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; 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; 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.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, 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; 256B.431, by adding subdivisions; 256B.434, subdivision 4, by adding a subdivision; 256B.5012, by adding a subdivision; 256B.69, subdivisions 4, 23; 256D.03, subdivisions 4, 4;

256D.045; 256D.44, subdivision 5; 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; 256J.95, subdivisions 3, 9; 256L.01, subdivision 4; 256L.03, subdivisions 1, 1, 1b, 5; 256L.04, subdivisions 2, 7, by adding subdivisions; 256L.05, subdivisions 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 adding a subdivision; 326.38; 326.40, subdivision 1; 326.42, subdivision 2; 514.981, subdivision 6; 524.3-805; 549.02, by adding a subdivision; 549.04; proposing coding for new law in Minnesota Statutes, chapters 62J; 62Q; 144; 151; 256; 256B; 256J; 256L; 326; 501B; 641; repealing Minnesota Statutes 2004, sections 119B.074; 157.215; 256B.0631; 256B.69, subdivision 5a; 256J.37, subdivisions 3a, 3b; 256L.035; 326.45; 514.991; 514.992; 514.993; 514.994; 514.995.

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

ARTICLE 1

HEALTH DEPARTMENT

Section 1. Minnesota Statutes 2004, section 103I.101, subdivision 6, is amended to read:

Subd. 6. [FEES FOR VARIANCES.] The commissioner shall charge a nonrefundable application fee of ~~$150~~ $175 to cover the administrative cost of processing a request for a variance or modification of rules adopted by the commissioner under this chapter.

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

Sec. 2. Minnesota Statutes 2004, section 103I.208, subdivision 1, is amended to read:

Subdivision 1. [WELL NOTIFICATION FEE.] The well notification fee to be paid by a property owner is:

(1) for a new well, ~~$150~~ $175, which includes the state core function fee;

(2) for a well sealing, ~~$30~~ $35 for each well, which includes the state core function fee, except that for monitoring wells constructed on a single property, having depths within a 25 foot range, and sealed within 48 hours of start of construction, a single fee of ~~$30~~ $35; and

(3) for construction of a dewatering well, ~~$150~~ $175, which includes the state core function fee, for each well except a dewatering project comprising five or more wells shall be

assessed a single fee of ~~$750~~ $875 for the wells recorded on the notification.

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

Sec. 3. Minnesota Statutes 2004, section 103I.208, subdivision 2, is amended to read:

Subd. 2. [PERMIT FEE.] The permit fee to be paid by a property owner is:

(1) for a well that is not in use under a maintenance permit, ~~$125~~ $150 annually;

(2) for construction of a monitoring well, ~~$150~~ $175, which includes the state core function fee;

(3) for a monitoring well that is unsealed under a maintenance permit, ~~$125~~ $150 annually;

(4) for monitoring wells used as a leak detection device at a single motor fuel retail outlet, a single petroleum bulk storage site excluding tank farms, or a single agricultural chemical facility site, the construction permit fee is ~~$150~~ $175, which includes the state core function fee, per site regardless of the number of wells constructed on the site, and the annual fee for a maintenance permit for unsealed monitoring wells is ~~$125~~ $150 per site regardless of the number of monitoring wells located on site;

(5) for a groundwater thermal exchange device, in addition to the notification fee for wells, ~~$150~~ $175, which includes the state core function fee;

(6) for a vertical heat exchanger, ~~$150~~ $175;

(7) for a dewatering well that is unsealed under a maintenance permit, ~~$125~~ $150 annually for each well, except a dewatering project comprising more than five wells shall be issued a single permit for ~~$625~~ $750 annually for wells recorded on the permit; and

(8) for excavating holes for the purpose of installing elevator shafts, ~~$150~~ $175 for each hole.

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

Sec. 4. Minnesota Statutes 2004, section 103I.235, subdivision 1, is amended to read:

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

(b) At the time of closing of the sale, the disclosure statement information, name and mailing address of the buyer, and the quartile, section, township, and range in which each well is located must be provided on a well disclosure certificate signed by the seller or a person authorized to act on behalf of the seller.

(c) A well disclosure certificate need not be provided if the seller does not know of any wells on the property and the deed or other instrument of conveyance contains the statement: "The Seller certifies that the Seller does not know of any wells on the described real property."

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

(e) This subdivision does not apply to the sale, exchange,

or transfer of real property:

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

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

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

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

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

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

certificate shall not be filed or recorded in the records maintained by the county recorder or registrar of titles. After noting "No wells on property" on the deed or other instrument of conveyance, the county recorder or registrar of titles shall destroy or return to the buyer the well disclosure certificate. The county recorder or registrar of titles shall collect from the buyer or the person seeking to record a deed or other instrument of conveyance, a fee of ~~$30~~ $40 for receipt of a completed well disclosure certificate. By the tenth day of each month, the county recorder or registrar of titles shall transmit the well disclosure certificates to the commissioner of health. By the tenth day after the end of each calendar quarter, the county recorder or registrar of titles shall transmit to the commissioner of health ~~$27.50~~ $32.50 of the fee for each well disclosure certificate received during the quarter. The commissioner shall maintain the well disclosure certificate for at least six years. The commissioner may store the certificate as an electronic image. A copy of that image shall be as valid as the original.

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

(k) The commissioner in consultation with county recorders

shall prescribe the form for a well disclosure certificate and provide well disclosure certificate forms to county recorders and registrars of titles and other interested persons.

(l) Failure to comply with a requirement of this subdivision does not impair:

(1) the validity of a deed or other instrument of conveyance as between the parties to the deed or instrument or as to any other person who otherwise would be bound by the deed or instrument; or

(2) the record, as notice, of any deed or other instrument of conveyance accepted for filing or recording contrary to the provisions of this subdivision.

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

Sec. 5. Minnesota Statutes 2004, section 103I.601, subdivision 2, is amended to read:

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

(b) A person must file an application and renewal application fee to renew the explorer's license by the date stated in the license. The renewal application fee is $75.

(c) If the licensee submits an application fee after the required renewal date, the licensee:

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

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

(d) An explorer ~~may~~ must designate a responsible individual to supervise and oversee the making of exploratory borings. Before an individual supervises or oversees an exploratory boring, the individual must file an application and application fee of $75 to qualify as a responsible individual. The

individual must take and pass an examination relating to construction, location, and sealing of exploratory borings. A professional engineer ~~registered~~ or geoscientist licensed under sections 326.02 to 326.15 or a ~~certified~~ professional geologist certified by the American Institute of Professional Geologists is not required to take the examination required in this subdivision, but must be ~~licensed~~ certified as a responsible individual to ~~make~~ supervise an exploratory boring.

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

144.122 [LICENSE, PERMIT, AND SURVEY FEES.]

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

(b) The commissioner shall adopt reasonable rules

establishing criteria and procedures for refusal to grant or renew licenses and registrations, and for suspension and revocation of licenses and registrations.

(c) The commissioner may refuse to grant or renew licenses and registrations, or suspend or revoke licenses and registrations, in accordance with the commissioner's criteria and procedures as adopted by rule.

(d) The commissioner may charge a fee for voluntary certification of medical laboratories and environmental laboratories, and for environmental and medical laboratory services provided by the department, without complying with paragraph (a) or chapter 14. Fees charged for environment and medical laboratory services provided by the department must be approximately equal to the costs of providing the services.

~~(e)~~ (e) The commissioner may develop a schedule of fees for diagnostic evaluations conducted at clinics held by the services for children with handicaps program. All receipts generated by the program are annually appropriated to the commissioner for use in the maternal and child health program.

~~(d)~~ (f) The commissioner shall set license fees for hospitals and nursing homes that are not boarding care homes at the following levels:

Joint Commission on Accreditation of Healthcare Organizations (JCAHO hospitals)	~~$7,055~~ $7,555 plus $13 per bed
Non-JCAHO hospitals	~~$4,680~~ $5,180 plus ~~$234~~ $247 per bed
Nursing home	$183 plus $91 per bed

The commissioner shall set license fees for outpatient surgical centers, boarding care homes, and supervised living facilities at the following levels:

Outpatient surgical centers	~~$1,512~~ $3,349
Boarding care homes	$183 plus $91 per bed
Supervised living facilities	$183 plus $91 per bed.

~~(e)~~ (g) Unless prohibited by federal law, the commissioner of health shall charge applicants the following fees to cover the cost of any initial certification surveys required to

determine a provider's eligibility to participate in the Medicare or Medicaid program:

Prospective payment surveys for hospitals	$ 900
Swing bed surveys for nursing homes	$1,200
Psychiatric hospitals	$1,400
Rural health facilities	$1,100
Portable x-ray providers	$ 500
Home health agencies	$1,800
Outpatient therapy agencies	$ 800
End stage renal dialysis providers	$2,100
Independent therapists	$ 800
Comprehensive rehabilitation outpatient facilities	$1,200
Hospice providers	$1,700
Ambulatory surgical providers	$1,800
Hospitals	$4,200
Other provider categories or additional resurveys required to complete initial certification	Actual surveyor costs: average surveyor cost x number of hours for the survey process.

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

(h) The commissioner shall charge the following fees for examinations, registrations, licenses, and inspections:

Plumbing examination	$ 50
Water conditioning examination	$ 50
Plumbing bond registration fee	$ 40
Water conditioning bond registration fee	$ 40
Master plumber's license	$120
Restricted plumbing contractor license	$ 90
Journeyman plumber's license	$ 55
Apprentice registration	$ 25
Water conditioning contractor license	$ 70

Water conditioning installer license		$ 35
Residential inspection fee (each visit)		$ 50
Public, commercial, and industrial inspections	Inspection fee	
25 or fewer drainage fixture units	$ 300	
26 to 50 drainage fixture units	$ 900	
51 to 150 drainage fixture units	$1,200	
151 to 249 drainage fixture units	$1,500	
250 or more drainage fixture units	$1,800	
Callback fee (each visit)	$ 100	

(i) Plumbing installations that require only fixture installation or replacement require a minimum of one inspection. Residence remodeling involving plumbing installations requires a minimum of two inspections. New residential plumbing installations require a minimum of three inspections. For purposes of this paragraph and paragraph (h), residences of more than four units are considered commercial.

Sec. 7. Minnesota Statutes 2004, section 144.147, subdivision 1, is amended to read:

Subdivision 1. [DEFINITION.] "Eligible rural hospital" means any nonfederal, general acute care hospital that:

(1) is either located in a rural area, as defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 405.1041, or located in a community with a population of less than ~~10,000~~ 15,000, according to United States Census Bureau statistics, outside the seven-county metropolitan area;

(2) has 50 or fewer beds; and

(3) is not for profit.

Sec. 8. [144.1476] [RURAL PHARMACY PLANNING AND TRANSITION GRANT PROGRAM.]

Subdivision 1. [DEFINITIONS.] (a) For the purposes of this section, the following definitions apply.

(b) "Eligible rural community" means:

(1) a Minnesota community that is located in a rural area, as defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 405.1041; or

(2) a Minnesota community that has a population of less than 10,000, according to the United States Bureau of Statistics, and that is outside the seven-county metropolitan area, excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud.

(c) "Health care provider" means a hospital, clinic, pharmacy, long-term care institution, or other health care facility that is licensed, certified, or otherwise authorized by the laws of this state to provide health care.

(d) "Pharmacist" means an individual with a valid license issued under chapter 151 to practice pharmacy.

(e) "Pharmacy" has the meaning given under section 151.01, subdivision 2.

Subd. 2. [GRANTS AUTHORIZED; ELIGIBILITY.] (a) The commissioner of health shall establish a program to award grants to eligible rural communities or health care providers in eligible rural communities for planning, establishing, keeping in operation, or providing health care services that preserve access to prescription medications and the skills of a pharmacist according to sections 151.01 to 151.40.

(b) To be eligible for a grant, an applicant must develop a strategic plan for preserving or enhancing access to prescription medications and the skills of a pharmacist. At a minimum, a strategic plan must consist of:

(1) a needs assessment to determine what pharmacy services are needed and desired by the community. The assessment must include interviews with or surveys of area and local health professionals, local community leaders, and public officials;

(2) an assessment of the feasibility of providing needed pharmacy services that identifies priorities and timelines for

potential changes; and

(3) an implementation plan.

