the child lives with the parent, the annual adjusted 9 10 gross income is reduced by \$2,400 prior to calculating the parental contribution. If the child resides in an institution 11 12 specified in section 256B.35, the parent is responsible for the personal needs allowance specified under that section in 13 addition to the parental contribution determined under this 14 section. The parental contribution is reduced by any amount 15 required to be paid directly to the child pursuant to a court 16 17 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.

25 (d) For purposes of paragraph (b), "income" means the 26 adjusted gross income of the natural or adoptive parents 27 determined according to the previous year's federal tax form, 28 except, effective retroactive to July 1, 2003, taxable capital 29 gains to the extent the funds have been used to purchase a 30 home and funds from early withdrawn qualified retirement accounts under the Internal Revenue Code shall not be counted as 31 32 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

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1 services. Annually upon redetermination or at termination of 2 eligibility, if the contribution exceeded the cost of services 3 provided, the local agency or the state shall reimburse that 4 excess amount to the parents, either by direct reimbursement if 5 the parent is no longer required to pay a contribution, or by a 6 reduction in or waiver of parental fees until the excess amount 7 is exhausted.

(f) The monthly contribution amount must be reviewed at 8 least every 12 months; when there is a change in household size; 9 and when there is a loss of or gain in income from one month to 10 another in excess of ten percent. The local agency shall mail a 11 written notice 30 days in advance of the effective date of a 12 change in the contribution amount. A decrease in the 13 contribution amount is effective in the month that the parent 14 verifies a reduction in income or change in household size. 15

(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, except that a court-ordered phild support payment actually paid on behalf of the child receiving services shall be deducted from the adjusted-gross income contribution of the parent making the payment prior-to calculating-the-parental-contribution-under-paragraph-(b).

(h) The contribution under paragraph (b) shall be increased 23 by an additional five percent if the local agency determines 24 that insurance coverage is available but not obtained for the 25 child. For purposes of this section, "available" means the 26 27 insurance is a benefit of employment for a family member at an annual cost of no more than five percent of the family's annual 28 income. For purposes of this section, "insurance" means health 29 and accident insurance coverage, enrollment in a nonprofit 30 health service plan, health maintenance organization, 31 32 self-insured plan, or preferred provider organization.

33 Parents who have more than one child receiving services 34 shall not be required to pay more than the amount for the child 35 with the highest expenditures. There shall be no resource 36 contribution from the parents. The parent shall not be required

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1 to pay a contribution in excess of the cost of the services
2 provided to the child, not counting payments made to school
3 districts for education-related services. Notice of an increase
4 in fee payment must be given at least 30 days before the
5 increased fee is due.

6 (i) The contribution under paragraph (b) shall be reduced
7 by \$300 per fiscal year if, in the 12 months prior to July 1:
8 (1) the parent applied for insurance for the child;

9

(2) the insurer denied insurance;

10 (3) the parents submitted a complaint or appeal, in writing 11 to the insurer, submitted a complaint or appeal, in writing, to 12 the commissioner of health or the commissioner of commerce, or 13 litigated the complaint or appeal; and

14 (4) as a result of the dispute, the insurer reversed its15 decision and granted insurance.

16 For purposes of this section, "insurance" has the meaning 17 given in paragraph (h).

18 A parent who has requested a reduction in the contribution 19 amount under this paragraph shall submit proof in the form and 20 manner prescribed by the commissioner or county agency, 21 including, but not limited to, the insurer's denial of 22 insurance, the written letter or complaint of the parents, court 23 documents, and the written response of the insurer approving 24 insurance. The determinations of the commissioner or county agency under this paragraph are not rules subject to chapter 14. 25 26 (j) Within the available appropriation for the biennium beginning July 1, 2005, the commissioner shall modify the 27 contribution amount under paragraph (a), giving priority to 28

29 reducing the parental contribution for the lowest income

30 parents. Notwithstanding paragraphs (a) to (i), the

31 commissioner shall implement the new parental fee formula as

32 soon as possible and request that the changes be codified in the

33 next legislative session.

34 Sec. 4. Minnesota Statutes 2004, section 256.01, is 35 amended by adding a subdivision to read:

36 <u>Subd. 14b.</u> [AMERICAN INDIAN CHILD WELFARE PROJECTS.] (a)

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l The commissioner of human services may authorize projects to test tribal delivery of child welfare services to American 2 Indian children and their parents and custodians living on the 3 reservation. The commissioner has authority to solicit and 4 determine which tribes may participate in a project. Grants may 5 be issued to Minnesota Indian tribes to support the projects. 6 The commissioner may waive existing state rules as needed to 7 accomplish the projects. Notwithstanding section 626.556, the 8 9 commissioner may authorize projects to use alternative methods 10 of investigating and assessing reports of child maltreatment, provided that the projects comply with the provisions of section 11 626.556 dealing with the rights of individuals who are subjects 12 of reports or investigations, including notice and appeal rights 13 and data practices requirements. The commissioner may seek any 14 15 federal approvals necessary to carry out the projects as well as 16 seek and use any funds available to the commissioner, including 17 use of federal funds, foundation funds, existing grant funds, 18 and other funds. The commissioner is authorized to advance state funds as necessary to operate the projects. Federal 19 20 reimbursement applicable to the projects is appropriated to the commissioner for the purposes of the projects. The projects 21 22 must be required to address responsibility for safety, permanency, and well-being of children. 23 (b) For the purposes of this section, "American Indian 24 25 child" means a person from birth to 18 years of age who is a tribal member or eligible for membership in one of the tribes 26 chosen for the project under this subdivision and who is 27 residing on the reservation of that tribe. 28 (c) In order to qualify for an American Indian child 29 welfare project, a tribe must: 30 (1) be one of the existing tribes with reservation land in 31 32 Minnesota; (2) have a tribal court with jurisdiction over child 33 34 custody proceedings; (3) have a substantial number of children for whom 35 determinations of maltreatment have occurred; 36 Article 6 Section 4 217

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1	(4) have capacity to respond to reports of abuse and
2	neglect under section 626.556;
3	(5) provide a wide range of services to families in need of
4	child welfare services; and
5	(6) have a tribal-state title IV-E agreement in effect.
6	(d) Grants awarded under this section may be used for the
7	nonfederal costs of providing child welfare services to American
8	Indian children on the tribe's reservation, including costs
9	associated with:
10	(1) assessment and prevention of child abuse and neglect;
11	(2) family preservation;
12	(3) facilitative, supportive, and reunification services;
13	(4) out-of-home placement for children removed from the
14	home for child protective purposes; and
15	(5) other activities and services approved by the
16	commissioner that further the goals of providing safety,
17	permanency, and well-being of American Indian children.
18	(e) When a tribe has initiated a project and has been
19	approved by the commissioner to assume child welfare
20	responsibilities for American Indian children of that tribe
21	under this section, the affected county social service agency is
22	relieved of responsibility for responding to reports of abuse
23	and neglect under section 626.556 for those children during the
24	time the tribal project is in effect and receiving funding for
25	the project. The commissioner shall work with tribes and
26	affected counties to develop procedures for data collection,
27	evaluation, and clarification of the ongoing role and financial
28	responsibilities of the county and tribe for child welfare
29	services prior to initiation of the project. Children who have
30	not been identified by the tribe as participating in the project
31	shall remain the responsibility of the county. Nothing in this
32	section changes the responsibilities of the county law
33	enforcement agency or court services.
34	(f) The commissioner shall collect information on outcomes
35	relating to child safety, permanency, and well-being of American
36	Indian children who are served in the projects. Participating

1 tribes must provide information to the state in a format deemed
2 acceptable by the state to meet state and federal reporting
3 requirements.

4 (g) For counties with tribes participating in the American
5 Indian Child Welfare Project, five percent of the total cost of
6 the nonfederal share is to be paid by the county.

Sec. 5. Minnesota Statutes 2004, section 256J.021, isamended to read:

9 256J.021 [SEPARATE STATE PROGRAM PROGRAMS FOR USE OF STATE 10 MONEY.]

(a) Beginning October 1, 2001, and each year thereafter, 11 12 the commissioner of human services must treat MFIP expenditures 13 made to or on behalf of any minor child under section 256J.02, subdivision 2, clause (1), who is a resident of this state under 14 15 section 256J.12, and who is part of a two-parent eligible 16 household as expenditures under a separately funded state program and report those expenditures to the federal Department 17 of Health and Human Services as separate state program 18 19 expenditures under Code of Federal Regulations, title 45, section 263.5. 20

(b) Beginning October 1, 2005, and each year thereafter, 21 22 the commissioner of human services must treat MFIP expenditures made to or on behalf of any minor child under section 256J.02, 23 subdivision 2, clause (1), who is a resident of this state under 24 section 256J.12, and who is part of a household participating in 25 the work participation rate enhancement program under section 26 256J.575 as expenditures under a separately funded state program 27 and report those expenditures to the federal Department of 28 Health and Human Services as separate state program expenditures 29 under Code of Federal Regulations, title 45, section 263.5. 30

31 Sec. 6. Minnesota Statutes 2004, section 256J.08,
32 subdivision 65, is amended to read:

33 Subd. 65. [PARTICIPANT.] "Participant" means a person who 34 is currently receiving cash assistance or the food portion 35 available through MFIP. A person who fails to withdraw or 36 access electronically any portion of the person's cash and food

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assistance payment by the end of the payment month, who makes a 1 2 written request for closure before the first of a payment month and repays cash and food assistance electronically issued for 3 that payment month within that payment month, or who returns any 4 uncashed assistance check and food coupons and withdraws from 5 the program is not a participant. A person who withdraws a cash 6 7 or food assistance payment by electronic transfer or receives and cashes an MFIP assistance check or food coupons and is 8 9 subsequently determined to be ineligible for assistance for that 10 period of time is a participant, regardless whether that assistance is repaid. The term "participant" includes the 11 caregiver relative and the minor child whose needs are included 12 in the assistance payment. A person in an assistance unit who 13 14 does not receive a cash and food assistance payment because the 15 case has been suspended from MFIP is a participant. A person who receives cash payments under the diversionary work program 16 17 under section 256J.95 is a participant. A person who receives 18 cash payments under the work participation rate enhancement program under section 256J.575 is a participant. 19 20 Sec. 7. Minnesota Statutes 2004, section 256J.21, subdivision 2, is amended to read: 21 22 Subd. 2. [INCOME EXCLUSIONS.] The following must be excluded in determining a family's available income: 23 24 (1) payments for basic care, difficulty of care, and 25 clothing allowances received for providing family foster care to 26 children or adults under Minnesota Rules, parts 9545.0010 to 27 9545.0260 and 9555.5050 to 9555.6265, and payments received and 28 used for care and maintenance of a third-party beneficiary who 29 is not a household member; (2) reimbursements for employment training received through 30 the Workforce Investment Act of 1998, United States Code, title 31

32 20, chapter 73, section 9201;

(3) reimbursement for out-of-pocket expenses incurred while
performing volunteer services, jury duty, employment, or
informal carpooling arrangements directly related to employment;
(4) all educational assistance, except the county agency

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must count graduate student teaching assistantships, 1 fellowships, and other similar paid work as earned income and, 2 after allowing deductions for any unmet and necessary 3 educational expenses, shall count scholarships or grants awarded 4 5 to graduate students that do not require teaching or research as 6 unearned income; 7 (5) loans, regardless of purpose, from public or private lending institutions, governmental lending institutions, or 8 9 governmental agencies; (6) loans from private individuals, regardless of purpose, 10 provided an applicant or participant documents that the lender 11 expects repayment; 12 13 (7)(i) state income tax refunds; and 14 (ii) federal income tax refunds; 15 (8)(i) federal earned income credits; 16 (ii) Minnesota working family credits; 17 (iii) state homeowners and renters credits under chapter 18 290A; and 19 (iv) federal or state tax rebates; 20 (9) funds received for reimbursement, replacement, or 21 rebate of personal or real property when these payments are made by public agencies, awarded by a court, solicited through public 22 appeal, or made as a grant by a federal agency, state or local 23 24 government, or disaster assistance organizations, subsequent to a presidential declaration of disaster; 25 (10) the portion of an insurance settlement that is used to 26 pay medical, funeral, and burial expenses, or to repair or 27 replace insured property; 28 29 (11) reimbursements for medical expenses that cannot be paid by medical assistance; 30 (12) payments by a vocational rehabilitation program 31 administered by the state under chapter 268A, except those 32 payments that are for current living expenses; 33 (13) in-kind income, including any payments directly made 34 by a third party to a provider of goods and services; 35 36 (14) assistance payments to correct underpayments, but only

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1 for the month in which the payment is received;

2 (15) payments for short-term emergency needs under section
3 256J.626, subdivision 2;

4 (16) funeral and cemetery payments as provided by section5 256.935;

6 (17) nonrecurring cash gifts of \$30 or less, not exceeding
7 \$30 per participant in a calendar month;

8 (18) any form of energy assistance payment made through 9 Public Law 97-35, Low-Income Home Energy Assistance Act of 1981, 10 payments made directly to energy providers by other public and 11 private agencies, and any form of credit or rebate payment 12 issued by energy providers;

(19) Supplemental Security Income (SSI), including
retroactive SSI payments and other income of an SSI recipient<sub>7</sub>
except-as-described-in-section-256J-377-subdivision-3b;

16 (20) Minnesota supplemental aid, including retroactive
17 payments;

(21) proceeds from the sale of real or personal property;
(22) state adoption assistance payments under section
259.67, and up to an equal amount of county adoption assistance
payments;

22 (23) state-funded family subsidy program payments made under section 252.32 to help families care for children with 23 mental retardation or related conditions, consumer support grant 24 funds under section 256.476, and resources and services for a 25 disabled household member under one of the home and 26 community-based waiver services programs under chapter 256B; 27 (24) interest payments and dividends from property that is 28 29 not excluded from and that does not exceed the asset limit; (25) rent rebates; 30

31 (26) income earned by a minor caregiver, minor child 32 through age 6, or a minor child who is at least a half-time 33 student in an approved elementary or secondary education 34 program;

35 (27) income earned by a caregiver under age 20 who is at
36 least a half-time student in an approved elementary or secondary

l education\_program;

(28) MFIP child care payments under section 119B.05;
(29) all other payments made through MFIP to support a
caregiver's pursuit of greater economic stability;

5 (30) income a participant receives related to shared living6 expenses;

7

(31) reverse mortgages;

8 (32) benefits provided by the Child Nutrition Act of 1966,
9 United States Code, title 42, chapter 13A, sections 1771 to
10 1790;

(33) benefits provided by the women, infants, and children (WIC) nutrition program, United States Code, title 42, chapter 13 13A, section 1786;

14 (34) benefits from the National School Lunch Act, United
15 States Code, title 42, chapter 13, sections 1751 to 1769e;

16 (35) relocation assistance for displaced persons under the
17 Uniform Relocation Assistance and Real Property Acquisition
18 Policies Act of 1970, United States Code, title 42, chapter 61,
19 subchapter II, section 4636, or the National Housing Act, United
20 States Code, title 12, chapter 13, sections 1701 to 1750jj;

21 (36) benefits from the Trade Act of 1974, United States
22 Code, title 19, chapter 12, part 2, sections 2271 to 2322;

(37) war reparations payments to Japanese Americans and
Aleuts under United States Code, title 50, sections 1989 to
1989d;

(38) payments to veterans or their dependents as a result
of legal settlements regarding Agent Orange or other chemical
exposure under Public Law 101-239, section 10405, paragraph
(a)(2)(E);

30 (39) income that is otherwise specifically excluded from 31 MFIP consideration in federal law, state law, or federal 32 regulation;

33 (40) security and utility deposit refunds;

34 (41) American Indian tribal land settlements excluded under
35 Public Laws 98-123, 98-124, and 99-377 to the Mississippi Band
36 Chippewa Indians of White Earth, Leech Lake, and Mille Lacs

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reservations and payments to members of the White Earth Band,
 under United States Code, title 25, chapter 9, section 331, and
 chapter 16, section 1407;

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

8 (43) income of the minor parent's parents and stepparents 9 equal to 200 percent of the federal poverty guideline for a 10 family size not including the minor parent and the minor 11 parent's child in households that include a minor parent living 12 with parents or stepparents not on MFIP when determining the 13 grant for the minor parent. The remainder of income is deemed 14 as specified in section 256J.37, subdivision lb;

15 (44) payments made to children eligible for relative 16 custody assistance under section 257.85;

17 (45) vendor payments for goods and services made on behalf 18 of a client unless the client has the option of receiving the 19 payment in cash; and

20 (46) the principal portion of a contract for deed payment.
21 Sec. 8. Minnesota Statutes 2004, section 256J.521,
22 subdivision 1, is amended to read:

23 Subdivision 1. [ASSESSMENTS.] (a) For purposes of MFIP employment services, assessment is a continuing process of 24 25 gathering information related to employability for the purpose 26 of identifying both participant's strengths and strategies for coping with issues that interfere with employment. 27 The job 28 counselor must use information from the assessment process to develop and update the employment plan under subdivision 2 or 3, 29 30 as appropriate, and to determine whether the participant qualifies for a family violence waiver including an employment 31 plan under subdivision 3, and to determine whether the 32 33 participant should be referred to the work participation rate enhancement program under section 256J.575. 34 35 (b) The scope of assessment must cover at least the

36 following areas:

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

6 (2) identification of personal and family circumstances 7 that impact the participant's ability to obtain and retain 8 employment, including: any special needs of the children, the 9 level of English proficiency, family violence issues, and any 10 involvement with social services or the legal system;

11 (3) the results of a mental and chemical health screening 12 tool designed by the commissioner and results of the brief 13 screening tool for special learning needs. Screening tools for mental and chemical health and special learning needs must be 14 approved by the commissioner and may only be administered by job 15 16 counselors or county staff trained in using such screening 17 tools. The commissioner shall work with county agencies to 18 develop protocols for referrals and follow-up actions after 19 screens are administered to participants, including guidance on 20 how employment plans may be modified based upon outcomes of 21 certain screens. Participants must be told of the purpose of 22 the screens and how the information will be used to assist the participant in identifying and overcoming barriers to 23 24 employment. Screening for mental and chemical health and special learning needs must be completed by participants who are 25 unable to find suitable employment after six weeks of job search 26 under subdivision 2, paragraph (b), and participants who are 27 determined to have barriers to employment under subdivision 2, 28 paragraph (d). Failure to complete the screens will result in 29 sanction under section 256J.46; and 30

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

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256J.49, subdivision 13, or referral to the work participation
 rate enhancement program under section 256J.575.

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

6 (d) The job counselor may require the participant to complete a professional chemical use assessment to be performed 7 according to the rules adopted under section 254A.03, 8 9 subdivision 3, including provisions in the administrative rules 10 which recognize the cultural background of the participant, or a 11 professional psychological assessment as a component of the 12 assessment process, when the job counselor has a reasonable 13 belief, based on objective evidence, that a participant's ability to obtain and retain suitable employment is impaired by 14 a medical condition. The job counselor may assist the 15 16 participant with arranging services, including child care assistance and transportation, necessary to meet needs 17 18 identified by the assessment. Data gathered as part of a professional assessment must be classified and disclosed 19 20 according to the provisions in section 13.46.

Sec. 9. Minnesota Statutes 2004, section 256J.53,
subdivision 2, is amended to read:

Subd. 2. [APPROVAL OF POSTSECONDARY EDUCATION OR TRAINING.] (a) In order for a postsecondary education or training program to be an approved activity in an employment plan, the participant must be working in unsubsidized employment at least 20 ten hours per week.

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

30 (1) the employment goal can only be met with the additional31 education or training;

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

(3) the education or training will result in significantly
 higher wages for the participant than the participant could earn

l without the education or training;

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

4 (5) there is a reasonable expectation that the participant 5 will complete the training program based on such factors as the 6 participant's MFIP assessment, previous education, training, and 7 work history; current motivation; and changes in previous 8 circumstances.

9 (c) The hourly unsubsidized employment requirement does not 10 apply for intensive education or training programs lasting 12 11 weeks or less when full-time attendance is required.

12 (d) Participants with an approved employment plan in place 13 on July 1, 2003, which includes more than 12 months of 14 postsecondary education or training shall be allowed to complete 15 that plan provided that hourly requirements in section 256J.55, 16 subdivision 1, and conditions specified in paragraph (b), and 17 subdivisions 3 and 5 are met. A participant whose case is subsequently closed for three months or less for reasons other 18 19 than noncompliance with program requirements and who returns to 20 MFIP shall be allowed to complete that plan provided that hourly 21 requirements in section 256J.55, subdivision 1, and conditions 22 specified in paragraph (b) and subdivisions 3 and 5 are met.

23 Sec. 10. [256J.575] [WORK PARTICIPATION RATE ENHANCEMENT 24 PROGRAM.]

Subdivision 1. [PURPOSE.] (a) The work participation rate
enhancement program (WORK PREP) is Minnesota's TANF program to
serve families who are not making significant progress within
MFIP due to a variety of barriers to employment.

29 (b) The goal of this program is to stabilize and improve the lives of families at risk of long-term welfare dependency or 30 family instability due to employment barriers such as physical 31 disability, mental disability, age, and caring for a disabled 32 household member. WORK PREP provides services to promote and 33 ;4 support families to achieve the greatest possible degree of self-sufficiency. Counties may provide supportive and other 35 allowable services funded by the MFIP consolidated fund under 36

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l	section 256J.626 to eligible participants.
2	Subd. 2. [DEFINITIONS.] The terms used in this section
3	have the meanings given them in paragraphs (a) to (d).
4	(a) The "work participation rate enhancement program" means
5	the program established under this section.
6	(b) "Case management" means the services provided by or
7	through the county agency to participating families, including
8	assessment, information, referrals, and assistance in the
9	preparation and implementation of a family stabilization plan
10	under subdivision 5.
11	(c) "Family stabilization plan" means a plan developed by a
12	case manager and the participant, which identifies the
13	participant's most appropriate path to unsubsidized employment,
14	family stability, and barrier reduction, taking into account the
15	family's circumstances.
16	(d) "Family stabilization services" means programs,
17	activities, and services in this section that provide
18	participants and their family members with assistance regarding,
19	but not limited to:
20	(1) obtaining and retaining unsubsidized employment;
21	(2) family stability;
22	(3) economic stability; and
23	(4) barrier reduction.
24	The goal of the program is to achieve the greatest degree
25	of economic self-sufficiency and family well-being possible for
26	the family under the circumstances.
27	Subd. 3. [ELIGIBILITY.] (a) The following MFIP or DWP
28	participants are eligible for the program under this section:
29	(1) a participant identified under section 256J.561,
30	subdivision 2, paragraph (d), who has or is eligible for an
31	employment plan developed under section 256J.521, subdivision 2,
32	paragraph (c);
33	(2) a participant identified under section 256J.95,
34	subdivision 12, paragraph (b), as unlikely to benefit from the
35	diversionary work program;
36	(3) a participant who meets the requirements for or has

	l	been granted a hardship extension under section 256J.425,
a.,	2	subdivision 2 or 3; and
	3	(4) a participant who is applying for supplemental security
	4	income or Social Security disability insurance.
	5	(b) Families must meet all other eligibility requirements
	6	for MFIP established in this chapter. Families are eligible for
	7	financial assistance to the same extent as if they were
	8	participating in MFIP.
	9	Subd. 4. [UNIVERSAL PARTICIPATION.] All caregivers must
	10	participate in family stabilization services as defined in
	11	subdivision 2.
-	12	Subd. 5. [CASE MANAGEMENT; FAMILY STABILIZATION PLANS;
	13	COORDINATED SERVICES.] (a) The county agency shall provide
	14	family stabilization services to families through a case
	15	management model. A case manager shall be assigned to each
	16	participating family within 30 days after the family begins to
	17	receive financial assistance as a participant of the work
	18	participation rate enhancement program. The case manager, with
	19	the full involvement of the family, shall recommend, and the
	20	county agency shall establish and modify as necessary, a family
	21	stabilization plan for each participating family.
	22	(b) The family stabilization plan shall include:
	23	(1) each participant's plan for long-term self-sufficiency,
	24	including an employment goal where applicable;
	25	(2) an assessment of each participant's strengths and
	26	barriers, and any special circumstances of the participant's
	27	family that impact, or are likely to impact, the participant's
	28	progress towards the goals in the plan; and
	29	(3) an identification of the services, supports, education,
	30	training, and accommodations needed to overcome any barriers to
	31	enable the family to achieve self-sufficiency and to fulfill
	32	each caregiver's personal and family responsibilities.
ganal di Per	<sup>2</sup> 3	(c) The case manager and the participant must meet within
	,4	30 days of the family's referral to the case manager. The
	35	initial family stabilization plan shall be completed within 30
	36	days of the first meeting with the case manager. The case

1	manager shall establish a schedule for periodic review of the
2	family stabilization plan that includes personal contact with
3	the participant at least once per month. In addition, the case
4	manager shall review and modify if necessary the plan under the
5	following circumstances:
6	(1) there is a lack of satisfactory progress in achieving
7	the goals of the plan;
8	(2) the participant has lost unsubsidized or subsidized
9	<pre>employment;</pre>
10	(3) a family member has failed to comply with a family
11	stabilization plan requirement;
12	(4) services required by the plan are unavailable; or
13	(5) changes to the plan are needed to promote the
14	well-being of the children.
15	(d) Family stabilization plans under this section shall be
16	written for a period of time not to exceed six months.
17	Subd. 6. [COOPERATION WITH PROGRAM REQUIREMENTS.] (a) TO
18	be eligible, a participant must comply with paragraphs (b) to
19	<u>(f).</u>
20	(b) Participants shall engage in family stabilization plan
21	activities listed in clause (1) or (2) for the number of hours
22	per week that the activities are scheduled and available, unless
23	good cause exists for not doing so, as defined in section
24	256J.57, subdivision 1:
25	(1) in single-parent families with no children under six
26	years of age, the case manager and the participant must develop
27	a family stabilization plan that includes 30 to 35 hours per
28	week of activities; and
29	(2) in single-parent families with a child under six years
30	of age, the case manager and the participant must develop a
31	family stabilization plan that includes 20 to 35 hours per week
32	of activities.
33	(c) The case manager shall review the participant's
34	progress toward the goals in the family stabilization plan every
35	six months to determine whether conditions have changed,
36	including whether revisions to the plan are needed.

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(d) When the participant has increased participation in 1 2 work-related activities sufficient to meet the federal 3 participation requirements of TANF, the county agency shall refer the participant to the MFIP program and assign the 4 participant to a job counselor. The participant and the job 5 counselor must meet within 15 days of referral to MFIP to 6 7 develop an employment plan under section 256J.521. No reapplication is necessary and financial assistance shall 8 continue without interruption. 9 (e) Participants who have not increased their participation 10 in work activities sufficient to meet the federal participation 11 requirements of TANF may request a referral to the MFIP program 12 and assignment to a job counselor after 12 months in the program. 13 (f) A participant's requirement to comply with any or all 14 family stabilization plan requirements under this subdivision 15 16 shall be excused when the case management services, training and educational services, and family support services identified in 17 18 the participant's family stabilization plan are unavailable for reasons beyond the control of the participant, including when 19 money appropriated is not sufficient to provide the services. 20 21 Subd. 7. [SANCTIONS.] (a) The financial assistance grant 22 of a participating family shall be reduced, according to section 256J.46, if a participating adult fails without good cause to 23 comply or continue to comply with the family stabilization plan 24 requirements in this subdivision, unless compliance has been 25 excused under subdivision 6, paragraph (f). 26 (b) Given the purpose of the work participation rate 27 enhancement program in this section and the nature of the 28 underlying family circumstances that act as barriers to both 29 employment and full compliance with program requirements, 30 sanctions are appropriate only when it is clear that there is 31 both ability to comply and willful noncompliance on the part of 32 33 the participant. (c) Prior to the imposition of a sanction, the county 34 agency must review the participant's case to determine if the 35 family stabilization plan is still appropriate and meet with the 36

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1	participants face-to-face. The participant may bring an
2	advocate to the face-to-face meeting. If a face-to-face meeting
3	is not conducted, the county agency must send the participant a
4	written notice that includes the information required under
5	clause (1):
6	(1) during the face-to-face meeting, the county agency must:
7	(i) determine whether the continued noncompliance can be
8	explained and mitigated by providing a needed family
9	stabilization service, as defined in subdivision 2, paragraph
10	<u>(d);</u>
11	(ii) determine whether the participant qualifies for a good
12	cause exception under section 256J.57, or if the sanction is for
13	noncooperation with child support requirements, determine if the
14	participant qualifies for a good cause exemption under section
15	256.741, subdivision 10;
16	(iii) determine whether activities in the family
17	stabilization plan are appropriate based on the family's
18	circumstances;
19	(iv) explain the consequences of continuing noncompliance;
20	(v) identify other resources that may be available to the
21	participant to meet the needs of the family; and
22	(vi) inform the participant of the right to appeal under
23	section 256J.40; and
24	(2) if the lack of an identified activity or service can
25	explain the noncompliance, the county must work with the
26	participant to provide the identified activity.
27	(d) After the requirements of paragraph (c) are met and
28	prior to imposition of a sanction, the county agency shall
29	provide a notice of intent to sanction under section 256J.57,
30	subdivision 2, and, when applicable, a notice of adverse action
31	as provided in section 256J.31.
32	(e) Section 256J.57 applies to this section except to the
33	extent that it is modified by this subdivision.
34	Sec. 11. [256J.621] [WORK PARTICIPATION BONUS.]
35	Upon exiting the diversionary work program (DWP) or upon
36	terminating MFIP cash assistance with earnings, a participant
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·····	. 1	who is employed and working 24 hours a week may be eligible for
	2	transitional assistance of \$50 per month to assist in meeting
	3	the family's basic needs as the participant continues to move
	4	toward self-sufficiency.
	5	To be eligible for a transitional assistance payment, the
	6	participant must not receive MFIP cash assistance or
	7	diversionary work program assistance during the month and must
	8	be employed an average of at least 24 hours a week.
	9	Transitional assistance shall be available for a maximum of 12
	10	months from the date the participant exited the diversionary
	11	work program or terminated MFIP cash assistance.
	12	The commissioner shall establish policies and develop forms
	13	to verify eligibility for transitional assistance. The forms
	14	must contain all data elements required to meet federal TANF
	15	reporting requirements.
	16	Expenditures on the transitional assistance program shall
	17	be state-funded and treated as segregated funds under the
	18	state's TANF maintenance of effort requirement. Months in which
	19	a participant receives transitional assistance under this
	20	section shall not count toward the participant's MFIP 60-month
	21	time limit.
and the second sec	22	This section shall take effect if federal law changes the
Seattine"	23	TANF work participation rates that states must meet and the
	24	commissioner determines that implementation of this program will
	25	enhance Minnesota's TANF work participation rates.
	26	Sec. 12. Minnesota Statutes 2004, section 256J.626,
	27	subdivision 1, is amended to read:
	28	Subdivision 1. [CONSOLIDATED FUND.] The consolidated fund
	29	is established to support counties and tribes in meeting their
	30	duties under this chapter. Counties and tribes must use funds
	31	from the consolidated fund to develop programs and services that
	32	are designed to improve participant outcomes as measured in
	33	section 256J.751, subdivision 2, and to provide case management
	34	services to participants of the work participation rate
	35	enhancement program. Counties may use the funds for any
	36	allowable expenditures under subdivision 2. Tribes may use the

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1 funds for\_any allowable expenditures under subdivision 2, except
2 those in clauses (1) and (6).

3 Sec. 13. Minnesota Statutes 2004, section 256J.626,
4 subdivision 2, is amended to read:

5 Subd. 2. [ALLOWABLE EXPENDITURES.] (a) The commissioner 6 must restrict expenditures under the consolidated fund to 7 benefits and services allowed under title IV-A of the federal 8 Social Security Act. Allowable expenditures under the 9 consolidated fund may include, but are not limited to:

(1) short-term, nonrecurring shelter and utility needs that are excluded from the definition of assistance under Code of Federal Regulations, title 45, section 260.31, for families who meet the residency requirement in section 256J.12, subdivisions 14 1 and 1a. Payments under this subdivision are not considered TANF cash assistance and are not counted towards the 60-month time limit;

17 (2) transportation needed to obtain or retain employment or
18 to participate in other approved work activities <u>or activities</u>
19 <u>under a family stabilization plan;</u>

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

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

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

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

33 (7) services to parenting and pregnant teens;

34 (8) supported work;

35 (9) wage subsidies;

36 (10) child care needed for MFIP or, the diversionary work

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program, or the work participation rate enhancement program 1 participants to participate in social services; 2 3 (11) child care to ensure that families leaving MFIP or diversionary work program will continue to receive child care 4 assistance from the time the family no longer qualifies for 5 6 transition year child care until an opening occurs under the 7 basic sliding fee child care program; and (12) services to help noncustodial parents who live in 8 9 Minnesota and have minor children receiving MFIP or DWP assistance, but do not live in the same household as the child, 10 11 obtain or retain employment; and 12 (13) services to help families participating in the work participation rate enhancement program achieve the greatest 13 14 possible degree of self-sufficiency. (b) Administrative costs that are not matched with county 15 funds as provided in subdivision 8 may not exceed 7.5 percent of 16 17 a county's or 15 percent of a tribe's allocation under this 18 section. The commissioner shall define administrative costs for purposes of this subdivision. 19 Sec. 14. Minnesota Statutes 2004, section 256J.626, 20 21 subdivision 3, is amended to read: Subd. 3. [ELIGIBILITY FOR SERVICES.] Families with a minor 22 child, a pregnant woman, or a noncustodial parent of a minor 23 child receiving assistance, with incomes below 200 percent of 24 the federal poverty guideline for a family of the applicable 25 size, are eligible for services funded under the consolidated 26 27 fund. Counties and tribes must give priority to families currently receiving MFIP or, the diversionary work program, or 28 the work participation rate enhancement program, and families at 29 risk of receiving MFIP or diversionary work program. 30

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31 Sec. 15. Minnesota Statutes 2004, section 256J.626,
32 subdivision 4, is amended to read:

33 Subd. 4. [COUNTY AND TRIBAL BIENNIAL SERVICE AGREEMENTS.] 34 (a) Effective January 1, 2004, and each two-year period 35 thereafter, each county and tribe must have in place an approved 36 biennial service agreement related to the services and programs

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1 in this chapter. In counties with a city of the first class
2 with a population over 300,000, the county must consider a
3 service agreement that includes a jointly developed plan for the
4 delivery of employment services with the city. Counties may
5 collaborate to develop multicounty, multitribal, or regional
6 service agreements.

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

9 (1) a statement of the needs of the service population and 10 strengths and resources in the community;

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

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

20 (4) strategies the county or tribe will pursue under the
 21 work participation rate enhancement program; and

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

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

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

35 (e) The commissioner must, within 60 days of receiving each 36 county or tribal service agreement, inform the county or tribe

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if the service agreement is approved. If the service agreement
 is not approved, the commissioner must inform the county or
 tribe of any revisions needed prior to approval.

4 (f) The service agreement in this subdivision supersedes5 the plan requirements of section ll6L.88.

Sec. 16. Minnesota Statutes 2004, section 256J.626,
7 subdivision 7, is amended to read:

8 Subd. 7. [PERFORMANCE BASE FUNDS.] (a) Beginning calendar 9 year 2005, each county and tribe will be allocated 95 100 percent of their initial calendar year allocation. Counties and 10 tribes will be allocated additional funds from federal TANF 11 12 bonus funds the state receives based on performance as follows: 13 (1) for calendar year 2005, a county or tribe that achieves 14 a 30 percent rate or higher on the MFIP participation rate under section 256J.751, subdivision 2, clause (8), as averaged across 15 16 the four quarterly measurements for the most recent year for 17 which the measurements are available, will receive an additional 18 allocation equal-to-2-5-percent-of-its-initial-allocation to be

19 determined by the commissioner based upon available funds; and 20 (2) for calendar year 2006, a county or tribe that achieves

21 a 40 percent rate or a five percentage point improvement over the previous year's MFIP participation rate under section 22 23 256J.751, subdivision 2, clause (8), as averaged across the four quarterly measurements for the most recent year for which the 24 25 measurements are available, will receive an additional allocation equal-to-2-5-percent-of-its-initial-allocation to be 26 determined by the commissioner based upon available funds; and 27 (3) for calendar year 2007, a county or tribe that achieves 28 a 50 percent rate or a five percentage point improvement over 29 the previous year's MFIP participation rate under section 30 256J.751, subdivision 2, clause (8), as averaged across the four 31 quarterly measurements for the most recent year for which the 32 measurements are available, will receive an additional 33 allocation equal-to-2-5-percent-of-its-initial-allocation to be 34 determined by the commissioner based upon available funds; and 35 (4) for calendar year 2008 and yearly thereafter, a county 36

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1 or tribe that achieves a 50 percent MFIP participation rate 2 under section 256J.751, subdivision 2, clause (8), as averaged 3 across the four quarterly measurements for the most recent year 4 for which the measurements are available, will receive an 5 additional allocation equal-to-2.5-percent-of-its-initial 6 allocation to be determined by the commissioner based upon 7 available funds; and

8 (5) for calendar years 2005 and thereafter, a county or 9 tribe that performs above the top of its range of expected 10 performance on the three-year self-support index under section 11 256J.751, subdivision 2, clause (7), in both measurements in the 12 preceding year will receive an additional allocation equal-to 13 five-percent-of-its-initial-allocation to be determined by the 14 commissioner based upon available funds; or

15 (6) for calendar years 2005 and thereafter, a county or 16 tribe that performs within its range of expected performance on the three-year self-support index under section 256J.751, 17 18 subdivision 2, clause (7), in both measurements in the preceding 19 year, or above the top of its range of expected performance in 20 one measurement and within its expected range of performance in 21 the other measurement, will receive an additional allocation 22 equal-to-2.5-percent-of-its-initial-allocation to be determined by the commissioner based upon available funds. 23

(b) Funds remaining unallocated after the performance-based
allocations in paragraph (a) are available to the commissioner
for innovation projects under subdivision 5.

(c)(i)-If-available-funds-are-insufficient-to-meet-county and-tribal-allocations-under-paragraph-(a),-the-commissioner-may make-available-for-allocation-funds-that-are-unobligated-and available-from-the-innovation-projects-through-the-end-of-the current-biennium.

32 (2)-If-after-the-application-of-clause-(1)-funds-remain 33 insufficient-to-meet-county-and-tribal-allocations-under 34 paragraph-(a)7-the-commissioner-must-proportionally-reduce-the 35 allocation-of-each-county-and-tribe-with-respect-to-their 36 maximum-allocation-available-under-paragraph-(a).

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Sec.-17. Minnesota Statutes 2004, section 256J.95, subdivision 3, is amended to read: 2 Subd. 3. [ELIGIBILITY FOR DIVERSIONARY WORK PROGRAM.] (a) 3 Except for the categories of family units listed below, all 4 5 family units who apply for cash benefits and who meet MFIP eligibility as required in sections 256J.11 to 256J.15 are 6 eligible and must participate in the diversionary work program. 7 8 Family units that are not eligible for the diversionary work 9 program include: 10 (1) child only cases; 11 (2) a single-parent family unit that includes a child under 12 12 weeks of age. A parent is eligible for this exception once 13 in a parent's lifetime and is not eligible if the parent has already used the previously allowed child under age one 14 15 exemption from MFIP employment services; 16 (3) a minor parent without a high school diploma or its equivalent; 17 18 (4) an 18- or 19-year-old caregiver without a high school 19 diploma or its equivalent who chooses to have an employment plan 20 with an education option; 21 (5) a caregiver age 60 or over; (6) family units with a caregiver who received DWP benefits 22 23 in the 12 months prior to the month the family applied for DWP, except as provided in paragraph (c); 24 (7) family units with a caregiver who received MFIP within 25 the 12 months prior to the month the family unit applied for 26 27 DWP; (8) a family unit with a caregiver who received 60 or more 28 months of TANF assistance; and 29 (9) a family unit with a caregiver who is disqualified from 30 DWP or MFIP due to fraud. 31 (b) A two-parent family must participate in DWP unless both 32 caregivers meet the criteria for an exception under paragraph ٦3 (a), clauses (1) through (5), or the family unit includes a 4 parent who meets the criteria in paragraph (a), clause (6), (7), 35 36 (8), or (9).

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1	(c) Once DWP eligibility is determined, the four months run
2	consecutively. If a participant leaves the program for any
3	reason and reapplies during the four-month period, the county
4	must redetermine eligibility for DWP.
5	(d) Newly arrived refugees and asylees as defined in Code
6	of Federal Regulations, title 45, chapter IV, section 400.2, who
7	have arrived in the United States within the last two months
8	shall be exempt from mandatory participation in the diversionary
9	work program and may enroll directly into the MFIP program.
10	[EFFECTIVE DATE.] This section is effective the day
11	following final enactment.
12	Sec. 18. Minnesota Statutes 2004, section 256J.95,
13	subdivision 9, is amended to read:
14	Subd. 9. [PROPERTY AND INCOME LIMITATIONS.] The asset
15	limits and exclusions in section 256J.20 apply to applicants and
16	recipients of DWP. All payments, unless excluded in section
17	256J.21, must be counted as income to determine eligibility for
18	the diversionary work program. The county shall treat income as
19	outlined in section 256J.377-except-for-subdivision-3a. The
20	initial income test and the disregards in section 256J.21,
21	subdivision 3, shall be followed for determining eligibility for
22	the diversionary work program.
23	Sec. 19. [REPEALER.]
24	Minnesota Statutes 2004, section 256J.37, subdivisions 3a
25	and 3b, are repealed effective July 1, 2005.
26	ARTICLE 7
27	MISCELLANEOUS
28	Section 1. [151.52] [MANUFACTURER PRICE REPORT.]
29	Subdivision 1. [REPORT.] All drug manufacturers registered
30	or licensed to do business in this state shall, on a quarterly
31	basis, report by National Drug Code the following pharmaceutical
32	pricing criteria to the commissioner of human services for each
33	of their drugs: average wholesale price, wholesale acquisition
34	cost, average manufacturer price as defined in United States
35	Code, title 42, chapter 7, subchapter XIX, section 1396r-8(k),
36	and best price as defined in United States Code, title 42,

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1	chapter 7, subchapter XIX, section 1396r-8(c)(1)(C). The
2	calculation of average wholesale price and wholesale acquisition
3	cost shall be the net of all volume discounts, prompt payment
4	discounts, chargebacks, short-dated product discounts, cash
5	discounts, free goods, rebates, and all other price concessions
6	or incentives provided to a purchaser that result in a reduction
7	in the ultimate cost to the purchaser. When reporting average
8	wholesale price, wholesale acquisition cost, average
9	manufacturer price, and best price, manufacturers shall also
10	include a detailed description of the methodology by which the
11	prices were calculated. When a manufacturer reports average
12	wholesale price, wholesale acquisition cost, average
13	manufacturer price, or best price, the president or chief
14	executive officer of the manufacturer shall certify on a form
15	provided by the commissioner of human services, that the
16	reported prices are accurate. Any information reported under
17	this section shall be classified as nonpublic data under section
18	13.02, subdivision 9. Notwithstanding the classification of
19	data in this section and subdivision 2, the Minnesota Attorney
20	General's Office, the federal Centers for Medicare and Medicaid
21	Services or another law enforcement agency may access and obtain
22	copies of the data required under this section and use that data
23	for law enforcement purposes.
24	Subd. 2. [PENALTIES AND REMEDIES.] The attorney general
25	may pursue the penalties and remedies available to the attorney
26	general under section 8.31 against any manufacturer who violates
27	this section.
28	Sec. 2. [151.55] [CANCER DRUG REPOSITORY PROGRAM.]
29	Subdivision 1. [DEFINITIONS.] (a) For the purposes of this
30	section, the terms defined in this subdivision have the meanings
31	given.
32	(b) "Board" means the Board of Pharmacy.
33	(c) "Cancer drug" means a prescription drug that is used to
34	treat:
35	(1) cancer or the side effects of cancer; or
36	(2) the side effects of any prescription drug that is used
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04/28/05 [REVISOR ] ;S/MD 05-4117 to treat cancer or the side effects of cancer. 1 2 (d) "Cancer drug repository" means a medical facility or pharmacy that has notified the board of its election to 3 participate in the cancer drug repository program. 4 5 (e) "Cancer supply" or "supplies" means prescription and nonprescription cancer supplies needed to administer a cancer 6 7 drug. (f) "Dispense" has the meaning given in section 151.01, 8 9 subdivision 30. (g) "Distribute" means to deliver, other than by 10 11 administering or dispensing. 12 (h) "Medical facility" means an institution defined in section 144.50, subdivision 2. 13 (i) "Medical supplies" means any prescription and 14 nonprescription medical supply needed to administer a cancer 15 16 drug. (j) "Pharmacist" has the meaning given in section 151.01, 17 subdivision 3. 18 19 (k) "Pharmacy" means any pharmacy registered with the Board of Pharmacy according to section 151.19, subdivision 1. 20 21 (1) "Practitioner" has the meaning given in section 151.01, subdivision 23. 22 23 (m) "Prescription drug" means a legend drug as defined in 24 section 151.01, subdivision 17. (n) "Side effects of cancer" means symptoms of cancer. 25 26 (0) "Single-unit-dose packaging" means a single-unit container for articles intended for administration as a single 27 28 dose, direct from the container. (p) "Tamper-evident unit dose packaging" means a container 29 30 within which a drug is sealed so that the contents cannot be 31 opened without obvious destruction of the seal. Subd. 2. [ESTABLISHMENT.] The Board of Pharmacy shall 32 establish and maintain a cancer drug repository program, under 33 34 which any person may donate a cancer drug or supply for use by 35 an individual who meets the eligibility criteria specified under

subdivision 4. Under the program, donations may be made on the

1	premises of a medical facility or pharmacy that elects to
2	participate in the program and meets the requirements specified
3	under subdivision 3.
4	Subd. 3. [REQUIREMENTS FOR PARTICIPATION BY PHARMACIES AND
5	MEDICAL FACILITIES.] (a) To be eligible for participation in the
6	cancer drug repository program, a pharmacy or medical facility
7	must be licensed and in compliance with all applicable federal
8	and state laws and administrative rules.
9	(b) Participation in the cancer drug repository program is
10	voluntary. A pharmacy or medical facility may elect to
11	participate in the cancer drug repository program by submitting
12	the following information to the board, in a form provided by
13	the board:
14	(1) the name, street address, and telephone number of the
15	pharmacy or medical facility;
16	(2) the name and telephone number of a pharmacist who is
17	employed by or under contract with the pharmacy or medical
18	facility, or other contact person who is familiar with the
19	pharmacy's or medical facility's participation in the cancer
20	drug repository program; and
21	(3) a statement indicating that the pharmacy or medical
22	facility meets the eligibility requirements under paragraph (a)
23	and the chosen level of participation under paragraph (c).
24	(c) A pharmacy or medical facility may fully participate in
25	the cancer drug repository program by accepting, storing, and
26	dispensing or administering donated drugs and supplies, or may
27	limit its participation to only accepting and storing donated
28	drugs and supplies. If a pharmacy or facility chooses to limit
29	its participation, the pharmacy or facility shall distribute any
30	donated drugs to a fully participating cancer drug repository
31	according to subdivision 8.
32	(d) A pharmacy or medical facility may withdraw from
33	participation in the cancer drug repository program at any time
34	upon notification to the board. A notice to withdraw from
35	participation may be given by telephone or regular mail.
36	Subd. 4. [INDIVIDUAL ELIGIBILITY REQUIREMENTS.] Any

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1	Minnesota resident who is diagnosed with cancer is eligible to
2	receive drugs or supplies under the cancer drug repository
3	program. Drugs and supplies shall be dispensed or administered
4	according to the priority given under subdivision 6, paragraph
5	<u>(d)</u> .
6	Subd. 5. [DONATIONS OF CANCER DRUGS AND SUPPLIES.] (a) Any
7	one of the following persons may donate legally obtained cancer
8	drugs or supplies to a cancer drug repository, if the drugs or
9	supplies meet the requirements under paragraph (b) or (c) as
10	determined by a pharmacist who is employed by or under contract
11	with a cancer drug repository:
12	(1) an individual who is 18 years old or older; or
13	(2) a pharmacy, medical facility, drug manufacturer, or
14	wholesale drug distributor, if the donated drugs have not been
15	previously dispensed.
16	(b) A cancer drug is eligible for donation under the cancer
17	drug repository program only if the following requirements are
18	met:
19	(1) the donation is accompanied by a cancer drug repository
20	donor form described under paragraph (d) that is signed by the
21	person making the donation or that person's authorized
22	representative;
23	(2) the drug's expiration date is at least six months later
24	than the date that the drug was donated;
25	(3) the drug is in its original, unopened, tamper-evident
26	unit dose packaging that includes the drug's lot number and
27	expiration date. Single-unit dose drugs may be accepted if the
28	single-unit-dose packaging is unopened; and
29	(4) the drug is not adulterated or misbranded.
30	(c) Cancer supplies are eligible for donation under the
31	cancer drug repository program only if the following
32	requirements are met:
33	(1) the supplies are not adulterated or misbranded;
34	(2) the supplies are in their original, unopened, sealed
35	packaging; and
36	(3) the donation is accompanied by a cancer drug repository

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1	donor form described under paragraph (d) that is signed by the
2	person making the donation or that person's authorized
3	representative.
4	(d) The cancer drug repository donor form must be provided
5	by the board and shall state that to the best of the donor's
6	knowledge the donated drug or supply has been properly stored
7	and that the drug or supply has never been opened, used,
8	tampered with, adulterated, or misbranded. The board shall make
9	the cancer drug repository donor form available on the
10	Department of Health's Web site.
11	(e) Controlled substances and drugs and supplies that do
12	not meet the criteria under this subdivision are not eligible
13	for donation or acceptance under the cancer drug repository
14	program.
15	(f) Drugs and supplies may be donated on the premises of a
16	cancer drug repository to a pharmacist designated by the
17	repository. A drop box may not be used to deliver or accept
18	donations.
19	(g) Cancer drugs and supplies donated under the cancer drug
20	repository program must be stored in a secure storage area under
21	environmental conditions appropriate for the drugs or supplies
22	being stored. Donated drugs and supplies may not be stored with
23	nondonated inventory.
24	Subd. 6. [DISPENSING REQUIREMENTS.] (a) Drugs and supplies
25	must be dispensed by a licensed pharmacist pursuant to a
26	prescription by a practitioner or may be dispensed or
27	administered by a practitioner according to the requirements of
28	chapter 151 and within the practitioner's scope of practice.
29	(b) Cancer drugs and supplies shall be visually inspected
30	by the pharmacist or practitioner before being dispensed or
31	administered for adulteration, misbranding, and date of
32	expiration. Drugs or supplies that have expired or appear upon
33	visual inspection to be adulterated, misbranded, or tampered
34	with in any way may not be dispensed or administered.
35	(c) Before a cancer drug or supply may be dispensed or
36	administered to an individual, the individual must sign a cancer

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1	drug repository recipient form provided by the board
2	acknowledging that the individual understands the information
3	stated on the form. The form shall include the following
4	information:
5	(1) that the drug or supply being dispensed or administered
6	has been donated and may have been previously dispensed;
7	(2) that a visual inspection has been conducted by the
8	pharmacist or practitioner to ensure that the drug has not
9	expired, has not been adulterated or misbranded, and is in its
10	original, unopened packaging; and
11	(3) that the dispensing pharmacist, the dispensing or
12	administering practitioner, the cancer drug repository, the
13	state Department of Health, and any other participant of the
14	cancer drug repository program cannot guarantee the safety of
15	the drug or supply being dispensed or administered and that the
16	pharmacist or practitioner has determined that the drug or
17	supply is safe to dispense or administer based on the accuracy
18	of the donor's form submitted with the donated drug or supply
19	and the visual inspection required to be performed by the
20	pharmacist or practitioner before dispensing or administering.
21	The board shall make the cancer drug repository form available
22	on the Department of Health's Web site.
23	(d) Drugs and supplies shall only be dispensed or
24	administered to individuals who meet the eligibility
25	requirements in subdivision 4 and in the following order of
26	priority:
27	(1) individuals who are uninsured;
28·	(2) individuals who are enrolled in medical assistance,
29	general assistance medical care, MinnesotaCare, Medicare, or
30	other public assistance health care; and
31	(3) all other individuals who are otherwise eligible under
32	subdivision 4 to receive drugs or supplies from a cancer drug
33	repository.
34	Subd. 7. [HANDLING FEES.] A cancer drug repository may
35	charge the individual receiving a drug or supply a handling fee
36	of no more than 250 percent of the medical assistance program

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	1	dispensing fee for each cancer drug or supply dispensed or
	2	administered.
	3	Subd. 8. [DISTRIBUTION OF DONATED CANCER DRUGS AND
	4	SUPPLIES.] (a) Cancer drug repositories may distribute drugs and
	5	supplies donated under the cancer drug repository program to
	6	other repositories if requested by a participating repository.
	7	(b) A cancer drug repository that has elected not to
	8	dispense donated drugs or supplies shall distribute any donated
	9	drugs and supplies to a participating repository upon request of
	10	the repository.
	11	(c) If a cancer drug repository distributes drugs or
	12	supplies under paragraph (a) or (b), the repository shall
	13	complete a cancer drug repository donor form provided by the
	14	board. The completed form and a copy of the donor form that was
	15	completed by the original donor under subdivision 5 shall be
	16	provided to the fully participating cancer drug repository at
	17	the time of distribution.
	18	Subd. 9. [RESALE OF DONATED DRUGS OR SUPPLIES.] Donated
	19	drugs and supplies may not be resold.
	20	Subd. 10. [RECORD-KEEPING REQUIREMENTS.] (a) Cancer drug
	21	repository donor and recipient forms shall be maintained for at
~	22	least five years.
	23	(b) A record of destruction of donated drugs and supplies
	24	that are not dispensed under subdivision 6 shall be maintained
	25	by the dispensing repository for at least five years. For each
	26	drug or supply destroyed, the record shall include the following
	27	information:
	28	(1) the date of destruction;
	29	(2) the name, strength, and quantity of the cancer drug
	30	destroyed;
	31	(3) the name of the person or firm that destroyed the drug;
	32	and
	33	(4) the source of the drugs or supplies destroyed.
	34	Subd. 11. [LIABILITY.] A medical facility or pharmacy
	35	participating in the program, a pharmacist dispensing a drug or
	36	supply pursuant to the program, a practitioner dispensing or
	_	
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1 administering a drug or supply pursuant to the program, or the 2 donor of a cancer drug or supply is immune from civil liability for an act or omission relating to the quality of a cancer drug 3 4 or supply that causes injury to or the death of an individual to whom the cancer drug or supply is dispensed or administered and 5 no disciplinary action shall be taken against a pharmacist or 6 7 practitioner so long as the drug or supply is donated, accepted, distributed, and dispensed or administered according to the 8 requirements of this section. This immunity does not apply if 9 10 the act or omission involves reckless, wanton, or intentional misconduct or malpractice unrelated to the quality of the 11 12 donated cancer drug or supply. Minnesota Statutes 2004, section 241.01, is 13 Sec. 3. 14 amended by adding a subdivision to read: Subd. 10. [PURCHASING FOR PRESCRIPTION DRUGS.] In 15 accordance with section 241.021, subdivision 4, the commissioner 16 17 may contract with a separate entity to purchase prescription 18 drugs for persons confined in institutions under the control of 19 the commissioner. Local governments may participate in this 20 purchasing pool in order to purchase prescription drugs for those persons confined in local correctional facilities in which 21 22 the local government has responsibility for providing health 23 care. If any county participates, the commissioner shall 24 appoint a county representative to any committee convened by the 25 commissioner for the purpose of establishing a drug formulary to 26 be used for state and local correctional facilities. 27 Sec. 4. Minnesota Statutes 2004, section 256.741, 28 subdivision 4, is amended to read: 29 Subd. 4. [EFFECT OF ASSIGNMENT.] Assignments in this section take effect upon a determination that the applicant is 30 eligible for public assistance. The amount of support assigned 31 32 under this subdivision may not exceed the total amount of public 33 assistance issued or the total support obligation, whichever is 34 less. Child care support collections made according to an 35 assignment under subdivision 2, paragraph (c), must be

36 deposited, subject to any limitations of federal law, by-the

1 commissioner-of-human-services-in-the-child-support-collection 2 account-in-the-special-revenue-fund-and-appropriated-to-the 3 commissioner-of-education-for-child-care-assistance-under 4 section-ll9B:03:--These-collections-are-in-addition-to-state-and 5 federal-funds-appropriated-to-the-child-care in the general fund. 6 Sec. 5. [256.957] [HEALTH CARE QUALITY IMPROVEMENT 7 ACCOUNT.]

A health care quality improvement account is established in
9 the general fund.

10 Sec. 6. Minnesota Statutes 2004, section 256B.0625, 11 subdivision 13e, is amended to read:

Subd. 13e. [PAYMENT RATES.] (a) The basis for determining 12 13 the amount of payment shall be the lower of the actual 14 acquisition costs of the drugs plus a fixed dispensing fee; the maximum allowable cost set by the federal government or by the 15 16 commissioner plus the fixed dispensing fee; or the usual and customary price charged to the public. The amount of payment 17 basis must be reduced to reflect all discount amounts applied to 18 the charge by any provider/insurer agreement or contract for 19 submitted charges to medical assistance programs. The net 20 21 submitted charge may not be greater than the patient liability for the service. The pharmacy dispensing fee shall be \$3.65, 22 23 except that the dispensing fee for intravenous solutions which must be compounded by the pharmacist shall be \$8 per bag, \$14 24 per bag for cancer chemotherapy products, and \$30 per bag for 25 total parenteral nutritional products dispensed in one liter 26 quantities, or \$44 per bag for total parenteral nutritional 27 products dispensed in quantities greater than one liter. Actual 28 acquisition cost includes quantity and other special discounts 29 except time and cash discounts. The actual acquisition cost of 30 a drug shall be estimated by the commissioner, at average 31 wholesale price minus 11.5 percent, except that where a drug has 32 had its wholesale price reduced as a result of the actions of 33 the National Association of Medicaid Fraud Control Units, the 34 estimated actual acquisition cost shall be the reduced average 35 wholesale price, without the 11.5 percent deduction. 36 The

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l maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to, but no higher than, 2 the maximum amount paid by other third-party payors in this 3 state who have maximum allowable cost programs. Establishment 4 of the amount of payment for drugs shall not be subject to the 5 6 requirements of the Administrative Procedure Act.

7 (b) An additional dispensing fee of \$.30 may be added to the dispensing fee paid to pharmacists for legend drug 8 9 prescriptions dispensed to residents of long-term care facilities when a unit dose blister card system, approved by the 10 11 department, is used. Under this type of dispensing system, the 12 pharmacist must dispense a 30-day supply of drug. The National Drug Code (NDC) from the drug container used to fill the blister 13 14 card must be identified on the claim to the department. The unit dose blister card containing the drug must meet the 15 16 packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the 17 18 pharmacy for reuse. The pharmacy provider will be required to 19 credit the department for the actual acquisition cost of all 20 unused drugs that are eligible for reuse. Over-the-counter 21 medications must be dispensed in the manufacturer's unopened 22 package. The commissioner may permit the drug clozapine to be 23 dispensed in a quantity that is less than a 30-day supply.

(c) Whenever a generically equivalent product is available, 24 25 payment shall be on the basis of the actual acquisition cost of 26 the generic drug, or on the maximum allowable cost established 27 by the commissioner.

(d) The basis for determining the amount of payment for 28 29 drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the provider, the 30 31 average wholesale price minus five percent, or the maximum 32 allowable cost set by the federal government under United States Code, title 42, chapter 7, section 1396r-8(e), and Code of 33 Federal Regulations, title 42, section 447.332, or by the 34 commissioner under paragraphs (a) to (c). 35

36

(e) The commissioner may consider the prices reported under

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1 section 151.52, when determining reimbursement payments under 2 this subdivision.

Sec. 7. Minnesota Statutes 2004, section 295.582, is
4 amended to read:

5

295.582 [AUTHORITY.]

Subdivision 1. [WHOLESALE DRUG DISTRIBUTOR TAX.] (a) A 6 7 hospital, surgical center, or health care provider that is subject to a tax under section 295.52, or a pharmacy that has 8 paid additional expense transferred under this section by a 9 10 wholesale drug distributor, may transfer additional expense generated by section 295.52 obligations on to all third-party 11 contracts for the purchase of health care services on behalf of 12 a patient or consumer. Nothing shall prohibit a pharmacy from 13 transferring the additional expense generated under section 14 15 295.52 to a pharmacy benefits manager. The additional expense transferred to the third-party purchaser or a pharmacy benefits 16 manager must not exceed the tax percentage specified in section 17 18 295.52 multiplied against the gross revenues received under the third-party contract, and the tax percentage specified in 19 section 295.52 multiplied against co-payments and deductibles 20 paid by the individual patient or consumer. The expense must 21 not be generated on revenues derived from payments that are 22 excluded from the tax under section 295.53. All third-party 23 purchasers of health care services including, but not limited 24 to, third-party purchasers regulated under chapter 60A, 62A, 25 62C, 62D, 62H, 62N, 64B, 65A, 65B, 79, or 79A, or under section 26 471.61 or 471.617, and pharmacy benefits managers must pay the 27 transferred expense in addition to any payments due under 28 existing contracts with the hospital, surgical center, pharmacy, 29 or health care provider, to the extent allowed under federal 30 law. A third-party purchaser of health care services includes, 31 but is not limited to, a health carrier or community integrated 32 service network that pays for health care services on behalf of 33 patients or that reimburses, indemnifies, compensates, or 34 otherwise insures patients for health care services. For 35 36 purposes of this section, a pharmacy benefits manager means an

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1 entity that performs pharmacy benefits management. А third-party purchaser or pharmacy benefits manager shall comply 2 with this section regardless of whether the third-party 3 4 purchaser or pharmacy benefits manager is a for-profit, not-for-profit, or nonprofit entity. A wholesale drug 5 distributor may transfer additional expense generated by section 6 7 295.52 obligations to entities that purchase from the wholesaler, and the entities must pay the additional expense. 8 9 Nothing in this section limits the ability of a hospital, surgical center, pharmacy, wholesale drug distributor, or health 10 11 care provider to recover all or part of the section 295.52 12 obligation by other methods, including increasing fees or 13 charges.

(b) Each third-party purchaser regulated under any chapter
cited in paragraph (a) shall include with its annual renewal for
certification of authority or licensure documentation indicating
compliance with paragraph (a).

(c) 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).

25 (d) If the commissioner responsible for regulating the third-party purchaser finds at any time that the third-party 26 purchaser has not complied with paragraph (a), the commissioner 27 may take enforcement action against a third-party purchaser 28 which is subject to the commissioner's regulatory jurisdiction 29 30 and which does not allow a hospital, surgical center, pharmacy, or provider to pass-through the tax. The commissioner may by 31 order fine or censure the third-party purchaser or revoke or 32 suspend the certificate of authority or license of the 33 34 third-party purchaser to do business in this state if the 35 commissioner finds that the third-party purchaser has not complied with this section. The third-party purchaser may 36

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1 appeal the commissioner's order through a contested case hearing
2 in accordance with chapter 14.

<u>Subd. 2.</u> [AGREEMENT.] <u>A contracting agreement between a</u>
<u>third-party purchaser or a pharmacy benefits manager and a</u>
<u>resident or nonresident pharmacy registered under chapter 151,</u>
<u>may not prohibit:</u>

7 (1) a pharmacy that has paid additional expense transferred 8 under this section by a wholesale drug distributor from 9 exercising its option under this section to transfer such 10 additional expenses generated by the section 295.52 obligations 11 on to the third-party purchaser or pharmacy benefits manager; or 12 (2) a pharmacy that is subject to tax under section 295.52, 13 subdivision 4, from exercising its option under this section to

14 recover all or part of the section 295.52 obligations from the 15 third-party purchaser or a pharmacy benefits manager.

Sec. 8. Minnesota Statutes 2004, section 641.15,subdivision 2, is amended to read:

Subd. 2. [MEDICAL AID.] Except as provided in section 18 466.101, the county board shall pay the costs of medical 19 services provided to prisoners. The amount paid by the Anoka 20 21 county-board and Dakota County boards for a medical service 22 shall not exceed the maximum allowed medical assistance payment rate for the service, as determined by the commissioner of human 23 services. The county is entitled to reimbursement from the 24 prisoner for payment of medical bills to the extent that the 25 prisoner to whom the medical aid was provided has the ability to 26 pay the bills. The prisoner shall, at a minimum, incur 27 co-payment obligations for health care services provided by a 28 county correctional facility. The county board shall determine 29 the co-payment amount. Notwithstanding any law to the contrary, 30 the co-payment shall be deducted from any of the prisoner's 31 funds held by the county, to the extent possible. If there is a 32 disagreement between the county and a prisoner concerning the 33 prisoner's ability to pay, the court with jurisdiction over the 34 defendant shall determine the extent, if any, of the prisoner's 35 ability to pay for the medical services. If a prisoner is 36

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covered by health or medical insurance or other health plan when l medical services are provided, the county providing the medical 2 services has a right of subrogation to be reimbursed by the 3 insurance carrier for all sums spent by it for medical services 4 to the prisoner that are covered by the policy of insurance or 5 health plan, in accordance with the benefits, limitations, 6 exclusions, provider restrictions, and other provisions of the 7 policy or health plan. The county may maintain an action to 8 9 enforce this subrogation right. The county does not have a right of subrogation against the medical assistance program or 10 11 the general assistance medical care program. 12 Sec. 9. [LANGUAGE INTERPRETER SERVICES STUDY.] The commissioner of commerce, in consultation with the 13 14 commissioners of health, human services, and employee relations, 15 and representatives of health plan companies, health care providers, and limited-English-speaking communities, and 16 17 communities that communicate through sign language shall study 18 and make recommendations on providing language interpreter 19 services to limited-English-speaking patients and patients who 20 communicate through sign language in order to facilitate the provision of health care services by health care providers and 21 health care facilities. The recommendations shall include: 22 23 (1) ways to address the needed availability of professional 24 interpreter services; 25 (2) an accreditation system for language interpreters, including appropriate standards for education, training, and 26 27 credentialing; and (3) criteria for determining financial responsibility for 28 29 providing interpreter services to patients, including the 30 responsible parties for arranging interpreter services and for 31 reimbursement for these services. The commissioner of commerce shall submit these 32 33 recommendations to the legislature by January 15, 2006. 34 Sec. 10. [REBATE REVENUE RECAPTURE.] 35 Any money received by the state from a drug manufacturer 36 due to errors in the pharmaceutical pricing used by the

1	manufacturer in determining the prescription drug rebate shall
2	be deposited in the health care quality improvement account
3	established in Minnesota Statutes, section 256.957.
4	Sec. 11. [REPEALER.]
5	Minnesota Statutes 2004, section 119B.074, is repealed.
6	ARTICLE 8
7	APPROPRIATIONS
8	Section 1. [HEALTH AND HUMAN SERVICES APPROPRIATIONS.]
9	The sums in the columns marked "APPROPRIATIONS" are added
10	to, or, if shown in parentheses, are subtracted from the
11	appropriations to the specified agencies in 2005 S.F. No. 1879,
12	article 5, if enacted. The appropriations are from the general
13	fund, unless another fund is named, and are available for the
14	fiscal year indicated for each purpose. The figures "2006" and
15	"2007," where used in this article, mean that the additions to
16	or subtractions from the appropriations listed under them are
17	for the fiscal year ending June 30, 2006, or June 30, 2007,
18	respectively. The "first year" is fiscal year 2006. The
19	"second year" is fiscal year 2007. The "biennium" is fiscal
20	years 2006 and 2007.
21	SUMMARY BY FUND
22 23	BIENNIAL 2006 2007 TOTAL
24	General \$ 48,398,000 \$ 78,851,000 \$ 127,249,000
25 26	State Government           Special Revenue         7,001,000         12,625,000         19,626,000
27 28	Health Care Access 39,339,000 57,519,000 96,858,000
29	Federal TANF(3,033,000)14,817,00011,784,000
30	Lottery Prize
31	Fund     400,000     400,000     800,000
32	TOTAL       \$ 92,105,000 \$ 164,212,000 \$ 256,317,000
33 34 35 36	APPROPRIATIONS Available for the Year Ending June 30 2006 2007
37 38	Sec. 2. COMMISSIONER OF HUMAN SERVICES
39 40	Subdivision 1. Total Appropriation \$ 83,181,000 \$ 148,602,000

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1	- Summary	y by Fund	
2	General	46,545,000	75,936,000
3 4	Health Care Access	39,269,000	57,449,000
5	Federal TANF	(3,033,000)	14,817,000
6 7	Lottery Cash Flow	400,000	400,000
8 9 10 11 12 13 14 15 16	[ADMINISTRATIVE REDUC fund appropriation in includes a department administrative reduct the first year and \$7 second year. The con ensure that any staff under this paragraph Minnesota Statutes, s	h this section -wide tion of \$6,885 7,201,000 the nmissioner sha f reductions m comply with	1 5,000 all nade
17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 4 35 36	fiscal year 2007 and Notwithstanding sect	2000, chapter , subdivision funds used as state share of nrough under section 256.74 notwithstandir section 290.06 respect to the n of the Minne t, the commiss bined amount of ed to the nue for deposi \$11,160,000 ir by \$7,000,000 subsequent ye ion 5, this	6, the the 1, 1, 1, 1, 1, 1, 1, 1, 1, 1,
44 45 46 47 48 50 51 52 53 54 55	\$756,000 in fiscal ye \$4,831,000 in fiscal \$5,183,000 in fiscal \$1,127,000 in fiscal commissioner shall and transfer of sufficient the federal child can fund to meet this app shall ensure that all are expended according child care and develop regulations. Notwith 5, this paragraph exp	] The following ated to the purposes of M care under section 119B.( ear 2006; year 2007; year 2009. The section at the year 2009. The section at the section at the section at the section at the propriation at the popent fund standing section pires June 30,	ing MFIP 05; nd The to pment nd funds eral
56	Subd. 2. Agency Mana	agement	
57	Summary	y by Fund	
58	General	(158,000)	(231,000)
59	Health Care Access	1,623,000	1,701,000

The amounts that may be spent from the 1 2 appropriation for each purpose are as 3 follows: 4 (a) Financial Operations 424,000 5 General 424,000 Health Care Access 152,000 6 183,000 [ADMINISTRATIVE BASE ADJUSTMENT - WEB 7 PAYMENT.] The health care access fund 8 9 base is increased by \$28,000 in fiscal year 2008 and \$61,000 in fiscal year 2009 for fees associated with web-based 10 11 payment collections. 12 13 (b) Legal and 14 **Regulation Operations** 15 General (5,208,000) (5, 482, 000)Health Care Access 75,000 16 75,000 (c) Information Technology 17 Operations 18 19 General 4,626,000 4,827,000 20 Health Care Access 1,396,000 1,443,000 21 Subd. 3. Revenue and Pass-Through Federal TANF 22 (17,712,000)(6,312,000)Subd. 4. Basic Health Care Grants 23 24 Summary by Fund 25 General 4,916,000 18,513,000 26 Health Care Access 30,843,000 51,903,000 27 The amounts that may be spent from this appropriation for each purpose are as 28 follows: 29 30 (a) MinnesotaCare Grants 31 Health Care Access 30,843,000 51,903,000 (b) MA Basic Health Care Grants -32 Families and Children 33 34 4,385,000 12,062,000 [GREATER MINNESOTA HOSPITAL PAYMENT 35 36 ADJUSTMENT.] Of the general fund appropriation, \$400,000 each year is 37 38 for greater Minnesota payment 39 adjustments under Minnesota Statutes, 40 section 256.969, subdivision 26, for 41 admissions occurring on or after July 42 1, 2005. 43 (c) Notwithstanding section 5, these 44 provisions shall not expire. 45 (d) MA Basic Health Care Grants - Elderly 46 and Disabled

1 (62,000)(838,000)(e) General Assistance Medical Care 2 Grants 3 4 3,092,000 9,266,000 5 (f) Health Care Grants - Other 6 Assistance 7 (2,500,000)(1,978,000)8 Subd. 5. Health Care Management 9 Summary by Fund 10 4,663,000 4,411,000 General Health Care Access 6,803,000 11 3,845,000 The amounts that may be spent from this 12 appropriation for each purpose are as 13 14 follows: 15 (a) Health Care Administration General 4,206,000 16 4,157,000 17 Health Care Access 4,353,000 3,152,000 18 (b) Health Care Operations 19 General 457,000 254,000 20 Health Care Access 693,000 2,450,000 21 Subd. 6. State-Operated Services 22 22,682,000 6,796,000 23 [EVIDENCE-BASED PRACTICE FOR METHAMPHETAMINE TREATMENT.] Of the 24 general fund appropriation, \$300,000 25 26 each year is to support development of 27 evidence-based practices for the 28 treatment of methamphetamine abuse at the state-operated services chemical 29 dependency program in Willmar. These funds shall be used to support research 30 31 on evidence-based practices for the treatment of methamphetamine abuse, 32 33 34 dissemination of the results of the 35 evidence-based practice research statewide, and creation of training for addiction counselors specializing in 36 37 the treatment of methamphetamine abuse. 38 39 Subd. 7. Continuing Care Grants 40 Summary by Fund 41 General 11,536,000 38,301,000 42 Lottery Prize Fund 400,000 400,000 43 The amounts that may be spent from this 44 appropriation for each purpose are as follows: 45 46 (a) Aging and Adult Service Grant

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	1	3,000 10,000	
	2 3	(b) Deaf and Hard-of-Hearing Service Grants	
	4	10,000 33,000	
	5	(c) Mental Health Grants	
	6	General 1,024,000 1,888,000	
	7	Lottery Prize Fund 400,000 400,000	
	8 9 10 11 12 13 14 15 16 17 18 9 20 21 23 24 25 26 7 28 9 31 32	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 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,	
et.	33 34 35 36 37 38 39 40	Of the general fund appropriation, \$5,000 the first year is to the commissioner to contract with a nonprofit organization that is knowledgeable about children's mental health issues to provide the research necessary for the task force to make recommendations and complete the report.	
	41 42 44 45 46 47 49 51 52 53 54	appropriation, \$350,000 the first year and \$145,000 the second year is to the commissioner to develop community alternatives to Anoka-Metro Regional Treatment Center under Minnesota Statutes, section 245.4661, subdivisions 8 to 11. Any amount of this appropriation that is unspent shall not cancel but shall be available until expended. Notwithstanding	
		(d) Medical Assistance Long-Term Care Waivers and Home Care Grants	
	57	(3 562 000) (4 171 000)	

57 (3,562,000) (4,171,000)

58 [LIMITING WAIVER GROWTH.] For each year 59 of the biennium ending June 30, 2007, 60 the commissioner of human services

1 shall make available additional allocations for community alternatives 2 3 for disabled individuals waivered services covered under Minnesota 4 Statutes, section 256B.49, at a rate of 5 6 105 per month or 1,260 per year, plus 7 any additional legislatively authorized growth. Priorities for the allocation of funds shall be for individuals 8 9 10 anticipated to be discharged from 11 institutional settings or who are at imminent risk of a placement in an institutional setting. 12 13

14 For each year of the biennium ending June 30, 2007, the commissioner shall 15 make available additional allocations 16 17 for traumatic brain injury waivered 18 services covered under Minnesota 19 Statutes, section 256B.49, at a rate of 165 per year. 165 per year. Priorities for the allocation of funds shall be for 20 21 22 individuals anticipated to be 23 discharged from institutional settings 24 or who are at imminent risk of a 25 placement in an institutional setting.