(c) A grant may be used by a recipient that has developed a strategic plan to implement transition projects to modify the type and extent of pharmacy services provided, in order to reflect the needs of the community. Grants may also be used by recipients:

(1) to develop pharmacy practices that integrate pharmacy and existing health care provider facilities; or

(2) to establish a pharmacy provider cooperative or initiatives that maintain local access to prescription medications and the skills of a pharmacist.

Subd. 3. [CONSIDERATION OF GRANTS.] In determining which applicants shall receive grants under this section, the commissioner of health shall appoint a committee comprised of members with experience and knowledge about rural pharmacy issues, including, but not limited to, two rural pharmacists with a community pharmacy background, two health care providers from rural communities, one representative from a statewide pharmacist organization, and one representative of the Board of Pharmacy. A representative of the commissioner may serve on the committee in an ex officio status. In determining who shall receive a grant, the committee shall take into account:

(1) improving or maintaining access to prescription medications and the skills of a pharmacist;

(2) changes in service populations;

(3) the extent community pharmacy needs are not currently met by other providers in the area;

(4) the financial condition of the applicant;

(5) the integration of pharmacy services into existing health care services; and

(6) community support.

The commissioner may also take into account other relevant factors.

Subd. 4. [ALLOCATION OF GRANTS.] (a) The commissioner shall establish a deadline for receiving applications and must

make a final decision on the funding of each application within 60 days of the deadline. An applicant must apply no later than March 1 of each fiscal year for grants awarded for that fiscal year.

(b) Any grant awarded must not exceed $50,000 a year and may not exceed a one-year term.

(c) Applicants may apply to the program each year they are eligible.

(d) Project grants may not be used to retire debt incurred with respect to any capitol expenditure made prior to the date on which the project is initiated.

Subd. 6. [EVALUATION.] The commissioner shall evaluate the overall effectiveness of the grant program and may collect progress reports and other information from grantees needed for program evaluation. An academic institution that has the expertise in evaluating rural pharmacy outcomes may participate in the program evaluation if asked by a grantee or the commissioner. The commissioner shall compile summaries of successful grant projects and other model community efforts to preserve access to prescription medications and the skills of a pharmacist, and make this information available to Minnesota communities seeking to address local pharmacy issues.

Sec. 9. Minnesota Statutes 2004, section 144.148, subdivision 1, is amended to read:

Subdivision 1. [DEFINITION.] (a) For purposes of this section, the following definitions apply.

(b) "Eligible rural hospital" means any nonfederal, general acute care hospital that:

(1) is either located in a rural area, as defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 405.1041, or located in a community with a population of less than ~~10,000~~ 15,000, according to United States Census Bureau statistics, outside the seven-county metropolitan area;

(2) has 50 or fewer beds; and

(3) is not for profit.

(c) "Eligible project" means a modernization project to update, remodel, or replace aging hospital facilities and equipment necessary to maintain the operations of a hospital.

Sec. 10. Minnesota Statutes 2004, section 144.1501, subdivision 1, is amended to read:

Subdivision 1. [DEFINITIONS.] (a) For purposes of this section, the following definitions apply.

(b) "Designated rural area" means:

(1) an area in Minnesota outside the counties of Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington, excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud; or

(2) a municipal corporation, as defined under section 471.634, that is physically located, in whole or in part, in an area defined as a designated rural area under clause (1).

(c) "Emergency circumstances" means those conditions that make it impossible for the participant to fulfill the service commitment, including death, total and permanent disability, or temporary disability lasting more than two years.

(d) "Medical resident" means an individual participating in a medical residency in family practice, internal medicine, obstetrics and gynecology, pediatrics, or psychiatry.

(e) "Midlevel practitioner" means a nurse practitioner, nurse-midwife, nurse anesthetist, advanced clinical nurse specialist, or physician assistant.

(f) "Nurse" means an individual who has completed training and received all licensing or certification necessary to perform duties as a licensed practical nurse or registered nurse.

(g) "Nurse-midwife" means a registered nurse who has graduated from a program of study designed to prepare registered nurses for advanced practice as nurse-midwives.

(h) "Nurse practitioner" means a registered nurse who has graduated from a program of study designed to prepare registered nurses for advanced practice as nurse practitioners.

(i) <u>"Pharmacist" means an individual with a valid license issued under chapter 151 to practice pharmacy.</u>

(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.

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

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

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

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

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

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

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

(3) for nurses who agree to practice in a Minnesota nursing home or intermediate care facility for persons with mental retardation or related conditions or to teach for at least 20 hours per week in the nursing field in a postsecondary program;

(4) for other health care technicians agreeing to teach for at least 20 hours per week in their designated field in a postsecondary program. The commissioner, in consultation with the Healthcare Education-Industry Partnership, shall determine

the health care fields where the need is the greatest, including, but not limited to, respiratory therapy, clinical laboratory technology, radiologic technology, and surgical technology; and

(5) for pharmacists who agree to practice in designated rural areas.

(b) Appropriations made to the account do not cancel and are available until expended, except that at the end of each biennium, any remaining balance in the account that is not committed by contract and not needed to fulfill existing commitments shall cancel to the fund.

Sec. 12. Minnesota Statutes 2004, section 144.1501, subdivision 3, is amended to read:

Subd. 3. [ELIGIBILITY.] (a) To be eligible to participate in the loan forgiveness program, an individual must:

(1) be a medical resident or a licensed pharmacist or be enrolled in a midlevel practitioner, registered nurse, or a licensed practical nurse training program; and

(2) submit an application to the commissioner of health.

(b) An applicant selected to participate must sign a contract to agree to serve a minimum three-year full-time service obligation according to subdivision 2, which shall begin no later than March 31 following completion of required training.

Sec. 13. Minnesota Statutes 2004, section 144.1501, subdivision 4, is amended to read:

Subd. 4. [LOAN FORGIVENESS.] The commissioner of health may select applicants each year for participation in the loan forgiveness program, within the limits of available funding. The commissioner shall distribute available funds for loan forgiveness proportionally among the eligible professions according to the vacancy rate for each profession in the required geographic area ~~or~~, facility type, or teaching area specified in subdivision 2. The commissioner shall allocate funds for physician loan forgiveness so that 75 percent of the funds available are used for rural physician loan forgiveness and 25 percent of the funds available are used for underserved

urban communities loan forgiveness. If the commissioner does not receive enough qualified applicants each year to use the entire allocation of funds for urban underserved communities, the remaining funds may be allocated for rural physician loan forgiveness. Applicants are responsible for securing their own qualified educational loans. The commissioner shall select participants based on their suitability for practice serving the required geographic area or facility type specified in subdivision 2, as indicated by experience or training. The commissioner shall give preference to applicants closest to completing their training. For each year that a participant meets the service obligation required under subdivision 3, up to a maximum of four years, the commissioner shall make annual disbursements directly to the participant equivalent to 15 percent of the average educational debt for indebted graduates in their profession in the year closest to the applicant's selection for which information is available, not to exceed the balance of the participant's qualifying educational loans. Before receiving loan repayment disbursements and as requested, the participant must complete and return to the commissioner an affidavit of practice form provided by the commissioner verifying that the participant is practicing as required under subdivisions 2 and 3. The participant must provide the commissioner with verification that the full amount of loan repayment disbursement received by the participant has been applied toward the designated loans. After each disbursement, verification must be received by the commissioner and approved before the next loan repayment disbursement is made. Participants who move their practice remain eligible for loan repayment as long as they practice as required under subdivision 2.

Sec. 14. Minnesota Statutes 2004, section 144.226, subdivision 1, is amended to read:

Subdivision 1. [WHICH SERVICES ARE FOR FEE.] The fees for the following services shall be the following or an amount prescribed by rule of the commissioner:

(a) The fee for the issuance of a certified vital record or a certification that the vital record cannot be found is ~~$8~~ $9. 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. The fee is nonrefundable.

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

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

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

(e) The fee for processing a request for the verification of information from vital records is ~~$8~~ $9 when the applicant furnishes the specific information to locate the vital record. When the applicant does not furnish specific information, the fee is $20 per hour for staff time expended. Specific information includes the correct date of the event and the correct name of the registrant. Fees charged shall approximate the costs incurred in searching and copying the vital records. The fee ~~shall be~~ is payable at the time of application and is nonrefundable.

(f) The fee for processing a request for the issuance of a copy of any document on file pertaining to a vital record or

statement that a related document cannot be found is ~~$8~~ $9. The fee is payable at the time of application and is nonrefundable.

Sec. 15. Minnesota Statutes 2004, section 144.226, is amended by adding a subdivision to read:

Subd. 5. [ELECTRONIC VERIFICATION.] A fee for the electronic verification of a vital event, when the information being verified is obtained from a certified birth or death record, shall be established through contractual or interagency agreements with interested local, state, or federal government agencies.

Sec. 16. Minnesota Statutes 2004, section 144.226, is amended by adding a subdivision to read:

Subd. 6. [ALTERNATIVE PAYMENT METHODS.] Notwithstanding subdivision 1, alternative payment methods may be approved and implemented by the state registrar or a local registrar.

Sec. 17. Minnesota Statutes 2004, section 144.3831, subdivision 1, is amended to read:

Subdivision 1. [FEE SETTING.] The commissioner of health may assess an annual fee of ~~$5.21~~ $6.36 for every service connection to a public water supply that is owned or operated by a home rule charter city, a statutory city, a city of the first class, or a town. The commissioner of health may also assess an annual fee for every service connection served by a water user district defined in section 110A.02.

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

Sec. 18. Minnesota Statutes 2004, section 144.551, subdivision 1, is amended to read:

Subdivision 1. [RESTRICTED CONSTRUCTION OR MODIFICATION.] (a) The following construction or modification may not be commenced:

(1) any erection, building, alteration, reconstruction, modernization, improvement, extension, lease, or other acquisition by or on behalf of a hospital that increases the bed capacity of a hospital, relocates hospital beds from one physical facility, complex, or site to another, or otherwise results in an increase or redistribution of hospital beds within

the state; and

(2) the establishment of a new hospital.

(b) This section does not apply to:

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

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

(3) a project for which a certificate of need was denied before July 1, 1990, if a timely appeal results in an order reversing the denial;

(4) a project exempted from certificate of need requirements by Laws 1981, chapter 200, section 2;

(5) a project involving consolidation of pediatric specialty hospital services within the Minneapolis-St. Paul metropolitan area that would not result in a net increase in the number of pediatric specialty hospital beds among the hospitals being consolidated;

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

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

another; or (iii) redistribution of hospital beds within the state or a region of the state;

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

(9) a construction project involving up to 35 new beds in a psychiatric hospital in Rice County that primarily serves adolescents and that receives more than 70 percent of its patients from outside the state of Minnesota;

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

(11) the relocation of licensed hospital beds from an existing state facility operated by the commissioner of human services to a new or existing facility, building, or complex operated by the commissioner of human services; from one regional treatment center site to another; or from one building or site to a new or existing building or site on the same campus;

(12) the construction or relocation of hospital beds ~~operated by a hospital~~ within or among hospitals having a statutory obligation to provide hospital and medical services for the indigent that does not result in a net increase in the

number of hospital beds;

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

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

(15) a construction project involving the addition of 20 new hospital beds used for rehabilitation services in an existing hospital in Carver County serving the southwest suburban metropolitan area. Beds constructed under this clause shall not be eligible for reimbursement under medical assistance, general assistance medical care, or MinnesotaCare;

(16) a project for the construction or relocation of up to 20 hospital beds for the operation of up to two psychiatric facilities or units for children provided that the operation of the facilities or units have received the approval of the commissioner of human services;

(17) a project involving the addition of 14 new hospital beds to be used for rehabilitation services in an existing hospital in Itasca County; ~~or~~

(18) a project to add 20 licensed beds in existing space at a hospital in Hennepin County that closed 20 rehabilitation beds in 2002, provided that the beds are used only for rehabilitation in the hospital's current rehabilitation building. If the beds are used 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.