26 Notwithstanding 2005 S.F. No. 1879, 27 article 11, section 2, subdivision 8, paragraph (d), if enacted, for each 28 year of the biennium ending June 30, 29 2007, the commissioner shall limit the 30 new diversion caseload growth in the 31 32 mental retardation and related 33 conditions waiver to 75 additional 34 allocations. Notwithstanding Minnesota 35 Statutes, section 256B.0916, 36 subdivision 5, paragraph (b), the 37 available diversion allocations shall 38 be awarded to support individuals whose health and safety needs result in an 39 40 imminent risk of an institutional 41 placement at any time during the fiscal 42 year.

43 (e) Medical Assistance Long-Term44 Care Facilities Grants

45 1,536,000 16,340,000

46 [RATE ADJUSTMENTS UNDER NEW NURSING 47 FACILITY REIMBURSEMENT SYSTEM.] Of this 48 appropriation, \$12,992,000 the second 49 year is to adjust nursing facility 50 rates in order to facilitate the 51 transition from the current ratesetting 52 system to the system developed under 53 Minnesota Statutes, section 256B.440.

54 [NURSING HOME MORATORIUM EXCEPTIONS.] 55 Of this appropriation, \$300,000 the 56 first year is to the commissioner for 57 the medical assistance costs of 58 moratorium exceptions approved by the 59 commissioner of health under Minnesota 60 Statutes, section 144A.073.

61 [ICF/MR DOWNSIZING.] Of this 62 appropriation, \$600,000 the first year 63 is for rate adjustments for 64 intermediate care facilities for

persons with mental retardation that 1 2 are downsizing. (f) Alternative Care Grants 3 10,131,000 4 18,774,000 (g) Chemical Dependency 5 Entitlement Grants 6 7 2,144,000 4,762,000 (h) Other Continuing Care 8 250,000 9 665,000 Subd. 8. Continuing Care Management 10 534,000 430,000 11 12 Subd. 9. Economic Support Grants 13 Summary by Fund General 2,106,000 14 7,456,000 15 Federal TANF 14,679,000 21,129,000 16 The amounts that may be spent from this 17 appropriation for each purpose are as 18 follows: 19 (a) Minnesota Family Investment Program 20 General -0-3,740,000 Federal TANF 13,783,000 19,898,000 21 22 (b) MFIP Child Care Assistance Grants 23 General -0-(3,740,000)24 Federal TANF 756,000 1,091,000 25 (c) Children Services Grants 26 1,124,000 6,074,000 (d) Children and Community Services 27 28 Grants 29 General Fund 3,000 11,000 140,000 140,000 30 Federal TANF (e) Minnesota Supplemental Aid Grants 31 118,000 32 363,000 33 (f) Group Residential Housing Grants 111,000 258,000 34 (g) Other Children's and Economic 35 36 Assistance Grants 37 750,000 750,000 38 [NEW CHANCE PROGRAM.] Of the TANF appropriation, \$140,000 each year is to the commissioner for a grant to the new 39 40

#### 04/28/05 1 chance program. The new chance program 2 shall provide comprehensive services 3 through a private, nonprofit agency to young parents in Hennepin County who have dropped out of school and are 4 5 receiving public assistance. 6 The 7 program administrator shall report 8 annually to the commissioner on skills 9 development, education, job training, and job placement outcomes for program 10 11 participants. [TRANSITIONAL HOUSING.] Of this 12 appropriation, \$750,000 each year is to 13 the commissioner for the transitional 14 15 housing program established in the 2005 Environment, Agriculture, and Economic 16 17 Development omnibus appropriations bill. Subd. 10. Children and Economic 18 19 Assistance Management 20 267,000 261,000 21 Sec. 3. COMMISSIONER OF HEALTH Subdivision 1. 22 Total 6,757,000 13,604,000 23 Appropriation 24 Summary by Fund 25 General 1,853,000 2,915,000 26 State Government 4,834,000 10,619,000 27 Special Revenue 28 Health Care Access 70,000 70,000 29 [RENTAL COSTS, ADMINISTRATIVE REDUCTIONS, FEE INCREASES, AND REVENUE TRANSFER.] (a) Of this appropriation, 30 31 \$722,000 the first year and \$2,583,000 32 33 the second year is for rental costs in 34 the new public health laboratory 35 building. 36 (b) The general fund appropriation in 37 this section includes a department-wide 38 administrative reduction of \$242,000 the first year and \$1,007,000 the 39 second year. The commissioner shall 40 41 ensure that any staff reductions made under this paragraph comply with Minnesota Statutes, section 43A.046. 42 43 44 (c) The commissioner shall increase all fees levied by the commissioner a pro rata amount in order to generate 45 46 revenue of \$712,000 the first year and \$1,808,000 the second year. These amounts shall be deposited in the 47 48 49 50 general fund. This paragraph shall not 51 apply to fees paid by occupational 52 therapists. (d) \$254,000 each year shall be 53 54 transferred from the state government 55 special revenue fund to the general fund. 56 57 Subd. 2. Health Improvement

1	- Summary	by Fund	
2	General	645,000	(154,000)
	State Government Special Revenue	335,000	335,000
5	Health Care Access	70,000	70,000

6 [TANF CARRYFORWARD.] Any unexpended 7 balance of the TANF appropriation in 8 the first year of the biennium in this 9 section and 2005 S.F. No. 1879, article 10 11, section 3, if enacted, does not 11 cancel but is available for the second 12 year.

13 [WORK GROUP ON CHILDHOOD OBESITY.] (a) 14 Of the general fund appropriation, 15 \$5,000 the first year and \$1,000 the second year is to the commissioner to 16 17 convene an interagency work group with 18 the commissioners of human services and education to study and make recommendations on reducing the rate of 19 20 21 obesity among the children in Minnesota.

(b) The work group shall determine the number of children who are currently 22 23 obese and set a goal, including 24 25 measurable outcomes for the state in 26 terms of reducing the rate of childhood obesity. The work group shall make recommendations on how to achieve this 27 28 29 goal, including, but not limited to, 30 increasing physical activities; 31 exploring opportunities to promote 32 physical education and healthy eating 33 programs; improving the nutritional 34 offerings through breakfast and lunch 35 menus; and evaluating the availability 36 and choice of nutritional products offered in public schools. 37

38 (c) The work group may include 39 representatives of the Minnesota Medical Association; the Minnesota Nurses Association; the Local Public 40 41 42 Health Association of Minnesota; the 43 Minnesota Dietetic Association; the 44 Minnesota School Food Service Association; the Minnesota Association 45 of Health, Physical Education, 46 47 Recreation, and Dance; the Minnesota School Boards Association; the 48 49 Minnesota School Administrators Association; the Minnesota Secondary 50 51 Principals Association; the vending 52 industry; and consumers.

53 (d) The commissioner must submit the 54 recommendations of the work group to 55 the legislature by January 15, 2007.

56 Subd. 3. Policy Quality and 57 Compliance

58Summary by Fund59State Government60Special Revenue770,000770,000770,000

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[STATEWIDE TRAUMA SYSTEM.] (a) Of the 1 general fund appropriation, \$382,000 the first year and \$352,000 the second 2 3 year is for development of a statewide 4 5 trauma system. 6 (b) The commissioner shall increase hospital licensing fees a pro rata 7 amount to increase fee revenue by 8 \$382,000 the first year and \$352,000 9 the second year. This revenue shall be 10 deposited in the general fund. 11 12 [AIDS PREVENTION FOR AFRICAN-BORN 13 RESIDENTS.] For fiscal year 2006 only, 14 the commissioner shall reallocate 15 \$300,000 from the grant program under Minnesota Statutes, section 145.928, 16 17 for grants in accordance with Minnesota Statutes, section 145.924, paragraph 18 19 (b), for a public education and 20 awareness campaign targeting 21 communities of African-born Minnesota 22 residents. The grants shall be 23 designed to: 24 (1) promote knowledge and understanding 25 about HIV and to increase knowledge in order to eliminate and reduce the risk 26 for HIV infection; 27 28 (2) encourage screening and testing for HIV; and 29 30 (3) connect individuals to public health and health care resources. 31 The 32 grants must be awarded to collaborative 33 efforts that bring together nonprofit 34 community-based groups with 35 demonstrated experience in addressing the public health, health care, and 36 social service needs of African-born 37 38 communities. 39 [FAMILY PLANNING GRANTS.] Of the 40 general fund appropriation, \$500,000 each year is to the commissioner for grants under Minnesota Statutes, 41 42 section 145.925, to family planning clinics serving outstate Minnesota that 43 44 demonstrate financial need. 45 46 Subd. 4. Health Protection 47 Summary by Fund 48 State Government 3,729,000 9,514,000 49 Special Revenue 50 Administrative Support Subd. 5. 51 Services 1,208,000 52 3,069,000 53 Sec. 4. HEALTH-RELATED BOARDS 54 Subdivision 1. Total 55 Appropriation 56 Summary by Fund Section 4 264 Article 8

2,167,000

2,006,000

1 State Government Special Revenue 2 2,167,000 2,006,000 [STATE GOVERNMENT SPECIAL REVENUE 3 FUND.] The appropriations in this 4 section are from the state government 5 special revenue fund, except where 6 7 noted. 8 [NO SPENDING IN EXCESS OF REVENUES.] The commissioner of finance shall not 9 permit the allotment, encumbrance, or expenditure of money appropriated in 10 11 12 this section in excess of the 13 anticipated biennial revenues or accumulated surplus revenues from fees 14 15 collected by the boards. Neither this provision nor Minnesota Statutes, 16 section 214.06, applies to transfers 17 from the general contingent account. 18 19 Subd. 2. Board of Dentistry 20 Summary by Fund 21 State Government 22 Special Revenue 150,000 -0-[ORAL HEALTH PILOT PROJECT.] Of this 23 24 appropriation, \$150,000 the first year 25 is to be transferred to the 26 commissioner of human services for an oral health care system pilot project. 27 28 Subd. 3. Board of Nursing 1,407,000 29 1,563,000 [MINNESOTA CENTER OF NURSING.] (a) Of 30 this appropriation, \$500,000 in fiscal year 2006 is to be used as start-up 31 32 33 funding to establish a Minnesota Center 34 of Nursing. The goals of the center 35 shall be to: 36 (1) maintain information on the current and projected supply and demand of 37 38 nurses through the collection and 39 analysis of data on the nursing 40 workforce; 41 (2) develop a strategic statewide plan 42 for the nursing workforce; 43 (3) convene work groups of stakeholders to examine issues and make 44 recommendations regarding factors 45 affecting nursing education, 46 47 recruitment, and retention; 48 (4) promote recognition, reward, and renewal activities for nurses in 49 50 Minnesota; and 51 (5) provide consultation, technical assistance, and data on the nursing 52 workforce to the legislature. 53 (b) The board shall report to the legislature by January 15, 2007, on the 54 55 Center of Nursing's progress, the 56

Article 8 Section 4 2

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265
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1 center's collaboration efforts with 2 other organizations and governmental

3 entities, and the activities conducted 4 by the center in achieving the goals

5 outlined.

6 [TRANSFERS FROM SPECIAL REVENUE FUND.] 7 The following transfers shall be made 8 as directed from the state government 9 special revenue fund:

10 (a) \$938,000 the first year and 11 \$1,207,000 the second year shall be 12 transferred to the commissioner of 13 human services for the long-term care 14 and home and community-based care 15 employee scholarship program.

(b) \$125,000 the first year and 16 \$200,000 the second year shall be 17 transferred to the health professional 18 19 education loan forgiveness program 20 account for loan forgiveness for nurses under Minnesota Statutes, section 144.1501. This appropriation shall 21 22 become part of base level funding for 23 24 the commissioner for the biennium 25 beginning July 1, 2007. 26 Notwithstanding section 5, this paragraph expires on June 30, 2009. 27

28 Subd. 4. Board of Pharmacy

499,000

#### 29

# 499,000

[RURAL PHARMACY PROGRAM.] Of this 30 appropriation, \$200,000 each year shall be transferred to the commissioner of 31 32 33 health for the rural pharmacy planning and transition grant program under 34 35 Minnesota Statutes, section 144.1476. Of this transferred amount, \$20,000 36 each year may be retained by the commissioner for related administrative 37 38 39 This appropriation shall become costs. part of base level funding for the 40 41 commissioner for the biennium beginning 42 July 1, 2007. Notwithstanding section 43 5, this paragraph expires on June 30, 44 2009.

45 [PHARMACIST LOAN FORGIVENESS.] \$200,000 each year shall be transferred to the 46 health professional education loan 47 forgiveness program account for loan forgiveness for pharmacists under Minnesota Statutes, section 144.501. This appropriation shall become part of 48 49 50 51 52 base level funding for the commissioner for the biennium beginning July 1, 2007. Notwithstanding section 5, 53 54 this paragraph expires on June 30, 2009. 55

56 [DRUG MANUFACTURER PRICING DISCLOSURE.] 57 (a) The board shall increase the 58 licensing or registration fee for 59 wholesale drug distributors and drug 60 manufacturers required under Minnesota 61 Statutes, chapter 151, by \$65 per year 62 beginning July 1, 2005.

1 (b) Of the appropriation in this 2 subdivision, \$74,000 each year is to be 3 transferred to the commissioner of 4 human services for the data received 5 under Minnesota Statutes, section 6 151.52.

7 Subd. 5. Board of Social 8 Work

9 105,000 100,000

10 [ADMINISTRATIVE MANAGEMENT.] This 11 appropriation is to provide administrative management under 12 Minnesota Statutes, section 148B.61, subdivision 4. The following boards 13 14 15 shall be assessed a prorated amount depending on the number of licensees 16 under the board's regulatory authority 17 providing mental health services within 18 their scope of practice: Board of 19 Medical Practice, the Board of Nursing, the Board of Psychology, the Board of 20 21 Social Work, the Board of Marriage and 22 Family Therapy, and the Board of 23 24 Behavioral Health and Therapy.

25 Sec. 5. [SUNSET OF UNCODIFIED LANGUAGE.]

All uncodified language in this article expires on June 30,

27 2007, unless a different expiration date is explicit.

Article 1HEALTH DEPARTMENT.page2Article 2HEALTH CARE - DEPARTMENT OF HUMAN SERVICES.page53Article 3HEALTH CARE COST CONTAINMENT.page109Article 4LONG-TERM CARE AND CONTINUING CARE.page126Article 5MENTAL AND CHEMICAL HEALTH.page182Article 6FAMILY SUPPORT.page212Article 7MISCELLANEOUS.page240Article 8APPROPRIATIONS.page255

#### APPENDIX

# Repealed Minnesota Statutes for 05-4117

## 119B.074 SPECIAL REVENUE ACCOUNT FOR CHILD CARE.

A child support collection account is established in the special revenue fund for the deposit of collections through the assignment of child support under section 256.741, subdivision 2. The commissioner of human services must deposit all collections made under section 256.741, subdivision 2, in the child support collection account. Money in this account is appropriated to the commissioner for assistance under section 119B.03 and is in addition to other state and federal appropriations.

157.215 PILOT PROJECT.

The commissioner of health is authorized to issue a request for participation to the regulated food and beverage service establishment industry and to select up to 25 pilot projects utilizing HACCP quality assurance principles for monitoring risk. 256B.0631 MEDICAL ASSISTANCE CO-PAYMENTS.

Co-payments. (a) Except as provided Subdivision 1. 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 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.

Subd. 2. Exceptions. Co-payments shall be subject to the following exceptions:

(1) children under the age of 21;(2) pregnant women for services that relate to the pregnancy or any other medical condition that may complicate the pregnancy;

(3) recipients expected to reside for at least 30 days in a hospital, nursing home, or intermediate care facility for the mentally retarded;

(4) recipients receiving hospice care;

(5) 100 percent federally funded services provided by an Indian health service;

(6) emergency services;(7) family planning services;

(8) services that are paid by Medicare, resulting in the medical assistance program paying for the coinsurance and deductible; and

(9) co-payments that exceed one per day per provider for nonpreventive visits, eyeglasses, and nonemergency visits to a hospital-based emergency room. Subd. 3. Collection. The medical assistance

reimbursement to the provider shall be reduced by the amount of

256B.0631

1R

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 subdivision 4.

Subd. 4. Uncollected debt. 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.

## 256B.69 PREPAYMENT DEMONSTRATION PROJECT.

Subd. 5a. Managed care contracts. (a) Managed care contracts under this section and sections 256L.12 and 256D.03, shall be entered into or renewed on a calendar year basis beginning January 1, 1996. Managed care contracts which were in effect on June 30, 1995, and set to renew on July 1, 1995, shall be renewed for the period July 1, 1995 through December 31, 1995 at the same terms that were in effect on June 30, 1995. The commissioner may issue separate contracts with requirements specific to services to medical assistance recipients age 65 and older.

(b) A prepaid health plan providing covered health services for eligible persons pursuant to chapters 256B, 256D, and 256L, is responsible for complying with the terms of its contract with the commissioner. Requirements applicable to managed care programs under chapters 256B, 256D, and 256L, established after the effective date of a contract with the commissioner take effect when the contract is next issued or renewed.

(c) Effective for services rendered on or after January 1, 2003, the commissioner shall withhold five percent of managed care plan payments under this section for the prepaid medical assistance and general assistance medical care programs pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. The withheld funds must be returned no sooner than July of the following year if performance targets in the contract are achieved. The commissioner may exclude special demonstration projects under subdivision 23. A managed care plan or a county-based purchasing plan under section 256B.692 may include as admitted assets under section 62D.044 any amount withheld under this paragraph that is reasonably expected to be returned.

256J.37 TREATMENT OF INCOME AND LUMP SUMS.

Subd. 3a. Rental subsidies; unearned income. (a) Effective July 1, 2003, the county agency shall count \$50 of the value of public and assisted rental subsidies provided through the Department of Housing and Urban Development (HUD) as unearned income to the cash portion of the MFIP grant. The full amount of the subsidy must be counted as unearned income when the subsidy is less than \$50. The income from this subsidy shall be budgeted according to section 256J.34. (b) The provisions of this subdivision shall not apply to

(b) The provisions of this subdivision shall not apply to an MFIP assistance unit which includes a participant who is: (1) age 60 or older;

256J.37

(2) a caregiver who is suffering from an illness, injury, or incapacity that has been certified by a qualified professional when the illness, injury, or incapacity is expected to continue for more than 30 days and prevents the person from obtaining or retaining employment; or
 (3) a caregiver whose presence in the home is required due

(3) a caregiver whose presence in the home is required due to the illness or incapacity of another member in the assistance unit, a relative in the household, or a foster child in the household when the illness or incapacity and the need for the participant's presence in the home has been certified by a qualified professional and is expected to continue for more than 30 days.

(c) The provisions of this subdivision shall not apply to an MFIP assistance unit where the parental caregiver is an SSI recipient.

(d) Prior to implementing this provision, the commissioner must identify the MFIP participants subject to this provision and provide written notice to these participants at least 30 days before the first grant reduction. The notice must inform the participant of the basis for the potential grant reduction, the exceptions to the provision, if any, and inform the participant of the steps necessary to claim an exception. A person who is found not to meet one of the exceptions to the provision must be notified and informed of the right to a fair hearing under section 256J.40. The notice must also inform the participant that the participant may be eligible for a rent reduction resulting from a reduction in the MFIP grant and encourage the participant to contact the local housing authority.

encourage the participant to contact the local housing authority. Subd. 3b. Treatment of supplemental security income. Effective July 1, 2003, the county shall reduce the cash portion of the MFIP grant by \$125 per SSI recipient who resides in the household, and who would otherwise be included in the MFIP assistance unit under section 256J.24, subdivision 2, but is excluded solely due to the SSI recipient status under section 256J.24, subdivision 3, paragraph (a), clause (1). If the SSI recipient receives 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. 256L.035 LIMITED BENEFITS COVERAGE FOR CERTAIN SINGLE ADULTS AND HOUSEHOLDS WITHOUT CHILDREN.

(a) "Covered health services" for individuals under section 256L.04, subdivision 7, with income above 75 percent, but not exceeding 175 percent, of the federal poverty guideline means:

(1) inpatient hospitalization benefits with a ten percent co-payment up to \$1,000 and subject to an annual limitation of \$10,000;

(2) physician services provided during an inpatient stay; and

(3) physician services not provided during an inpatient stay, outpatient hospital services, freestanding ambulatory surgical center services, chiropractic services, lab and diagnostic services, 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

256L.035

(iii) \$5 co-pay per nonpreventive physician 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.

Enrollees are responsible for all co-payments in this subdivision.

(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.

(c) 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).

(d) 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.

326.45 STATE LICENSE; EXAMINATION; APPLICATION. The provisions of sections 326.37 to 326.45 which require state licenses to engage in the work or business of plumbing, and the provisions which provide for the examination of applicants for such licenses, shall only apply in cities having a population of 5,000 or more.

514.991 ALTERNATIVE CARE LIENS; DEFINITIONS. Subdivision 1. Applicability. The definitions in this section apply to sections 514.991 to 514.995.

Subd. 2. Alternative care agency, agency, or department. "Alternative care agency," "agency," or "department" means the Department of Human Services when it pays for or provides alternative care benefits for a nonmedical assistance recipient directly or through a county social services agency under chapter 256B according to section 256B.0913.

Subd. 3. Alternative care benefit or benefits. "Alternative care benefit" or "benefits" means a benefit provided to a nonmedical assistance recipient under chapter 256B according to section 256B.0913.

Subd. 4. Alternative care recipient or recipient. "Alternative care recipient" or "recipient" means a person who receives alternative care grant benefits.

Subd. 5. Alternative care lien or lien. "Alternative care lien" or "lien" means a lien filed under sections 514.992 to 514.995.

514.991

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## APPENDIX

#### Repealed Minnesota Statutes for 05-4117

514.992 ALTERNATIVE CARE LIEN.

Subdivision 1. Property subject to lien; lien amount. (a) Subject to sections 514.991 to 514.995, payments made by an alternative care agency to provide benefits to a recipient or to the recipient's spouse who owns property in this state constitute a lien in favor of the agency on all real property the recipient owns at and after the time the benefits are first paid.

(b) The amount of the lien is limited to benefits paid for services provided to recipients over 55 years of age and provided on and after July 1, 2003.

Attachment. (a) A lien attaches to and Subd. 2. becomes enforceable against specific real property as of the date when all of the following conditions are met:

the agency has paid benefits for a recipient;

(2) the recipient has been given notice and an opportunity

for a hearing under paragraph (b);
 (3) the lien has been filed as provided for in section 514.993 or memorialized on the certificate of title for the property it describes; and

(4) all restrictions against enforcement have ceased to apply.

(b) An agency may not file a lien until it has sent the recipient, their authorized representative, or their legal representative written notice of its lien rights by certified mail, return receipt requested, or registered mail and there has been an opportunity for a hearing under section 256.045. No person other than the recipient shall have a right to a hearing under section 256.045 prior to the time the lien is filed. The hearing shall be limited to whether the agency has met all of the prerequisites for filing the lien and whether any of the exceptions in this section apply. (c) An agency may not file a lien against the recipient's

homestead when any of the following exceptions apply:

(1) while the recipient's spouse is also physically present and lawfully and continuously residing in the homestead; (2) a child of the recipient who is under age 21 or who is

blind or totally and permanently disabled according to supplemental security income criteria is also physically present on the property and lawfully and continuously residing on the property from and after the date the recipient first receives benefits;

(3) a child of the recipient who has also lawfully and continuously resided on the property for a period beginning at least two years before the first day of the month in which the recipient began receiving alternative care, and who provided uncompensated care to the recipient which enabled the recipient to live without alternative care services for the two-year period;

(4) a sibling of the recipient who has an ownership interest in the property of record in the office of the county recorder or registrar of titles for the county in which the real property is located and who has also continuously occupied the homestead for a period of at least one year immediately prior to the first day of the first month in which the recipient received benefits and continuously since that date.

(d) A lien only applies to the real property it describes. Continuation of lien. A lien remains Subd. 3.

effective from the time it is filed until it is paid, satisfied,

514.992

#### APPENDIX

# Repealed Minnesota Statutes for 05-4117

discharged, or becomes unenforceable under sections 514.991 to 514.995.

Priority of lien. (a) A lien which attaches Subd. 4. to the real property it describes is subject to the rights of anyone else whose interest in the real property is perfected of record before the lien has been recorded or filed under section 514.993, including:

(1) an owner, other than the recipient or the recipient's spouse;

(2) a good faith purchaser for value without notice of the lien;

(3) a holder of a mortgage or security interest; or

(4) a judgment lien creditor whose judgment lien has attached to the recipient's interest in the real property.

(b) The rights of the other person have the same protections against an alternative care lien as are afforded against a judgment lien that arises out of an unsecured obligation and arises as of the time of the filing of an alternative care grant lien under section 514.993. The lie shall be inferior to a lien for property taxes and special The lien assessments and shall be superior to all other matters first appearing of record after the time and date the lien is filed or recorded.

Subd. 5. Settlement, subordination, and release. (a) An agency may, with absolute discretion, settle or subordinate the lien to any other lien or encumbrance of record upon the terms and conditions it deems appropriate.

(b) The agency filing the lien shall release and discharge the lien:

if it has been paid, discharged, or satisfied;
 if it has received reimbursement for the amounts

secured by the lien, has entered into a binding and legally enforceable agreement under which it is reimbursed for the amount of the lien, or receives other collateral sufficient to secure payment of the lien;

(3) against some, but not all, of the property it describes upon the terms, conditions, and circumstances the agency deems appropriate;

(4) to the extent it cannot be lawfully enforced against the property it describes because of an error, omission, or other material defect in the legal description contained in the lien or a necessary prerequisite to enforcement of the lien; and

(5) if, in its discretion, it determines the filing or

enforcement of the lien is contrary to the public interest.
 (c) The agency executing the lien shall execute and file
 the release as provided for in section 514.993, subdivision 2.

Subd. 6. Length of lien. (a) A lien shall be a lien on the real property it describes for a period of ten years from the date it attaches according to subdivision 2, paragraph (a), except as otherwise provided for in sections 514.992 to 514.995. The agency filing the lien may renew the lien for one additional ten-year period from the date it would otherwise expire by recording or filing a certificate of renewal before The certificate of renewal shall be recorded the lien expires. 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 certificate need not be attested, the lien it renews. certified, or acknowledged as a condition for recording or

enforceable as provided for in sections 514.991 to 514.995 notwithstanding any laws limiting the enforceability of judgments.

Subd. 2. Homestead exemption. The lien may not be enforced against the homestead property of the recipient or the spouse while they physically occupy it as their lawful residence. Subd. 3. Agency claim or remedy. Sections 514.992 to

Subd. 3. Agency claim or remedy. Sections 514.992 to 514.995 do not limit the agency's right to file a claim against the recipient's estate or the estate of the recipient's spouse, do not limit any other claims for reimbursement the agency may have, and do not limit the availability of any other remedy to the agency.

514.995 AMOUNTS RECEIVED TO SATISFY LIEN.

Amounts the agency receives to satisfy the lien must be deposited in the state treasury and credited to the fund from which the benefits were paid.