Sec. 19. Minnesota Statutes 2004, section 144.562, subdivision 2, is amended to read:

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

(b) Except for those critical access hospitals established under section 144.1483, clause (10), and section 1820 of the federal Social Security Act, United States Code, title 42, section 1395i-4, that have an attached nursing home, eligible hospitals are allowed a total of ~~1,460~~ 2,000 days of swing bed use per year~~,-provided-that-no-more-than-ten-hospital-beds-are used-as-swing-beds-at-any-one-time~~. Critical access hospitals that have an attached nursing home are allowed swing bed use as provided in federal law.

(c) Except for critical access hospitals that have an attached nursing home, the commissioner of health ~~must~~ may approve swing bed use beyond ~~1,460~~ 2,000 days as long as there are no Medicare certified skilled nursing facility beds available within 25 miles of that hospital that are willing to admit the patient. Critical access hospitals exceeding 2,000 swing bed days must maintain documentation that they have contacted skilled nursing facilities within 25 miles to determine if any skilled nursing facility beds are available that are willing to admit the patient.

(d) After reaching 2,000 days of swing bed use in a year, an eligible hospital to which this limit applies may admit six additional patients to swing beds each year without seeking

approval from the commissioner or being in violation of this subdivision. These six swing bed admissions are exempt from the limit of 2,000 annual swing bed days for hospitals subject to this limit.

(e) A health care system that is in full compliance with this subdivision may allocate its total limit of swing bed days among the hospitals within the system, provided that no hospital in the system without an attached nursing home may exceed 2,000 swing bed days per year.

Sec. 20. [144.602] [DEFINITIONS.]

Subdivision 1. [APPLICABILITY.] For purposes of sections 144.601 to 144.608, the terms defined in this section have the meanings given them.

Subd. 2. [COMMISSIONER.] "Commissioner" means the commissioner of health.

Subd. 3. [MAJOR TRAUMA.] "Major trauma" means a sudden severe injury or damage to the body caused by an external force that results in potentially life-threatening injuries or that could result in the following disabilities:

(1) impairment of cognitive or mental abilities;

(2) impairment of physical functioning; or

(3) disturbance of behavioral or emotional functioning.

Subd. 4. [TRAUMA HOSPITAL.] "Trauma hospital" means a hospital that voluntarily meets the commissioner's criteria under section 144.603 and that has been designated as a trauma hospital under section 144.605.

Sec. 21. [144.603] [STATEWIDE TRAUMA SYSTEM CRITERIA.]

Subdivision 1. [CRITERIA ESTABLISHED.] The commissioner shall adopt criteria to ensure that severely injured people are promptly transported and treated at trauma hospitals appropriate to the severity of injury. Minimum criteria shall govern emergency medical service trauma triage and transportation guidelines, designation of hospitals as trauma hospitals, interhospital transfers, a trauma registry, and a trauma system governance structure.

Subd. 2. [BASIS; VERIFICATION.] The commissioner shall

base the establishment, implementation, and modifications to the criteria under subdivision 1 on the department-published Minnesota comprehensive statewide trauma system plan. The commissioner shall seek the advice of the Trauma Advisory Council in implementing and updating the criteria, using accepted and prevailing trauma transport, treatment, and referral standards of the American College of Surgeons, the American College of Emergency Physicians, the Minnesota Emergency Medical Services Regulatory Board, the national Trauma Resources Network, and other widely-recognized trauma experts. The commissioner shall adapt and modify the standards as appropriate to accommodate Minnesota's unique geography and the state's hospital and health professional distribution and shall verify that the criteria are met by each hospital voluntarily participating in the statewide trauma system.

Subd. 3. [RULE EXEMPTION AND REPORT TO THE LEGISLATURE.] In developing and adopting the criteria under this section, the commissioner of health is exempt from chapter 14, including section 14.386. By September 1, 2009, the commissioner must report to the legislature on implementation of the voluntary trauma system, including recommendations on the need for including the trauma system criteria in rule.

Sec. 22. [144.604] [TRAUMA TRIAGE AND TRANSPORTATION.]

Subdivision 1. [TRANSPORT REQUIREMENT.] Unless the Emergency Medical Services Regulatory Board has approved a licensed ambulance service's deviation from the guidelines under section 144E.101, subdivision 14, the ambulance service must transport major trauma patients from the scene to the highest state-designated trauma hospital within 30 minutes' transport time.

Subd. 2. [EXCEPTIONS.] Notwithstanding subdivision 1:

(1) patients with compromised airways must be transported immediately to the nearest designated trauma hospital; and

(2) level II trauma hospitals capable of providing definitive trauma care must not be bypassed to reach a level I trauma hospital.

Subd. 3. [UNDESIGNATED HOSPITALS.] No major trauma patient shall be transported to a hospital not participating in the statewide trauma system unless no trauma hospital is available within 30 minutes' transport time.

[EFFECTIVE DATE.] This section is effective July 1, 2009.

Sec. 23. [144.605] [DESIGNATING TRAUMA HOSPITALS.]

Subdivision 1. [NAMING PRIVILEGES.] Unless it has been designated a trauma hospital by the commissioner, no hospital shall use the term trauma center or trauma hospital in its name or its advertising or shall otherwise indicate it has trauma treatment capabilities.

Subd. 2. [DESIGNATION; REVERIFICATION.] The commissioner shall designate four levels of trauma hospitals. A hospital that voluntarily meets the criteria for a particular level of trauma hospital shall apply to the commissioner for designation and, upon the commissioner's verifying the hospital meets the criteria, be designated a trauma hospital at the appropriate level for a three-year period. Prior to the expiration of the three-year designation, a hospital seeking to remain part of the voluntary system must apply for and successfully complete a reverification process, be awaiting the site visit for the reverification, or be awaiting the results of the site visit. The commissioner may extend a hospital's existing designation for up to 18 months on a provisional basis if the hospital has applied for reverification in a timely manner but has not yet completed the reverification process within the expiration of the three-year designation and the extension is in the best interest of trauma system patient safety. To be granted a provisional extension, the hospital must be:

(1) scheduled and awaiting the site visit for reverification;

(2) awaiting the results of the site visit; or

(3) responding to and correcting identified deficiencies identified in the site visit.

Subd. 3. [ACS VERIFICATION.] The commissioner shall grant the appropriate level I, II, or III trauma hospital designation

to a hospital that successfully completes and passes the American College of Surgeons (ACS) verification standards at the hospital's cost, submits verification documentation to the Trauma Advisory Council, and formally notifies the Trauma Advisory Council of ACS verification.

Subd. 4. [LEVEL III DESIGNATION; NOT ACS VERIFIED.] (a) The commissioner shall grant the appropriate level III trauma hospital designation to a hospital that is not ACS verified but that successfully completes the designation process under paragraph (b).

(b) The hospital must complete and submit a self-reported survey and application to the Trauma Advisory Council for review, verifying that the hospital meets the criteria as a level III trauma hospital. When the Trauma Advisory Council is satisfied the application is complete, the commissioner shall arrange a site review visit. Upon successful completion of the site review, the review team shall make written recommendations to the Trauma Advisory Council. If approved by the Trauma Advisory Council, a letter of recommendation shall be sent to the commissioner for final approval and designation.

Subd. 5. [LEVEL IV DESIGNATION.] (a) The commissioner shall grant the appropriate level IV trauma hospital designation to a hospital that successfully completes the designation process under paragraph (b).

(b) The hospital must complete and submit a self-reported survey and application to the Trauma Advisory Council for review, verifying that the hospital meets the criteria as a level IV trauma hospital. When the Trauma Advisory Council is satisfied the application is complete, the council shall review the application and, if the council approves the application, send a letter of recommendation to the commissioner for final approval and designation. The commissioner shall grant a level IV designation and shall arrange a site review visit within three years of the designation and every three years thereafter, to coincide with the three-year reverification process.

Subd. 6. [CHANGES IN DESIGNATION.] Changes in a trauma

hospital's ability to meet the criteria for the hospital's level of designation must be self-reported to the Trauma Advisory Council and to other regional hospitals and local emergency medical services providers and authorities. If the hospital cannot correct its ability to meet the criteria for its level within six months, the hospital may apply for redesignation at a different level.

Subd. 7. [HIGHER DESIGNATION.] A trauma hospital may apply for a higher trauma hospital designation one time during the hospital's three-year designation by completing the designation process for that level of trauma hospital.

Subd. 8. [LOSS OF DESIGNATION.] The commissioner may refuse to designate or redesignate or may revoke a previously issued trauma hospital designation if a hospital does not meet the criteria of the statewide trauma plan, in the interests of patient safety, or if a hospital denies or refuses a reasonable request by the commissioner or the commissioner's designee to verify information by correspondence or an on-site visit.

Sec. 24. [144.606] [INTERHOSPITAL TRANSFERS.]

Subdivision 1. [WRITTEN PROCEDURES REQUIRED.] A level III or IV trauma hospital must have predetermined, written procedures that direct the internal process for rapidly and efficiently transferring a major trauma patient to definitive care, including:

(1) clearly identified anatomic and physiologic criteria that, if met, will immediately initiate transfer to definitive care;

(2) a listing of appropriate ground and air transport services, including primary and secondary telephone contact numbers; and

(3) immediately available supplies, records, or other necessary resources that will accompany a patient.

Subd. 2. [TRANSFER AGREEMENTS.] (a) A level III or IV trauma hospital may transfer patients to a hospital with which the trauma hospital has a written transfer agreement.

(b) Each agreement must be current and with a trauma

hospital or trauma hospitals capable of caring for major trauma injuries.

(c) A level III or IV trauma hospital must have a current transfer agreement with a hospital that has special capabilities in the treatment of burn injuries and a transfer agreement with a second hospital that has special capabilities in the treatment of burn injuries, should the primary transfer hospital be unable to accept a burn patient.

Sec. 25. [144.607] [TRAUMA REGISTRY.]

Subdivision 1. [REGISTRY PARTICIPATION REQUIRED.] A trauma hospital must participate in the statewide trauma registry.

Subd. 2. [TRAUMA REPORTING.] A trauma hospital must report major trauma injuries as part of the reporting for the traumatic brain injury and spinal cord injury registry required in sections 144.661 to 144.665.

Subd. 3. [APPLICATION OF OTHER LAW.] Sections 144.661 to 144.665 apply to a major trauma reported to the statewide trauma registry, with the exception of sections 144.662, clause (2), and 144.664, subdivision 3.

Sec. 26. [144.608] [TRAUMA ADVISORY COUNCIL.]

Subdivision 1. [TRAUMA ADVISORY COUNCIL ESTABLISHED.] (a) A Trauma Advisory Council is established to advise, consult with, and make recommendations to the commissioner on the development, maintenance, and improvement of a statewide trauma system.

(b) The council shall consist of the following members:

(1) a trauma surgeon certified by the American College of Surgeons who practices in a level I or II trauma hospital;

(2) a general surgeon certified by the American College of Surgeons whose practice includes trauma and who practices in a designated rural area as defined under section 144.1501, subdivision 1, paragraph (b);

(3) a neurosurgeon certified by the American Board of Neurological Surgery who practices in a level I or II trauma hospital;

(4) a trauma program nurse manager or coordinator

practicing in a level I or II trauma hospital;

(5) an emergency physician certified by the American College of Emergency Physicians whose practice includes emergency room care in a level I, II, III, or IV trauma hospital;

(6) an emergency room nurse manager who practices in a level III or IV trauma hospital;

(7) a family practice physician whose practice includes emergency room care in a level III or IV trauma hospital located in a designated rural area as defined under section 144.1501, subdivision 1, paragraph (b);

(8) a nurse practitioner, as defined under section 144.1501, subdivision 1, paragraph (h), or a physician assistant, as defined under section 144.1501, subdivision 1, paragraph (j), whose practice includes emergency room care in a level IV trauma hospital located in a designated rural area as defined under section 144.1501, subdivision 1, paragraph (b);

(9) a pediatrician certified by the American Academy of Pediatrics whose practice includes emergency room care in a level I, II, III, or IV trauma hospital;

(10) an orthopedic surgeon certified by the American Board of Orthopedic Surgery whose practice includes trauma and who practices in a level I, II, or III trauma hospital;

(11) the state emergency medical services medical director appointed by the Emergency Medical Services Regulatory Board;

(12) a hospital administrator of a level III or IV trauma hospital located in a designated rural area as defined under section 144.1501, subdivision 1, paragraph (b);

(13) a rehabilitation specialist whose practice includes rehabilitation of patients with major trauma injuries or traumatic brain injuries and spinal cord injuries as defined under section 144.661;

(14) an attendant or ambulance director who is an EMT, EMT-I, or EMT-P within the meaning of section 144E.001 and who actively practices with a licensed ambulance service in a primary service area located in a designated rural area as

defined under section 144.1501, subdivision 1, paragraph (b); and

(15) the commissioner of public safety or the commissioner's designee.