514.995

Trkg. Gov Rec Line / Bill Ref Fund BACT DESCRIPTION

	LAGENCIES	(90,903				(104,871)			(52,457)	(90,978)		(27,848)	(57,399)	95,353	149,712	245,066				154,088	377,514	413,
GF	General Fund State Government Special Revenue Fund	(171,162 645		) (457,177)	(359,942)	(361,231) 978	(721,173) 2,047	(38,521)	(52,457)	(90,978)	(29,551)	(27,848)	(57,399)	57,069 1,608	72,429 2,959	129,499 4,567				38,521 4,567	200,313 3,545	495, 4,
HCAF	Health Care Access Fund	79,614			236,362	255,382	491,744	0	0	0	0	0	0	39,941	62,860	102,801				102,801	180,255	4,9
TANF	Federal TANF	0	0	0	0	0	0	0	0	0	0	0	0	(3,665)		7,399					(7,399)	7;3
LOTT OTH	Other Funds	0	0	-	0	0	0	0	0	0	0	0	0	400	400	800		400		800	800	8
									v		, v			U				0	,, v			
																	313	39	352			
HUMAN SEF	VICES TARGET - DIRECT APPROPRIATIONS		I	1		1						A. 1997 (1995)				-			1	lI		
	Target Proposals			276,198 260,566												129,500 129,499						
	Over/(Under) Target			15,632				6-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1								(1)			1. S			
HCAF FUND	BALANCE			1.																		
100	February 2005 Porecast	61,819	204,563		469,758	771,320		81,819	204,563		469,758	771,320		82,619	207,663		475,558	780,420				
	Investment income change (cumulative, per DOF)	(1,275) (930)	(6,889) (40)		(21,726)	(50,220) 2,880		0	0		6 800	0		(918)	(2,721)		(8,100)	(21,042)	atore			a e
	Non-DHS proposals (cumulative, per DOF) Provider tax transfers (cumulative, per DOF)	49,413	102,072	1. A.	151,513	2,880		800 0	3,100 0		5,800	9,100		0	0			0				
	End of year balance transfers (cumulative, per DOF)	26,615	56,377		6,377	(43,623)		0	0		0	. 0		0	0		0	Q				
	DHS Proposals (cumulative)	(79,614) 76,028	(197,634) 158,449		(433,996) 173,086	(689,378)		0	0		476 550	0		(39,941)	(102,801)		(186,230)	(283,056)			23	
	Ending Balance HealthMatch Reserve	70,028	130,449		113,000	194,779		82,619	207,663		475,558	780,420		41,760 44,000	102,141 88,000		281,228	476,322 88,000				
	Balance after Reserve													(2,240)	14,141		193,228	388,322				
FEDERAL T	ANF BALANCE																					
	February 2004 Forecast	51,849	33,477		14,263	0		51,849	33,477		14,263	0		51,849 3,665	33,477		14,263	0				
	Proposais (cumulative) Ending Balance	51,849	33,477		14,263	0		51,849	33,477		14,263	0		3,665 55, <del>5</del> 14	(7,399) 26,078		(14,263)	0				
	TI				ľ	· · · · · · · · · · · · · · · · · · ·		1	r			<u> </u>		) 1	1	21 - C. C.	r i i i i i i i i i i i i i i i i i i i	1000	1	T.		
		104.442	1460 4001	(060 500)	1495 007	(407.070)	(000 000)	100 504	150 457	100.070	(00.554)	(07.0.10)	(177.000)	00.075	440.000	0.40 0.55	400.000			445 654		
GF	IT OF HUMAN SERVICES	(91,144) (170,758)	(169,422) (287,442)		(361,369)	(107,276) (362,658)	(232,283) (724,027)	(38,521) (38,521)	(52,457)	(90,978) (90,978)	(29,551) (29,551)	(27,848)	(57,399)	93,675 57,069	146,683 72,429	240,359 129,499	196,234 105,611	234,966 152,073	431,200 257,684	149,381 38,521	373,801 200,285	409,94
SGSR	State Government Special Revenue Fund	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	430,7
HCAF	Health Care Access Fund	79,614	118,020	197,634	236,362	255,382	491,744	0	0	0	0	0	0	39,871	62,790	102,661	83,359	96,756	180,115	102,661	180,115	(94,9
LOTT	Federal TANF           Lottery Prize Fund	0	0	0	0	0	0	0	0	0	0	0	0	(3,665) 400	11,064 400	7,399 800	6,864 400	(14,263) 400	(7,399) 800	7,399 800	(7,399) 800	7,3
отн	Other Funds	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		000	0	
																	313	39	352			
GF DEPARTMEN	IT OF HEALTH General Fund	(404)	432 1,427	673 1,023	2,496 1,427	2,405 1,427	4,901 2,854	0	0	0	0	0	0	(639)	1,023	384	1,466 14	624 14		384	2,090 28	(2)
SGSR	State Government Special Revenue Fund	645	(995)	(350)	1,069	978	2,047	0	0	0	0	0	0	(709)	953	244	1,382	540	1,922	244	1,922	5
HCAF	Health Care Access Fund	0	0.	0	0	0	0	0	0	. 0	0	0	0	70	70	140	70	70	140	140	140	14
OTH OTH	Federal TANF           Other Funds	- 0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
VETERANS N	NURSING HOMES BOARD	0	0	0	0	0	0	0	0	0	0	0	o	0	0	0	0	0	0	0	0	
GF	General Fund	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
OTH	Other Funds	0	0	0	0	0	0	0	. 0	0	0	0	0	0	0	0	0	0	0	0	0	
											Ĺ			· · ·						-		
	ATED BOARDS	0	n	0	0	·. 0	. 0	0		. 0	0	0	: 0	2,317	2,006	4,323	774	849	1,623	4,323	1,623	4,32
SGSR	State Government Special Revenue Fund	0	0	0	0	. 0	0	0	0	0	0	0	0	2,317	2,006	4,323	774	_849	1,623	4,323	1,623	4,32
HCAF	Health Care Access Fund	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
OTH	Other Funds	0	0	0	. 0	0	0	0	0	0	0	0	0	· 0	0	0	0	0	0	0	0	
				·																		
		0	. 0	· · · ·				0				0	0	. 0	0	0	0	0	0		0	
EMERGENIC	(MEDICAL SERVICES BOARD	0	0	. 0	0	0	0	.0	0	0	0	0	. 0	. 0.	0	0	0	0	0	0	0	
EMERGENC	General Fund	0		0	0	0	0	0	0	0	. 0	. 0	0	. 0	0	0	0	0	0	0	0	
GF SGSR	General Fund State Government Special Revenue Fund	0	0	<u> </u>									_ 1			- 1	- 1					
GF SGSR	General Fund		0	0	0	0	. 0	0	0	0	· 0	0	0	. 0	0	0	0	0	0	0	0	

 GOVERNOR'S RECOMMENDATION
 SENATE POSITION - SF 1879

 FY 2007
 FY 06-07
 FY 2008
 FY 2009
 FY 08-09
 FY 2006
 FY 2007
 FY 06-07
 FY 2008
 FY 2009
 FY 08-09

2005 .c ./E SESSION

 SENATE POSITION - HHS OMNIBUS BUDGET BILL
 SENATE TOTAL POSITION
 SENATE TOTAL vs GOV

 FY 2006
 FY 2007
 FY 06-07
 FY 2008
 FY 2009
 FY 08-09
 FY 06-07
 FY 06-07
 FY 08-09

FY 2006

#### HEALTH and HU. C CES BUDGET NET FISCAL IMPACT OF PROPOSALS

kg. Gov Rec		1	GO	VERNOR'S RE	COMMENDAT	TION		Τ		SENATE POS	ITION - SF 18	79		s	ENATE POS	ITION - HHS	OMNIBUS B	UDGET BILL	••••	SENATE TOTA	N POSITION	SENATE TOT	AL NO CC
ne / Bill Ref Fund BAC	DESCRIPTION	FY 2006					FY 08-09	FY 200		7 FY 06-07			FY 08-09	FY 2006	FY 2007	FY 06-07	FY 2008	FY 2009	FY 08-09	FY 06-07	FY 08-09	FY 06-07	FY 08-
73	· · · · · · · · · · · · · · · · · · ·									+													
	DN DISABILITY	0	0	0	0	0	0	C		) 0	0	0	0	0	0	0	0	0	0	0	0	0	
75 GF	General Fund	0	0	0	0	0					0	-	0		0	0	0		0	0	0	0	
76 OTH	Other Funds	0	0		UU	. U	0		<u> </u>	,	<sup>0</sup>		U U	0	0	0		0	0			0	
78									1														
79 OMBUDSM/	AN FOR MENTAL HEALTH AND MENTAL RETARDATION	0	0	0	0	0	0	n		0	0	0	0	0	0	0	0	0	0	0		0	
81 GF	General Fund	0		0	0	0	0	0			0	· 0	0		0	0	0		0	0	0	0	
82 OTH	Other Funds	0	0	0	0	0	0	0	0 0	0 0	0	0	0	0	0	0	0	0	0	0	0	0	
83			<u> </u>																				
85																							
	AN FOR FAMILIES	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	/
87 GF 88 OTH	Other Funds	0	0	0	0	0	0	0		0	0		0		0		0	ol	0	0		0	
89																							
29			~				I		- I.											I.		I	
31 DEPARTMENT OF	HUMAN SERVICES			1																			
32					r					· / · · · · · · · · · · · · · · · · · ·	-	) 											
33 34 Page 7 FACILITIES	CONSOLIDATION LEASE COSTS	4,131	4,321	8,452	4,321	4,321	8,642	0	0	0	0	0	0	4,131	4,321	8,452	4,321	4,321	8,642	8,452	8,642		
35 GF 13	General fund operations	3,107	3,279	6,386	3,279	3,279	6,558	0	0 0		. 0	0	0	3,107	3,279	6,386	3,279	3,279	6,558	6,386	6,558	0	(
36 HCAF 13 37 GF 13	HCAF operations Major systems operations	1,396	1,443 1,488	2,839 2,918	1,443	1,443	2,886 2,976	0			0	0	0	1,396 1,430	1,443	2,839 2,918	1,443 1,488	1,443 1,488	2,886 2,976	2,839 2,918	2,886	0	
37 GF 13 38 GF REV	Administrative ffp	(1,243)	(1,312)	(2,555)	(1,312)	(1,312)		. 0			0	0	0	(1,243)	(1,312)	(2,555)	(1,312)	(1,312)	(2,624)	(2,555)	(2,624)	0	
39 HCAF REV	1 Administrative ffp	(559)	(577)	(1,136)	(577)	(577)		0	0 0	0	0	0	0	(559)	(577)	(1,136)	(577)	(577)	(1,154)	(1,136)	(1,154)	0	(
40 41 Rider GENERAL F	UND ADMINISTRATIVE REDUCTION TO SUPPORT LEASE COSTS	. 0'	0	0	0	0	0	0	0	0	. 0	0	0	(4,131)	(4,321)	(8,452)	(4,321)	(4,321)	(8,641)	(8,452)	(8,641)	(8,452)	(8,641
42 GF 11	Across the board admin reduction	0	0	0	0	0	0	0	0		0	0	0	(6,885)	(7,201)	(14,086)	(7,201)	(7,201)	(14,402)	(14,086)	(14,402)	(14,086)	(14,402
13 GF REV1	1 Administrative Reimbursement (40% ffp)	0	0	0	0	0	0	0	0	0	0	0	0	2,754	2,880	5,634	2,880	2,880	5,761	5,634	5,761	5,634	5,761
	TATUTORY REQUIREMENTS FOR LICENSING	325	264	589	264	264	528	0	0	0	0	0	0	493	432	924	432	432	863	924	863	335	335
AND BACKG	ROUND STUDIES																						
17 18 Licensing Perfor	rmnace Standards	313	269	582	269	269	538	0	0	0	0	0	0	314	270	583	270	270	539	583	539		
	Administration (13 FTEs)	1,045	898	1,943	898	898	1,796	0	0		0		0	523	449	972	449	449	898	972	898	(972)	(898
	1 Administrative ffp	(418)	(359)	(777)	(359)	(359)		0	0	0	0	0	0	(209)	(180)	(389)	(180)	(180)	(359)	(389)	(359)	389	359
GF REV2	2 Increase licensing fees	(314)	(270)	(584)	(270)	(270)	(540)	0														584	540
53 Fund Umbrella R	Rule Implementation	100	83	183	83	83	166	0	0		0	0	0	100	83	183	83	83	166	183	166	0	0
	Administration (2 FTEs)	167	138	305 (122)	138 (55)	138 (55)		0	0	0	0	0	0	167 (67)	138 (55)	305 (122)	138 (55)	138 (55)	276 (110)	305 (122)	276	0	
5 GF REV1	1 Administrative ffp	(67)	(55)	(122)	(00)		(110)							(0,7	(00/	(122/	(00)	(00)	(110)	(122)	(110)		0
7 Increase Backgr	ound Study Fees to Cover Costs	(88)	(88)	(176)	(88)	(88)	(176)	0	0	0	0	0	0	79	79	158	79	79	158	158	158	334	334
	Increase fees to \$20 (PCPO, SNSA, court appted guardian) Operating deficit (direct & Indirect)	(167) 167	(167) 167	(334) 334	(167) 167	<u>(167)</u> 167		0	0	0	0	0	0	0	0	0	0	0	0	0	0	334 (334)	334 (334)
0 GF 11	Operating deficit (direct & Indirect)													167	167	334	167	167	334	334	334	334	334
	Indirect cost reimbursement to GF	(88)	(88)	(176)	(88)	(88)	(176)	0	0	0	0	0	0	(88)	(88)	(176)	(88)	(88)	(176)	(176)	(176)	(88)	(264)
2 3 Page 11 MEETING ST		608	505	1,113	505	505	1,010	0	0	0	0	0	0	419	505	924	505	505	1,010	924	1,010	(189)	0
4 FAIR HEARIN	NGS							0	0		0	0											
5 GF 11 6 GF REV1	Administration (11 FTEs)	1,013 (405)	842 (337)	1,855 (742)	842 (337)	(337)	` 1,684 (674)	0	0		0	0	0	698 (279)	(337)	1,540 (616)	842 (337)	(337)	1,684 (674)	1,540 (616)	1,684 (674)	(315)	0
	Administrative ffp							······	ļ														
		0	4,838	4,838	4,838	4,838 4,838	9,676 9,676	0	0		0	0	0	0	4,596 4,838	4,596 4,838	4,596 4,838	4,596 4,838	9,192 9,676	4,596	9,192 9,676	(242)	(484)
	Children's services grants County share 5% of total costs	0	4,838	4,838	4,838	4,038	9,676	0	. 0		0	0	0	0	4,636 (242)	4,838 (242)	4,838 (242)	4,838 (242)	(484)	(242)	(484)	(242)	(484)
1				_																	· · · · · · · · · · · · · · · · · · ·		
2 ADJUST APP	PROPRIATION FOR ADOPTION ASSISTANCE	(1,340)	(1,491)	(2,831)	1,500	4,508	6,008	(1,340)	(1,491)	(2,831)	1,500	4,508	6,008	0	0	0	0	0	0	(2,831)	- 6,008	0	n
4 AND RELATIV	VE CUSTODY ASSISTANCE	(.,																					
	Adoption assistance	(526)	(449)	(975)	(204)	3,861 647	5,565 443	(526)			1,704 (204)	3,861 647	5,565	0	0	0	0	0		(975) (1,856)	5,565 443	0	0
7	Relative custody assistance	(814)	(1,042)	(1,856)				(814)	(1,042)	(1,000)	(204)		445			J					1.1.1		0
8 Page 15 PREVENT HC	DMELESSNESS FOR YOUNG ADULTS	1,125	1,122	2,247	1,122	1,122	2,244	. 10	0	. 0	0	0	0	1,125	1,122	2,247	1,122	1,122	2,244	2,247	2,244	. 0	0
	ING FROM LONG-TERM FOSTER CARE Demonstration project: transition planning with supportive housing	1,085	1,085	2,170	1,085	1,085	2,170	. 0	· . 0.		0	0	0	1,085	1,085	2,170	1,085	1,085	2,170	2,170	2,170		· ·
1 GF 35	Staff to administer/coordinate demonstration programs (1 fte)	72	66	138	. 66	66	132	30 <u>0</u>			0	. 0	0	72	66	138	66	66	132	138	132	0	0
2 GF REV1	Administrative ffp	(32)	(29)	(61)	(29)	(29)	(58)	0	0		0	0	0	(32)	(29)	(61)	(29)	(29)	(58)	(61)	(58)	0	0
3 4 Pege 17 ADDRESS HC	DMELESSNESS WITH SUPPORTIVE HOUSING	5,000	5,000	10,000	5,000	5,000	10,000	ş. 0.	. 0	0	. 0	0	0	· · · · · · · · · · · · · · · · · · ·	0	0	0	0	0	0		(10,000)	(10,000)
SERVICES GI	PANTS	5,000			E C		10,000					1.1									- 54	· )	
an a	acking - Bill TrackingNewTargetForFinanceMay3_2005.xis		1.11						an tan ing sing sing sing sing sing sing sing				and Afrika Sanatina		ara la a Alta de la composition Alta de la composition						離り正常	jili e	
	가슴 같은 것이 있는 것이 있다. 가지 않는 것이 있는 것이 같은 것이 같은 것이 있는 것이 있는 것이 있는 것이 있는 것이 같은 것이 있는 것이 같은 것이 있는 것이 있는 것이 같은 것이 있는 것이 같은 것이 있는 것이 있는 것이 있는 것이 있는 것이 있는 것																			1.1	1.5		e Maria di
									- 2 2					i di Se	51 						Sec. Sec. Sec.	4	1. A.
Detailed Budget Tra	acking - Bill TrackingNewTargetForFinanceMav3 (2005 xls					an di seria. Seria di seria	5/2/20	005, 4:00 P	M			1.38 - 12-2	11月1日)。 11月1日日(11月1日)。	. story	4 - 1. 						Tab 1: Pao		
				2			5/2/20							. N. 13	1. 4 <u>. 1</u> . 1. 19 <sup>1</sup> -						- <b>9</b> -	∋2 of 11 ິ⊫	9 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	14월66년 - 17월 17일 전철 18일 전 18일 월 1		Settion (+	i de produit d		en trad,		( 13 SP/3	ξ					1	1. 19							8 1	

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#### HEALTH and HUMAN SE JGET NET FISCAL IMPACT OF ......POSALS

		0.01		COMMENDAT					NATE DOOL	TION OF 4970						IDOET DU L		CHATE TOT			
Trkg.         Gov Rec           Line         / Bill Ref         Fund         BACT         DESCRIPTION	FY 2006	FY 2007				FY 08-09	EV 2006	FY 2007		TION - SF 1879 FY 2008 FY 2009	FY 08-09			TION - HHS		FY 2009	EV 09 00	EV 06 07	EX 08 00	SENATE TOT	FY 08-09
	112000	112007	1100-07	112000	F1 2005	FT 00-09	FT 2000	F1 2007	FT 00-07	F12008F12008	F100-09	FT 2000	FT 2007	F1 00-07	F1 2000	F1 2003	FT 00-05	F100-07	F1 00-09	<u> </u>	F1 00-09
186 GF 32 Other children's and families grants	5,000	5,000	10,000	5,000	5,000	10,000	0	0	0	0	0	·	0		0			0		(10,000)	(10,000)
187	0,000	0,000	10,000	0,000	0,000	10,000				v		v						*	· · · · ·	(10,000)	(10,000)
188 Page 18 DELAY PROJECTS OF REGIONAL SIGNIFICANCE	(25,000)	(25,000)	(50,000)	0	0	0	(25,000)	(25,000)	(50,000)	0 0	0	0	0	0	0	0	0	(50,000)	0		0
189 GF 27 Delay projects of regional significance	(25,000)	(25,000)	(50,000)	0	0		(25,000)	(25,000)	(50,000)	ŭ	0	0	0	- 0	0	0		(50,000)		0	0
190	(==)==/	(	(00,000/			-	(20,000)	(20,000)	(00,000)			*		*				(00,000/	· · · · ·	¥_	v
191 Page 19 FREEZE MAXIMUM RATES PAID FOR CHILD CARE ASSISTANCE	(22,289)	(30,268)	(52,557)	(31,348)	(32,039)	(63,387)	0	0	0	0 0	0	0	0	0	0	0	0	0	0	52,557	63,387
192 GF 22 MFIP child care assistance grants	(22,289)	(30,318)	(52,607)	(31,348)	(32,039)		0	0		0 0					0					52,607	63,387
193 GF 36 MAXIS-MEC <sup>2</sup>	0	50	50	0	(02,000)	(00,007)	0		0		0			0						(50)	03,387
194						°	v	•	v	ů				¥			¥			(50)	
195 Page 20 MDE TRANSFER ACCOUNTING SOLUTION	0	0	0		0	0	0	0	0	0 0	0	0	0	0	0	0	0	0		0	
196 GF 10 Financial operations	424	424	848	424	424	848	0				0	424	424	848	424	424	848	848	848	0	
	123	123	246	123	123		0	0	0	0 0	0	123	123	246	123	123	246	246	246	0	0
197         GF         11         Legal & regulatory operations           198         GF         13         Technical operations	60	60	120	60	60	120		0			0	60	60	120	60	60	120	120	120	0	
199         GF         35         Children & economic assistance administration         .	195	195	390	195	195	390	0				0	195	195	390	195	195	390	390	390	0	
200 GF REV1 Administrative fip	(802)	(802)	(1,604)	(802)	(802)		0	0		0 0		(802)	(802)	(1,604)	(802)	(802)	(1,604)	(1,604)	(1,604)	0	0
201 DED 10 Financial operations	(424)	(424)	(848)	(424)	(424)	(848)	0	0		0 0	0	(424)	(424)	(848)	(424)	(424)	(848)	(848)	(848)	0	0
							0	0	0	0 0	0										
202         DED         11         Legal & regulatory operations           203         DED         13         Technical operations	(123) (60)	(123)	(246)	(123)	(123)	(246)	0	0		0 0		(123)	(123)	(246)	(123)	(123)	(246)	(246)	(246)	0	
	(60)	(195)	(120)	(60)	(60)	(120)	0	0	- 0	0 0	0	(60)	(60)	(120)	(60)	(60)	(120)	(120)	(120)	0	0
	802	802	(390)	(195) 802	(195) 802	(390) 1,604	0			0 0		(195) 802	(195) 802	(390) 1,604	(195) 802	(195) 802	(390)	(390) 1,604	(390)	0	
205         DED         REV3         Agency indirect costs - dedicated revenue           206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206         206	002	602	1,604	002	602	1,604	- 0		0	0	°	802	802	1,604	802	802	1,604	1,604	1,604		0
	0	0		0	0	0	0	0	0	0 0	- n	0	0	0	0	0		0			
	6,692	3,192	9,884	3,192	3,192	6,384		0	v	0 0		0	0		0	0		0	V	U	U
208         TANF         15         Increase TANF transfer to MFIP child care           209         TANF         15         Reduce undesignated TANF refinancing	(6,692)						0	0	0	0 0		0				0		0	0	(9,884)	(6,384)
	(6,692)	(3,192)	(9,884)	(3,192)	(3,192)	(6,384)	0	0	0	0 0	0		0	0					0	9,884	6,384
210         GF         22         Decrease general fund for MFIP child care           211         GF         REV2         Reduce non-dedicated revenue to general fund	6,692	(3,192) 3,192	(9,884) 9,884	(3,192) 3,192	(3,192) 3,192	(6,384) 6,384	0	0		0 0		0	. 0	0	0	0		0		9,884	6,384
	6,692	3,192	9,884	3,192	3,192	6,384	0	0		0 0	0	0	. 0	<u></u>	0			0		(9,884)	(6,384)
	(6,692)						0	0		0 0		0	0		0				0		(6,384)
	(0,092)	(3,192)	(9,884)	(3,192)	(3,192)	(6,384)		0	0	0 0									0	9,884	6,384
214 -	· · · · ·				{															0	
215 SF 254 REPEAL MFIP PENALTIES	0	0	0	0	0	0	0	0	. 0	0 0	0	12,798	13,921	26,719	13,875	13,795	27,670	26,719	27,670	26,719	27,670
216 TANF 15 Undue undesignated TANF refinancing	0	0	0	0	0	0	0	0	0	0 0	0	(6,692)	(3,192)	(9,884)	(3,192)	(3,192)	(6,384)	(9,884)	(6,384)	(9,884)	(6,384)
217 GF REV2 Undue undesignated TANF refinancing	0	0	0	0	0	0	0	0	0	0 0	0	6,692	3,192	9,884	3,192	3,192	6,384	9,884	6,384	9,884	6,384
218 TANF 15 Reduce transfer to General Fund for Working Family Credit financing	0	0	0	0	0	0	0	0	0	0 0	0	(11,020)	(6,860)	(17,880)	(7,000)	(7,000)	(14,000)	(17,880)	(14,000)	(17,880)	(14,000)
219 GF REV2 Reduce transfer to General Fund for Working Family Credit financing	0	0	0	0	0	0	0	0	0	0 0	0	11,020	6,860	17,880	7,000	7,000	14,000	17,880	14,000	17,880	14,000
220 TANF 20 Subsidized housing penalty	0	0	0	0	0	0	0	0	0	0 0	0	3,085	3,356	6,441	3,345	3,326	6,671	6,441	6,671	6,441	6,671
221 TANF 20 SSI penalty	0	0	0	0	0	0	0	0	0	0 0	0	9,713	10,565	20,278	10,530	10,469	20,999	20,278	20,999	20,278	20,999
222																					
223 SF 1955 MFIP WORK PARTICIPATION RATE ENHANCEMENT INITIATIVE	0	0	0	0	0	0	0	0	0	0 0	0	63	5,578	5,641	5,578	5,578	11,156	5,641	11,156	5,641	11,156
224 TANE 20 Change sanction policy for Work Prep program	0	0	0	0	0	0	0	0	0	0 0	0	63	63	126	63	63	126	126	126	126	126
225 TANE 20 Work participation bonus	0	0	0	0	0	0	0	0	0	0 0	0	0	4,584	4,584	4,584	4,584	9,168	4,584	9,168	4,584	9,168
226 TANE 20 DWP bonus	0	0	0	0	0	0	0	0	0	0 0	0	0	931	931	931	931	1,862	931	1,862	931	1,862
227 TANE 15 TANE to Childcare Development Fund - Increased funding for Work Prep Program	0			0				0		0 0		0	3,740	3,740	4,078	0	4,078	3,740	4,078	3,740	4,078
		0	<u>`</u>  -	0		,				0											
228 TANF 20 MFIP/DWP Grants - Increased funding for Work Prep Program	0		0		0					0 0	0		(3,740)	(3,740)	(4,078)	U	(4,078)	(3,740)	(4,078)	(3,740)	(4,078)
229 GF 20 MFIP/DWP Grants - Increased funding for Work Prep Program	0		0	0	0	0	0	0	0	0 0	0	0	3,740	3,740	4,078	0	4,078	3,740	4,078	3,740	4,078
230 GF 22 MFIP Child Care Assistance - Increased funding for Work Prep Program	0	0	0	0	0	0	0	0	0	0 0	0	0	(3,740)	(3,740)	(4,078)	0	(4,078)	(3,740)	(4,078)	(3,740)	(4,078)
231	ļļ																				
232 SF 1520 MFIP DIVERSIONARY WORK PROGRAM PARTICIPATION EXPEMPTION FOR CERTAIN	0	0	0	0	0	0	0	0	0	0 0	0	163	134	297	134	134	268	297	268	297	268
233 REFUGEES AND ASYLEES																					
234 TANE 20 MFIP/DWP grants	0	0	0	0	0	0	0	0	0	0 0	0	163	134	297	134	134	268	297	268	297	268
235																					
236 SF 1817 REDUCE WEEKLY WORK HOURS REQUIRED FOR MFIP PARTICIPANTS	0	0	0	0	0	0	0	0	0	0 0		127	252	379	251	248	499	379	499	379	499
													202		201	<u> </u>		513	400		
237 FOR APPROVED POST-SECONDARY EDUCATION PROGRAM												107	250	270	054	248		379	400		
238 TANE 20 MFIP/DWP grants				U								127	252	379	251	248	499	3/9	499	379	499
239	·····								·····												
240 SF XXXX INCREASE INCOME ELIGIBILITY FOR TRANSITION YEAR CHILD CARE	. 0	0	0	0	0	0	0	0	0	0 0	0	268	424	692	448	472	920	692	920	692	920
241 TANE 15 Transitional year service costs	0	0	0	0	0	0	0	0	0	0 0	0	255	404	659	426	449	875	659	875	659	875
242 TANF 15 Administration	0	. 0	0	0	0	0	. 0	0	. 0	0 0	0	13	20	33	22	23	45	33	45	33	45
243																					
244 SF XXXX DECREASE CO-PAYS FOR MFIP/TY CHILD CARE	0	· .0	- o	0	а О	0	0	0	0	0 0	ol	488	667	1,155	657	655	1,312	1,155	1,312	1,155	1,312
245 TANF 15 MFIP/TY year service costs	. 0	0	0	0	. 0	0	0	0	0	0 0	0	465	635	1,100	626	624	1,250	1,100	1,250	1,100	1,250
246 TANF 15 County Administrative Allowance	0	0	0	0	. 0	0	. 0	0	0	0 0	0	23	. 32	55	31	31	62	55	62	55	62
247																					
248 SF 769 APPROPRIATION FOR NEW CHANCE PROGRAM	. se - O	0	0	0		n		0	0.0	0 0		140	140	280	140	140	280	. 280	280	280	280
		0		0				<u> </u>		0 0		140	140		140	140	280	280		280	
249 TANF 27 Appropriation		U							v			140	140	280	140	140		280	280	280	280
250											·····										
251 GENERAL FUND MFIP FINANCING	0	0.	0	0	0	0	- 0	0	0	0 0	0	0	0	0	0	0	0	0	0	0	0
252 GF 20 Finance MFIP 08/09	0	0	( 0		0	. 0	. 0	0	.0	0Ö	0	10 20	0	0	4,027	25,093	29,120	0	29,120	0	29,120
253 TANE 20 Finance MFIP 08/09					· · · · · · · · · · · · · · · · · · ·					··········		1 N. 21 (1			(4,027)	(25,093)	(29,120)	0	(29,120)	0	(29,120)
255 SF XXXX APPRORIATION FOR TRANSITIONAL HOUSING	0	9 0	0	0 2			· · O. )	. 0	0	0	0	360	360	720	360	360	720	720	720	720	720
256 GF 32 Appropriation - Other children and economic assistance grants	Sec. 0	0	. : 0	0	0	-10 o to	0	*et = 0-	0	o) o)	r: 0	360	360	720	360	360	720	720	720	720	720

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Trkg. Gov Re	c				GOV	ERNOR'S REC	OMMENDAT	ION			SI	ENATE POSI	TION - SF 187	9		S	ENATE POS	ITION - HHS	OMNIBUS B	UDGET BILL		SENATE TOT	AL POSITION	SENATE TO	TAL vs GOV
		BACT	DESCRIPTION	FY 2006			FY 2008		FY 08-09	FY 2006	FY 2007	FY 06-07	FY 2008	FY 2009	FY 08-09	FY 2006	FY 2007	FY 06-07	FY 2008	FY 2009	FY 08-09	FY 06-07	FY 08-09	FY 06-07	FY 08-09
											<u> </u>			· · · · · ·											
257	MEDI	CADEN	DERNIZATION ACT CHANGES	(2 274)	(10,623)	(13,997)	(10,229)	(10,229)	(20,458)	(7,225)	(14,204)	(21,429)	(13,810)	(13,810)	(27,620)		0		0	- 0	0	(21,429)	(27,620)	(7,432)	(7,162)
259 Fage 2		SE 44	Adjust PDP to forecast	(3,374) (4,720)	(9,803)	(14,523)	(9,898)	(9,554)	(19,452)	(4,720)		(14,523)		(9,554)	(19,452)	0	0	0	0	0	0	(14,523)	(19,452)	0	0
260		GF 44	Transform PDP 1/1/06	(2,253)	(4,007)	(6,260)	(3,912)	(4,256)	(8,168)	(2,253)		(6,260)	(3,912)	(4,256)	(8,168)	0	0	0	0	0	0	(6,260)	(8,168)	0	0
261		F REV2		(252)	(394)	(646)	0	0	0	(252)		(646)		0	0	0	0	0	0	0	0	(646)	0	0	0
262	G	GF 70	Aging grants (enroliment & assistance)	4,988	3,417	8,405	3,417	3,417	6,834	0		0	0	0	0	0	0		0		0	0	0	(8,405)	(6,834)
263	G	SF 70	Aging grants (redirect Rx, Connect)	(949)	(949)	(1,898)	(949)	(949)	(1,898)	0		0	0	0	0	0	0	-	0		0	0	0	1,898	1,898
264 265	G	SF 70	Aging grants (offset request with federal grants)	(372)	(372)	(744)	(372)	(372)	(744)	0		0	0	0	0	0	0		0		0	0	0	744	744
265	6	F 85	Aging grants (offset request with one-time fed supplement to SHIP) Administration (3 fites)	350	307	(259) 657	307	307	614	0		0	0	0	0	0	0		0		0	0	0	(657)	(614)
267			Administration (ftes / FY 2008-09: 1, 7, 6, 6)	76	501	577	501	501	1,002	0		0	0	0	0	0	0		0	0	. 0	0	0	(577)	(1,002)
268			MAXIS costs	12	0	12	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(12)	0
269			MMIS costs	175	0	175	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0	(175)	0
270		F 51		_0	1,000	1,000	1,000	1,000	2,000	0		0	0	. 0	0	0	0		0	0	0	0	0	(1,000)	(2,000) 646
271	G	F REV1	Administrative ffp	(170)	(323)	(493)	(323)	(323)	(646)	0	0	0	0		0	0	0	0	0	- 0	0		0	493	646
273 Page 2	COST	EFFECT	IVE PHARMACEUTICAL PURCHASING	(8,022)	(6,220)	(14,242)	(6,802)	(7,429)	(14,231)	(2,860)	(2,585)	(5,445)	(2,741)	(3,000)	(5,741)	0	0	0	0	0	0	(5,445)	(5,741)	8,797	8,490
274		<u> </u>		(-)/		(1.1/2.1-1/	1-11			(-)1					(-), -),										
275	Selectiv	e Distributi	on of Specialty Pharmaceuticals	(133)	(205)	(338)	(228)	(248)	(476)	(133)	(205)	(338)	(228)	(248)	(476)		0	0	0	0	0	(338)	(476)	0	0
276	GI	F 41	MA families and children	(17)	(39)	(56)	(43)	(45)	(88)	(17)	(39)	(56)	(43)	(45)	(88)		0	0	0	0	0	(56)	(88)	0	0
277			MA elderly and disabled	(117)	(151)	(268)	(170)	(189)	(359)	(117)	(151)	(268)	(170)	(189)	(359)		0	0	0	0	0	(268)	(359)	0	0
278		F 43 F 44	GAMC PDP	(7)	(15)	(22)	(15)	(14)	(29)	(7)	(15) (8)	(22)	(15)	(14)	(29) (15)		0	0	0	0	0	(22)	(29) (15)	0	0
279 280			MMIS costs	8	(8)	8	0	(8)	0	(6) 8	0	8	0	(8)	(15)	0	0	0	0	0	0	8	0	0	0
281	GI	F 44	Interaction with Medicare Modernization Act Changes - Page 22	6	8	14	7	8	15	6	8	14	7	8	15	0	0	0	0	0	0	14	15	Ő	0
282																									
283			Factor Products	(343)	(517)	(860)	(582)	(643)	(1,225)	(343)	(517)	(860)	(582)	(643)	(1,225)	0	0	0	0	0	0	(860)	(1,225)	0	0
284			MA families and children	(47)	(105)	(152)	(117)	(125)	(242)	(47)		(152)	(117)	(125)	(242)		0	0	0	0	0	(152)	(242)	0	0
285 - 286 287			MA elderly and disabled MMIS costs	(321)	(412)	(733)	(465)	(518)	(963)	(321)	(412)	(733)	(465) 0	(518)	(983)	0	0	0	0		0	(733)	(983)	- 0	0
286			HealthMatch small effect	18	0	18	0	0	- 0	18	0	18	0	0	0	0	0	0	0	0		18	0	0	0
288				10	¥										· · · · · ·										
289	Align Pa	yment for A	Administered Drugs With Modicare Rates	(451)	(502)	(953)	(552)	(607)	(1,159)	(451)	(502)	(953)	(552)	(607)	(1,159)	0	0	0	0	0	0	(953)	(1,159)	0	0
289 290 291	GF	F 41	MA families and children	(83)	(91)	(174)	(101)	(111)	(212)	(83)	(91)	(174)	(101)	(111)	(212)	0	0	0	0	0	0	(174)	(212)	0	0
291			MA elderly and disabled	(339)	(373)	(712)	(410)	(451)	(861)	(339)	(373)	(712)	(410)	(451)	(861)	0	0	0	0	0	0	(712)	(861)	0	0
292		F 43		(34)	(38)	(72)	(41)	(45)	(86)	(34)	(38)	(72)	(41)	(45)	(86)	0	0	0	0	0	0	(72)	(86)	0	0
293 294	GF	51	MMIS costs	•					0	5					0		0	0							0
294	Reduce	Pharmacy I	Payments to AWP Minus 14%	(5,162)	(3,635)	(8,797)	(4,061)	(4,429)	(8,490)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8,797	8,490
296	GF	F 41	MA families and children	(616)	(687)	(1,303)	(764)	(805)	(1,569)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,303	1,569
297	GF	F 42	MA elderly and disabled	(4,180)	(2,681)	(6,861)	(3,026)	(3,371)	(6,397)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6,861	6,397 524
298		F 43		(254)	(267)	(521)	(271)	(253)	(524)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	521	524
299		F 44		(224)	(140)	(364)	(131)	(140)	(271)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	364 (252)	271 (271)
300 301	GF GF	44	Interaction with Medicare Modernization Act Changes - Page 22	112	140	252	131	140	271						U			•						(202)	(271)
302	Prior Aut	thorization	of New Drugs	(1,933)	(1,361)	(3,294)	(1,379)	(1,502)	(2,881)	(1,933)	(1,361)	(3,294)	(1,379)	(1,502)	(2,881)	0	0	0	0	0	0	(3,294)	(2,881)	0	0
303			MA families and children	(231)	(257)	(488)	(258)	(271)	(529)	(231)	(257)	(488)	(258)	(271)	(529)	0	0	0	0	0	0	(488)	(529)	0	0
304	GF	- 42	MA elderly and disabled	(1,565)	(1,004)	(2,569)	(1,020)	(1,136)	(2,156)	(1,565)	(1,004)	(2,569)	(1,020)	(1,136)	(2,156)	0	0	0	0	0	0	(2,569)	(2,156)	0	0
305		- 43		(95)	(100)	(195)	(101)	(95)	(196)	(95)	(100)	(195)	(101)	(95)	(196)	0	0	0	0	0	0	(195)	(196)	0	0
306		44		(84)	(53)	(137)	(44)	(47)	(91)	(84)	(53)	(137)	(44)	(47)	(91)	0	0		. 0	0	0	(137) 95	(91) 91	0	0
307 308	GF GF	44	Interaction with "Medicare Modernization Act Changes" proposal - Page 22	42	53		49		91	42		30		4/	91	U							91	······	
309 SF 65	PRESC	RIPTION	DRUG DISCOUNT ASSISTANCE PROGRAM	0	0	0	0	0	0	0	0	. 0	0	0	0	0	1,022	1,022	(596)	(74)	(670)	1,022	(670)	1,022	(670)
310			General Fund transfer out - float	0	0	0	0	. 0	0	- 0	0	0	0	0	0	0	1,022	1,022	0	0	· 0	1,022	0	1,022	0
311	GF	REV2	General Fund transfer in - from special revenue account	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(909)	- (113)	(1,022)	0	(1,022)	0	(1,022)
312			Special revenue fund transfer in	0	0	0	0	0	0	0	0	0	0	0	0	0	(1,022)	(1,022)	0	0	0	(1,022)	0	(1,022)	0
313 314			Special revenue fund rebate revenue	0	0		0	0		0	0	0	0	0	0	0	(320)	(320)	(2,870) 909	(4,725)	(7,595) 1,022	(320)	(7,595) 1,022	(320)	(7,595) 1,022
314		0 45 0 45	Special revenue fund transfer out Special revenue fund other expenses	0			0	0		0		- 0	·	. 0	0	0	1,342	1,342	2,274	4,651	6,925	1,342	6,925	1,342	6,925
316		1	About tetette tella ontal adballaca				<b>`</b>														2,02.0				
317 Pege 24A	DEDIC	ATE GAN	AC PHARMACY REBATES TO PHARMACY ASSISTANCE PROGRAM	0	0	0	0	0	0	. 0	0	- 0	0	0	0	(370)	(2,250)	(2,620)	(2,250)	(2,250)	(4,500)	(2,620)	(4,500)	(2,620)	(4,500)
318	DED	45	Prescription drug assistance program	370	2,250	2,620	2,250	2,250	4,500	0	0	0	0	0	0	. 0	0	0	0	. 0	0	0	. 0	(2,620)	(4,500)
319			GAMC rebates	(370)	(2,250)	(2,620)	(2,250)	(2,250)	(4,500)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2,620	4,500
320	GF	REV2	GAMC rebates	0	0	0	0	0		0	.0	0	.0	0	. 0	(370)	(2,250)	(2,620)	(2,250)	(2,250)	(4,500)	(2,620)	(4,500)	(2,620)	(4,500)
321 322 Rider	PDP G	RANTAC	COUNT REDUCTION	0	0	0	0	as 0	0	·· · 0	0	1	0		· 0	(2,500)	(3,000)	(5,500)	(3,000)	(3,000)	(6,000)	(5,500)	(6;000)	(5,500)	(6,000)
322 Kider 323			Prescription Drug Program	0	0	0		0		0	0	0			0	(2,500)	(3,000)	(5,500)	(3,000)	(3,000)	(6,000)	(5,500)	(6,000)	(5,500)	(6,000)
324	<u> </u>															•						-			
325 SF 973			FOR MEDICATION THERAPY MANAGEMENT SERVICES	0	0	.s~ 0		on . 0	0	··i 0	. 0	0	: 0	0	÷ 0	40	(124)	(84)	(250)	(321)	(571)	(84)	(571)	(84)	(571)
326			Rx Service costs - admin.	0	0	0		.e. 0.		0	. 0	0	0	۰,	. 0	.59	272	331	- 389	389	777	331	-777	331	777
327	GF		MA elderly and disabled - effect on other services	0	.0	0	0	0	0	0	0		0	0	0	(36)	(426)	(461)	(639)	(710)	(1,348)	(461)	(1,348)	(461)	(1,348)
328			Administrative costs Contract for evaluation	0	0		ő						0	0		29	50	50 29	0	0		50 29	0	29	
329 330			Contract for evaluation Administrative fip	0	0	0	u U	0	0			0				(12)	(20)	(32)	0	0		(32)	0	(32)	0
0001	U GP	LUCA I	International date the		<u> </u>	<u> </u>	<u> </u>		<u> </u>		·····						1-3/	102/1		<u> </u>	~ ~ 1	(**/I		10-11	

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Trkg. Gov Rec		1	60	VERNOR'S RE	COMMENDAT	10N			9	ENATE POS	ITION - SF 1879			1 5			OMNIBUS	BUDGET BIL	1	SENATE TOT		SENATE TO	
Line / Bill Ref Fund BAC	ACT DESCRIPTION	FY 2006	FY 2007	FY 06-07	FY 2008	FY 2009	FY 08-09	FY 2006	FY 2007			FY 2009	FY 08-09	FY 2006	FY 200	7 FY 06-0	7 FY 200	8 FY 200	9 FY 08-0	FY 06-07	FY 08-09	FY 06-07	FY 08-0
Carlo / Diarton / Carlo																							
331																							
	CTION TO HOSPITAL RATES	(17,323)	(38,178)		(43,157)	(47,282)		0	0	0	0	0	0	0	0	0	· · · ·		0	0	0	55,501	90,439
	11 MA families and children	(7,117)	(18,528)		(21,623)	(23,887)		0		0	0	0		0	0					0	0	25,645	45,510
	12 MA elderly and disabled	(4,997)	(8,278)			(10,121)		0	0	0	0	0	0	0	0	0				0	0	13,275	19,404
	I3 GAMC	(3,290)	(7,635)			(9,684)	(18,560)	0	0		0	0	- 0	0	0					0	0	10,925 6,343	18,560
	MinnesolaCare     Interaction with "Restructure HC Prog. Eligibility" proposal - Page 29 / MNCare reduction	(2,106) 812	(4,237) 1,551		(3,773) 1,564	(3,968) 1,651	(7,741) 3,215			0	0	0		0	0					0	0	(2,363)	(3,215
	Interaction with "Restructure HC Prog. Eligibility" proposal - Page 29 / MNCare shift to MA	53	349		150	23	173	0	0	0	0	0	0	0	.0	0				0	- 0	(402)	(17:
	2 Interaction with "Restructure HC Prog. Eligibility" proposal - Page 29 / MNCare shift to MA	(20)	(71)		(94)	(114)		0	0	0	0	0	0	0	0	0		0 0	0 0	0	0	91	(173 208
	Interaction with "Restructure HC Prog. Eligibility" proposal - Page 29 / MNCare shift to GAMC	(658)	(1,329)		(1,222)	(1,182)		0	0	0	0	0	0	0	0	0		0 0	0 0	0	0	1,987	2,404
341																		_					
	IC INPATIENT HOSPITAL RATE INCREASE FOR 16 DRGS FOR	0	0	0	0	0	0	0	0		0	0	0	400	400	800	400	400	800	800	800	800	800
	S IN NON-METRO COUNTIES												-			+							
	1 MA families and children	0	0	0	0	0	0	0	0	0	0	0	0	181 146	181	362			362	362 292	362 292	362	362
	2 MA elderly and disabled	0	0	0	0	0	0	0		0	0	0	0	73	73					146	146	292 146	292
347 347	3 GAMC				· · · · ·					ŭ				10							110	140	
	TURE HEALTH CARE PROGRAM ELIGIBILITY	(35,363)	(40,766)	(76,129)	(32,402)	· (33,581)	(65,983)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	76,129	65,983
	1 Legal & regulatory operations	436	0	436	0	0	0	o	0	0	0	0	0	0	0	0	(	0	0	0	0	(436)	0
- 350 HCAF REV	V1 Administrative ffp	(174)	0	(174)	0	0	0	0	0	0	0	0	0	0	0	0	(		0	0	0	174	0
351 HCAF 40	0 Eliminate MNCare	(86,258)	(89,445)		(84,431)	(90,972)	(175,403)	0	0	0	0	0	0	0	0	0			0	0	0	175,703	175,403
	1 Shift to MA F&C	(3,575)	(18,568)		(4,796)	(368)	(5,164)	0	0	0	0	0	0	0	0	0			0	<u> </u>	0	22,143	5,164
	2 Shift to MA E&D	2,158	4,422	6,580	5,373	6,464	11,837	0	0	0	0	0	0	0	0				0	0	0	(6,580)	(11,837
	3 Shift to GAMC	30,754 19,996	27,193 35,632	57,947 55,628	12,693 38,759	11,201	23,894 78,853		0	0	0	0	0	0	0	- 0	0	0	0	0	0	(57,947) (55,628)	(23,894) (78,853)
355 GF 43 356 GF 36	3 GAMC spenddown / eliminate GHO	19,996	30,032	12	30,/39	40,094	10,003	0	0	0	0		U	0	U	1 0			0		n .	(12)	
357 HCAF 51		26	0	28	0	0		0	0	0	0	0	0	0	0	0		0	0	0	0	(12)	0
358 HCAF 51	1 HealthMatch - 4 month delay	1,262	0	1,262	0	0	0	0	0	0	0	0	0	0	0	0	C	0	0	0	0	(1,262)	0
359																							
360 SF 255 REPEAL MIN	INNESOTACARE LIMITED BENEFIT SET/\$5000 CAP	0	0	0	0	0	0	0	0	0	0	0	0	30,077	36,150					66,227	129,480	66,227	129,480
361 HCAF 40	0 MinnesotaCare Grants	0	0	0	0	0	0	0	0	0	0	0	0	30,077	36,150	66,227	58,172	71,308	129,480	66,227	129,480	66,227	129,480
362						-								400	0.000	0.400		10.100	00.400	0.400	00.400		
	MINNESOTACARE ELIGIBLITY FOR ADULTS WOUT CHILDREN TO 190% FPG	0	0	0	0	U 0	0	0	0	0	0	0	0	469	9,030					9,499	23,182	9,499	23,182
364 HCAF 40 365	0 MinnesolaCare Grants	- · · ·				0				U	0	0	0	469	9,030	9,499	11,019	12,163	23,182	9,499	23,182	9,499	23,182
	ADD-BACK OF DEPRECIATION FOR FARM SELF EMPLOYED INCOME	0	0	0	. 0	0	0	0	0	0	0	0	0	0	742	742	578	597	1,175	742	1,175	742	1,175
	MinnesotaCare Grants - administration	0	0	0	0	0	0	0	0	0	0	0	0	0	45				33	45	33	45	33
	MinnesotaCare Grants - families and children	0	0	0	0	0	0	0	0	0	0	0	0	0	271	271	258	284	542	271	542	271	542
369 HCAF 40	MinnesotaCare Grants - families and children           MinnesotaCare Grants - adults without children	0	0	0	0	0	0	0	0	0	0	0	0	0	426	. 426	304	296	600	426	600	426	600
370 HCAF 51	1 Healthmatch effect	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
371			0											925	4 420	0.074	4 502	4 700	2 202	2 974	2 202	2 074	
	500 DENTAL CAP FROM MA, GAMC, & MINNESOTACARE	0	0	U	0	0	0	0	0	0	0	0	0	835 458	1,439 831	2,274			3,292	2,274	3,292	2,274	3,292
	1 MA families and children 2 MA elderly and disabled	0	0			0			0		0		0	335	535	870				870	1,914	870	1,914
	3 GAMC	0	0	0	0	0	0	0	0	0	0	0	0	26	52	78				78	122	78	122
	MinnesotaCare Grants - families and children	0	0	0	0	0	0	0	0	0	0	0	0	12	17	29				29	38	29	38
	MinnesotaCare Grants - adults without children	0	0	0	0	0	0	0	0	0	0	0	0	4	4	8		2	4	8	4	8	4
378								-															
	CO-PAYS FOR MA AND GAMC FOR PHARMACY AND DENTAL	0	0	0	0	. 0	0	0	0	0	0	0	0	5,965	15,418	21,383		18,969		21,383	36,500	21,383	36,500
380 GF 41	MA families and children	0	0	0	0	0	0	0	0	0	0	0	0	1,931	5,347	7,278			12,393 3,740	7,278	12,393	7,278	12,393
	2 MA elderly and disabled	0	0	0	0	0	0	0	0		0	0	0	1,324 2,710	1,619 8,452	2,943 11,162	1,790 9,789			2,943	20,367	2,943	3,740 20,367
382 GP 43 383		*+					° -								0,702								20,001
	ACARE OPTION FOR SMALL EMPLOYERS	0	0	0	0	0	0	0	0	0	0	0	0	2,950	7,015	9,965	10,128	11,199	21,327	9,965	21,327	9,965	21,327
	MinnesotaCare Grants	0	0	0	0	0	0	0	0	0	0	0	0	589	6,552	7,141	9,824		20,755	7,141	20,755	7,141	20,755
386 HCAF 50	Admin- policy and program costs	0	0	0	0	0	0	0	0	0	0	0	0	133	78	211			0	211	0	211	0
387 HCAF 51	Admin - operations	0	0	0	0	0	0	0	0	0	0	0	0	297	693	990	506	447	953	990	953	990	953
388 HCAF 51	HealthMatch Delay - systems costs	0	0	0	0	0	0	0	0	0	0	0	0	2,103	. 0	2,103		0	0	2,103	0	2,103	0
	V1 Administrative ffp													(53)	(31)	(84)			(381)	(84) (396)	(394)	(84)	(204)
390 . HCAF REV1 391	V1 Administrative ffp													(119)	(277)	(396)	(202	) (179)	(381)	(0.0)	(381)	(396)	(381)
392 SF 65 APPROPRIAT	ATION FOR ONE MONTH DELAY HEALTHMATCH IMPLEMENTATION IN FY06	0	0	0	0	0	·	0	0.	0.	0	. 0	0	(175)	(328)	(503)	(58)	(5)	(63)	(503)	(63)	(503)	(63)
	MA families and children	0	0	0	0	ò	0	0	0	. 0	0	0	0	(1,729)	(4,083)	(5,812)	(1,048			(5,812)	(1,124)	(5,812)	(1,124)
	GAMC	0	0	0	0	0	0	÷ о	0	0	0	. 0	0	(1,558)	(3,786)	(5,344)	(985	) (72)	(1,057)	(5,344)	(1,057)	(5,344)	(1,057
	HealthMatch Delay - forecast delay program costs	a 1 0	0	0	0	0	. 0	0.	0	. 0	0	0	0	3,112	7,541	10,653	1,975			10,653	2,118	10,653	2,118
396		1. C												· · · ·									
397 SF 828 REPORT ON	N EMPLOYERS AND MINNESOTA HEALTH CARE PROGRAMS	2 0	a 0	0	· 0	0	. 0.	* <b>0</b> /4	0	0	0	0	0	216	<u>,</u> 0	216	0	0	0	216	0	216	0
398 GF 50	Administrative cost for study - 4 fles	0	· 0	·. 0	0	0.	0	0	0	0	0	0	0	302	0	302	0		0	302	0	302	0
399 . GF 51	Systems/operations							· 0	0		0	0		35	0	35	0	0	0	35	0	35	0
400 GF REV1	V1 Administrative ffp	0	<u>ē.</u> -0	. 0	. 0	0	. 0	0	. 0	0	· 0	0	0	(121)	0	(121)	0	0	0	(121)	0	(121)	0
401		2,558	1.15.1 (099)	1 705	14 5471	12 070	14 5071	(604)	(2,075)	(2,766)	(3,106)	(4,152)	(7,258)	3,431	(1,334)	2,097	(5,687)	(13,303)	(18,990)	(669)	(26,248)	(2,394)	104 664
402 Page 30 BETTER MAN	ANAGE HEALTH CARE COSTS # 01 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2,338	*@** <b>(833)</b> *	<b>1,725</b>	(1,517)	(3,070)	(4,587)	(691)	(2,0/3)	(2,700)	(3,100)	(4,102)	( <u>),20</u> 6)	3,431	(1,334)	2,09/	(0,007)	(10,003)	(10,000)	(009)	(20,240)	(4,394)	(21,661
	s Froud and Abuse Statt And Abuse Statt	131	(425)	(294)	(932)	(1,400)	(2:332)					. 1.0	· · · · · ·	131	(425)	(294)	(932)	(1.400)	(2.332)	(294)	(2,332)		n
Better Address F	a neuro orona de la casa de la cas	101	174.0/	1204)	(#31)	1,400/	(KIOSKI)	4	· •		Y	1.155.5		1916 [7	(440)		1002	10,400	14/00/2		1=/001/	×	

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#### SENATE TOTAL POSITION SENATE TOTAL VS GOV GOVERNOR'S RECOMMENDATION **SENATE POSITION - SF 1879** SENATE POSITION - HHS OMNIBUS BUDGET BILL Trkg. Gov Rec Line / Bill Ref Fund BACT DESCRIPTION FY 2006 FY 08-09 FY 2006 FY 2008 FY 2009 FY 08-09 FY 2007 FY 06-07 FY 2008 FY 2009 FY 2007 FY 06-07 FY 2006 FY 2007 FY 06-07 FY 2008 FY 2009 FY 08-09 FY 06-07 FY 08-09 FY 06-07 FY 08-09 11 405 GF 42 MA FFS (SIRS activity) (117) (468 (585 (93 (1,404) (2,34 (117 (468) (585 (936 (1,404) (2,340) (585 (2.340 ۵ 406 GF 51 Administration (SIRS - 3 FTEs) 279 234 234 468 279 234 468 513 468 0 513 234 0 234 513 234 0 407 GF REV1 Administrative ffp (112) (94) (206) (9 (94) (188) (112) (94) (206) (94 (94) (188 (206) (188 0 0 408 GF 51 MMIS - SIRS analytical tools 120 20 140 20 40 0 120 20 140 20 20 40 140 40 0 0 20 GF REV2 MA recoveries 409 (39) (117) (156) (156) (156) (312) (39) (117) (156) (156) (156) (312) (156) (312) 0 0 410 411 Comply With Federal Program Integrity Requirements GF 50 Administration (PERM 7 FTEs, MEQC - 7 FTEs) 1,244 1.016 2,260 1,012 1,006 2,018 1,468 1,151 2,619 1,152 1,145 2,297 2,619 2,297 359 279 1,351 1,351 2,702 412 1,606 1,351 2,957 1,351 2,702 1,606 1,351 2,957 1,351 2,702 2,957 0 0 (1,080) 0 413 GF REV1 Administrative ffp (642) (540) (1, 182)(540) (540) (1,080) 0 0 (642) (540 (1,182) (540) (540) (1,080) (1,182) 414 HCAF 11 Appeals for fraud prevention activity (1 fte) 75 75 150 75 75 150 0 0 75 75 150 75 75 150 150 150 0 (30) (60) (60 0 415 HCAF REV1 Administrative ffp (30) (60) (30) (30) 0 0 (30) (30) (60) (30) (30) (60) (60) (197) 416 HCAF 40 MnCare - Fraud Prevention (43) (96 (139) (95) (102) (197) (43) (96 (139) (95 (102) (197) (139) 0 417 HCAF 50 Administration (FPI - 5 FTEs) 505 380 885 380 380 760 505 380 885 380 380 760 885 760 0 | 0 418 HCAF REV1 Administrative ffp (202) (152) (354) (152) (152) (304) (202) (152) (354) (152) (152) (304 (354) (304 0 HCAF 50 Administration (quality control - 4 FTEs) 419 332 272 604 272 272 544 332 272 604 272 272 544 604 544 0 Λ HCAF REV1 Administrative f/p HCAF 40 Interaction with "Restructure HC Prog. Eligibility" proposal - Page 29 / MnCare - Fraud Prev 420 (133 (109) (242) (109) (109) (218) (133) (109) (242) (109) (109 (218) (242) (218) 421 18 40 58 35 36 71 n 0 ٥ ٥ 0 n 0 (58) 171 422 HCAF 50 Interaction with "Restructure HC Prog. Eligibility" proposal - Page 29 / Admin ( FPI - (3) FTEs) (319) (224) (543) (224) (224) (448) ٥ ۵ 0 543 448 423 HCAF REV1 Interaction with "Restructure HC Prog. Eligibility" proposal - Page 29 / Administrative ffp 127 90 217 90 90 180 0 0 0 0 0 0 0 0 (217 (180) HCAF 50 Interaction with "Restructure HC Prog. Eligibility" proposal - Page 29 / Admin (QC - (1) FTEs) (83) (68) 151 136 424 (151) (68) (68) (136) 0 0 (54) 425 HCAF REV1 Interaction with "Restructure HC Prog. Eligibility" proposal - Page 29 / Administrative ffp 33 27 60 27 54 (60 27 426 | || Recover Uncompensated Transfers of Income and Assets - In SF 1879 (96) (144) (192) (240) (384 427 (240) (192) (384) (96) (144) (192) (192) (384) (240) GF 42 MA elderly and disabled (192) (384 (144) (384 (144) (384) (240) 428 (96) (240) (192) (96) (240) (192) (192) 429 863 36 (124) 430 Recover From Estates Assets Held in Irrevocable Trusts or Annulties (88) (404) (459) (863 GF 51 Administration (1 fte) 60 60 60 (120) (120)431 120 60 120 0 0 0 0 0 432 GF REV2 AC recoveries (10) (10 (40 (45) (85 0 0 0 10 85 850 150 433 GF REV2 MA recoveries (150)(150) (400) (450) (850) 0 0 0 48 434 GF REV1 Administrative ffp (24) (24) (48) (24) (24) (48 0 48 435 (23.264) (4.047)(23.264) (4.047 436 Make Trust Available (676) (3,371, (4,047 (8,487) (14,777) (23,264) GF 72 MA Long Term Care Facilities Grants GF 73 MA recoveries 437 0 (439) (2,192) (2,631 (5,300) (8.815) (14,115 (2,631 (14,115 (2,631 (14,115 0 438 0 0 0 0 0 0 0 (87) (505) (592 (1,390) (2,637) (4,027) (592) (4,027) (592) (4,027 439 GF 42 Administrative ffp (150) (674) (824 (1,797) (3,325) (5,122) (824) (5,122) (824) (5,122) 440 441 337 (225) 337 (225) 11: (225) (225) (450) 112 (450) plement Intensive Medical Care Management (225) 112 (225) (450 0 0 442 GF 42 MA FFS (563) (1,125) (1,688) (1,125) (1,125) (2,250 0 (563) (1,125) (1,688 (1,125) (1,125) (2,250 (1,688) (2,250) 0 443 GF 50 Administrative contract 1,500 1,500 3,000 1,500 1,500 3,000 0 1,500 1,500 3,000 1,500 1,500 3,000 3,000 3,000 (1,200 (600) (1,200) (1,200) 444 GF REV1 Administrative ffp (600 (600 (1,200) (600) (600) (1,200) (600) (600) (600) (1,200 445 (595) (1,931) (595) (1,931) (2,914) (3,960) (2,526) (6,874) 0 446 Improve Cost Effectiveness of Coverage - In SF 1879 (2,526) (2,914) (3,960) (6,874) (2,526) (6,874) 188 GF 50 Medical director's salary and benefits (1 fte) 200 388 188 188 376 200 188 18 388 376 447 188 388 376 87 75 150 162 150 87 75 162 75 150 75 162 448 GF 50 Staff costs to support medical policy function (1 ftes) 75 75 GF 50 Evidence based practice center subscription fee 50 42 84 92 84 449 50 42 92 42 42 42 92 42 (249) (249) (969 (1,291) (904) (2,260) 450 GF 41 MA families and children ffs (655) (904) (969) (1.291)(2.260 (655 (904) (2,260)(1,788 (2,411) (1,687) (4,199) (465) (1,222)(1,687) (1,788) (2,411) (4,199 (1,222) (1,687) (4,199) 451 GF 42 MA elderly and disabled ffs (465) 0 (441) (330) (781) 452 GF 43 GAMC ffs (93) (237) (330) (340) (441) (781 (93 (237) (330) (340 (781) 0 453 GF 51 MMIS costs 10 0 10 0 0 10 10 0 0 0 10 0 454 GF REV1 Administrative ffp (135) (122) (257) (122) (122) (244) (135) (122) (257) (122) (122) (244) (257) (244) 455 3.506 4,469 394 456 Improve Health Care Enrollment Process 1.431 915 2,346 2.036 2,039 4,075 0 2.080 1.426 3.506 2.673 1,796 4.469 1,160 (5,958) 457 HCAF 50 Administration costs 3,383 2,377 5,760 4.454 2,994 7,448 3,383 2,377 5,760 891 599 1,490 5,760 1,490 458 HCAF 51 MMIS costs 50 50 50 50 0 50 0 459 HCAF REV1 Administrative ffp (1,353) (951) (2,304) (1,782) (1,198) (2,980 (1,353) (951) (2,304) (356) (240) (596 (2,304) (596) 2,384 0 0 3,563 2,395 5,958 5,958 5,958 460 GF 50 Administration costs 0 461 GF REV1 Administrative ffp • • 0 (1,425) (958) (2,383) 0 (2,383) (2,383) HCAF 50 Interaction with "Restructure HC Prog. Eligibility" proposal - Page 29 / Admin costs HCAF 51 Interaction with "Restructure HC Prog. Eligibility" proposal - Page 29 / MMIS costs HCAF 61 Interaction with "Restructure HC Prog. Eligibility" proposal - Page 29 / Administrative fip HCAF REV1 Interaction with "Restructure HC Prog. Eligibility" proposal - Page 29 / Administrative fip 462 (1,081) (852) (1,933) (1,061) 405 (656 0 0 ٥ 1,933 656 463 0 0 0 0 0 • 0 464 432 341 773 425 (162) 263 (773) (263) 465 466 201 67 70 85 155 102 121 223 91 110 201 132 158 290 290 46 467 ncrease Use of Web Payment Method HCAF 10 Financial management - admin fee 152 152 183 335 220 263 483 335 483 183 0 468 33 220 263 483 (73) (134) (88) (105) (193) (134) (193) (61) 469 HCAF REV1 Administrative ffp (61) (73) (134 (88) (105) (193) 0 77 112 470 HCAF 10 Interaction with "Restructure HC Prog. Eligibility" proposal - Page 29 / Admin costs (35) (42) (77 (51) (61) (112) 0 (45 (31) 471 HCAF REV1 Interaction with "Restructure HC Prog. Eligibility" proposal - Page 29 / Administrative ffp 14 17 31 21 24 45 0 472 (1;369) (3,163) (4,532)(3, 253)(6,496) (4, 532)(6,496 , 473 SF 65 PRIOR AUTHORIZATION OF CERTAIN HEALTH CARE SERVICES 0 36444 (3, 243)(6,496) (4,532)(2,320) 474 GF 41 MA families and children - managed care 0 0 (410) (1.112)(1.522) (1,157) (1,163) (2,320 (1,522 (2,320) (1,522) 0 0 1.1.1 ۰**n** 0 · 0 . . 0 . 0 475 GF 42 MA elderly and disabled -managed care 0 (301) (723) (1.024) (729) (734) (1.463 (1.024) (1,463) (1.024)(1.463) 0 0 0 0 . 0 476 GF 43 GAMC -managed care 2.43 -0 · 0 | 0 01 0 0 .0 (85) (269) (354) (292) (294) (586 (354) (586) (354) (586) (388) 477 GF 41 MA familles and children - ffs 0 1250 0 1.10 20 (126) (183) (309) (197) (191) (388 (309 (388) (309) (1.163)

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Bit         Bit <td></td> <td></td> <td></td> <td></td> <td>(53,204)</td> <td>(99,523)</td> <td>(40,586)</td> <td></td> <td>(80,167)</td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td></td> <td></td>					(53,204)	(99,523)	(40,586)		(80,167)	0	0		0	0	0	0	0	0	0	0	0	0	0			
Image         Image <th< td=""><td>HCAF 43</td><td>43</td><td>GAMC - other proposals</td><td></td><td>53,204</td><td>99,523</td><td></td><td>39,581</td><td>80,167</td><td>0</td><td>1 1</td><td>0</td><td></td><td>0</td><td>0</td><td></td><td>0</td><td>0</td><td>0</td><td></td><td>0</td><td></td><td>0</td><td>(99,523)</td><td></td></th<>	HCAF 43	43	GAMC - other proposals		53,204	99,523		39,581	80,167	0	1 1	0		0	0		0	0	0		0		0	(99,523)		
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Image: marrier bial and marrier bi	SF 984 ALLOW PRI	RIVAT	E VENDORS TO PROVIDE RELOCATION SERVICE COORDINATION	0	0	0	0	0		0	0	0	0	0	0	21	(175)	(154)	(586)	(980)	(1.566)	(154)	(1,566)	(154)		
Image: married biase with a second biase w				0	0	0	0	0	0	0	0	0	0	0	0							45				
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Image: Marrier Manage: Constraint data on the segment of the seg	. GF 73	73	MA Walvers and Home Care	0	0	0	0	0	0	0	0	0	0	0	0	0	549	549	1,487	2,381	3,868	549	3,868			
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Part         MARKE         CARE         CARE        CARE        CARE		EV1	Administrative ffp	0	0	0	0	0	0	0	0	0	0	0	0	(14)	(14)	(28)	(14)	(14)	(28)	(28)	(28)	(28)		
BASE VALUE         Image and the second of the second	The MANAGE C	CARE	OAD CROMEN IN HOME AND COMMUNITY	142 7641	(20.045)	(52 705)	(21 440)	(44 204)	(40.040)	(4.405)	(7 402)	(9 507)	(44.204)	(44 204)	(22 700)					·		(0.507)	(44 20 4)	- 44 400		
Image: Propring in the second operation second operatioperation second operation second operation second operation seco				(13,701)	[38,945]	(52,706)	(31,449)	(11,394)	(42,843)	(1,405)	(7,102)	(8,507)	(11,394)	(11,394)	(22,788)	U			U			(8,507)	(11,394)	44,199		
of         73         We work in 50 proget         General Control         General Contro         General Control <th< td=""><td></td><td></td><td></td><td>(10.346)</td><td>(26.229)</td><td>(36.575)</td><td>(16.209)</td><td>0</td><td>(16.209)</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>- 0</td><td>0</td><td>0</td><td>0</td><td></td><td>0</td><td>36 575</td><td></td></th<>				(10.346)	(26.229)	(36.575)	(16.209)	0	(16.209)	0	0	0	0	0	0	0	0	- 0	0	0	0		0	36 575		
No.P         7.0         MMCAUE         CMAUE         CMAUE        CMAUE        CMAUE      <	GF 73	73	TBI waiver limits: 150 per year					0		0	0	0	0	0	0	0	0	0	0	0	0	0	0			
n P 7         M met         Op         Op<         Op<        Op       <	GF 73	73	MR/RC walver - reduced diversions: 50 div's per year for emergencies			(10,633)	(14,242)	(14,242)		(1,756)	(8,877)	(10,633)	(14,242)	(14,242)	(28,484)	0	0	0	0	0	0	(10,633)	(28,484)			
B BCD MULTER LYS INCREASE ORE CURRENT GAPS         Image         Image <td>GF 73</td> <td>73</td> <td>MA offset</td> <td>3,440</td> <td>9,736</td> <td>13,176</td> <td>7,862</td> <td>2,848</td> <td>10,710</td> <td>351</td> <td>1,775</td> <td>2,126</td> <td>2,848</td> <td>2,848</td> <td>5,696</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>2,126</td> <td>5,696</td> <td>(11,050)</td> <td></td>	GF 73	73	MA offset	3,440	9,736	13,176	7,862	2,848	10,710	351	1,775	2,126	2,848	2,848	5,696	0	0	0	0	0	0	2,126	5,696	(11,050)		
B BCD MULTER LYS INCREASE ORE CURRENT GAPS         Image         Image <td></td> <td>0.00</td> <td></td> <td>(44.040)</td> <td>(00 540)</td> <td>(44 000)</td> <td>(47.944)</td> <td>4 004</td> <td></td> <td>(44.055)</td> <td>(40.000)</td> <td>(() 0 0 0 0</td> <td></td>		0.00														(44.040)	(00 540)	(44 000)	(47.944)	4 004		(44.055)	(40.000)	(() 0 0 0 0		
Image: Note:					U			U				v				(11,842)	(29,513)	(41,355)	(17,341)	1,321	(16,020)	(41,355)	(16,020)	(41,355)	(	
of 7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7         7					0	0	0			0	0		0	0		(10.021)	(24 797)	(34 818)	(14.965)		(14 965)	(34.818)	(14.965)	(34,818)		
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or   73         Martinet         · · · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·         · · ·        · · ·				0	0	0	0	0	0	0	0	0	0	0	0					1,606						
Image: Problem interval         Problem interval         Problem interval				0	0	0	0	0	0	0	0	0	0	0	0	2,996	7,556	10,552	4,665	0	4,665	10,552	4,665	10,552		
Image: Final Part of P	GF 73	73 /	Add back MA Offset for 10% for 75 divs funded in Omnibus bill	0	0	0	0	0	0	0	0	0	0	0	0	(35)	(178)	(213)	(285)	· (285)	(570)	(213)	(570)	(213)		
Image: Final Part of P																14	14 500	10 000	14 0571	(5 202)	(40.000)			10.000		
GF       72       MALTO Facilities Granta       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0<				U U		0			v	0		<u> </u>	U	U N												
GF       42       Maderly and diababid       Moderly and diababid <th< td=""><td></td><td></td><td></td><td></td><td>0</td><td></td><td></td><td></td><td></td><td>0</td><td>0</td><td></td><td>n</td><td>0</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></th<>					0					0	0		n	0												
of 85         Continuing care Management         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0        0        0         0					0					0	0	0	0	0	0											
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off       72       MALTO Facilities Grants       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0																	- AAE	AAE	405	405				445		
GF 101       MODIFY SWING BED SERVICES REQUIREMENTS       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0				U .		·			U		-														-	
fg 72         M AITC Facilities Grants               0               0               0               0               0               0               MA ITC Facilities Grants               0               0               0               0               0               0               0               0               0               0               0               0               0               0               ft               ft             ft	GF 72	<u>"</u>    '	In Li o Facilitara Ciditita						, v	J	<u> </u>		· · · ·				110	110	120	120				110		
fg 72         M AITC Facilities Grants               0               0               0               0               0               0               MA ITC Facilities Grants               0               0               0               0               0               0               0               0               0               0               0               0               0               0               ft               ft             ft	SF 1101 MODIFY SW	WING	BED SERVICES REQUIREMENTS	0	9 <b>O</b>		. 0	- 0	0	0	: 0	0	0	0	0	4	.4	8	4	4	8	8	8	8		
RDER         EXTEND EXISTING AURITORIUM EXCEPTIONS FOR 36 MONTHS         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0	GF 72	12	A LTC Facilities Grants	5 C C	0	0	0	0	0	0	0	. 0			0	4	4	8	4	.4	8	8	8	8		
RIDER         EXTEND EXISTING NURSING FACILITY MORITORIUM EXCEPTIONS FOR 36 MONTHS         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0				· · ·												:										
OF         72         MALTC Facilities Grants         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0 <td>RIDER EXTEND EX</td> <td>XISTI</td> <td>NG NURSING FACILITY MORITORIUM EXCEPTIONS FOR 36 MONTHS</td> <td>0</td> <td> 0</td> <td>0</td> <td>0</td> <td>. 0</td> <td>0</td> <td> 0</td> <td>0</td> <td>Ó</td> <td>0</td> <td>0</td> <td>0</td> <td>(405)</td> <td>(675)</td> <td>(1,080)</td> <td>0</td> <td>0</td> <td>0</td> <td>(1,080)</td> <td>0</td> <td>(1,080)</td> <td></td>	RIDER EXTEND EX	XISTI	NG NURSING FACILITY MORITORIUM EXCEPTIONS FOR 36 MONTHS	0	0	0	0	. 0	0	0	0	Ó	0	0	0	(405)	(675)	(1,080)	0	0	0	(1,080)	0	(1,080)		
					0.		0	0		6 1 ° · 0	0	0		0	0				0	• 0	0		0			
sr xxxx: INURSING HOME MORITORIUM EXCEPTION FUND       1       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0	Menand Contractor	N 21	1.4 A set of the se																							
Détailéd Budgét Tracking - Bill TrackingNewTargelForFinanceMay3_2005.xls       5/2/2005. 4:00 PM	SF XXXX NURSING HO	HOME	MORITORIUM EXCEPTION FUND	13 T O .	÷ 0	0	0	0	at) <b>O</b> [4	0	0	1 7 0			0	0	300	300	1,500	3,000	4,500	300	4,500	300		
Sétailed Budgét Tracking - Bill TrackingNewTargetForFinanceMay3_2005.xls         5/2/2005, 4:00 PM	المجارية المتعاوم والمحال والمعارية	1994	비행 이 지수는 것 같은 것을 물을 했다. 것은 것은 것은 것을 통하는 것을 못하는 것을 것을 것이 같이 않았다. 것을 것을 것이 없는 것을 것이 없다. 것을 못하는 것을 못하는 것을 것이 없다. 것을 것이 없는 것이 없다. 것을 것이 없다. 것이 것이 않았다. 것이 것이 것이 없는 것이 없다. 것이 않았는 것이 않았는 것이 않았다. 것이 않았는 것이 않았다. 것이 않았는 것이 없다. 것이 않았는 것이 없다. 것이 않았다. 것이 않았다. 것이 않았다. 것이 것이 않았다. 것이 것이 않았다. 것이 것이 않았						a de la composición d				i ya shire e													
Detailed Budget Tracking - Bill TrackingNewTargetForFinanceMay3_2005x/s Tab 1: Page 7 of 11	온 같이 많은 것 같아?		지수는 이 그는 데 신도가 가지 말했다. 한 생각의 성장에 소가 내					1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 - 1999 -				1.1					*									
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#### HEALTH and HUIL S. ICES BUDGET NET FISCAL IMPACT OF PROPOSALS