(c) Council members whose appointment is dependent on practice in a level III or IV trauma hospital may be appointed to an initial term based upon their statements that the hospital intends to become a level III or IV facility by July 1, 2009.

Subd. 2. [COUNCIL ADMINISTRATION.] (a) The council must meet at least twice a year but may meet more frequently at the call of the chair, a majority of the council members, or the commissioner.

(b) The terms, compensation, and removal of members of the council are governed by section 15.059, except that the council expires June 30, 2015.

(c) The council may appoint subcommittees and workgroups. Subcommittees shall consist of council members. Workgroups may include noncouncil members. Noncouncil members shall be compensated for workgroup activities under section 15.059, subdivision 3, but shall receive expenses only.

Subd. 3. [REGIONAL TRAUMA ADVISORY COUNCILS.] (a) Up to eight regional trauma advisory councils may be formed as needed.

(b) Regional trauma advisory councils shall advise, consult with, and make recommendation to the state Trauma Advisory Council on suggested regional modifications to the statewide trauma criteria that will improve patient care and accommodate specific regional needs.

(c) Each regional advisory council must have no more than 15 members. The commissioner, in consultation with the Emergency Medical Services Regulatory Board and the commissioner of public safety, shall name the council members.

(d) Regional council members may receive expenses in the same manner and amount as authorized by the plan adopted under section 43A.18, subdivision 2.

Sec. 27. Minnesota Statutes 2004, section 144.9504, subdivision 2, is amended to read:

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

(1) within 48 hours of a child or pregnant female in the residence being identified to the agency as having a venous blood lead level equal to or greater than ~~70~~ 60 micrograms of lead per deciliter of whole blood;

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

(3) within ten working days of a child in the residence being identified to the agency as having a venous blood lead level equal to or greater than ~~20~~ 15 micrograms of lead per deciliter of whole blood;

~~(4) within ten working days of a child in the residence being identified to the agency as having a venous blood lead level that persists in the range of 15 to 19 micrograms of lead per deciliter of whole blood for 90 days after initial identification; or~~

~~(5)~~ within ten working days of a pregnant female in the residence being identified to the agency as having a venous blood lead level equal to or greater than ten micrograms of lead per deciliter of whole blood.

(b) Within the limits of available local, state, and federal appropriations, an assessing agency may also conduct a lead risk assessment for children with any elevated blood lead level.

(c) In a building with two or more dwelling units, an assessing agency shall assess the individual unit in which the conditions of this section are met and shall inspect all common areas accessible to a child. If a child visits one or more other sites such as another residence, or a residential or commercial child care facility, playground, or school, the assessing agency shall also inspect the other sites. The

assessing agency shall have one additional day added to the time frame set forth in this subdivision to complete the lead risk assessment for each additional site.

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

(e) The assessing agency shall conduct the lead risk assessment according to rules adopted by the commissioner under section 144.9508. An assessing agency shall have lead risk assessments performed by lead risk assessors licensed by the commissioner according to rules adopted under section 144.9508. If a property owner refuses to allow a lead risk assessment, the assessing agency shall begin legal proceedings to gain entry to the property and the time frame for conducting a lead risk assessment set forth in this subdivision no longer applies. A lead risk assessor or assessing agency may observe the performance of lead hazard reduction in progress and shall enforce the provisions of this section under section 144.9509. Deteriorated painted surfaces, bare soil, and dust must be

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

(f) Each assessing agency shall establish an administrative appeal procedure which allows a property owner to contest the nature and conditions of any lead order issued by the assessing agency. Assessing agencies must consider appeals that propose lower cost methods that make the residence lead safe. The commissioner shall use the authority and appeal procedure granted under sections 144.989 to 144.993.

(g) Sections 144.9501 to 144.9509 neither authorize nor prohibit an assessing agency from charging a property owner for the cost of a lead risk assessment.

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

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

(1) ~~nonrefundable~~ base certification fee, ~~$1,200~~ $1,600; ~~and~~

(2) sample preparation techniques fees, $100 per technique; and

(3) test category certification fees:

Test Category	Certification Fee
Clean water program bacteriology	~~$600~~ $800
Safe drinking water program bacteriology	~~$600~~ $800

Clean water program inorganic chemistry	~~$600~~ $800
Safe drinking water program inorganic chemistry	~~$600~~ $800
Clean water program chemistry metals	~~$800~~ $1,200
Safe drinking water program chemistry metals	~~$800~~ $1,200
Resource conservation and recovery program chemistry metals	~~$800~~ $1,200
Clean water program volatile organic compounds	~~$1,200~~ $1,500
Safe drinking water program volatile organic compounds	~~$1,200~~ $1,500
Resource conservation and recovery program volatile organic compounds	~~$1,200~~ $1,500
Underground storage tank program volatile organic compounds	~~$1,200~~ $1,500
Clean water program other organic compounds	~~$1,200~~ $1,500
Safe drinking water program other organic compounds	~~$1,200~~ $1,500
Resource conservation and recovery program other organic compounds	~~$1,200~~ $1,500
Clean water program radiochemistry	$2,500
Safe drinking water program radiochemistry	$2,500
Resource conservation and recovery program agricultural contaminants	$2,500
Resource conservation and recovery program emerging contaminants	$2,500

(b) ~~The total biennial certification fee is the base fee plus the applicable test category fees.~~

~~(c)~~ Laboratories located outside of this state that require an on-site ~~survey will~~ inspection shall be assessed an additional ~~$2,500~~ $3,750 fee.

(c) The total biennial certification fee includes the base fee, the sample preparation techniques fees, the test category fees, and, when applicable, the on-site inspection fee.

(d) Fees must be set so that the total fees support the laboratory certification program. Direct costs of the certification service include program administration, inspections, the agency's general support costs, and attorney general costs attributable to the fee function.

(e) A change fee shall be assessed if a laboratory requests additional analytes or methods at any time other than when applying for or renewing its certification. The change fee is equal to the test category certification fee for the analyte.

(f) A variance fee shall be assessed if a laboratory requests and is granted a variance from a rule adopted under this section. The variance fee is $500 per variance.

(g) Refunds or credits shall not be made for analytes or methods requested but not approved.

(h) Certification of a laboratory shall not be awarded until all fees are paid.

Sec. 29. Minnesota Statutes 2004, section 144E.101, is amended by adding a subdivision to read:

Subd. 14. [TRAUMA TRIAGE AND TRANSPORT GUIDELINES.] A licensee shall have written age appropriate trauma triage and transport guidelines consistent with the criteria established by the Trauma Advisory Council and approved by the board. The board may approve a licensee's requested deviations to the guidelines due to the availability of local or regional trauma resources if the changes are in the best interest of the patient's health.

Sec. 30. Minnesota Statutes 2004, section 157.15, is amended by adding a subdivision to read:

Subd. 19. [STATEWIDE HOSPITALITY FEE.] "Statewide hospitality fee" means a fee to fund statewide food, beverage, and lodging program development activities, including training for inspection staff, technical assistance, maintenance of a statewide integrated food safety and security information system, and other related statewide activities that support the food, beverage, and lodging program activities.

Sec. 31. Minnesota Statutes 2004, section 157.16, subdivision 2, is amended to read:

Subd. 2. [LICENSE RENEWAL.] Initial and renewal licenses for all food and beverage service establishments, hotels, motels, lodging establishments, and resorts shall be issued for the calendar year for which application is made and shall expire

on December 31 of such year. Any person who operates a place of business after the expiration date of a license or without having submitted an application and paid the fee shall be deemed to have violated the provisions of this chapter and shall be subject to enforcement action, as provided in the Health Enforcement Consolidation Act, sections 144.989 to 144.993. In addition, a penalty of ~~$25~~ $50 shall be added to the total of the license fee for any food and beverage service establishment operating without a license as a mobile food unit, a seasonal temporary or seasonal permanent food stand, or a special event food stand, and a penalty of ~~$50~~ $100 shall be added to the total of the license fee for all restaurants, food carts, hotels, motels, lodging establishments, and resorts operating without a license for a period of up to 30 days. A late fee of $300 shall be added to the license fee for establishments operating more than 30 days without a license.

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

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

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

Subd. 3. [ESTABLISHMENT FEES; DEFINITIONS.] (a) The following fees are required for food and beverage service establishments, hotels, motels, lodging establishments, and resorts licensed under this chapter. Food and beverage service establishments must pay the highest applicable fee under paragraph ~~(e)~~ (d), clause (1), (2), (3), or (4), and establishments serving alcohol must pay the highest applicable fee under paragraph ~~(e)~~ (d), clause (6) or (7). The license fee for new operators previously licensed under this chapter for the same calendar year is one-half of the appropriate annual license fee, plus any penalty that may be required. The license fee for operators opening on or after October 1 is one-half of the

appropriate annual license fee, plus any penalty that may be required.

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

(c) A special event food stand shall pay a flat fee of ~~$35~~ $40 annually. "Special event food stand" means a fee category where food is prepared or served in conjunction with celebrations, county fairs, or special events from a special event food stand as defined in section 157.15.

(d) In addition to the base fee in paragraph (b), each food and beverage service establishment, other than a special event food stand, and each hotel, motel, lodging establishment, and resort shall pay an additional annual fee for each fee category ~~as~~, additional food service, or required additional inspection specified in this paragraph:

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

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

(ii) frozen pizza that is heated and served;

(iii) a continental breakfast such as rolls, coffee, juice, milk, and cold cereal;

(iv) soft drinks, coffee, or nonalcoholic beverages; or

(v) cleaning for eating, drinking, or cooking utensils, when the only food served is prepared off site.

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

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

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

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

breakfast establishment;

(iv) is a boarding establishment; or

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

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

(i) possesses food service equipment that includes a range, oven, steam table, salad bar, or salad preparation area;

(ii) possesses food service equipment that includes more than one deep fat fryer, one grill, or two hot holding containers; or

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

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

(4) Large establishment, ~~$350~~ $460. "Large establishment" means either:

(i) a fee category that (A) meets the criteria in clause (3), items (i) or (ii), for a medium establishment, (B) seats more than 175 people, and (C) offers the full menu selection an average of five or more days a week during the weeks of operation; or

(ii) a fee category that (A) meets the criteria in clause (3), item (iii), for a medium establishment, and (B) prepares and serves 500 or more meals per day.

(5) Other food and beverage service, including food carts, mobile food units, seasonal temporary food stands, and seasonal permanent food stands, ~~$40~~ $50.

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

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

"Alcohol beverage service, other than beer or wine table

service" means a fee category where alcoholic mixed drinks are served or where beer or wine are served from a bar.

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

(9) First public swimming pool, ~~$140~~ $180; each additional public swimming pool, ~~$80~~ $100. "Public swimming pool" means a fee category that has the meaning given in Minnesota Rules, part 4717.0250, subpart 8.

(10) First spa, ~~$80~~ $110; each additional spa, ~~$40~~ $50. "Spa pool" means a fee category that has the meaning given in Minnesota Rules, part 4717.0250, subpart 9.