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of         Ferr         Mathebuse         Gene         Gene        Gene        Gene <th< th=""><th>591</th><th>GF 78</th><th>Consumer support grants .</th><th>0</th><th></th><th>0</th><th>0</th><th>0</th><th>0</th><th></th><th>0</th><th>0</th><th>0 0</th><th></th><th></th><th></th><th></th><th>474</th><th>911</th><th></th><th></th><th>911</th></th<>	591	GF 78	Consumer support grants .	0		0	0	0	0		0	0	0 0					474	911			911
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est         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i         i		GF REV	1 Administrative ffp	0	0	0	0			0 0	0		0 0	(28)	(14)	(42)	0		0	(42)	(42)	0
eer i i issued automic CA for eache MPs i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i i	595																					
B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B       B											0											
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60         67         78         Partic bick bick back back back back back back back ba	599										0		0 0	0	0	0			0			
off         RZ         Finance in originating water, finance water, water water, water main water, water main water, water water, water	600	GF 72	Partial hold harmless/safety net - effective 10/01/07	0		2,500		1,000		0 0	0	0	0 0	0	0	0	0	0	0		(2,500)	
60//         7//         Anisocies for ever rise system         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0        0         0        0        <	601	GF 72	Faster phase-in for high quality NFs - effective 10/01/07			0				-	0					0			0			
04         17         Maintaktion from         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0	602				0	0	6,203									0						(18,912)
605       67       72       0x three segrents       0x       0x       0x       0x       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92       12,92 </th <th>604</th> <th></th> <th></th> <th>0</th> <th>0</th> <th>0</th> <th>0</th> <th>0</th> <th>0</th> <th></th> <th>0</th> <th></th> <th></th> <th></th> <th></th> <th>0</th> <th></th> <th></th> <th>0</th> <th></th> <th></th> <th>0</th>	604			0	0	0	0	0	0		0					0			0			0
666	605			0	0	0	0	0	0	0 0	0	0	0 0	0	12,992	12,992	0	0	0	12,992	12,992	0
66         7.3         MALTC scatter grants         0.0         0.0         0.0         0.0         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         1.800         <	606			<u>_</u>		l							0 0		1 200	2140	9 507	2 702	- E 270	2 1 46 5 270	0440	
60       67       72       MALTC failling grants       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0 </th <th></th> <th></th> <th></th> <th>0</th> <th>0</th> <th></th> <th>0</th> <th></th> <th>0</th> <th></th> <th>U</th> <th></th>				0	0		0		0		U											
610       67       42       MAsichendhersenerMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisenererMisener       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0	609			0	0	0	0		0		0		0 0									
11       12       12       12       12       12       12       12       12       12       12       12       12       12       12       12       12       12       12       12       12       12       12       12       12       12       12       12       12       12       12       12       12       12       12       12       12       12       12       12       12       12       12       12       12       12       12       12       12       12       12       12       12       14       12       14       12       14       12       14       12       14       12       14       12       14       12       14       12       14       12       14       12       14       12       14       12       14       12       14       12       14       12       14       12       14       12       14       12       14       12       14       12       14       12       14       12       14       12       14       12       14       12       14       12       14       12       14       12       12       12       12 <td< th=""><th>610</th><th>GF 42</th><th>MA basic health care elderly and disabled</th><th>0</th><th></th><th>0</th><th>0</th><th></th><th>0</th><th></th><th>. 0</th><th></th><th></th><th>16</th><th>60</th><th></th><th>96</th><th>129</th><th>225</th><th>76 22</th><th>76</th><th>225</th></td<>	610	GF 42	MA basic health care elderly and disabled	0		0	0		0		. 0			16	60		96	129	225	76 22	76	225
613       67       71       Alternative care grants       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0	611			0		0			0		·		0 0									
61       OF 80       GRH grants       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0				0	0	0	0		0		0		0 0			236						
61       0f       74       Add/mental health grants       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0	614			0	0	0	0		0		0	0	0 0									
off       26       Operating water       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0	615	GF 74	Adult mental health grants	0	. 0	0	0		0		0		0 0	76	91	167	91	91		167 183	167	
618       GF       27       Community social services grants       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0	616	GF 26	Children mental health grants	0	0	0			0		0		0 0			0					0	0
619       GF       75       Defandhard of having Grants <t< th=""><th></th><th></th><th></th><th>0</th><th>0</th><th></th><th></th><th></th><th>0</th><th></th><th></th><th></th><th>0 0</th><th></th><th></th><th>26</th><th></th><th>15</th><th>30</th><th></th><th>26</th><th>30</th></t<>				0	0				0				0 0			26		15	30		26	30
620       6F       70       Aging and actult services grants       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0	619	GF 75	Deaf and hard of hearing Grants	0	. 0				0 3.3		ő		0 0	1		3		2	4		3	4
621       GF       76       State share of CD Terl       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0	620	GF 70	Aging and adult services grants			0			0 1.51				0 0			0					0	0
522 GF 85 Continuing Care Management - admin costs 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	621	GF 76	State share of CD Tier I			0							0 0			241					241	305
GF         REV1         Administrative fig         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0					-	C 0					0	0	0 0			70					70	70
e25 GF 51 MMS Systema Costs	624	GF REVI	Administrative ffp					440 <b>0</b> 347	0 (14)		. 0	0	0							(28) (28		(28)
			MMIS Systems Costs	0	· 0			0	0 371	0 0	0	0	0 0	7		7	0	0	0	7 0		0

Time i Firege Bud

The Low Part	·····	····		T	60	EPNOP'S P	COMMENDAT			1		NATE DOS	TION - SF 187	'0						UDGET BILL	·····	SENATE TOTA	I POSITION	SENATE TO	TAL No COV
Trkg. Gov Rec Line / Bill Ref	Fund B	BACT	DESCRIPTION	FY 2006		FY 06-07			9 FY 08-09	FY 2006	FY 2007	FY 06-07	FY 2008	FY 2009	FY 08-09	FY 2006	FY 2007	FY 06-07	FY 2008	FY 2009	FY 08-09	FY 06-07		FY 06-07	
626	GF	73	Transfer to General Fund from Board of Nursing SGSR Account	0	0	0	0	0	0	0	0	0	0	0	0	(938)	(1,207)	(2,145)	0	0	0	(2,145)	0	(2,145)	0
627				0	0		0	0	0			0	0	0		205	270	E74	606	502	4 349	E74	4.040	574	4 040
628 SF 1395 0 629			LTERNATIVES FOR ANOKA REGIONAL TREATMENT CENTER	0	0	0	0	U 0		U 0	0	0	0	0	0	295 118	279 363	574 481		592 502	1,218 996	574 481	1,218 996	574 481	1,218 996
630	GF	30	Minnesola Supplemental Ald Grants Group Residential Housing Grants	0	0	0	0	0		0	0	0	0	0	0	(72)	(195)				(496)	(267)	(496)	(267)	(496
631			MA elderly and disabled	0	0	0	0	0		0	0	0	0	0	0	(101)	(55)	(156)		134	268	(156)	268	(156)	268
632		43		0	0	0	0	0	0	0	0	0	0	0	0	0	15	15	31	31	62	15	62	15	62
633	GF	74	Mental Health Grants	0	0	0	0	0	0	0	0	0	0	0	0	350	145	495			3,319	495	3,319	495	3,319
634	GF		State Operated Services	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(1,250)		(3,694)	0	(3,694)	0	(3,694)
635	GF R	REV2	Decrease in county share payments to Anoka RTC				0		0	0	0	0	0	0	0	0	0	0	250	489 12	739	0	739	0	739
636 637	HCAF 4	40	MNCare without FFP	0	<u> </u>	0		0	0	· · · · ·					0		0		12	12	24		24	0	24
638 Page 43	SOS FOR	ENSIC	SERVICES UTILIZATION	4,556	5,846	10,402	8,703	11,671	20,374	0	0	0	0	0	0	4,556	5,846	10,402	8,703	11,671	20,374	10,402	20,374	0	0
639	GF S	90	SOS appropriated services - operating costs	5,062	6,496	11,558	9,670	12,968	22,638	0	0	0	0	0	0	5,062	6,496	11,558	9,670	12,968	22,638	11,558	22,638	0	0
640	GF R	EV2	SOS collections - 10% county share	(506)	(650)	(1,156)	(967)	(1,297	) (2,264)	0	0				0	(506)	(650)	(1,156)	(967)	(1,297)	(2,264)	(1,156)	(2,264)	0	0
641																17 000						17 000			
			TED SERVICES ADULT MENTAL HEALTH PROGRAM TRANSITION	17,320	0	17,320	0	0	0	0	0	0	0	0	0	17,320	0	17,320	0	0	0	17,320	0	0	0
643 644	GF	90	SOS appropriated services - operating costs	17,320	0	17,320	0	0	°	0	0	0	0	0	0	17,320	0	17,320	0	0	0	17,320	0	0	0
	ISCHAR	GEPI	ANNING FOR MENTALLY ILL OFFENDERS	0	0	0	. 0	0	0	0	0	0	0	0	0	0	173	173	124	100	224	173	224	173	224
646			Administrative costs - enrollment & planning, 3.5 ftes	0	0	0	0	0	0	0	0	0	0	0	0	0	288	288	206	166	372	288	372	288	372
647			Administrative ffp	0	0	0	0	0	0	0	0	0	0	0	0	0	(115)	(115)	(82)	(66)	(148)	(115)	(148)	(115)	(148)
648				1																					
	MPROVE	MENT	AL HEALTH COVERAGE	205	3,201	3,406	4,724	6,228		0	0	0	0	0	0	205	2,064	2,269	3,217	4,266	7,483	2,269	7,483	(1,137)	(3,469)
650 651	GF 4	41	MA F&C - treatment foster care benefit	0	2,274 130	2,274 163	3,014	3,922	6,936 326	0	0	0	0	0	0	0	2,274	2,274	3,014 163	3,922	6,936 326	2,274	6,936 326	0	
652	GF 4	42	MA F&C - pysch case consultation-children MA E&D - pysch case consultation-adults	33	390	488	488	488			0	0	0	0		98	130 390	488	468	488	326	488	326 976	0	0
653	GF 4	41	MA F&C - assertive community treatment benefit	0	356	356	1,008	1,604		0	0	0	0	0	0	0	356	356	1,008	1,604	2,612	356	2,612	0	0
654			Staff support for new benefits	85	85	170	85	85	170	0	0	0	0	0	0	85	85	170	85	85	170	170	170	0	0
655	GF RE	EV1	Administrative FFP	(34)	(34)	(68)	(34)	(34)	(68)	0	0	0	0	0	0	(34)	(34)	(68)	(34)	(34)	(68)	(68)	(68)	0	0
656			MMIS costs	5	0	5	0	. 0	0	0	0	0	0	0	0	5	0	5	0	0	0	5	0	0	0
657	GF 5	51	HealthMatch small effect	18	0	18	0	0	0	0	0	0	0	0	0	18	0	18	0	0	0	18	0	0	0
658 659	GF RE	EV2	County share 25% of total costs			0		0	0	0							(1,137)	(1,137)	(1,507)	(1,962)	(3,469)	(1,137)	(3,469)	(1,137)	(3,469)
	OLLABO	RATIC	ON BETWEEN SCHOOLS AND MENTAL HEALTH PROVIDERS STUDY	0	0	0	0	0	0	0	0	0	0	0	0	3	0	3	0	0	0	3	0	3	0
661				0	0	0	0	0	0	0	0	0	0	0	0	5	0	5	0	0	0	5	0	5	0
662	GF RE	EV1 A	Administrative FFP	0	0	0	0	0	0	0	0	0	0	0	0	(2)	0	(2)	0	0	0	(2)	0	(2)	0
663																									
			AMBLING GRANT PROGRAM	0	0	0	0	0	0	0	0	0	0	0	0	400	400	800	400	400	800	800	800	800	800
665	LOTT 7	14 /	Appropriation	0	0	0	0	0	0	0	0	0	0	0	0	400	400	800	400	400	800	800	800	800	800
	YPAND N	AETHA	MPHETAMINE TREATMENT CAPACITY	300	300	600	300	300	600	0	0	0	0	0	0	0	0	0	0	0	0	0		(600)	(600)
			TH CHILDREN																						(000)
669			Methamphetamine treatment grants	300	300	600	300	300	600	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(600)	(600)
670																									
			MINE EVIDENCE-BASED TREATMENT, WILLMAR	0	0	0	0	0	0	0	0	0	0	0	0	300	300	600	300	300	600	600	600	600	600
672	GF 9	x0   N	Mothamphetamine treatment grants	0	0	0	0	0	0	0	0	0	0	0	0	300	300	600	300	300	600	600	600	600	600
673		E COV	INTY SHARE OF CODTE TREATMENT COSTS FOR		•	0	0	0	0	0	0		0	0	0	2,039	4,626	6,665	4,568	4,851	9,419	6,665	9,419	6,665	9,419
			INTY SHARE OF CCDTF TREATMENT COSTS FOR			J		J		v					v	2,005		0,000	-4000		01710		5,413		0,410
676			CD entitlement grants	0	0	0	0	0	0	0	0	0	0	0	0	2,039	4,626	6,665	4,568	4,851	9,419	6,665	9,419	6,665	9,419
677																									
678		LL.		L	l											l.									
679														1											
680 DEPARTA	TENT OF	- HEAI	LIH																						
682		Π																						[	
683 Page 9 E	LIMINATE	E SUIC	DIDE PREVENTION GRANTS	(983)	(983)	(1,966)	(983)	(983)	(1,966)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,966	1,966
684	GF 1	1 5	Suicide prevention grants	(983)	(983)	(1,966)	. (983)	(963)	(1,966)			0	0	0	:0	0	0	0	0	0	0	0	0	1,966	1,966
685				(550)	(ECO)	(4 4 2 0)	(560)	(550)	(4 420)			0	0	0		0		0	0	0		0		1,120	4 4 2 0
			TAL LOAN FORGIVENESS PROGRAM	(560)	(560)	(1,120)	(560)	(560)	(1,120) (1,120)		0		0	0		. 0 .	0	0	0	0	0	0	U	1,120	<b>1,120</b> 1,120
687	GF 1		Dental loan forgiveness grants	(000)	(000)	(1,120)	(000)	(000)	(1,120)				······						•			······································		1,120	1,120
689 Page 10 A S	TATETR	AUMA	SYSTEM	382	352	734	352	352	704	0	. 0	0	0	0	0	0	0	0	0	0	0	0	0	(734)	(704)
690			State Trauma System	382	352	734	352		704	0	. 0	0	. 0	0	0	382	352	734	352	352	704	734	704	. 0	0
691			ncrease Hospital License Fees	0	. 0	0	· 0	0	0	0	0	. 0	. 0	0	-0	(382)	(352)	(734)	(352)	(352)	(704)	(734)	(704)	(734)	(704)
692										<u> </u>	<u> </u>														
693 Page 23 E	LIMINATE	E OFFI	ICE OF COMPLIMENTARY AND ALTERNATIVE PRACTICE	(65)	(65)	(130)	(65)	(65)	(130)	0	: 0	0	0	· 0	0	0	0	. 0	0	0	0	0	0	130	130
694	GF 2	2   E	Ilminate office of complimentary and alternative practice	(65)	(65)	(130)	(65)	(65)	(130)				0	0		0	0	0	0	0			0	130	130
695	CREASE	VITA	L RECORDS ACTIVITY	(316)	(416)	(732)	384	384	768	0	0	0	0	0	0		0	0		0	0	0	o	732	(768)
			ncrease vital records activity	1,104	1,004	2,108	1,804	1,804	3,608	. 0 .	0	. 0	0	0	. :0	770	770	1,540	770	770	1,540	1,540	1,540	(568)	(2,068)
698	SGSR RE	EV Ir	norease fees (Grazi - Contra Con	, (1,420)	(1,420)	(2,840)	(1,420)	(1,420)	(2,840)	0 ;	120 . 0	0	0	0	2	1. ky 0 }	0	0	0	0	0	0	0	2,840	2,840
699	SGSR RE	EV	ncrease base fee for certified copy of a record by \$1 (\$8 to \$9)	. 0	Ó		0			0	0	11.14	0	0	17 184	(600)	(600)	(1,200)	(600)	(600)	(1,200)	(1,200)	(1,200)	(1,200)	(1,200)

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		COV		COMMENDAT	101					TION			05	NATE POSITIC					SENATE TOT		SENATE TO	THE
Trikg.         Gov Rec           Line         / Bill Ref           Fund         BACT           DESCRIPTION	FY 2006			FY 2008		FY 08-09	FY 2006			FY 2008	FY 2009	FY 08-09		FY 2007				FY 08-09	FY 06-07	FY 08-09	FY 06-07	FY 08-09
	112000		110001	112000	112000	1100 00			11 00 01	1.2000								1.00.00				1100-05
700 SGSR REV Increase amendment/replacement/delayed registration fee by \$20 (\$20 to \$40)	0	0	0	0	0	0	0	0		0	0		(170)	(170)	(340)	(170)	(170)	(340)	(340)	(340)	(340)	(340)
701																						
702 Page 23 OCCUPATIONAL THERAPY LICENSE FEE SUSPENSION	(254)	(254)	(508)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	508	0
703 SGSR REV Fee holiday - decrease revenues	(254)	(254)	(508)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	508	0
704 705 Page 17 METH LAB REMEDIATION	100	100	200	100	100	200	0	0	0	0	0			0		0	0		0	0	(200)	(200)
705         GF         3         Meth lab remediation - technical assistance to local units of government	100	100	200	100	100	200	0	0	0	0	0	0	<b>v</b>  -			v		0	0	0	(200)	(200)
				100																		(200)
708 Page 11 DRINKING WATER SERVICE CONNECTION FEE INCREASE	381	(798)	(417)	137	137	274	0	0	0	0	0	0	381	(798)	(417)	137	137	274	(417)	274	0	0
709 SGSR 3 Increase appropriation for drinking water protection program	381	635	1,016	1,570	1,570		0	0	0	0	0	0	381	635	1,016	1,570	1,570	3,140	1,016	3,140	0	0
710 SGSR REV Increase drinking water connectin fee from \$5.21 to \$6.36	0	(1,433)	(1,433)	(1,433)	(1,433)	(2,866)	0	0	0	0	0	0	0	(1,433)	(1,433)	(1,433)	(1,433)	(2,866)	(1,433)	(2,866)	0	0
711																						
712 Page 21 WELL MANAGEMENT PROGRAM	356	50	406	50	50	100	0	0	0	0	0	0	356	50	406	50	50	100	406	100	0	0
713         SGSR         3         Increase appropriation for well management program           714         SGSR         REV         Increase variety of well management fees	356	601 (551)	957	. 601 (551)	601	1,202 (1,102)	0	0	0		0	0	356	601	957 (551)	601 (551)	601	1,202	957 (551)	1,202	0	0
714         SGSR         REV         Increase variety of well management fees           715		(001)	(551)	(551)	(551)	(1,102)	· · · · ·		V					(551)	(001)	(331)	(551)	(1,102)	(301)	(1,102)		
716 Page 19 PLUMBING PROGRAM	255	255	510	255	255	510	0	0	0	0	0	0	255	255	510	255	255	510	510	510	0	
717 SGSR 3 Increase appropriation for plumbing plan review services and inspections	250	250	500	250	250	500	0	0	0	0	0	0	250	250	500	250	250	500	500	500	0	
718 SGSR REV Modification to plumbing review fee schedule	5	5	10	5	5	10	0	0	0	0	0	0	5	5	10	5	5	10	10	10	0	0
719																						
720 Page 13 FOOD MANAGER'S CERTIFICATION FEE	(29)	(29)	(58)	(29)	(29)	(58)	0	0	0	0	0	0	(29)	(29)	(58)	(29)	(29)	(58)	(58)	(58)	0	0
721 SGSR 3 Increase appropriation for food manager's certification program	62	62	124	62	62	124	0	0	0	0	0	0	62	62	124	62	62	124	124	124	0	0
722 SGSR REV Fee increase for food manager's certification from \$15 to \$28	(91)	(91)	(182)	(91)	(91)	(182)	0	0	0		0	0	(91)	(91)	(182)	(91)	(91)	(182)	(182)	(182)	0	0
723 724 Page 14 FOOD, BEVERAGE AND LODGING PROGRAM FEE	226	226	452	226	226	452	0	<u> </u>	0	0		0	226	226	452	226	226	452	452	452		
Yz4         Fage 14         FOOD, BEVENAGE AND LODGING PROGRAM FEE           725         SGSR         3         Increase appropriation for food, beverage and lodging program	1,552	1,552	3,104	1,552	1,552	3,104		0	0	0	0	0	1,552	1,552	3,104	1,552	1,552	3,104	3,104	3,104	0	- 0
	(1,326)	(1,326)	(2,652)	(1,326)	(1,326)	(2,652)	0	0	0	0	0	0	(1,326)	(1,326)	(2,652)	(1,326)	(1,326)	(2,652)	(2,652)	(2,652)	0	0
726         SGSR         REV         Increase license fee for food, beverage and lodging establishments           727																						
728 Page 16 LAB CERTIFICATION PROGRAM	26	(29)	(3)	46	(45)	1	0	. 0	0	0	0	0	26	(29)	(3)	46	(45)	1	(3)	1	0	0
729 SGSR 3 Increase appropriation for environmental laboratory program	186	186	372	186	186	372	0	0	0	0	0	0	186	186	372	186	186	372	372	372	0	0
730 SGSR REV Increase fee revenue	(160)	(215)	(375)	(140)	(231)	(371)	0	0	0	0	0	0	(160)	(215)	(375)	(140)	(231)	(371)	(375)	(371)	0	0
	(200)	(200)	(400)	(200)	(200)	(400)	0	0		0	0		(200)	(200)	(400)	(200)	(200)	(400)	(400)	(400)		
732         Page 6         OPERATIONS SUPPORT - DIVISION MANAGEMENT           733         GF         1         Reallocation to pay for increased rent for new lab building	(200)	(200)	(400) (400)	(200)	(200)	(400)	0	0	0		0	0	(200)	(200)	(400)	(200)	(200)	(400)	(400)	(400)	0	
733 GP 1 Realification to pay for increased rent for new tab building	(200)	(200)	(400)	(200)	(200)	(400)				v		°	(200)	(200)	(400)	(200)	(200)	(400)	(400)	(400/		
735 Page 8 OPERATIONS SUPPORT - DENTAL HEALTH PROGRAM	(72)	(72)	(144)	(72)	(72)	(144)	0	0	0	0	0	0	(72)	(72)	(144)	(72)	(72)	(144)	(144)	(144)	0	0
736 GF 1 Reallocation to pay for increased rent for new lab building	(72)	(72)	(144)	(72)	(72)	(144)	0	0	0	0	0	0	(72)	(72)	(144)	(72)	(72)	(144)	(144)	(144)	0	0
737																						
738 Page 8 OPERATIONS SUPPORT - OFFICE OF STATE REGISTRAR	(140)	(140)	(280)	(140)	(140)	(280)	0	0	0	0	0	0	(140)	(140)	(280)	(140)	(140)	(280)	(280)	(280)	0	0
739 GF 1 Reallocation to pay for increased rent for new lab building	(140)	(140)	(280)	(140)	(140)	(280)	0	0	0	0	0	0	(140)	(140)	(280)	(140)	(140)	(280)	(280)	(280)	0	0
740 741 Page 8 OPERATIONS SUPPORT - RADIATION CONTROL	(21)	(21)	(42)	(21)	(21)	(42)	0	0		0	0		(21)	(21)	(42)	(21)	(21)	(42)	(42)	(42)	0	
741         Fages         OF EXAMPLIES SUPPORT = RADIATION CONTINUE           742         GF         1         Reallocation to pay for increased rent for new lab building	(21)	(21)	(42)	(21)	(21)	(42)	0	0	0	0	0	0	(21)	(21)	(42)	(21)	(21)	(42)	(42)	(42)	0	
743															·····			(				
	(19)	(19)	(38)	(19)	(19)	(38)	0	0	0	0	0	0	(19)	(19)	(38)	(19)	(19)	(38)	(38)	(38)	0	0
745 . GF 1 Reallocation to pay for increased rent for new lab building	(19)	(19)	(38)	(19)	(19)	(38)	0	0	0	0	0	0	(19)	(19)	(38)	(19)	(19)	(38)	(38)	(38)	0	0
746																		(00)	(00)			
747 Page 6 OPERATIONS SUPPORT - VACCINE OUTBREAK FUND	(34)	(34)	(68)	(34)	(34)	(68)	0	0	0	0	0	0	(34)	(34)	(68)	(34)	(34)	(68)	(68)	(68)	0	0
748 GF 1 Reallocation to pay for increased rent for new lab building	(34)	(34)	(68)	(34)	(34)	(68)		U	U	U			(34)	(34)	(68)	(34)	(34)	(68)	(68)	(68)		0
750 Page 8 OPERATIONS SUPPORT - INCREASE FOR RENT FOR NEW PUBLIC HEALTH LAB BLDG	1,208	3,069	4,277	3,069	3,069	6,138	0	0	0	0	0	0	(19)	(15)	(34)	0	0	0	(34)	0	(4,311)	(6,138)
751 GF 5 Increase for rent	722	2,583	3,305	2,583	2,583	5,166	0	0	0	0	0	0	722	2,583	3,305	2,583	2,583	5,166	3,305	5,166	0	0
752 GF 1 Administrative reduction	0	0	0	0	0	0	0	0	0	0	0	0	(242)	(1,007)	(1,249)	(1,007)	(1,007)	(2,014)	(1,249)	(2,014)	(1,249)	(2,014)
753 GF REV Across the board increase for existing MDH fees (except occupational therapy board)	0	0	0	0	0	0	0	0	0	0	0	0	(731)	(1,823)	(2,554)	(1,808)	(1,808)	(3,616)	(2,554)	(3,616)	(2,554)	(3,616)
754 GF REV Transfer from occupational therapy SGSR account	0	0	0	0	0	0	0	0	0	0	0	0	(254)	(254)	(508)	(254)	(254)	(508)	(508)	(508)	(508)	(508)
755 GF 5 Operations support - library support - reallocation within BACT - [non-add]	(188)	(188)	(376)	(188)	(188)	(376)	0	0	0	0	0		(188)	(188)	(376)	(188)	(188)	(376)	(376)	(376)	0	0
756         GF         5         Operations support - F & FM (inventory management) - reallocation within BACT - [non-add]           757         GF         5         Operations support - communications office - reallocation within BACT - [non-add]	(124)	(124)	(248)	(124)	(124)	(248)	- 0	0	0		0	v	(124)	(124)	(248) (100)	(124)	(124)	(248)	(248)	(24B) (100)	0	0
757         GF         5         Operations support - communications office - realiscation within BAOT - [non-add]           758         GF         5         Operations support - HR - realiscation within BAOT - [non-add]	(188)	(50)	(100) (376)	(50) (188)	(50) (188)	(100) (376)	· 0	0	. 0		0		(188)	(188)	(376)	(188)	(188)	(376)	(376)	(376)	0	
759 GF 5 Operations support - R - readocation minut BNO1 - [non-add]	(50)	(50)	(100)	(100)	(50)	(100)	0	0	0	0	ō	o	(50)	(50)	(100)	(50)	(50)	(100)	(100)	(100)	ol	
760 GF 5 Increase for rent within BACT from reallocation [non-add]	600	600	1,200	600	600	1,200	. 0	0	0	0	0	0	600	600	1,200	600	600	1,200	1,200	1,200	0	0
761 GF 5 Reallocation from operations support - division management	200	200	400	200	200	400	0	0	0	0	0	0	200	200	400	200	200	400	400	400	0	0
762 GF 5 Reallocation from operations support - dental health	. 72	72	144	72	72	144	· 0	0	0	0	0	0	72	72	144	72	72	144	144	144	0	0
763 GF 5 Reallocation from operations support - office of state registrar-admin	140	. 140	280	140	140	280	0	0	0	0	0	0	140	140	280	140	140	280	280	280	0	0
764 GF 5 Reallocation from operations support - radiation control reduction	21		42	21	21	42	0	. 0.	0	0	0	0	19	21 19	42	21 19	21	42	42	42	0	0
765         GF         6         Resilection from operations support - EH management           766         GF         5         Resilection from operations support - vaccine outbreak fund	19	19	38	19	19	38	0		0		0		34	34	68	34	34	88	68			
766 GF 5 Reallocation from operations support - vaccine outbreak fund			1, 00									ř										
768 Page 6 ADVERSE HEALTH EVENT REPORTING	0	0	0	0	0	0	0	0	0	0	0	.0	0	0	0	0	0	0	0	0	0	0
769 SGSR 1 Appropriation to provide on-going funding for adverse health reporting law	335	335	670	335	335	670	0	. 0	· 0	0	0	0	335	335	670	335	335	670	670	670	0	0
770 SGSR REV Increse fees for hospitals and outpatient surgical centers	(335)	(335)	(670)	(335)	. (335)	(670)	0	.0	0	. 0	· . 0	0	(335)	(335)	(670)	(335)	(335)	(670)	(670)	(670)	0	0
771						· · · · ·											/=					
772 SF 1115 PLUMBERS LICENSING AND INSPECTION REQUIREMENTS	<u>.</u> 0	0	0	0		·6 0.*	0	0	0	0	0	01.61	(1,924)	. 1,278	(646)	697	(54)	643	(646)	643	(646)	643
773 SGSR 3 Salary and fringes	0	0	0	L O	0	30 . O .	8 8 1 1 <b>1 0</b> 1	0	.0	- 0	0		537	761	1,298	761	761	1,522	1,298	1,522	1,298	1,522

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 $= \sum_{k=1,2,3}^{n-1} e^{-\frac{1}{2} \sum_$ 