(11) Private sewer or water, ~~$40~~ $50. "Individual private water" means a fee category with a water supply other than a community public water supply as defined in Minnesota Rules, chapter 4720. "Individual private sewer" means a fee category with an individual sewage treatment system which uses subsurface treatment and disposal.

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

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

(e) A fee of ~~$150~~ $350 for review of the construction plans must accompany the initial license application for ~~food and beverage service establishments~~ restaurants, hotels, motels, lodging establishments, or resorts with five or more sleeping units.

(f) When existing food and beverage service establishments, hotels, motels, lodging establishments, or resorts are extensively remodeled, a fee of ~~$150~~ $250 must be submitted with the remodeling plans. A fee of $250 must be submitted for new construction or remodeling for a restaurant with a limited food menu selection, a seasonal permanent food stand, a mobile food unit, or a food cart, or for a hotel, motel, resort, or lodging establishment addition of less than five sleeping units.

(g) Seasonal temporary food stands and special event food stands are not required to submit construction or remodeling plans for review.

Sec. 34. Minnesota Statutes 2004, section 157.16, is amended by adding a subdivision to read:

Subd. 3a. [STATEWIDE HOSPITALITY FEE.] Every person, firm, or corporation that operates a licensed boarding establishment, food and beverage service establishment, seasonal temporary or permanent food stand, special event food stand, mobile food unit, food cart, resort, hotel, motel, or lodging establishment in Minnesota must submit to the commissioner a $35 annual statewide hospitality fee for each licensed activity. The fee for establishments licensed by the Department of Health is required at the same time the licensure fee is due. For establishments licensed by local governments, the fee is due by July 1 of each year.

Sec. 35. Minnesota Statutes 2004, section 157.20, subdivision 2, is amended to read:

Subd. 2. [INSPECTION FREQUENCY.] The frequency of inspections of the establishments shall be based on the degree of health risk.

(a) High-risk establishments must be inspected at least once ~~a year~~ every 12 months.

(b) Medium-risk establishments must be inspected at least once every 18 months.

(c) Low-risk establishments must be inspected at least once every ~~two years~~ 24 months.

Sec. 36. Minnesota Statutes 2004, section 157.20,

subdivision 2a, is amended to read:

Subd. 2a. [RISK CATEGORIES.] (a) [HIGH-RISK ESTABLISHMENT.] "High-risk establishment" means any food and beverage service establishment, hotel, motel, lodging establishment, or resort that:

(1) serves potentially hazardous foods that require extensive processing on the premises, including manual handling, cooling, reheating, or holding for service;

(2) prepares foods several hours or days before service;

(3) serves menu items that epidemiologic experience has demonstrated to be common vehicles of food-borne illness;

(4) has a public swimming pool; or

(5) draws its drinking water from a surface water supply.

(b) [MEDIUM-RISK ESTABLISHMENT.] "Medium-risk establishment" means a food and beverage service establishment, hotel, motel, lodging establishment, or resort that:

(1) serves potentially hazardous foods but with minimal holding between preparation and service; or

(2) serves foods, such as pizza, that require extensive handling followed by heat treatment.

(c) [LOW-RISK ESTABLISHMENT.] "Low-risk establishment" means a food and beverage service establishment, hotel, motel, lodging establishment, or resort that is not a high-risk or medium-risk establishment.

(d) [RISK EXCEPTIONS.] Mobile food units, seasonal permanent and seasonal temporary food stands, food carts, and special event food stands are not inspected on an established schedule and therefore are not defined as high-risk, medium-risk, or low-risk establishments.

(e) [SCHOOL INSPECTION FREQUENCY.] Elementary and secondary school food service establishments must be inspected according to the assigned risk category or by the frequency required in the Richard B. Russell National School Lunch Act, whichever frequency is more restrictive.

Sec. 37. Minnesota Statutes 2004, section 326.01, is amended by adding a subdivision to read:

Subd. 9a. [RESTRICTED PLUMBING CONTRACTOR.] A "restricted plumbing contractor" is any person skilled in the planning, superintending, and practical installation of plumbing who is otherwise lawfully qualified to contract for plumbing and installations and to conduct the business of plumbing, who is familiar with the laws and rules governing the business of plumbing, and who performs the plumbing trade in cities and towns with a population of fewer than 5,000 according to federal census.

Sec. 38. Minnesota Statutes 2004, section 326.37, subdivision 1, is amended to read:

Subdivision 1. [RULES.] The state commissioner of health ~~may~~ shall, by rule, prescribe minimum uniform standards ~~which shall be uniform, and which standards shall thereafter be~~ effective for all new plumbing installations, including additions, extensions, alterations, and replacements ~~connected with any water or sewage disposal system owned or operated by or for any municipality, institution, factory, office building, hotel, apartment building, or any other place of business regardless of location or the population of the city or town in which located~~. Notwithstanding the provisions of Minnesota Rules, part 4715.3130, as they apply to review of plans and specifications, the commissioner may allow plumbing construction, alteration, or extension to proceed without approval of the plans or specifications by the commissioner.

The commissioner shall administer the provisions of sections 326.37 to ~~326.45~~ 326.451 and for such purposes may employ plumbing inspectors and other assistants.

Sec. 39. Minnesota Statutes 2004, section 326.37, is amended by adding a subdivision to read:

Subd. 1a. [INSPECTION.] All new plumbing installations, including additions, extensions, alterations, and replacements, shall be inspected by the commissioner for compliance with accepted standards of construction for health, safety to life and property, and compliance with applicable codes. The Department of Health must have full implementation of its

inspections plan in place and operational July 1, 2007. This subdivision does not apply where a political subdivision requires, by ordinance, plumbing inspections similar to the requirements of this subdivision.

Sec. 40. Minnesota Statutes 2004, section 326.38, is amended to read:

326.38 [LOCAL REGULATIONS.]

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

Sec. 41. Minnesota Statutes 2004, section 326.40, subdivision 1, is amended to read:

Subdivision 1. [~~PLUMBERS MUST BE LICENSED IN CERTAIN CITIES; MASTER AND JOURNEYMAN PLUMBERS~~ MASTER, JOURNEYMAN, AND RESTRICTED PLUMBING CONTRACTORS; PLUMBING ON ONE'S OWN PREMISES; RULES FOR EXAMINATION.] ~~In any city now or hereafter having 5,000 or more population, according to the last federal census, and having a system of waterworks or sewerage, no person, firm, or corporation shall engage in or work at the business of a master plumber or journeyman plumber unless licensed to do so by the state commissioner of health.~~ No person, firm, or corporation may engage in or work at the business of a master plumber, restricted plumbing contractor, or journeyman plumber unless licensed to do so by the commissioner of health under sections 326.37 to 326.451. A license is not required for:

(1) persons performing building sewer or water service installation who have completed pipe laying training as prescribed by the commissioner of health; or

(2) persons selling an appliance plumbing installation service at point of sale if the installation work is performed by a plumber licensed under sections 326.37 to 326.451.

A master plumber may also work as a journeyman plumber. Anyone not so licensed may do plumbing work which complies with the provisions of the minimum standard prescribed by the state commissioner of health on premises or that part of premises owned and actually occupied by the worker as a residence, unless otherwise forbidden to do so by a local ordinance.

~~In any such city~~ No person, firm, or corporation shall engage in the business of installing plumbing nor install plumbing in connection with the dealing in and selling of plumbing material and supplies unless at all times a licensed master plumber or restricted plumbing contractor, who shall be responsible for proper installation, is in charge of the plumbing work of the person, firm, or corporation.

The Department of Health shall prescribe rules, not inconsistent herewith, for the examination and licensing of

plumbers.

Sec. 42. [326.402] [RESTRICTED PLUMBING CONTRACTOR LICENSE.]

Subdivision 1. [LICENSURE.] The commissioner shall grant a restricted plumbing contractor license to any person who applies to the commissioner and provides evidence of having at least two years of practical plumbing experience in the plumbing trade preceding application for licensure.

Subd. 2. [USE OF LICENSE.] A restricted plumbing contractor may engage in the plumbing trade only in cities and towns with a population of fewer than 5,000 according to federal census.

Subd. 3. [APPLICATION PERIOD.] Applications for restricted plumbing contractor licenses must be submitted to the commissioner prior to January 1, 2006.

Subd. 4. [USE PERIOD FOR RESTRICTED PLUMBING CONTRACTOR LICENSE.] A restricted plumbing contractor license does not expire and remains in effect for as long as that person engages in the plumbing trade.

Subd. 5. [PROHIBITION OF TRANSFERENCE.] A restricted plumbing contractor license must not be transferred or sold to any other person.

Subd. 6. [RESTRICTED PLUMBING CONTRACTOR LICENSE RENEWAL.] The commissioner shall adopt rules for renewal of the restricted plumbing contractor license.

Sec. 43. Minnesota Statutes 2004, section 326.42, subdivision 2, is amended to read:

Subd. 2. [FEES.] Plumbing system plans and specifications that are submitted to the commissioner for review shall be accompanied by the appropriate plan examination fees. If the commissioner determines, upon review of the plans, that inadequate fees were paid, the necessary additional fees shall be paid prior to plan approval. The commissioner shall charge the following fees for plan reviews and audits of plumbing installations for public, commercial, and industrial buildings:

(1) systems with both water distribution and drain, waste,

and vent systems and having:

(i) 25 or fewer drainage fixture units, $150;

(ii) 26 to 50 drainage fixture units, $250;

(iii) 51 to 150 drainage fixture units, $350;

(iv) 151 to 249 drainage fixture units, $500;

(v) 250 or more drainage fixture units, $3 per drainage fixture unit to a maximum of $4,000; and

(vi) interceptors, separators, or catch basins, $70 per interceptor, separator, or catch basin design;

(2) building sewer service only, $150;

(3) building water service only, $150;

(4) building water distribution system only, no drainage system, $5 per supply fixture unit or $150, whichever is greater;

(5) storm drainage system, a minimum fee of $150 or:

(i) $50 per drain opening, up to a maximum of $500; and

(ii) $70 per interceptor, separator, or catch basin design;

(6) manufactured home park or campground, one to 25 sites, $300;

(7) manufactured home park or campground, 26 to 50 sites, $350;

(8) manufactured home park or campground, 51 to 125 sites, $400;

(9) manufactured home park or campground, more than 125 sites, $500;

(10) accelerated review, double the regular fee, one-half to be refunded if no response from the commissioner within 15 business days; and

(11) revision to previously reviewed or incomplete plans:

(i) review of plans for which commissioner has issued two or more requests for additional information, per review, $100 or ten percent of the original fee, whichever is greater;

(ii) proposer-requested revision with no increase in project scope, $50 or ten percent of original fee, whichever is greater; and

(iii) proposer-requested revision with an increase in

project scope, $50 plus the difference between the original project fee and the revised project fee.

Sec. 44. [326.451] [INSPECTORS.]

(a) The commissioner shall set all reasonable criteria and procedures by rule for inspector certification, certification period, examinations, examination fees, certification fees, and renewal of certifications.

(b) The commissioner shall adopt reasonable rules establishing criteria and procedures for refusal to grant or renew inspector certifications, and for suspension and revocation of inspector certifications.

(c) The commissioner shall refuse to renew or grant inspector certifications, or suspend or revoke inspector certifications, in accordance with the commissioner's criteria and procedures as adopted by rule.

Sec. 45. [AIDS PREVENTION INITIATIVE FOCUSING ON AFRICAN-BORN RESIDENTS.]

The commissioner of health shall award grants in accordance with Minnesota Statutes, section 145.924, paragraph (b), for a public education and awareness campaign targeting communities of African-born Minnesota residents. The grants shall be designed to promote knowledge and understanding about HIV and to increase knowledge in order to eliminate and reduce the risk for HIV infection; to encourage screening and testing for HIV; and to link individuals to public health and health care resources. The grants must be awarded to collaborative efforts that bring together nonprofit community-based groups with demonstrated experience in addressing the public health, health care, and social service needs of African-born communities.

Sec. 46. [CERVICAL CANCER ELIMINATION STUDY.]

(a) The commissioner of health shall develop a statewide integrated and comprehensive cervical cancer prevention plan, including strategies for promoting and implementing the plan. The plan must include activities that identify and implement methods to improve the cervical cancer screening rates in Minnesota, including, but not limited to:

(1) identifying and disseminating appropriate evidence-based cervical cancer screening guidelines to be used in Minnesota;

(2) increasing the use of appropriate screening based on these guidelines for patients seen by medical groups in Minnesota and monitoring results of these medical groups; and

(3) reducing the number of women who should but have not been screened.

(b) In developing the plan, the commissioner shall also identify and examine limitations and barriers in providing cervical cancer screening, diagnosis tools, and treatment, including, but not limited to, medical care reimbursement, treatment costs, and the availability of insurance coverage.

(c) The commissioner may work with a nonprofit quality improvement organization in Minnesota to identify evidence-based guidelines for cervical cancer screening and to identify methods to improve the cervical cancer screening rates among medical groups; and may work with a nonprofit health care result reporting organization to monitor results by medical groups in Minnesota.

(d) The commissioner may convene an advisory committee that includes representatives of health care providers, the American Cancer Society, health plan companies, the University of Minnesota Academic Health Center, community health boards, and the general public.

(e) The commissioner shall submit a report to the legislature by January 15, 2006, on:

(1) the statewide cervical cancer prevention plan, including a description of the plan activities and strategies developed for promoting and implementing the plan;

(2) methods for monitoring the results by medical groups and by the entire state of cervical cancer screening improvement activities; and

(3) recommended changes to existing laws, programs, or services in terms of reducing the occurrence of cervical cancer by improving insurance coverage for the prevention, diagnosis,

and treatment for cervical cancer.

Sec. 47. [CLINICAL TRIAL WORK GROUP; REPORT.]

The commissioners of health and commerce shall, in consultation with the commissioner of employee relations, convene a work group regarding health plan coverage of routine care associated with clinical trials. The work group must explore what high-quality clinical trials beyond cancer-only clinical trials should be covered by health plans. All other types of clinical trials, disease-based or technology-based such as drug trials or device trials should be considered. The work group shall use the current, cancer-only model voluntary agreement that includes definitions of high-quality clinical trials, protocol induced costs, and routine care costs as a starting point for discussions. As determined appropriate, the work group shall establish model voluntary agreement guidelines for health plan coverage of routine patient care costs incurred by patients participating in high quality clinical trials. The work group shall be made up of representatives of consumers, patient advocates, health plan companies, fully insured and self-insured purchasers, providers, and other health care professionals involved in the care and treatment of patients. The commissioners shall submit the findings and recommendations of the work group to the chairs of the senate and house committees having jurisdiction over health policy and finance by January 15, 2006.

Sec. 48. [REPORT TO THE LEGISLATURE ON SWING BED USAGE.]

The commissioner of health shall review swing bed and related data reported under Minnesota Statutes, sections 144.562, subdivision 3, paragraph (f); 144.564; and 144.698. The commissioner shall report and make any appropriate recommendations to the legislature by January 31, 2007, on:

(1) the use of swing bed days by all hospitals and by critical access hospitals;

(2) occupancy rates in skilled nursing facilities within 25 miles of hospitals with swing beds; and

(3) information provided by rural providers on the use of

swing beds and the adequacy of rural services across the continuum of care.

Sec. 49. [RULE AMENDMENT.]

The commissioner of health shall amend Minnesota Rules, part 4626.2015, subparts 3, item C; and 6, item B, to conform with Minnesota Statutes, section 157.16, subdivision 2a. The commissioner may use the good cause exemption under Minnesota Statutes, section 14.388, subdivision 1, clause (3). Minnesota Statutes, section 14.386, does not apply, except to the extent provided under Minnesota Statutes, section 14.388.

Sec. 50. [REVISOR'S INSTRUCTION.]

The revisor of statutes shall change all references to Minnesota Statutes, section 326.45, to Minnesota Statutes, section 326.451, in Minnesota Statutes, sections 144.99, 326.44, 326.61, and 326.65.

Sec. 51. [REPEALER.]

Minnesota Statutes 2004, sections 157.215; and 326.45, are repealed.

ARTICLE 2

HEALTH CARE - DEPARTMENT OF HUMAN SERVICES

Section 1. Minnesota Statutes 2004, section 62D.12, subdivision 19, is amended to read:

Subd. 19. [COVERAGE OF SERVICE.] A health maintenance organization may not deny or limit coverage of a service which the enrollee has already received solely on the basis of lack of prior authorization or second opinion, to the extent that the service would otherwise have been covered under the member's contract by the health maintenance organization had prior authorization or second opinion been obtained. This subdivision does not apply to health maintenance organizations for services provided in the prepaid health programs administered under chapter 256B, 256D, or 256L.

Sec. 2. Minnesota Statutes 2004, section 62M.06, subdivision 2, is amended to read:

Subd. 2. [EXPEDITED APPEAL.] (a) When an initial determination not to certify a health care service is made prior

to or during an ongoing service requiring review and the attending health care professional believes that the determination warrants an expedited appeal, the utilization review organization must ensure that the enrollee and the attending health care professional have an opportunity to appeal the determination over the telephone on an expedited basis. In such an appeal, the utilization review organization must ensure reasonable access to its consulting physician or health care provider. For review of initial determinations not to certify a service for prepaid health care programs under chapter 256B, 256D, or 256L, the health care provider conducting the review must follow coverage policies adopted by the health plan company that are based upon published evidence-based care guidelines as established by a nonprofit Minnesota quality improvement organization, a nationally recognized guideline development organization, or by the professional association of the specialty that typically provides the service.

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

(a) A utilization review organization shall notify in writing the enrollee, attending health care professional, and

claims administrator of its determination on the appeal within 30 days upon receipt of the notice of appeal. If the utilization review organization cannot make a determination within 30 days due to circumstances outside the control of the utilization review organization, the utilization review organization may take up to 14 additional days to notify the enrollee, attending health care professional, and claims administrator of its determination. If the utilization review organization takes any additional days beyond the initial 30-day period to make its determination, it must inform the enrollee, attending health care professional, and claims administrator, in advance, of the extension and the reasons for the extension.

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

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

(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:

(1) a complete summary of the review findings;

(2) qualifications of the reviewers, including any license, 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.

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

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

Sec. 4. [62Q.175] [COVERAGE EXEMPTIONS.]

Notwithstanding any law to the contrary, no health plan company is required to provide coverage for any health care service included on the list established under section 256B.0625, subdivision 46.

Sec. 5. Minnesota Statutes 2004, section 256.045, subdivision 3a, is amended to read:

Subd. 3a. [PREPAID HEALTH PLAN APPEALS.] (a) All prepaid health plans under contract to the commissioner under chapter 256B or 256D must provide for a complaint system according to section 62D.11. When a prepaid health plan denies, reduces, or terminates a health service or denies a request to authorize a previously authorized health service, the prepaid health plan must notify the recipient of the right to file a complaint or an appeal. The notice must include the name and telephone number of the ombudsman and notice of the recipient's right to request

a hearing under paragraph (b). ~~When a complaint is filed, the prepaid health plan must notify the ombudsman within three working days.~~ Recipients may request the assistance of the ombudsman in the complaint system process. The prepaid health plan must issue a written resolution of the complaint to the recipient within 30 days after the complaint is filed with the prepaid health plan. A recipient is not required to exhaust the complaint system procedures in order to request a hearing under paragraph (b).

(b) Recipients enrolled in a prepaid health plan under chapter 256B or 256D may contest a prepaid health plan's denial, reduction, or termination of health services, a prepaid health plan's denial of a request to authorize a previously authorized health service, or the prepaid health plan's written resolution of a complaint by submitting a written request for a hearing according to subdivision 3. A state human services referee shall conduct a hearing on the matter and shall recommend an order to the commissioner of human services. The referee may not overturn a decision by a prepaid health plan to deny or limit coverage for services if the prepaid health plan has used coverage policies adopted by the health plan company that are based upon published evidence-based criteria or guidelines in making the determination unless the recipient can show by clear and convincing evidence that the determination should be overturned. The commissioner need not grant a hearing if the sole issue raised by a recipient is the commissioner's authority to require mandatory enrollment in a prepaid health plan in a county where prepaid health plans are under contract with the commissioner. The state human services referee may order a second medical opinion from the prepaid health plan or may order a second medical opinion from a nonprepaid health plan provider at the expense of the prepaid health plan. Recipients may request the assistance of the ombudsman in the appeal process.

(c) In the written request for a hearing to appeal from a prepaid health plan's denial, reduction, or termination of a health service, a prepaid health plan's denial of a request to

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

Sec. 6. Minnesota Statutes 2004, section 256.9365, is amended to read:

256.9365 [~~PURCHASE OF CONTINUATION COVERAGE FOR AIDS PATIENTS~~ HIV HEALTH CARE ACCESS PROGRAM.]

Subdivision 1. [PROGRAM ESTABLISHED.] The commissioner of human services shall establish a ~~program to pay private health plan premiums for persons who have contracted human immunodeficiency virus (HIV) to enable them to continue coverage under a group or individual health plan. If a person is determined to be eligible under subdivision 2, the commissioner shall pay the portion of the group plan premium for which the individual is responsible, if the individual is responsible for at least 50 percent of the cost of the premium, or pay the individual plan premium. The commissioner shall not pay for that portion of a premium that is attributable to other family members or dependents~~ health care access program for low-income Minnesotans living with HIV that provides access to HIV treatment consistent with the guidelines of the United States Public Health Service. The program shall provide assistance with medical insurance premiums to secure or maintain necessary health care insurance coverage.

Subd. 2. [ELIGIBILITY REQUIREMENTS.] To be eligible for the HIV health care access program, an applicant must ~~satisfy the following requirements~~:

(1) ~~the applicant must~~ provide a physician's statement verifying that the applicant is infected with HIV ~~and is, or within three months is likely to become, too ill to work in the applicant's current employment because of HIV related disease~~;

(2) ~~the applicant's~~ have a monthly gross family income ~~must~~

that does not exceed 300 percent of the federal poverty guidelines, after deducting medical expenses and insurance premiums;

(3) ~~the applicant must~~ not own assets with a combined value of more than $25,000, excluding:

(i) all assets excluded under section 256B.056;

(ii) retirement accounts, Keogh plans, and pensions plans; and

(iii) medical expense accounts set up through the individual's employer; ~~and~~

(4) ~~if applying for payment of group plan premiums, the applicant must be covered by an employer's or former employer's group insurance plan~~ have no health insurance coverage; have no health insurance coverage because of ineligibility due to a preexisting condition; or face loss of health insurance coverage due to a change in employment status;

(5) reside in Minnesota;

(6) have been determined ineligible for Medicare, Medicaid, MinnesotaCare, and general assistance medical care; and

(7) meet monthly cost-sharing obligations as provided for in subdivision 4.

Subd. 3. [~~COST-EFFECTIVE COVERAGE~~ BENEFITS.] The commissioner shall pay that portion of the group plan premium for which the individual is responsible or shall pay the individual plan premium. The commissioner shall not pay for that portion of a premium that is attributable to other family members or dependents. Requirements for the payment of individual plan premiums under subdivision 2, clause (5), must be designed to ensure that the state cost of paying an individual plan premium does not exceed the estimated state cost that would otherwise be incurred in the medical assistance or general assistance medical care program. The commissioner shall purchase the most cost-effective coverage available for eligible individuals. Efforts shall be made to obtain coverage that is consistent with the guidelines of the United States Public Health Service for HIV treatment, and to the extent possible,

provides comprehensive coverage that includes medical, mental health, and substance abuse treatment.

Subd. 4. [COST-SHARING RESPONSIBILITIES.] (a) The commissioner may establish cost-sharing responsibilities for individuals determined to be eligible for the HIV health care access program that are consistent with guidelines established in the federal Ryan White Care Act. These obligations, when appropriate, should be consistent with cost-sharing requirements for other Minnesota health care programs.