# DGET المعنية (DGET NET FISCAL IMPACT OF ، DOSALS

Detailed Budget Tracking - Bill TrackingNewTargetForFinanceMay3\_2005 xis

Trka,	Goy Rec	1			GOVERNOR'S RECOMMENDATION							S	SENATE POSITION - HHS OMNIBUS BUDGET BILL SENATE TOTAL POSITION SENATE TOTAL								TAL VE GOV					
Line	/ Bill Ref	Fund	BACT	DESCRIPTION	FY 2006		FY 06-07			FY 08-09	FY 2006		FY 06-07			FY 08-09						FY 08-09	FY 06-07	FY 08-09	FY 06-07	
																										1100-03
774		SGS	R 3	Supplies and Expenses	0	0	0	0	0	0	0	0	0	0	0	0	405	5,467	5,872	5,467	5,467	10,934	5,872	10,934	5,872	10,934
775			R REV	Increase Public, Commercial and Industrial Fees					0	0	0	0	0	0	0	0	(2,866)	(4,950)	(7,816)			(11,813)	(7,816)	(11,813)	(7,816)	(11,813)
776		1															(=10-07	()/	(1)0107	(e)e=1/	(-1/	1110107	(/////////	(11,013)	(7,010)	(11,013)
777	SF 908	DON	ATED DE	NTAL PROGRAM	0	0	0	0	0	0	0	0	0	0	0	0	70	70	140	70	70	140	140	140	140	140
778				Appropriation	0	0	0	0	0	0	0	0	0	0	0	0	70	70	140	70		140	140	140	140	140
779			· [ · - ]					<u> </u>						v	v				140	10		140	140	140	140	140
780		INTER	AGENC	Y WORK GROUP ON CHILDHOOD OBESITY	0	0	0	0	0	0	0	0	0	0	0		5	1	6	0	0	- 0	6			
781	01.00			Interagency workgroup meetings	0		0	0	0			0		0	0		5			0		- 0	6		- 0	0
782			+ • +	Interagency workgroup meetings	v			<u> </u>		v		· · · · · ·					5	'	0					0	6	0
	or yoov	FAMI	V DI ANI	NING GRANTS APPROPRIATION FOR GREATER MN CLINICS	0	0	0	0	0	0	0	0	0		0	0	500	500	1,000	500	500	1,000	1.000	4 000		
783	SFAM				0	0		0	<u> </u>	0	0	0					500	500					- Andrewski	1,000	1,000	1,000
		6		Appropriation		0		0	U	0							500	500	1,000	500	500	1,000	1,000	1,000	1,000	1,000
785 786																										
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813								*	21- C.																en e	
814	HEALTI	I-REL	ATED B	DARDS				1.00																2.0		
815																								1.5		
816		-	T									1		ľ			1	ſ		1	T				1	
817	SF1567	BOAR	D OF PH	ARMACY - TRANSFER TO MDH FOR THE RURAL PHARMACY	0	0	0	0	0	0	0	0	0	0	0	0	400	400	800	400	400	800	800	800	800	800
818				N GRANT PROGRAM - LOAN FORGIVENESS	0	0		0																000		000
819				Appropriation for the MDH Rural Pharmacy Preservation Grant Program	0	0	0	0	0	0	0	0	0	0	0	0	200	200	400	200	200	400	400	400	400	400
820				Appropriation for MDH Rural Pharmacist Loan Forgiveness Program			×	<del>`</del>		v	ů						200	200	400	200	200	400		400	400	400
821		000															200				200					
822	SF 227	BOAR	D OF PH	ARMACY - CANCER DRUG REPOSITORY PROGRAM	0	0	0	0	0	0	0	0	0	0	0	0	25	25	50	25	25	50	50	50	50	50
823		SGSF	09	Adminstration5 fte	0	0	0	0	0	0	0	0	0	0	0	0	25	25	50	25	25	50	50	50	50	50
824									-																	
825	SF 23	BOAR	O OF PH	ARMACY - PHARMACEUTICAL PRICE REPORTING	0	0	0	0	0	0	0	0	0	0	0	0	74	74	148	74	74	148	148	148	148	148
826		SGSF	09	Transfer for DHS amount of increase license fees on wholesale drug manufacturers	0	0	0	0	0	0	0	0	0	0	0	0	74	74	148	74	74	148	148	148	148	148
827																										140
828	Rider	BOAR	O OF NU	RSING - TRANSFER TO DHS FOR LONG-TERM CARE AND	0	0	0	0	0	0	0	0	0	0	0	0	938	1.207	2,145	0	0	0	2,145	0	2.145	0
829				MMUNITY BASED EMPLOYEE SCHOLARSHIPS	-																				£, 140	
830				Appropriation for DHS LTC scholarship program	0	0	0	0	0	0	0	0	0	0	0	0	. 938	1,207	2,145	0	0	0	2,145		2,145	
831				A CONTRACTOR OF THE OWNER																*					2, 140	
	SF 1163	BOAR	OF NUI	SING - TRANSFER TO MDH FOR NURSE AND ALLIED HEALTH	0	0	0	0	0	0	0	0	0	0	0	0	125	200	325	275	350	625	325	625	325	625
833				NESS PROGRAM																					520	025
834				Appropriation for health professional loan forgiveness program	0	0		0	0	0	0	· · · ·	0	0	0	0	125	200	325	275	350	625	325	625	325	625
835		0001		Propriedune in the second of the lower of grinting program						<b>v</b>			° -			°				210				020	320	020
	SE XXXY	BOAR	OF SO	CIAL WORK - OFFICE MENTAL HEALTH PRACTICE APPROPRIATION	0	0	0	0	0	0	0	0	0	0	0	0	105	100	205	0	0		205		205	
837	01 ////			Appropriation		0		0	0				0				105	100	205		0		205			0
838		3030	10				°[-									•f	105	100	205				205		- 205	0
839	Rider	BOAP	OF NU	SING - APPROPRIATION FOR CENTER FOR EXCELLENCE				0	0				<u>n</u>  -				500		500	0	0		500		F00	
839	ruer			Appropriation	0	0		0	0								500		500		0	<u>v</u>  -	500		500	0
840		363K	00	Арргорлавил				0									000		000	0	0		500	0	500	0
	07 10001	POAR	OFDEN	ITISTRY - DENTAL ACCESS PROGRAM START-UP		0			0								150		150				150			
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843 844		SGSR	02	Appropriation	0	0	0	0	0	0	0	0	0		0	0	150	0	001	0	. 0	0	150	0	0	0

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Repeirs et

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#### IVE SESSION

No. Contraction and a second

Tab 1: Page 11 of 11

200

# [COUNSEL ] KC/DG SCS2278A24

1	Senator moves to amend S.F. No. 2278 as follows:
2	Page 162, line 4, delete "SEPTEMBER" and insert "OCTOBER"
3	Page 162, lines 6 and 19, delete "September" and insert
4	"October"
5	Page 163, line 4, delete "December 31 each year" and insert
6	"March 31, 2006, and December 31, 2006, respectively"
7	Page 167, line 14, delete "SEPTEMBER" and insert "OCTOBER"
8	Page 167, line 16, delete " <u>September</u> " and insert " <u>October</u> "
9	Page 168, line 14, delete "December 31 each year" and
10	insert "March 31, 2006, and December 31, 2006, respectively"
11	Page 178, line 6, delete " <u>September</u> " and insert " <u>October</u> "
12	Pages 255 to 267, delete article 8 and insert:
13	"ARTICLE 8
14	APPROPRIATIONS
15	Section 1. [HEALTH AND HUMAN SERVICES APPROPRIATIONS.]
16	The sums in the columns marked "APPROPRIATIONS" are added
17	to, or, if shown in parentheses, are subtracted from the
18	appropriations to the specified agencies in 2005 S.F. No. 1879,
19	article 11, if enacted. The appropriations are from the general
20	fund, unless another fund is named, and are available for the
21	fiscal year indicated for each purpose. The figures "2006" and
22	"2007," where used in this article, mean that the additions to
23	or subtractions from the appropriations listed under them are
24	for the fiscal year ending June 30, 2006, or June 30, 2007,
25	respectively. The "first year" is fiscal year 2006. The
26	"second year" is fiscal year 2007. The "biennium" is fiscal
27	years 2006 and 2007.
28	SUMMARY BY FUND
29 30	BIENNIAL 2006 2007 TOTAL
31	General \$ 37,776,000 \$ 64,173,000 \$ 101,949,000
32 33	State Government Special Revenue 7,151,000 12,625,000 19,776,000
34 35	Health Care Access 42,451,000 65,060,000 107,511,000
36	Federal TANF (3,665,000) 11,064,000 7,399,000
37 38	Lottery Prize Fund 400,000 400,000 800,000

[COUNSEL ] KC/DG SCS2278A24

TOTAL \$ 1 84,113,000 \$ 153,322,000 \$ 237,435,000 2 APPROPRIATIONS 3 Available for the Year 4 Ending June 30 5 2006 2007 COMMISSIONER OF 6 Sec. 2. 7 HUMAN SERVICES Subdivision 1. 8 Total \$ 75,525,000 \$ 138,198,000 9 Appropriation 10 Summary by Fund 11 General 36,409,000 61,744,000 12 Health Care 42,381,000 Access 64,990,000 13 11,064,000 Federal TANF (3,665,000) 14 15 Lottery Cash 400,000 16 Flow 400,000 17 Subd. 2. Agency Management Summary by Fund 18 (165,000)(231,000)19 General 1,623,000 1,701,000 Health Care Access 20 The amounts that may be spent from the 21 22 appropriation for each purpose are as 23 follows: 24 (a) Financial Operations 424,000 424,000 25 General 26 Health Care Access 152,000 183,000 [ADMINISTRATIVE REDUCTION.] The general 27 28 fund appropriation in this section includes a department-wide 29 administrative reduction of \$6,885,000 30 the first year and \$7,201,000 the second year. The commissioner shall 31 32 33 ensure that any staff reductions made under this paragraph comply with Minnesota Statutes, section 43A.046. 34 35 36 (b) Legal and 37 Regulation Operations 38 General (5,208,000)(5, 482, 000)39 Health Care Access 75,000 75,000 40 (c) Information Technology Operations 41 42 General 4,619,000 4,827,000 43 Health Care Access 1,396,000 1,443,000 44 Subd. 3. Revenue and Pass-Through 45 Federal TANF (16,956,000) (5,221,000)

SCS2278A24

### 05/02/05

[REDUCED TANF TRANSFER.] 1 Notwithstanding Laws 2000, chapter 488, 2 article 8, section 2, subdivision 6, with respect to TANF funds used as refinancing for the state share of the 3 4 5 child support pass-through under 6 Minnesota Statutes, section 256.741, 7 8 subdivision 15, and notwithstanding 9 Minnesota Statutes, section 290.0671, subdivision 6a, with respect to the 10 TANF-funded expansion of the Minnesota 11 12 working family credit, the commissioner shall reduce the combined amount of the 13 TANF funds transferred to the 14 15 commissioner of revenue for deposit in the general fund by \$11,020,000 in 16 fiscal year 2006, by \$6,860,000 in fiscal year 2007, and by \$7,000,000 in fiscal year 2008 and subsequent years. 17 18 19 20 Notwithstanding section 7, this 21 paragraph shall not expire. 22 [TANF TRANSFER TO FEDERAL CHILD CARE AND DEVELOPMENT FUND.] The following 23 24 amounts are appropriated to the commissioner for the purposes of MFIP 25 transition year child care under 26 Minnesota Statutes, section 119B.05; 27 28 \$756,000 in fiscal year 2006; \$4,831,000 in fiscal year 2007; \$5,183,000 in fiscal year 2008; and \$1,127,000 in fiscal year 2009. The 29 30 31 The commissioner shall authorize the 32 33 transfer of sufficient TANF funds to 34 the federal child care and development fund to meet this appropriation and shall ensure that all transferred funds 35 36 37 are expended according to the federal child care and development fund 38 39 regulations. Notwithstanding section 40 7, this paragraph expires June 30, 2009. 41 Subd. 4. Economic Support Grants 42 Summary by Fund 1,722,000 7,109,000 General 43 44 Federal TANF 13,291,000 16,285,000 The amounts that may be spent from this 45 appropriation for each purpose are as 46 47 follows: (a) Minnesota Family Investment Program 48 3,740,000 -0-49 General 13,151,000 16,145,000 Federal TANF 50 (b) MFIP Child Care Assistance Grants 51 (3,740,000)-0-52 (c) Children Services Grants 53 6,074,000 54 1,119,000 (d) Children and Community Services 55 56 Grants

1	General Fund	3,000	11,000
2	Federal TANF	140,000	140,000
3 $4$ $5$ $6$ $7$ $8$ $9$ $10$ $11$ $12$ $13$ $14$ $15$ $16$	[NEW CHANCE PROGRAM appropriation, \$140 the commissioner fo chance program. Th shall provide compr through a private, young parents in He have dropped out of receiving public as program administrat annually to the com development, educat and job placement o participants.	,000 each year r a grant to the e new chance pro- ehensive service nonprofit agency nnepin County wi school and are sistance. The or shall report missioner on sk ion, job training	e new ogram es y to ho ills ng,
17	(e) Minnesota Suppl	emental Aid Gra	nts
18	118,000	363,000	
19	(f) Group Residenti	al Housing Gran	ts
20	122,000	301,000	
21 22	(g) Other Children' Assistance Grants	s and Economic	
23	360,000	360,000	
24 25 26 27 28 29	for the transitiona established in the Agriculture, and Ec	the commission l housing progr 2005 Environmen onomic Developm	am t,
30 31			
32	272,000	261,000	
33	Subd. 6. Basic Hea	lth Care Grants	
34	Summa	ry by Fund	
35	General	14,000	6,844,000
36	Health Care Access	30,843,000	51,903,000
37 38 39	appropriation for e		
40	(a) MinnesotaCare G	rants	
41	Health Care Access	30,843,000	51,903,000
42 43 44 45 46 47 48	appropriation, \$3,1 year and \$7,541,000 for the MinnesotaCa related to a one-mo implementation of t	12,000 the firs the second yea are program cost onth delay in	r is
49	(b) MA Basic Health		

4

50 Families and Children

3,746,000 1 339,000 [GREATER MINNESOTA HOSPITAL PAYMENT 2 ADJUSTMENT.] Of the general fund 3 appropriation for medical assistance 4 5 basic health care grants - families and children, medical assistance basic 6 7 health care grants - elderly and disabled, and general assistance 8 medical care, \$400,000 each year is for 9 greater Minnesota payment adjustments 10 under Minnesota Statutes, section 256.969, subdivision 26, for admissions 11 12 occurring on or after July 1, 2005. 13 [PROVIDER RATES NOT TO INCREASE.] 14 Provider rates under medical assistance 15 and general assistance medical care, 16 17 except for rates paid for dental services and pharmacy services, in 18 effect on June 30, 2005, shall not be increased as a result of the repeal of 19 20 recipient co-payments effective July 1, 21 22 2005. 23 (c) MA Basic Health Care Grants - Elderly and Disabled 24 (1, 146, 000)(727,000)25 (d) General Assistance Medical Care 26 27 Grants 28 1,029,000 4,349,000 (e) Health Care Grants - Other 29 Assistance 30 (2,500,000)31 (1,978,000)[PRESCRIPTION DRUG DISCOUNT PROGRAM.] 32 Of the general fund appropriation for 33 the second year, \$1,022,000 is to be transferred to the Minnesota 34 35 36 prescription drug dedicated fund established in Minnesota Statutes, 37 38 section 156.9545, subdivision 11. This 39 is a onetime appropriation and shall not become part of base level funding 40 for the biennium beginning July 1, 2007. 41 42 Subd. 7. Health Care Management 43 Summary by Fund 4,670,000 44 General 4,411,000 9,915,000 45 Health Care Access 11,386,000 46 The amounts that may be spent from this 47 appropriation for each purpose are as 48 follows: (a) Health Care Administration 49 50 General 4,206,000 4,157,000 51 Health Care Access 7,465,000 10,693,000

(b) Health Care Operations

52

1 General 464,000 254,000

2 Health Care Access 2,450,000 693,000

3 Subd. 8. Continuing Care Grants

4 Summary by Fund

5 General 6,616,000 36,090,000

6 Lottery Prize Fund 400,000 400,000

7 The amounts that may be spent from this 8 appropriation for each purpose are as 9 follows:

10 (a) Aging and Adult Service Grant

11 3,000 10,000

12 (b) Alternative Care Grants

13 10,468,000 19,442,000

14 (c) Medical Assistance Long-Term 15 Care Facilities Grants

16 (2,799,000) (12,569,000)

[RATE ADJUSTMENTS UNDER NEW NURSING 17 18 FACILITY REIMBURSEMENT SYSTEM.] Of this 19 appropriation, \$12,992,000 the second year is to adjust nursing facility 20 rates in order to facilitate the 21 transition from the current ratesetting 22 system to the system developed under 23 24 Minnesota Statutes, section 256B.440.

[NURSING HOME MORATORIUM EXCEPTIONS.] 25 26 During the first year, the commissioner 27 of health may approve moratorium exception projects under Minnesota 28 29 Statutes, section 144A.073, for which 30 the full annualized state share of medical assistance costs does not 31 32 exceed \$3,000,000.

33 [ICF/MR DOWNSIZING.] Of this
34 appropriation, \$300,000 each year is
35 for rate adjustments for intermediate
36 care facilities for persons with mental
37 retardation that are downsizing.

38 (d) Medical Assistance Long-Term 39 Care Waivers and Home Care Grants

40 (4,354,000) (3,279,000)

41 [LIMITING WAIVER GROWTH.] For each year 42 of the biennium ending June 30, 2007, the commissioner of human services 43 44 shall make available additional 45 allocations for community alternatives 46 for disabled individuals waivered 47 services covered under Minnesota Statutes, section 256B.49, at a rate of 48 49 105 per month or 1,260 per year, plus any additional legislatively authorized 50 51 growth. Priorities for the allocation of funds shall be for individuals 52 53 anticipated to be discharged from

institutional settings or who are at 1 2 imminent risk of a placement in an 3 institutional setting. For each year of the biennium ending 4 June 30, 2007, the commissioner shall 5 make available additional allocations 6 7 for traumatic brain injury waivered services covered under Minnesota 8 Statutes, section 256B.49, at a rate of 9 165 per year. Priorities for the 10 allocation of funds shall be for 11 individuals anticipated to be 12 discharged from institutional settings 13 or who are at imminent risk of a 14 placement in an institutional setting. 15 Notwithstanding 2005 S.F. No. 1879, 16 17 article 11, section 2, subdivision 8, paragraph (d), if enacted, for each 18 year of the biennium ending June 30 19 2007, the commissioner shall limit the new diversion caseload growth in the 20 21 22 mental retardation and related 23 conditions waiver to 75 additional allocations. Notwithstanding Minnesota 24 Statutes, section 256B.0916, 25 26 subdivision 5, paragraph (b), the 27 available diversion allocations shall be awarded to support individuals whose 28 health and safety needs result in an imminent risk of an institutional 29 30 placement at any time during the fiscal 31 32 year. 33 (e) Mental Health Grants 950,000 34 General 1,888,000 35 Lottery Prize Fund 400,000 400,000 [ALTERNATIVES TO ANOKA-METRO REGIONAL 36 TREATMENT CENTER.] Of this 37 appropriation, \$350,000 the first year and \$145,000 the second year is to the 38 39 40 commissioner to develop community alternatives to Anoka-Metro Regional 41 Treatment Center under Minnesota 42 Statutes, section 245.4661, subdivisions 8 to 11. Any amount of 43 44 45 this appropriation that is unspent shall not cancel but shall be available 46 until expended. Notwithstanding 47 section 7, this paragraph shall not 48 expire. 49 50 (f) Deaf and Hard-of-Hearing Service Grants 51 52 9,000 33,000 53 (g) Chemical Dependency 54 Entitlement Grants 55 2,144,000 4,762,000 56 (h) Other Continuing Care 57 195,000 665,000 58 Subd. 9. Continuing Care Management

1	599,000 465	,000		
2	[TASK FORCE ON COLLABORAT	IVE SEF	RVICES.]	
3	The commissioner, in colla	aborati	ion with	
4	the commissioner of educa		shall	
5	create a task force to dia collaboration between sch		ad a	
6 7	mental health providers t			
8	colocation and integrated			
9	identify barriers to coll			
10	develop a model contract;			
11	examples of successful co			
12 13	The task force shall also recommendations on how to			
14	children's mental health			
15				
16	representatives of school			
17	administrative personnel;			
18 19	education directors, coun advocacy organizations, s			
20	workers and psychologists		inity compolars hurses	
21	mental health professiona	ls, hea	alth	
22	plans, and other interest			
23	The task force shall pres			
24 25	to the chairs of the educ health policy committees			
26	2006.	Jy ICDI	Ludiy I,	
27	Of the general fund appro		on,	
28 29	\$5,000 the first year is commissioner to contract			
30	nonprofit organization th			
31	knowledgeable about child	ren's 1		
32	health issues to provide			
33 34	necessary for the task fo recommendations and compl			
54	recommendations and compr	ele life	e report.	
35	Subd. 10. State-Operated	Servio	ces	
36	22,682,000 6,796	,000		
37	[EVIDENCE-BASED PRACTICE	FOR		
38	METHAMPHETAMINE TREATMENT		the	
39	general fund appropriatio			
40	each year is to support d			
41 42	evidence-based practices treatment of methamphetam			
42	the state-operated servic			
44	dependency program in Wil			
45	funds shall be used to su			
46	on evidence-based practic			
47 48	treatment of methamphetam dissemination of the resu			
40 49	evidence-based practice r			
50				
51				
52	the treatment of methamph	etamine	e abuse.	
53	Sec. 3. COMMISSIONER OF	HEALTH		
54 55	Subdivision 1. Total Appropriation		6,271,000	13,118,000
56	Summary by	Fund		
57	General 1,3	67,000	2,429,000	
58	State Government			
59		34,000	10,619,000	
60	Health Care Access	70,000	70,000	

[RENTAL COSTS, ADMINISTRATIVE 1 REDUCTIONS, FEE INCREASES, AND REVENUE 2 TRANSFER.] (a) Of this appropriation, 3 \$722,000 the first year and \$2,583,000 the second year is for rental costs in 4 5 the new public health laboratory 6 building. 7 (b) The general fund appropriation in 8 this section includes a department-wide 9 administrative reduction of \$242,000 10 the first year and \$1,007,000 the 11 second year. The commissioner shall ensure that any staff reductions made 12 13 under this paragraph comply with 14 Minnesota Statutes, section 43A.046. 15 (c) The commissioner shall increase all 16 17 fees levied by the commissioner a pro rata amount in order to generate 18 revenue of \$731,000 the first year and \$1,823,000 the second year. These 19 20 amounts shall be deposited in the 21 general fund. This paragraph shall not 22 apply to fees paid by occupational 23 therapists. 24 (d) \$254,000 each year shall be 25 transferred from the state government 26 special revenue fund to the general 27 28 fund. Subd. 2. Community and Family 29 30 Health Improvement Summary by Fund 31 159,000 (640,000)General 32 33 State Government Special Revenue 335,000 335,000 34 35 Health Care Access 70,000 70,000 36 [TANF CARRYFORWARD.] Any unexpended 37 balance of the TANF appropriation in the first year of the biennium in this section and 2005 S.F. No. 1879, article 11, section 3, if enacted, does not 38 39 40 cancel but is available for the second 41 42 year. [WORK GROUP ON CHILDHOOD OBESITY.] (a) 43 Of the general fund appropriation, 44 45 \$5,000 the first year and \$1,000 the second year is to the commissioner to 46 47 convene an interagency work group with the commissioners of human services and 48 education to study and make 49 50 recommendations on reducing the rate of obesity among the children in Minnesota. 51 (b) The work group shall determine the 52 53 number of children who are currently 54 obese and set a goal, including measurable outcomes for the state in 55 terms of reducing the rate of childhood 56 The work group shall make 57 obesity. 58 recommendations on how to achieve this 59 goal, including, but not limited to, 60 increasing physical activities;

1 exploring opportunities to promote 2 physical education and healthy eating 3 programs; improving the nutritional 4 offerings through breakfast and lunch 5 menus; and evaluating the availability 6 and choice of nutritional products 7 offered in public schools.

8 (c) The work group may include representatives of the Minnesota 9 Medical Association; the Minnesota 10 Nurses Association; the Local Public 11 Health Association of Minnesota; the 12 Minnesota Dietetic Association; the 13 Minnesota School Food Service 14 15 Association; the Minnesota Association of Health, Physical Education, 16 Recreation, and Dance; the Minnesota 17 School Boards Association; the 18 19 Minnesota School Administrators 20 Association; the Minnesota Secondary Principals Association; the vending 21 22 industry; and consumers.

(d) The commissioner must submit therecommendations of the work group tothe legislature by January 15, 2007.

26 Subd. 3. Policy Quality and 27 Compliance

28

Summary by Fund

770,000

29 State Government
30 Special Revenue

770,000

31 [STATEWIDE TRAUMA SYSTEM.] (a) Of the 32 general fund appropriation, \$382,000 33 the first year and \$352,000 the second 34 year is for development of a statewide 35 trauma system.

36 (b) The commissioner shall increase
37 hospital licensing fees a pro rata
38 amount to increase fee revenue by
39 \$382,000 the first year and \$352,000
40 the second year. This revenue shall be
41 deposited in the general fund.

42 [AIDS PREVENTION FOR AFRICAN-BORN 43 RESIDENTS.] For fiscal year 2006 only, 44 the commissioner shall reallocate \$300,000 from the grant program under 45 46 Minnesota Statutes, section 145.928, for grants in accordance with Minnesota 47 48 Statutes, section 145.924, paragraph 49 (b), for a public education and 50 awareness campaign targeting 51 communities of African-born Minnesota The grants shall be 52 residents. 53 designed to:

54 (1) promote knowledge and understanding 55 about HIV and to increase knowledge in 56 order to eliminate and reduce the risk 57 for HIV infection;

58 (2) encourage screening and testing for 59 HIV; and

60 (3) connect individuals to public

The health and health care resources. 1 grants must be awarded to collaborative 2 efforts that bring together nonprofit 3 community-based groups with 4 demonstrated experience in addressing 5 the public health, health care, and 6 social service needs of African-born 7 8 communities. [FAMILY PLANNING GRANTS.] Of the 9 general fund appropriation, \$500,000 10 each year is to the commissioner for 11 grants under Minnesota Statutes, 12 section 145.925, to family planning clinics serving outstate Minnesota that 13 14 demonstrate financial need. 15 Subd. 4. Health Protection 16 Summary by Fund 17 18 State Government 3,729,000 9,514,000 Special Revenue 19 20 Subd. 5. Administrative Support 21 Services 1,208,000 3,069,000 22 Sec. 4. VETERANS NURSING HOMES BOARD 23 [VETERANS HOMES SPECIAL REVENUE 24 ACCOUNT.] The general fund 25 appropriations made to the board in 2005 S.F. No. 1879, if enacted, may be 26 27 transferred to a veterans homes special 28 revenue account in the special revenue 29 fund in the same manner as other 30 receipts are deposited according to 31 Minnesota Statutes, section 198.34, and 32 are appropriated to the board for the 33 operation of board facilities and 34 35 programs. 36 Sec. 5. HEALTH-RELATED BOARDS 37 Subdivision 1. Total 38 Appropriation 2,317,000 2,006,000 Summary by Fund 39 40 State Government 41 Special Revenue 2,317,000 2,006,000 42 [STATE GOVERNMENT SPECIAL REVENUE 43 FUND.] The appropriations in this section are from the state government 44 45 special revenue fund, except where 46 noted. 47 [NO SPENDING IN EXCESS OF REVENUES.] The commissioner of finance shall not 48 49 permit the allotment, encumbrance, or 50 expenditure of money appropriated in 51 this section in excess of the 52 anticipated biennial revenues or 53 accumulated surplus revenues from fees collected by the boards. Neither this 54 55 provision nor Minnesota Statutes, 56 section 214.06, applies to transfers

from the general contingent account.

57

beginning July 1, 2007.

Board of Dentistry 1 Subd. 2. Summary by Fund 2 3 State Government 150,000 -0-Special Revenue 4 [ORAL HEALTH PILOT PROJECT.] Of this 5 appropriation, \$150,000 the first year 6 is to be transferred to the 7 commissioner of human services for an 8 oral health care system pilot project. 9 Board of Nursing 10 Subd. 3. 1,407,000 11 1,563,000 [MINNESOTA CENTER OF NURSING.] (a) Of 12 this appropriation, \$500,000 in fiscal 13 year 2006 is to be used as start-up 14 funding to establish a Minnesota Center 15 The goals of the center 16 of Nursing. 17 shall be to: 18 (1) maintain information on the current and projected supply and demand of 19 nurses through the collection and 20 analysis of data on the nursing 21 22 workforce; (2) develop a strategic statewide plan 23 for the nursing workforce; 24 (3) convene work groups of stakeholders 25 to examine issues and make 26 27 recommendations regarding factors affecting nursing education, 28 29 recruitment, and retention; 30 (4) promote recognition, reward, and renewal activities for nurses in 31 32 Minnesota; and 33 (5) provide consultation, technical 34 assistance, and data on the nursing workforce to the legislature. 35 (b) The board shall report to the 36 37 legislature by January 15, 2007, on the 38 Center of Nursing's progress, the center's collaboration efforts with 39 40 other organizations and governmental entities, and the activities conducted 41 42 by the center in achieving the goals outlined. 43 44 [TRANSFERS FROM SPECIAL REVENUE FUND.] Of this appropriation, the following transfers shall be made as directed 45 46 47 from the state government special 48 revenue fund: (a) \$938,000 the first year and 49 50 \$1,207,000 the second year shall be 51 transferred to the commissioner of 52 human services for the long-term care 53 and home and community-based care 54 employee scholarship program. This appropriation shall not become part of 55 56 base level funding for the biennium

(b) \$125,000 the first year and 1 \$200,000 the second year shall be 2 transferred to the health professional 3 education loan forgiveness program 4 account for loan forgiveness for nurses 5 under Minnesota Statutes, section 6 144.1501. This appropriation shall 7 become part of base level funding for the commissioner for the biennium 8 9 beginning July 1, 2007, but shall not 10 be part of base level funding for the 11 biennium beginning July 1, 2009. Notwithstanding section 7, this 12 13 paragraph expires on June 30, 2009. 14

# 15 Subd. 4. Board of Pharmacy

# 16 499,000 499,000

[RURAL PHARMACY PROGRAM.] Of this 17 appropriation, \$200,000 each year shall be transferred to the commissioner of 18 19 health for the rural pharmacy planning 20 and transition grant program under 21 Minnesota Statutes, section 144.1476. Of this transferred amount, \$20,000 22 23 each year may be retained by the 24 commissioner for related administrative 25 This appropriation shall become 26 costs. part of base level funding for the commissioner for the biennium beginning July 1, 2007. Notwithstanding section 27 28 29 7, this paragraph expires on June 30, 30 31 2009.

[PHARMACIST LOAN FORGIVENESS.] \$200,000 32 each year shall be transferred to the 33 34 health professional education loan forgiveness program account for loan forgiveness for pharmacists under Minnesota Statutes, section 144.501. 35 36 37 38 This appropriation shall become part of base level funding for the commissioner 39 for the biennium beginning July 1, 4041 2007. Notwithstanding section 7, this 42 paragraph expires on June 30, 2009.

[DRUG MANUFACTURER PRICING DISCLOSURE.]
(a) The board shall increase the
licensing or registration fee for
wholesale drug distributors and drug
manufacturers required under Minnesota
Statutes, chapter 151, by \$65 per year
beginning July 1, 2005.

50 (b) Of the appropriation in this
51 subdivision, \$74,000 each year is to be
52 transferred to the commissioner of
53 human services for the data received
54 under Minnesota Statutes, section
55 151.52.

56 [CANCER DRUG REPOSITORY PROGRAM.] Of 57 this appropriation, \$25,000 each year 58 is for the cancer drug repository 59 program under Minnesota Statutes, 60 section 151.55. This appropriation shall become part of base level funding 61 for the board for the biennium 62 beginning July 1, 2007, but shall not be part of the base for the biennium 63 64

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beginning July 1, 2009. 1 Notwithstanding section 7, this 2 paragraph expires June 30, 2009. 3 4 Subd. 5. Board of Social 5 Work 105,000 100,000 6 7 [ADMINISTRATIVE MANAGEMENT.] This appropriation is to provide 8 administrative management under 9 Minnesota Statutes, section 148B.61, 10 subdivision 4. The following boards 11 12 shall be assessed a prorated amount depending on the number of licensees under the board's regulatory authority 13 14 providing mental health services within 15 their scope of practice: Board of 16 Medical Practice, the Board of Nursing, 17 18 the Board of Psychology, the Board of Social Work, the Board of Marriage and 19 Family Therapy, and the Board of 20 Behavioral Health and Therapy. 21 [BASE LEVEL FUNDING ADJUSTMENTS.] 22 Sec. 6. 23 Base level funding for the biennium beginning July 1, 2007, for nonentitlement grants and administration appropriations in 24 25 this article shall be shown in legislative tracking documents. Notwithstanding section 7, this section shall expire on June 30, 26 27 2009. Sec. 7. [SUNSET OF UNCODIFIED LANGUAGE.] 28 29 All uncodified language in this article expires on June 30, 30 2007, unless a different expiration date is explicit." 31 Renumber the sections in sequence and correct the internal 32 references

33 Amend the title accordingly

[COUNSEL ] JW SCS2278A12 05/02/05 Senator ..... moves to amend S.F. No. 2278 as follows: 1 Page 17, line 33, delete "or" and after "area" insert ", or 2 specialty type" 3 Page 18, line 2, after "communities" insert "and pediatric 4 psychiatry" 5 Page 18, line 4, after "communities" insert "or pediatric 6 7 psychiatry" Page 56, after line 12, insert: 8 "Sec. 4. Minnesota Statutes 2004, section 256.045, 9 10 subdivision 3, is amended to read: [STATE AGENCY HEARINGS.] (a) State agency Subd. 3. 11 hearings are available for the following: (1) any person 12 applying for, receiving or having received public assistance, 13 medical care, or a program of social services granted by the 14 state agency or a county agency or the federal Food Stamp Act 15 whose application for assistance is denied, not acted upon with 16 17 reasonable promptness, or whose assistance is suspended, reduced, terminated, or claimed to have been incorrectly paid; 18 (2) any patient or relative aggrieved by an order of the 19 commissioner under section 252.27; (3) a party aggrieved by a 20 ruling of a prepaid health plan; (4) except as provided under 21 chapter 245C, any individual or facility determined by a lead 22 agency to have maltreated a vulnerable adult under section 23 626.557 after they have exercised their right to administrative 24 25 reconsideration under section 626.557; (5) any person whose claim for foster care payment according to a placement of the 26 child resulting from a child protection assessment under section 27 626.556 is denied or not acted upon with reasonable promptness, 28 regardless of funding source; (6) any person to whom a right of 29 appeal according to this section is given by other provision of 30 law; (7) an applicant aggrieved by an adverse decision to an 31 application for a hardship waiver under section 256B.15; (8) an 32 applicant aggrieved by an adverse decision to an application or 33 4 redetermination for a Medicare Part D prescription drug subsidy under section 256B.04, subdivision 4a; (9) except as provided 35 under chapter 245A, an individual or facility determined to have 36

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maltreated a minor under section 626.556, after the individual 1 or facility has exercised the right to administrative 2 reconsideration under section 626.556; or (9) (10) except as 3 provided under chapter 245C, an individual disqualified under 4 sections 245C.14 and 245C.15, on the basis of serious or 5 recurring maltreatment; a preponderance of the evidence that the 6 individual has committed an act or acts that meet the definition 7 of any of the crimes listed in section 245C.15, subdivisions 1 8 to 4; or for failing to make reports required under section 9 626.556, subdivision 3, or 626.557, subdivision 3. Hearings 10 regarding a maltreatment determination under clause (4) 11 or  $(\theta)$  (9) and a disqualification under this clause in which the 12 basis for a disqualification is serious or recurring 13 maltreatment, which has not been set aside under sections 14 245C.22 and 245C.23, shall be consolidated into a single fair 15 hearing. In such cases, the scope of review by the human 16 services referee shall include both the maltreatment 17 determination and the disqualification. The failure to exercise 18 the right to an administrative reconsideration shall not be a 19 bar to a hearing under this section if federal law provides an 20 individual the right to a hearing to dispute a finding of 21 maltreatment. Individuals and organizations specified in this 22 section may contest the specified action, decision, or final 23 disposition before the state agency by submitting a written 24 request for a hearing to the state agency within 30 days after 25 receiving written notice of the action, decision, or final 26 disposition, or within 90 days of such written notice if the 27 applicant, recipient, patient, or relative shows good cause why 28 the request was not submitted within the 30-day time limit. 29 The hearing for an individual or facility under clause (4), 30

(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 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 1 a contested case proceeding under the provisions of chapter 14. 2 Hearings requested under clause (8) (9) apply only to incidents 3 of maltreatment that occur on or after July 1, 1997. A hearing 4 for an individual or facility under clause  $(\theta)$  (9) is only 5 available when there is no juvenile court or adult criminal 6 If such action is filed in either court while 7 action pending. an administrative review is pending, the administrative review 8 must be suspended until the judicial actions are completed. If 9 10 the juvenile court action or criminal charge is dismissed or the criminal action overturned, the matter may be considered in an 11 administrative hearing. 12

For purposes of this section, bargaining unit grievanceprocedures are not an administrative appeal.

The scope of hearings involving claims to foster care 15 payments under clause (5) shall be limited to the issue of 16 whether the county is legally responsible for a child's 17 placement under court order or voluntary placement agreement 18 and, if so, the correct amount of foster care payment to be made 19 on the child's behalf and shall not include review of the 20 propriety of the county's child protection determination or 21 child placement decision. 22

(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 included in the amended
community social services plan.

31 (d) The commissioner may summarily affirm the county or 32 state agency's proposed action without a hearing when the sole 33 issue is an automatic change due to a change in state or federal 4 law."