Subd. 5. [FISCAL INTEGRITY.] The commissioner shall manage the HIV health care access program to assure that the program spending does not exceed the resources made available by the federal government and the legislature. The commissioner shall make necessary program changes to assure the fiscal integrity of the program.

Subd. 6. [CONTINUATION OF CARE.] The commissioner shall establish policies and procedures to ensure that initial and continued access to HIV treatment is provided to recipients who meet the eligibility requirements outlined in subdivision 2.

Subd. 7. [COORDINATION WITH FEDERAL PROGRAMS.] The commissioner shall administer the HIV health care access program in coordination with funding received from the Ryan White Care Act.

Subd. 8. [COMMUNITY ADVISORY PROCESS.] The commissioner shall establish a community advisory process for assessing the effectiveness of the policies and procedures established for the HIV health care access program. As appropriate to minimize duplicative efforts, the process shall include consultation with, coordination with, and reporting to the Minnesota HIV Services Planning Council. Public notification shall be made of the committee's members and meetings.

Sec. 7. [256.9545] [PRESCRIPTION DRUG DISCOUNT PROGRAM.]

Subdivision 1. [ESTABLISHMENT; ADMINISTRATION.] The commissioner shall establish and administer the prescription drug discount program, effective July 1, 2005.

Subd. 2. [COMMISSIONER'S AUTHORITY.] The commissioner

shall administer a drug rebate program for drugs purchased according to the prescription drug discount program. The commissioner shall execute a rebate agreement from all manufacturers that choose to participate in the program for those drugs covered under the medical assistance program. For each drug, the amount of the rebate shall be equal to the rebate as defined for purposes of the federal rebate program in United States Code, title 42, section 1396r-8. The rebate program shall utilize the terms and conditions used for the federal rebate program established according to section 1927 of title XIX of the federal Social Security Act.

Subd. 3. [DEFINITIONS.] For the purpose of this section, the following terms have the meanings given them.

(a) "Commissioner" means the commissioner of human services.

(b) "Participating manufacturer" means a manufacturer as defined in section 151.44, paragraph (c), that agrees to participate in the prescription drug discount program.

(c) "Covered prescription drug" means a prescription drug as defined in section 151.44, paragraph (d), that is covered under medical assistance as described in section 256B.0625, subdivision 13, and that is provided by a participating manufacturer that has a fully executed rebate agreement with the commissioner under this section and complies with that agreement.

(d) "Health carrier" means an insurance company licensed under chapter 60A to offer, sell, or issue an individual or group policy of accident and sickness insurance as defined in section 62A.01; a nonprofit health service plan corporation operating under chapter 62C; a health maintenance organization operating under chapter 62D; a joint self-insurance employee health plan operating under chapter 62H; a community integrated systems network licensed under chapter 62N; a fraternal benefit society operating under chapter 64B; a city, county, school district, or other political subdivision providing self-insured health coverage under section 471.617 or sections 471.98 to 471.982; and a self-funded health plan under the Employee Retirement Income Security Act of 1974, as amended.

(e) "Participating pharmacy" means a pharmacy as defined in section 151.01, subdivision 2, that agrees to participate in the prescription drug discount program.

(f) "Enrolled individual" means a person who is eligible for the program under subdivision 4 and has enrolled in the program according to subdivision 5.

Subd. 4. [ELIGIBILITY.] To be eligible for the program, an applicant must:

(1) be a permanent resident of Minnesota as defined in section 256L.09, subdivision 4;

(2) not be enrolled in Medicare, medical assistance, general assistance medical care, or MinnesotaCare;

(3) not be enrolled in and have currently available prescription drug coverage under a health plan offered by a health carrier or employer or under a pharmacy benefit program offered by a pharmaceutical manufacturer; and

(4) not be enrolled in and have currently available prescription drug coverage under a Medicare supplement plan, as defined in sections 62A.31 to 62A.44, or policies, contracts, or certificates that supplement Medicare issued by health maintenance organizations or those policies, contracts, or certificates governed by section 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section 1395, et seq., as amended.

Subd. 5. [APPLICATION PROCEDURE.] (a) Applications and information on the program must be made available at county social services agencies, health care provider offices, and agencies and organizations serving senior citizens. Individuals shall submit applications and any information specified by the commissioner as being necessary to verify eligibility directly to the commissioner. The commissioner shall determine an applicant's eligibility for the program within 30 days from the date the application is received. Upon notice of approval, the applicant must submit to the commissioner the enrollment fee specified in subdivision 10. Eligibility begins the month after the enrollment fee is received by the commissioner.

(b) An enrollee's eligibility must be renewed every 12 months with the 12-month period beginning in the month after the application is approved.

(c) The commissioner shall develop an application form that does not exceed one page in length and requires information necessary to determine eligibility for the program.

Subd. 6. [PARTICIPATING PHARMACY.] (a) Upon implementation of the prescription drug discount program, until January 1, 2008, a participating pharmacy, in accordance with a valid prescription, must sell a covered prescription drug to an enrolled individual at the medical assistance rate.

(b) After January 1, 2008, a participating pharmacy, in accordance with a valid prescription, must sell a covered prescription drug to an enrolled individual at the medical assistance rate, minus an amount that is equal to the rebate amount described in subdivision 8, plus the amount of any switch fee established by the commissioner under subdivision 10, paragraph (b).

(c) Each participating pharmacy shall provide the commissioner with all information necessary to administer the program, including, but not limited to, information on prescription drug sales to enrolled individuals and usual and customary retail prices.

Subd. 7. [NOTIFICATION OF REBATE AMOUNT.] The commissioner shall notify each participating manufacturer, each calendar quarter or according to a schedule to be established by the commissioner, of the amount of the rebate owed on the prescription drugs sold by participating pharmacies to enrolled individuals.

Subd. 8. [PROVISION OF REBATE.] To the extent that a participating manufacturer's prescription drugs are prescribed to a resident of this state, the manufacturer must provide a rebate equal to the rebate provided under the medical assistance program for any prescription drug distributed by the manufacturer that is purchased by an enrolled individual at a participating pharmacy. The participating manufacturer must

provide full payment within 38 days of receipt of the state invoice for the rebate, or according to a schedule to be established by the commissioner. The commissioner shall deposit all rebates received into the Minnesota prescription drug dedicated fund established under subdivision 11. The manufacturer must provide the commissioner with any information necessary to verify the rebate determined per drug.

Subd. 9. [PAYMENT TO PHARMACIES.] Beginning January 1, 2008, the commissioner shall distribute on a biweekly basis an amount that is equal to an amount collected under subdivision 8 to each participating pharmacy based on the prescription drugs sold by that pharmacy to enrolled individuals on or after January 1, 2008.

Subd. 10. [ENROLLMENT FEE; SWITCH FEE.] (a) The commissioner shall establish an annual enrollment fee that covers the commissioner's expenses for enrollment, processing claims, and distributing rebates under this program.

(b) The commissioner shall establish a reasonable switch fee that covers expenses incurred by participating pharmacies in formatting for electronic submission claims for prescription drugs sold to enrolled individuals.

Subd. 11. [DEDICATED FUND; CREATION; USE OF FUND.] (a) The Minnesota prescription drug dedicated fund is established as an account in the state treasury. The commissioner of finance shall credit to the dedicated fund all rebates paid under subdivision 8, any federal funds received for the program, all enrollment fees paid by the enrollees, and any appropriations or allocations designated for the fund. The commissioner of finance shall ensure that fund money is invested under section 11A.25. All money earned by the fund must be credited to the fund. The fund shall earn a proportionate share of the total state annual investment income.

(b) Money in the fund is appropriated to the commissioner to reimburse participating pharmacies for prescription drugs the rebate discount provided to enrolled individuals under subdivision 6, paragraph (b); to reimburse the commissioner for

costs related to enrollment, processing claims, and distributing rebates and for other reasonable administrative costs related to administration of the prescription drug discount program; and to repay the appropriation provided for this section. The commissioner must administer the program so that the costs total no more than funds appropriated plus the drug rebate proceeds.

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

Sec. 8. Minnesota Statutes 2004, section 256.969, is amended by adding a subdivision to read:

Subd. 27. [ANNUAL NONMEDICAL ASSISTANCE PAYMENT.] (a) In addition to any other payment under this section, the commissioner shall make the following payments:

(1) for a hospital located in Minnesota and not eligible for payments under subdivision 20, with a medical assistance inpatient utilization rate greater than 19 percent of total patient days during the base year, a payment equal to 13 percent of the total of the operating and payment rates;

(2) for a hospital located in Minnesota in a specified urban area outside of the seven-county metropolitan area and not eligible for payments under subdivision 20, with a medical assistance inpatient utilization rate less than or equal to 19 percent of total patient days during the base year, a payment equal to ten percent of the total of the operating and property payment rates. For purposes of this clause, the following cities are specified urban areas: Detroit Lakes, Rochester, Willmar, Hutchinson, Alexandria, Austin, Cambridge, Brainerd, Hibbing, Mankato, Duluth, St. Cloud, Grand Rapids, Wyoming, Fergus Falls, Albert Lea, Winona, Virginia, Thief River Falls, and Wadena; and

(3) for a hospital located in Minnesota but not located in a specified urban area under clause (2) and not eligible for payments under subdivision 20, with a medical assistance inpatient utilization rate less than or equal to 19 percent of total patient days during the base year, a payment equal to five percent of the total of the operating and property payment rates.

(b) The payments under paragraph (a) shall be 100 percent state dollars derived from federal reimbursements to the commissioner to reimburse nonstate expenditures reported under section 256B.199.

(c) The payments under paragraph (a) shall be paid annually on July 1, beginning July 1, 2005, or upon the receipt of federal reimbursements under section 256B.199, whichever occurs last, for services to be rendered in the fiscal year beginning on July 1, based on services rendered in the previous calendar year.

(d) The commissioner shall not adjust rates paid to a prepaid health plan under contract with the commissioner to reflect payments provided in paragraph (a).

(e) If federal reimbursements are not available under section 256B.199 for all payments under paragraph (a), the commissioner shall reduce payments under paragraph (a) on a pro rata basis so that payments under paragraph (a) do not exceed the federal reimbursements.

(f) For purposes of this subdivision, medical assistance does not include general assistance medical care.

(g) The commissioner may ratably reduce or increase the payments under this subdivision in order to ensure that these total payments equal the amount of reimbursement received by the commissioner under section 256B.199.

(h) The commissioner may, in consultation with the nonstate entities identified in section 256B.199, adjust the amounts reported by nonstate entities under section 256B.199 when application for reimbursement is made to the federal government, and otherwise adjust the provisions of this subdivision in order to maximize payments to qualifying hospitals.

[EFFECTIVE DATE.] This section is effective the day following final enactment. The commissioner of human services shall submit necessary medical assistance plan amendments to implement this section within 30 days of enactment.

Sec. 9. Minnesota Statutes 2004, section 256B.02, subdivision 12, is amended to read:

Subd. 12. [THIRD-PARTY PAYER.] "Third-party payer" means a person, entity, or agency or government program that has a probable obligation to pay all or part of the costs of a medical assistance recipient's health services. Third-party payer includes an entity under contract with the recipient to cover all or part of the recipient's medical costs.

Sec. 10. Minnesota Statutes 2004, section 256B.056, is amended by adding a subdivision to read:

Subd. 3d. [REDUCTION OF EXCESS ASSETS.] Assets in excess of the limits set forth in subdivisions 3 to 3c may be reduced to allowable limits as follows:

(a) Assets may be reduced in any of the three calendar months before the month of application in which the applicant seeks coverage by:

(1) designating burial funds up to $1500 for each applicant, spouse, and MA-eligible dependent child; and

(2) paying health service bills incurred in the retroactive period for which the applicant seeks eligibility, starting with the oldest bill. After assets are reduced to allowable limits, eligibility begins with the next dollar of MA-covered health services incurred in the retroactive period. Applicants reducing assets under this subdivision who also have excess income shall first spend excess assets to pay health service bills and may meet the income spenddown on remaining bills.