35 Page 57, after line 31, insert:

36 "Sec. 6. Minnesota Statutes 2004, section 256B.04, is

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1	amended by adding a subdivision to read:
2	Subd. 4a. [MEDICARE PRESCRIPTION DRUG SUBSIDY.] The
3	commissioner shall perform all duties necessary to administer
4	eligibility determinations for the Medicare Part D prescription
5	drug subsidy and facilitate the enrollment of eligible medical
6	assistance recipients into Medicare prescription drug plans as
7	required by the Medicare Prescription Drug, Improvement, and
8	Modernization Act of 2003 (MMA), Public Law 108-173, and Code of
9	Federal Regulations, title 42, sections 423.30 to 423.56 and
10	<u>423.771 to 423.800.</u> "
11	Page 57, line 34, delete " <u>PROGRAM</u> " and insert " <u>PROGRAMS</u> "
12	Page 57, line 35, before "PROGRAM" insert " <u>INSURANCE</u>
13	ASSISTANCE"
14	Page 59, line 9, before " <u>The</u> " insert " <u>(</u> a) For individuals
15	who are uninsured or insured with 50 percent or less of the
16	premium by an employer,"
17	Page 59, line 14, after the period, insert:
18	" <u>(b)</u> "
19	Page 59, line 15, strike "2" and insert "1"
20	Page 59, line 30, after " <u>appropriate</u> " insert " <u>for efficient</u>
21	program administration"
22	Page 59, line 33, before " <u>The</u> " insert " <u>(a)</u> "
23	Page 59, line 36, after the period, insert:
24	" <u>(b)</u> "
25	Page 60, after line 2, insert:
26	"(c) Each year following the release of the November
27	revenue forecast, the commissioner shall report to the chairs of
28	the appropriate health and human services finance committees the
29	forecasted need for the HIV health care access programs included
30	in this section. The report shall include information about the
31	anticipated enrollment, service utilization, service costs,
32	state, federal, and special revenue resources available to fund
33	the program needs, and any anticipated funding shortfall.
34	(d) When a shortfall of funding is projected,
35	recommendations should be included to assure that the program

36 expenditures are maintained within the anticipated available

1	funding."
2	Page 60, line 3, before " <u>The</u> " insert " <u>(a)</u> "
3	Page 60, line 6, after the period, insert:
4	"(b) The policies and procedures shall consider the impacts
5	of continued HIV treatment on:
6	(1) reducing the risk for HIV transmission;
7	(2) preventing program recipients from becoming drug
8	resistant; and
9	(3) the prevention of the development of drug-resistant
10	strains of HIV."
11	Page 60, line 7, delete "FEDERAL" and insert "FEDERALLY
12	FUNDED HIV HEALTH CARE ACCESS" and before " <u>The</u> " insert " <u>(a)</u> "
13	Page 60, line 10, after the period, insert:
14	"(b) Within the limits of the federal funding available for
15	these purposes, the commissioner may provide access to drugs
16	that treat HIV and manage the side effects of HIV treatment to
17	persons who meet the eligibility requirements in subdivision 2.
18	(c) The commissioner may establish co-payment obligations
19	for drugs purchased under this section."
20	Page 60, line 22, delete " <u>, effective July 1, 2005</u> "
21	Page 73, line 12, strike everything after "percent"
22	Page 73, strike lines 13 to 15
23	Page 73, line 16, strike everything before the period
24	Page 78, line 35, after " <u>and</u> " insert " <u>propose a</u> "
25	Page 79, line 1, before the period, insert " <u>, reporting</u>
26	separately for managed care and fee-for-service recipients"
27	Page 79, line 3, delete " <u>or single-physician practices</u> "
28	Page 79, line 11, delete " <u>or single-physician practice</u> "
29	Page 79, line 17, delete " <u>develop</u> " and insert " <u>advise on</u>
30	the development of"
31	Page 79, line 27, delete "provide" and insert "propose"
32	Page 80, delete lines 15 to 17
33	Page 80, line 18, delete " <u>(e)</u> " and insert " <u>(d)</u> "
4	Page 80, line 19, after " <u>and</u> " insert " <u>proposed</u> "
35	Page 80, line 23, delete " <u>(f)</u> " and insert " <u>(e)</u> " and delete "
36	April" and insert "October"

05/02/05 [COUNSEL ] JW SCS2278A12 Page 80, line 25, delete ", single-physician practice," and 1 delete "hospital" and insert "hospitals where possible" 2 Page 80, line 26, after the first "and" insert "when 3 4 feasible" Page 80, lines 27 and 28, delete ", single-physician 5 6 practice," 7 Page 83, delete lines 14 to 24 and insert: "(a) Hennepin County, Hennepin County Medical Center, 8 Ramsey County, Regions Hospital, the University of Minnesota, 9 10 and Fairview-University Medical Center shall annually report to 11 the commissioner by June 1, beginning June 1, 2005, payments made during the previous calendar year that may qualify for 12 reimbursement under federal law. Subject to the reports due 13 14 June 1, 2005, the amounts for calendar year 2004 are expected to be as follows: 15 16 (1) Hennepin County and Hennepin County Medical Center, 17 \$31,980,000; 18 (2) Ramsey County and Regions Hospital, \$20,980,000; and 19 (3) University of Minnesota and Fairview-University Medical Center, \$11,050,000." 20 Page 91, after line 28, insert: 21 "Sec. 31. Minnesota Statutes 2004, section 256L.01, 22 subdivision 5, is amended to read: 23 24 Subd. 5. [INCOME.] (a) "Income" has the meaning given for earned and unearned income for families and children in the 25 26 medical assistance program, according to the state's aid to families with dependent children plan in effect as of July 16, 27 1996. The definition does not include medical assistance income 28 methodologies and deeming requirements. The earned income of 29 30 full-time and part-time students under age 19 is not counted as income. Public assistance payments and supplemental security 31 32 income are not excluded income. 33 (b) For purposes of this subdivision, and unless otherwise 34 specified in this section, the commissioner shall use reasonable 35 methods to calculate gross earned and unearned income including, but not limited to, projecting income based on income received 36

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	-	within the next 20 days the last 90 days or the last 12 months
_	1	within the past 30 days, the last 90 days, or the last 12 months.
	2	[EFFECTIVE DATE.] This section is effective July 1, 2005."
	3	Page 93, line 13, strike "equal to or"
	4	Page 99, line 29, after the comma, insert " <u>an applicant or</u>
	5	enrollee who is entitled to" and after "or" insert "enrolled in
	6	Medicare Part"
	7	Page 99, line 31, strike "1395w-4" and insert " <u>1395w-152</u> "
	8	and after "considered" insert " <u>to have</u> "
	9	Page 99, line 32, after "enrollee" insert " <u>who is entitled</u>
	10	to premium-free Medicare Part A" and after "refuse" insert "to
	11	apply for or enroll in"
	12	Page 107, delete lines 19 to 21 and insert:
	13	"(d) This section expires July 1, 2007, or upon the
	14	completion of the prior authorization system required under
	15	subdivision 1, paragraph (b), whichever is earlier."
	16	Page 108, line 3, delete " <u>later</u> " and insert " <u>earlier</u> "
	17	Page 108, delete section 49 and insert:
	18	"Sec. 49. [ORAL HEALTH CARE PILOT PROJECT.]
	19	The commissioner shall implement a two-year pilot project
	20	to provide services for state program recipients through a new
	21	oral health care delivery system. The commissioner shall
	22	contract with a qualified entity or entities to administer the
	23	pilot project."
,	24	Page 158, line 20, delete " <u>life</u> "
	25	Page 158, delete lines 21 to 24 and insert "a deceased
	26	recipient's life estates and jointly owned interests in farm and
	27	income producing real property they own of record on the date
	28	they die if their interest in the property ends at their death,
	29	the surviving remainderman or surviving joint tenant owns their
	30	interest in the property of record on that date, and all of the
	31	following conditions apply with respect to the surviving
	32	remainderman or the surviving joint tenant and their interest in
	33	the property:"
n// 789ms. ,	}4	Page 159, line 34, delete everything after "The"
	35	Page 159, delete lines 35 and 36
	36	Page 160, line 1, delete everything before "amendments"

	05/02/05 [COUNSEL ] JW SCS2278A12
1	Page 161, line 15, delete "relating"
2	Page 161, delete line 16 and insert "are effective"
3	Page 161, line 17, delete "2003" and insert "2005"
4	Page 161, line 36, delete "retroactively"
5	Page 162, line 1, delete "from July 1, 2003" and insert
6	" <u>July 1, 2005</u> "
7	Page 175, line 23, delete " <u>life</u> "
8	Page 175, delete lines 24 to 27 and insert " <u>a deceased</u>
9	recipient's life estates and jointly owned interests in farm and
10	income producing real property they own of record on the date
11	they die if their interest in the property ends at their death,
12	the surviving remainderman or surviving joint tenant owns their
13	interest in the property of record on that date, and all of the
14	following conditions apply with respect to the surviving
15	remainderman or surviving joint tenant and their interest in the
16	property:"
17	Page 178, line 1, delete "retroactively"
18	Page 178, line 2, delete "from July 1, 2003" and insert
19	"July 1, 2005"
20	Page 181, line 31, after " <u>lien</u> " insert " <u>and estate claims</u>
21	recovery"
22	Page 181, line 35, after " <u>sections</u> " insert " <u>256B.15 and</u> "
23	Page 182, line 2, delete " <u>retroactively</u> "
24	Page 182, delete line 3 and insert "July 1, 2005."
25	Page 182, line 19, delete " <u>retroactively from</u> "
26	Page 182, delete line 20 and insert "effective July 1,
27	2005. On and after the repeal date all alternative care liens
28	of record shall be of no force and effect, shall not be liens on
29	real property, and examiners of title shall disregard these
30	liens and shall not carry them forward to subsequent
31	certificates of title."
32	Page 189, after line 19, insert:
33	"Sec. 7. Minnesota Statutes 2004, section 245.4874, is
34	amended to read:
35	245.4874 [DUTIES OF COUNTY BOARD.]
36	(a) The county board in each county shall use its share of

# [COUNSEL ] JW SCS2278A12

# 05/02/05

1 mental health and Community Social Services Act funds allocated 2 by the commissioner according to a biennial children's mental 3 health component of the community social services plan that is 4 approved by the commissioner. The county board must:

5 (1) develop a system of affordable and locally available
6 children's mental health services according to sections 245.487
7 to 245.4887;

(2) establish a mechanism providing for interagency 8 coordination as specified in section 245.4875, subdivision 6; 9 (3) develop a biennial children's mental health component 10 of the community social services plan which considers the 11 assessment of unmet needs in the county as reported by the local 12 children's mental health advisory council under section 13 245.4875, subdivision 5, paragraph (b), clause (3). The county 14 shall provide, upon request of the local children's mental 15 health advisory council, readily available data to assist in the 16 determination of unmet needs; 17

(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,

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1 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;

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

9 (11) assure that mental health professionals, mental health 10 practitioners, and case managers employed by or under contract 11 to the county to provide mental health services are qualified 12 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 for children of
cultural or racial minority heritage; and

(14) consistent with section 245.486, arrange for or 22 23 provide a children's mental health screening to a child receiving child protective services or a child in out-of-home 24 placement, a child for whom parental rights have been 25 26 terminated, a child found to be delinquent, and a child found to 27 have committed a juvenile petty offense for the third or subsequent time, unless a screening has been performed within 28 the previous 180 days, or the child is currently under the care 29 of a mental health professional. The court or county agency 30 31 must notify a parent or guardian whose parental rights have not 32 been terminated of the potential mental health screening and the option to prevent the screening by notifying the court or county 33 34 agency in writing. The screening shall be conducted with a screening instrument approved by the commissioner of human 35 36 services according to criteria that are updated and issued

annually to ensure that approved screening instruments are valid 1 and useful for child welfare and juvenile justice populations, 2 and shall be conducted by a mental health practitioner as 3 defined in section 245.4871, subdivision 26, or a probation 4 officer or local social services agency staff person who is 5 trained in the use of the screening instrument. Training in the 6 use of the instrument shall include training in the 7 administration of the instrument, the interpretation of its 8 validity given the child's current circumstances, the state and 9 federal data practices laws and confidentiality standards, the 10 parental consent requirement, and providing respect for families 11 and cultural values. If the screen indicates a need for 12 assessment, the child's family, or if the family lacks mental 13 health insurance, the local social services agency, in 14 consultation with the child's family, shall have conducted a 15 diagnostic assessment, including a functional assessment, as 16 defined in section 245.4871. The administration of the 17 screening shall safeguard the privacy of children receiving the 18 screening and their families and shall comply with the Minnesota 19 Government Data Practices Act, chapter 13, and the federal 20 Health Insurance Portability and Accountability Act of 1996, 21 Public Law 104-191. Screening results shall be considered 22 private data and the commissioner shall not collect individual 23 screening results. 24

25 (b) When the county board refers clients to providers of 26 children's therapeutic services and supports under section 256B.0943, the county board must clearly identify the 27 nonchildren's therapeutic services and supports covered services 28 components and identify the reimbursement source for those 29 requested services, the method of payment, and the payment rate 30 31 to the provider." Page 213, line 25, after "(2)" insert "if the adjusted 32 gross income is equal to or greater than 175 percent of the 33 federal poverty guidelines and less than or equal to 200 percent 4

35 of the federal poverty guidelines, the parental contribution

36 shall be one percent of the adjusted gross income;

	05/02/05 [COUNSEL ] JW SCS2278A12	
1	<u>(3)</u> "	
2	Page 213, lines 26 and 30, strike "175" and insert " <u>200</u> "	
3	Page 213, lines 27 and 33, strike "375" and insert " <u>420</u> "	
4	Page 213, line 34, strike "(3)" and insert " <u>(4)</u> " and strik	٢e
5	"375" and insert " <u>420</u> "	
6	Page 214, line 2, strike "(4)" and insert " <u>(5)</u> "	
7	Page 214, line 6, strike "(5)" and insert" <u>(6)</u> "	
8	Page 216, delete lines 26 to 33	
9	Page 240, line 25, delete " <u>July 1, 2005</u> " and insert " <u>the</u>	
10	first day of the second month after the date of approval by the	2
11	United States Department of Agriculture"	
12	Renumber the sections in sequence and correct the internal	L
13	references	

14 Amend the title accordingly

Senator ..... moves to amend S.F. No. 2278 as follows: 1 2 Page 254, after line 11, insert: "Sec. 9. Laws 2003, First Special Session chapter 14, 3 article 13C, section 2, subdivision 6, is amended to read: 4 COMMISSIONER OF 5 Sec. 2. HUMAN SERVICES 6 7 Subd. 6. Basic Health Care Grants 8 Summary by Fund General 1,499,941,000 1,533,016,000 9 Health Care Access 268,151,000 10 282,605,000 [UPDATING FEDERAL POVERTY GUIDELINES.] 11 Annual updates to the federal poverty guidelines are effective each July 1, 12 13 following publication by the United 14 15 States Department of Health and Human Services for health care programs under 16 Minnesota Statutes, chapters 256, 256B, 17 256D, and 256L. 18 19 The amounts that may be spent from this 20 appropriation for each purpose are as 21 follows: 22 (a) MinnesotaCare Grants 23 Health Care Access 267,401,000 281,855,000 [MINNESOTACARE FEDERAL RECEIPTS.] 24 25 Receipts received as a result of 26 federal participation pertaining to administrative costs of the Minnesota 27 28 health care reform waiver shall be 29 deposited as nondedicated revenue in 30 the health care access fund. Receipts 31 received as a result of federal participation pertaining to grants 32 33 shall be deposited in the federal fund 34 and shall offset health care access 35 funds for payments to providers. [MINNESOTACARE FUNDING.] The 36 37 commissioner may expend money appropriated from the health care 38 access fund for MinnesotaCare in either fiscal year of the biennium. 39 40 41 (b) MA Basic Health Care Grants -42 Families and Children 43 568,254,000 General 582,161,000 44 [SERVICES TO PREGNANT WOMEN.] The 45 commissioner shall use available federal money for the State-Children's 46 Health Insurance Program for medical 47 48 assistance services provided to 49 pregnant women who are not otherwise 50 eligible for federal financial 51 participation beginning in fiscal year 52 2003. This federal money shall be 53 deposited in the federal fund and shall offset general funds for payments to 54

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providers. Notwithstanding section 14,
 this paragraph shall not expire.

3 [MANAGED CARE RATE INCREASE.] (a) Effective January 1, 2004, the 4 commissioner of human services shall 5 increase the total payments to managed 6 care plans under Minnesota Statutes, section 256B.69, by an amount equal to 7 8 the cost increases to the managed care 9 plans from by the elimination of: (1) 10 the exemption from the taxes imposed 11 under Minnesota Statutes, section 12 297I.05, subdivision 5, for premiums 13 paid by the state for medical 14 15 assistance, general assistance medical care, and the MinnesotaCare program; 16 17 and (2) the exemption of gross revenues subject to the taxes imposed under 18 Minnesota Statutes, sections 295.50 to 19 295.57, for payments paid by the state 20 for services provided under medical 21 22 assistance, general assistance medical care, and the MinnesotaCare program. 23 24 Any increase based on clause (2) must be reflected in provider rates paid by 25 26 the managed care plan unless the managed care plan is a staff model 27 28 health plan company.

29 (b) The commissioner of human services shall increase by two-percent the 30 applicable tax rate in effect under 31 32 Minnesota Statutes, section 295.52, the 33 fee-for-service payments under medical assistance, general assistance medical care, and the MinnesotaCare program for 34 35 services subject to the hospital, 36 surgical center, or health care 37 provider taxes under Minnesota 38 Statutes, sections 295.50 to 295.57, 39 effective for services rendered on or 40 41 after January 1, 2004.

42 (c) The commissioner of finance shall 43 transfer from the health care access 44 fund to the general fund the following 45 amounts in the fiscal years indicated: 46 2004, \$16,587,000; 2005, \$46,322,000; 47 2006, \$49,413,000; and 2007, 48 \$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 55 56 hospitals, surgical centers, and health care providers as payments for services provided under medical assistance, 57 58 59 general assistance medical care, and 60 the MinnesotaCare program, including payments received directly from the 61 state or from a prepaid plan, under Minnesota Statutes, sections 295.50 to 62 63 64 295.57; and

65 (2) premiums paid by the state under

medical assistance, general assistance 1 medical care, and the MinnesotaCare program under Minnesota Statutes, 2 3 section 297I.05, subdivision 5. 4 The commissioner of finance shall 5 6 monitor and adjust if necessary the 7 amount transferred each fiscal year from the health care access fund to the 8 general fund to ensure that the amount 9 transferred equals the tax revenue 10 collected for the items described in 11 clauses (1) and (2) for that fiscal 12 13 year. 14 (e) Notwithstanding section 14, these 15 provisions shall not expire. (c) MA Basic Health Care Grants - Elderly 16 and Disabled 17 741,605,000 General 695,421,000 18 19 [DELAY MEDICAL ASSISTANCE FEE-FOR-SERVICE - ACUTE CARE.] The 20 following payments in fiscal year 2005 21 from the Medicaid Management 22 Information System that would otherwise 23 have been made to providers for medical 24 assistance and general assistance 25 medical care services shall be delayed 26 and included in the first payment in 27 fiscal year 2006: 28 29 (1) for hospitals, the last two payments; and 30 31 (2) for nonhospital providers, the last 32 payment. This payment delay shall not include 33 payments to skilled nursing facilities, 34 intermediate care facilities for mental 35 36 retardation, prepaid health plans, home 37 health agencies, personal care nursing providers, and providers of only waiver 38 services. The provisions of Minnesota 39 Statutes, section 16A.124, shall not apply to these delayed payments. 40 41 42 Notwithstanding section 14, this 43 provision shall not expire. 44 [DEAF AND HARD-OF-HEARING SERVICES.] If, after making reasonable efforts, 45 the service provider for mental health 46 47 services to persons who are deaf or 48 hearing impaired is not able to earn 49 \$227,000 through participation in 50 medical assistance intensive rehabilitation services in fiscal year 51 52 2005, the commissioner shall transfer 53 \$227,000 minus medical assistance 54 earnings achieved by the grantee to deaf and hard-of-hearing grants to 55 enable the provider to continue 56 57 providing services to eligible persons. 58 (d) General Assistance Medical Care 59 Grants

60 General

223,960,000 196,617,000

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05/02/05 [COUNSEL ] KC (e) Health Care Grants - Other 1 Assistance 2 3,067,000 3,407,000 3 General 750,000 750,000 4 Health Care Access [MINNESOTA PRESCRIPTION DRUG DEDICATED 5 FUND.] Of the general fund 6 appropriation, \$284,000 in fiscal year 7 2005 is appropriated to the 8 9 commissioner for the prescription drug dedicated fund established under the 10 prescription drug discount program. 11 [DENTAL ACCESS GRANTS CARRYOVER 12 13 AUTHORITY.] Any unspent portion of the 14 appropriation from the health care access fund in fiscal years 2002 and 15 2003 for dental access grants under 16 17 Minnesota Statutes, section 256B.53, shall not cancel but shall be allowed 18 to carry forward to be spent in the biennium beginning July 1, 2003, for 19 20 21 these purposes. 22 [STOP-LOSS FUND ACCOUNT.] The 23 appropriation to the purchasing 24 alliance stop-loss fund account 25 established under Minnesota Statutes, section 256.956, subdivision 2, for 26 27 fiscal years 2004 and 2005 shall only be available for claim reimbursements 28 for qualifying enrollees who are 29 30 members of purchasing alliances that meet the requirements described under 31 32 Minnesota Statutes, section 256.956, subdivision 1, paragraph (f), clauses (1), (2), and (3). 33 34 35 (f) Prescription Drug Program General 36 9,239,000 9,226,000 37 [PRESCRIPTION DRUG ASSISTANCE PROGRAM.] Of the general fund appropriation, 38 \$702,000 in fiscal year 2004 and 39 \$887,000 in fiscal year 2005 are for 40 41 the commissioner to establish and administer the prescription drug assistance program through the 42 43 Minnesota board on aging. 44 45 [REBATE REVENUE RECAPTURE.] Any funds received by the state from a drug 46 manufacturer due to errors in the 47 48 pharmaceutical pricing used by the 49 manufacturer in determining the 50 prescription drug rebate are appropriated to the commissioner to 51 augment funding of the prescription 52 53 drug program established in Minnesota 54 Statutes, section 256.955." 55 Renumber the sections in sequence and correct the internal 56 references 57 Amend the title accordingly

1	Senator	moves to amend S.F.	No.	2278 as	follows:
2	Page 11, delet	e lines 17 to 23			

1	Senator moves to amend S.F. No. 2278 as
2	follows: 2 25 K
3	Page <del>121</del> , after line <del>17</del> , insert:
4	"Sec. 8. [62J.495] [HEALTH INFORMATION TECHNOLOGY AND
5	INFRASTRUCTURE ADVISORY COMMITTEE.]
6	Subdivision 1. [ESTABLISHMENT; MEMBERS; DUTIES.] (a) The
7	commissioner shall establish a Health Information Technology and
8	Infrastructure Advisory Committee governed by section 15.059 to
9	advise the commissioner on the following matters:
10	(1) assessment of the use of health information technology
11	by the state, licensed health care providers and facilities, and
12	local public health agencies;
13	(2) recommendations for implementing a statewide
14	interoperable health information infrastructure, to include
15	estimates of necessary resources, and for determining standards
16	for administrative data exchange, clinical support programs, and
17	maintenance of the security and confidentiality of individual
18	patient data; and
19	(3) other related issues as requested by the commissioner.
20	(b) The members of the Health Information Technology and
21	Infrastructure Advisory Committee shall include the
22	commissioners, or commissioners' designees, of health, human
23	services, and commerce and additional members to be appointed by
24	the commissioner to include persons representing Minnesota's
25	local public health agencies, licensed hospitals and other
26	licensed facilities and providers, the medical and nursing
27	professions, health insurers and health plans, the state quality
28	improvement organization, academic and research institutions,
29	consumer advisory organizations with an interest and expertise
30	in health information technology, and other stakeholders as
31	identified by the Health Information Technology and
32	Infrastructure Advisory Committee.
33	Subd. 2. [ANNUAL REPORT.] The commissioner shall prepare
34	and issue an annual report not later than January 30 of each
35	year outlining progress to date in implementing a statewide
36	health information infrastructure and recommending future

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1	projects.
2	Subd. 3. [EXPIRATION.] Notwithstanding section 15.059,
3	this section expires June 30, 2009."
4	Page $\frac{11}{126}$ , after line $\frac{35}{18}$ , insert:
5	"Sec. 13. Minnesota Statutes 2004, section 144.147,
6	subdivision 2, is amended to read:
7	Subd. 2. [GRANTS AUTHORIZED.] The commissioner shall
8	establish a program of grants to assist eligible rural
9	hospitals. The commissioner shall award grants to hospitals and
10	communities for the purposes set forth in paragraphs (a) and (b).
11	(a) Grants may be used by hospitals and their communities
12	to develop strategic plans for preserving or enhancing access to
13	health services. At a minimum, a strategic plan must consist of:
14	(1) a needs assessment to determine what health services
15	are needed and desired by the community. The assessment must
16	include interviews with or surveys of area health professionals,
17	local community leaders, and public hearings;
18	(2) an assessment of the feasibility of providing needed
19	health services that identifies priorities and timeliness for
20	potential changes; and
21	(3) an implementation plan.
22	The strategic plan must be developed by a committee that
23	includes representatives from the hospital, local public health
24	agencies, other health providers, and consumers from the
25	community.
26	(b) The grants may also be used by eligible rural hospitals
27	that have developed strategic plans to implement transition
28	projects to modify the type and extent of services provided, in
29	order to reflect the needs of that plan. Grants may be used by
30	hospitals under this paragraph to develop hospital-based
31	physician practices that integrate hospital and existing medical
32	practice facilities that agree to transfer their practices,
33	equipment, staffing, and administration to the hospital. The
34	grants may also be used by the hospital to establish a health
35	provider cooperative, a telemedicine system, <u>an electronic</u>
36	health records system, or a rural health care system or to cover

	1	expenses associated with being designated as a critical access
	2	hospital for the Medicare rural hospital flexibility program.
, and any a	3	Not more than one-third of any grant shall be used to offset
	4	losses incurred by physicians agreeing to transfer their
	5	practices to hospitals. The commissioner shall give priority to
	6	grant applications for projects involving electronic health
	7 > 8	records systems. Proc 15, line 4, before the period, insert Sec. 14. Minnesota Statutes 2004, section 144.148,
	9	subdivision 1, is amended to read:
	10	Subdivision 1. [DEFINITION.] (a) For purposes of this
	11	section, the following definitions apply.
	12	(b) "Eligible rural hospital" means any nonfederal, general
ر به معر	13	acute care hospital that:
	14	(1) is either located in a rural area, as defined in the
	15	federal Medicare regulations, Code of Federal Regulations, title
	16	42, section 405.1041, or located in a community with a
	17	population of less than 10,000, according to United States
	18	Census Bureau statistics, outside the seven-county metropolitan
	19	area;
	20	(2) has 50 or fewer beds; and
	21	(3) is not for profit.
	22	(c) "Eligible project" means a modernization project to
	23	update, remodel, or replace aging hospital facilities and
	24	equipment necessary to maintain the operations of a hospital $\underline{i}$
	25	including establishing an electronic health records system. The
	26	commissioner shall give priority to grant applications for
	27	projects involving electronic health records systems.
Poje 15,	28	<sup>11</sup> Sec. 15. Minnesota Statutes 2004, section 144.1483, is
after line"	29	amended to read:
Instri -	30	144.1483 [RURAL HEALTH INITIATIVES.]
	31	The commissioner of health, through the Office of Rural
	32	Health, and consulting as necessary with the commissioner of
	33	human services, the commissioner of commerce, the Higher
	34	Education Services Office, and other state agencies, shall:

(1) develop a detailed plan regarding the feasibility of 35 coordinating rural health care services by organizing individual 36

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medical providers and smaller hospitals and clinics into
 referral networks with larger rural hospitals and clinics that
 provide a broader array of services;

4 (2) develop-and-implement-a-program-to-assist-rural
5 communities-in-establishing-community-health-centers,-as
6 required-by-section-144-1486;

7 (3) develop recommendations regarding health education and 8 training programs in rural areas, including but not limited to a 9 physician assistants' training program, continuing education 10 programs for rural health care providers, and rural outreach 11 programs for nurse practitioners within existing training 12 programs;

13 (4) (3) develop a statewide, coordinated recruitment
14 strategy for health care personnel and maintain a database on
15 health care personnel as required under section 144.1485;

16 (5) (4) develop and administer technical assistance
17 programs to assist rural communities in: (i) planning and
18 coordinating the delivery of local health care services; and
19 (ii) hiring physicians, nurse practitioners, public health
20 nurses, physician assistants, and other health personnel;

21 (6) (5) study and recommend changes in the regulation of 22 health care personnel, such as nurse practitioners and physician 23 assistants, related to scope of practice, the amount of on-site 24 physician supervision, and dispensing of medication, to address 25 rural health personnel shortages;

26 (7) (6) support efforts to ensure continued funding for
27 medical and nursing education programs that will increase the
28 number of health professionals serving in rural areas;

29 (8) (7) support efforts to secure higher reimbursement for 30 rural health care providers from the Medicare and medical 31 assistance programs;

32 (9) (8) coordinate the development of a statewide plan for 33 emergency medical services, in cooperation with the Emergency 34 Medical Services Advisory Council;

 $(\frac{10}{9})$  establish a Medicare rural hospital flexibility 36 program pursuant to section 1820 of the federal Social Security

Act, United States Code, title 42, section 1395i-4, by 1 developing a state rural health plan and designating, consistent 2 with the rural health plan, rural nonprofit or public hospitals 3 in the state as critical access hospitals. Critical access 4 hospitals shall include facilities that are certified by the 5 state as necessary providers of health care services to 6 residents in the area. Necessary providers of health care 7 services are designated as critical access hospitals on the 8 basis of being more than 20 miles, defined as official mileage 9 as reported by the Minnesota Department of Transportation, from 10 the next nearest hospital, being the sole hospital in the 11 county, being a hospital located in a county with a designated 12 medically underserved area or health professional shortage area, 13 14 or being a hospital located in a county contiguous to a county with a medically underserved area or health professional 15 shortage area. A critical access hospital located in a county 16 17 with a designated medically underserved area or a health 18 professional shortage area or in a county contiguous to a county with a medically underserved area or health professional 19 shortage area shall continue to be recognized as a critical 20 access hospital in the event the medically underserved area or 21 health professional shortage area designation is subsequently 22 withdrawn; and 23

2.000 (Chap).

24 (11) carry out other activities necessary to address
25 rural health problems.
26 Page 37, after line and insert
26 Sec. 16. Minnesota Statutes 2004, section 145.9268, is

27 amended to read:

28 145.9268 [COMMUNITY CLINIC GRANTS.]

29 Subdivision 1. [DEFINITION.] For purposes of this section,
30 "eligible community clinic" means:

(1) a <u>nonprofit</u> clinic that provides <u>is established to</u> provide health services under-conditions-as-defined-in-Minnesota Rules,-part-9505.0255, to low income or rural population groups; provides medical, preventive, dental, or mental health primary care services; and utilizes a sliding fee scale <u>or other</u> procedure to determine eligibility for charity care or to ensure

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1	that no person will be denied services because of inability to
2	pay;
3	(2) <u>a governmental entity or</u> an Indian tribal government or
4	Indian health service unit that provides services and utilizes a
5	sliding fee scale or other procedure as described under clause
6	<u>(1);</u> or
7	(3) a consortium of clinics comprised of entities under
8	clause (1) or (2) <u>; or</u>
9	(4) a nonprofit, tribal, or governmental entity proposing
10	the establishment of a clinic that will provide services and
11	utilize a sliding fee scale or other procedure as described
12	under clause (1).
13	Subd. 2. [GRANTS AUTHORIZED.] The commissioner of health
14	shall award grants to eligible community clinics to plan,
15	establish, or operate services to improve the ongoing viability
16	of Minnesota's clinic-based safety net providers. Grants shall
17	be awarded to support the capacity of eligible community clinics
18	to serve low-income populations, reduce current or future
19	uncompensated care burdens, or provide for improved care
20	delivery infrastructure. The commissioner shall award grants to
21	community clinics in metropolitan and rural areas of the state,
22	and shall ensure geographic representation in grant awards among
23	all regions of the state.
24	Subd. 3. [ALLOCATION OF GRANTS.] (a) To receive a grant
25	under this section, an eligible community clinic must submit an
26	application to the commissioner of health by the deadline
27	established by the commissioner. A grant may be awarded upon
28	the signing of a grant contract. Community clinics may apply
29	for and the commissioner may award grants for one-year or
30	two-year periods.
31	(b) An application must be on a form and contain
32	information as specified by the commissioner but at a minimum
33	must contain:
34	(1) a description of the purpose or project for which grant

35 funds will be used;

36

(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

6 grant.

(c) The commissioner shall review each application to 7 determine whether the application is complete and whether the 8 applicant and the project are eligible for a grant. In 9 10 evaluating applications according to paragraph (d), the commissioner shall establish criteria including, but not limited 11 to: the priority-level eligibility of the project; the 12 13 applicant's thoroughness and clarity in describing the problem grant funds are intended to address; a description of the 14 applicant's proposed project; a description of the population 15 16 demographics and service area of the proposed project; the manner in which the applicant will demonstrate the effectiveness 17 of any projects undertaken; and evidence of efficiencies and 18 19 effectiveness gained through collaborative efforts. The 20 commissioner may also take into account other relevant factors, 21 including, but not limited to, the percentage for which 22 uninsured patients represent the applicant's patient base and 23 the degree to which grant funds will be used to support services 24 increasing or maintaining access to health care services. 25 During application review, the commissioner may request 26 additional information about a proposed project, including 27 information on project cost. Failure to provide the information 28 requested disqualifies an applicant. The commissioner has 29 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. Fn-addition;
the-commissioner-shall-give-priority;-in-declining-order;-to
grant-applications-for-projects-that: In addition, the

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1 commissioner shall give priority to grant applications for projects involving electronic health records systems. 2 Subd. 3a. [AWARDING GRANTS.] (a) The commissioner may 3

award grants for activities to: 4 (1) provide a direct offset to expenses incurred for 5

services provided to the clinic's target population; 6 7 (2) establish, update, or improve information, data 8 collection, or billing systems, including electronic health

records systems; 9

(3) procure, modernize, remodel, or replace equipment used 10 11 in the delivery of direct patient care at a clinic;

(4) provide improvements for care delivery, such as 12 increased translation and interpretation services; or 13

(5) build a new clinic or expand an existing facility; or 14

(6) other projects determined by the commissioner to 15 improve the ability of applicants to provide care to the 16 vulnerable populations they serve. 17

18 (e) (b) A grant awarded to an eligible community clinic may not exceed \$300,000 per eligible community clinic. For an 19 20 applicant applying as a consortium of clinics, a grant may not 21 exceed \$300,000 per clinic included in the consortium. The commissioner has discretion over the number of grants awarded. 22 [EVALUATION AND REPORT.] The commissioner of 23 Subd. 4. 24 health shall evaluate the overall effectiveness of the grant 25 program. The commissioner shall collect progress reports to 26 evaluate the grant program from the eligible community clinics 27 receiving grants. Every two years, as part of this evaluation, the commissioner shall report to the legislature on priority 28 29 areas-for-grants-set-under-subdivision-3 the needs of community

30 clinics and provide any recommendations for adding or

changing priority-areas eligible activities." Mye 53, line ? after "Sections" insert Sec. 17. -[REPEALER.] 31

32

Minnesota Statutes 2004, section 144.1486, is repealed." 33

34 Renumber the sections in sequence and correct the internal 35 references

36 Amend the title accordingly