(b) Assets may be reduced beginning the month of application by:

(1) paying bills for health services that would otherwise be paid by medical assistance; and

(2) using any means other than a transfer of assets for less than fair market value as defined in section 256B.0595, subdivision 1, paragraph (b).

Sec. 11. Minnesota Statutes 2004, section 256B.056, subdivision 5, is amended to read:

Subd. 5. [EXCESS INCOME.] A person who has excess income is eligible for medical assistance if the person has expenses for medical care that are more than the amount of the person's

excess income, computed by deducting incurred medical expenses from the excess income to reduce the excess to the income standard specified in subdivision 5c. The person shall elect to have the medical expenses deducted at the beginning of a one-month budget period or at the beginning of a six-month budget period. The commissioner shall allow persons eligible for assistance on a one-month spenddown basis under this subdivision to elect to pay the monthly spenddown amount in advance of the month of eligibility to the state agency in order to maintain eligibility on a continuous basis. If the recipient does not pay the spenddown amount on or before the ~~20th~~ last business day of the month, the recipient is ineligible for this option for the following month. The local agency shall code the Medicaid Management Information System (MMIS) to indicate that the recipient has elected this option. The state agency shall convey recipient eligibility information relative to the collection of the spenddown to providers through the Electronic Verification System (EVS). A recipient electing advance payment must pay the state agency the monthly spenddown amount on or before noon on the ~~20th~~ last business day of the month in order to be eligible for this option in the following month.

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

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

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

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

Sec. 13. Minnesota Statutes 2004, section 256B.056, subdivision 5b, is amended to read:

Subd. 5b. [INDIVIDUALS WITH LOW INCOME.] Recipients of medical assistance not residing in a long-term care facility who have slightly fluctuating income which is below the medical assistance income limit shall report and verify their income ~~on a semiannual basis~~ every six months. The six-month period begins the month of application.

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

Sec. 14. Minnesota Statutes 2004, section 256B.056, subdivision 7, is amended to read:

Subd. 7. [PERIOD OF ELIGIBILITY.] Eligibility is available for the month of application and for three months prior to application if the person was eligible in those prior months. Eligibility for months prior to application is determined independently from eligibility for the month of application and future months. A redetermination of eligibility must occur every 12 months. The 12-month period begins with the month of application.

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

Sec. 15. Minnesota Statutes 2004, section 256B.056, is amended by adding a subdivision to read:

Subd. 9. [NOTICE.] The state agency must be given notice of monetary claims against a person, entity, or corporation that may be liable to pay all or part of the cost of medical care when the state agency has paid or becomes liable for the cost of that care. Notice must be given according to paragraphs (a) to (d).

(a) An applicant for medical assistance shall notify the state or local agency of any possible claims when the applicant submits the application. A recipient of medical assistance shall notify the state or local agency of any possible claims when those claims arise.

(b) A person providing medical care services to a recipient of medical assistance shall notify the state agency when the person has reason to believe that a third party may be liable

for payment of the cost of medical care.

(c) A party to a claim that may be assigned to the state agency under this section shall notify the state agency of its potential assignment claim in writing at each of the following stages of a claim:

(1) when a claim is filed;

(2) when an action is commenced; and

(3) when a claim is concluded by payment, award, judgment, settlement, or otherwise.

(d) Every party involved in any stage of a claim under this subdivision is required to provide notice to the state agency at that stage of the claim. However, when one of the parties to the claim provides notice at that stage, every other party to the claim is deemed to have provided the required notice for that stage of the claim. If the required notice under this paragraph is not provided to the state agency, all parties to the claim are deemed to have failed to provide the required notice. A party to the claim includes the injured person or the person's legal representative, the plaintiff, the defendants, or persons alleged to be responsible for compensating the injured person or plaintiff, and any other party to the cause of action or claim, regardless of whether the party knows the state agency has a potential or actual assignment claim.

Sec. 16. Minnesota Statutes 2004, section 256B.057, subdivision 1, is amended to read:

Subdivision 1. [INFANTS AND PREGNANT WOMEN.] (a) ~~(1)~~ An infant less than one year of age is eligible for medical assistance if countable family income is equal to or less than 275 percent of the federal poverty guideline for the same family size. A pregnant woman who has written verification of a positive pregnancy test from a physician or licensed registered nurse is eligible for medical assistance if countable family income is equal to or less than ~~200~~ 275 percent of the federal poverty guideline for the same family size. For purposes of this subdivision, "countable family income" means the amount of income considered available using the methodology of the AFDC

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

~~(2) For applications processed within one calendar month prior to the effective date, eligibility shall be determined by applying the income standards and methodologies in effect prior to the effective date for any months in the six-month budget period before that date and the income standards and methodologies in effect on the effective date for any months in the six-month budget period on or after that date. The income standards for each month shall be added together and compared to the applicant's total countable income for the six-month budget period to determine eligibility.~~

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

~~(2) For applications processed within one calendar month prior to July 1, 2003, eligibility shall be determined by applying the income standards and methodologies in effect prior to July 1, 2003, for any months in the six-month budget period before July 1, 2003, and the income standards and methodologies in effect on the expiration date for any months in the six-month budget period on or after July 1, 2003. The income standards for each month shall be added together and compared to the applicant's total countable income for the six-month budget period to determine eligibility.~~

(c) ~~Dependent care and child support paid under court order shall be deducted from the countable income of pregnant women.~~ An amount equal to the amount of earned income exceeding 275 percent of the federal poverty guideline plus the earned income disregards and deductions of the AFDC program under the state's AFDC plan as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law 104-193, that exceeds 275 percent of the federal poverty guideline will be deducted for pregnant women and infants less than one year of age.

(d) An infant born on or after January 1, 1991, to a woman

who was eligible for and receiving medical assistance on the date of the child's birth shall continue to be eligible for medical assistance without redetermination until the child's first birthday, as long as the child remains in the woman's household.

[EFFECTIVE DATE.] The amendments to paragraphs (a) and (b) are effective retroactively from July 1, 2004, and the amendment to paragraph (c) is effective retroactively from October 1, 2003.

Sec. 17. Minnesota Statutes 2004, section 256B.0625, subdivision 9, is amended to read:

Subd. 9. [DENTAL SERVICES.] ~~(a)~~ Medical assistance covers dental services. Dental services include, with prior authorization, fixed bridges that are cost-effective for persons who cannot use removable dentures because of their medical condition.

~~(b) Coverage of dental services for adults age 21 and over who are not pregnant is subject to a $500 annual benefit limit and covered services are limited to:~~

~~(1) diagnostic and preventative services;~~

~~(2) restorative services; and~~

~~(3) emergency services.~~

~~Emergency services, dentures, and extractions related to dentures are not included in the $500 annual benefit limit.~~

Sec. 18. Minnesota Statutes 2004, section 256B.0625, subdivision 13f, is amended to read:

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

(b) Prior authorization may be required by the commissioner before certain formulary drugs are eligible for payment. The Formulary Committee may recommend drugs for prior authorization directly to the commissioner. The commissioner may also request

that the Formulary Committee review a drug for prior authorization. Before the commissioner may require prior authorization for a drug:

(1) the commissioner must provide information to the Formulary Committee on the impact that placing the drug on prior authorization may have on the quality of patient care and on program costs, information regarding whether the drug is subject to clinical abuse or misuse, and relevant data from the state Medicaid program if such data is available;

(2) the Formulary Committee must review the drug, taking into account medical and clinical data and the information provided by the commissioner; and

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

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

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

(1) there is no generically equivalent drug available; and

(2) the drug was initially prescribed for the recipient prior to July 1, 2003; or

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

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

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

(e) The commissioner may require prior authorization for brand name drugs whenever a generically equivalent product is

available, even if the prescriber specifically indicates "dispense as written-brand necessary" on the prescription as required by section 151.21, subdivision 2.

[EFFECTIVE DATE.] This section is effective June 30, 2005.

Sec. 19. Minnesota Statutes 2004, section 256B.0625, is amended by adding a subdivision to read:

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

(1) performing or obtaining necessary assessments of the patient's health status;

(2) formulating a medication treatment plan;

(3) monitoring and evaluating the patient's response to therapy, including safety and effectiveness;

(4) performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events;

(5) documenting the care delivered and communicating essential information to the patient's other primary care providers;

(6) providing verbal education and training designed to enhance patient understanding and appropriate use of the patient's medications;

(7) providing information, support services, and resources designed to enhance patient adherence with the patient's therapeutic regimens; and

(8) coordinating and integrating medication therapy management services within the broader health care management

services being provided to the patient. Nothing in this subdivision shall be construed to expand or modify the scope of practice of the pharmacist as defined in section 151.01, subdivision 27.

(b) To be eligible for reimbursement for services under this subdivision, a pharmacist must meet the following requirements:

(1) have a valid license issued under chapter 151;

(2) have graduated from an accredited college of pharmacy on or after May of 1996 or completed a structured and comprehensive education program approved by the Board of Pharmacy and the American Council of Pharmaceutical Education for the provision and documentation of pharmaceutical care management services that has both clinical and didactic elements;

(3) be practicing in an ambulatory care setting as part of a multidisciplinary team or have developed a structured patient care process that is offered in a private or semiprivate patient care area that is separate from the commercial business that also occurs in the setting; and

(4) make use of an electronic patient record system that meets state standards.

(c) For the purposes of reimbursement for medication therapy management services, the commissioner may enroll individual pharmacists as medical assistance providers. The commissioner may also establish contact requirements between the pharmacist and recipient, including limiting the number of reimbursable consultations per recipient.

(d) The commissioner, after receiving recommendations from professional medical associations, professional pharmacy associations, and consumer groups shall convene an 11-member Medication Therapy Management Advisory Committee, to advise the commissioner on the implementation and administration of medication therapy management services. The committee shall be comprised of two licensed physicians; two licensed pharmacists; two consumer representatives; two health plan representatives;

and three members with expertise in the area of medication therapy management, who may be licensed physicians or licensed pharmacists. The committee is governed by section 15.059, except that committee members do not receive compensation or reimbursement for expenses. The advisory committee shall expire on June 30, 2007.

(e) The commissioner shall evaluate the effect of medication therapy management on quality of care, patient outcomes, and program costs, and shall include a description of any savings generated in the medical assistance program that can be attributable to this coverage. The evaluation shall be submitted to the legislature by December 15, 2007. The commissioner may contract with a vendor or an academic institution that has expertise in evaluating health care outcomes for the purpose of completing the evaluation.

Sec. 20. Minnesota Statutes 2004, section 256B.0625, is amended by adding a subdivision to read:

Subd. 46. [LIST OF HEALTH CARE SERVICES NOT ELIGIBLE FOR COVERAGE.] (a) The commissioner of human services, in consultation with the commissioner of health, shall biennially establish a list of diagnosis/treatment pairings that are not eligible for reimbursement under this chapter and chapters 256D and 256L, effective for services provided on or after July 1, 2007. The commissioner shall review the list in effect for the prior biennium and shall make any additions or deletions from the list as appropriate, taking into consideration the following:

(1) scientific and medical information;

(2) clinical assessment;

(3) cost-effectiveness of treatment;

(4) prevention of future costs; and

(5) medical ineffectiveness.

(b) The commissioner may appoint an ad hoc advisory panel made up of physicians, consumers, nurses, dentists, chiropractors, and other experts to assist the commissioner in reviewing and establishing the list. The commissioner shall solicit comments and recommendations from any interested persons

and organizations and shall schedule at least one public hearing.

(c) The list must be established by January 15, 2007, for the list effective July 1, 2007, and by October 1 of the even-numbered years beginning October 1, 2008, for the lists effective the following July 1. The commissioner shall publish the list in the State Register by November 1 of the even-numbered years beginning November 1, 2008. The list shall be submitted to the legislature by January 15 of the odd-numbered years beginning January 15, 2007.

Sec. 21. [256B.072] [PERFORMANCE REPORTING AND QUALITY IMPROVEMENT PAYMENT SYSTEM.]

(a) The commissioner of human services shall establish a performance reporting and payment system for health care providers who provide health care services to public program recipients covered under chapters 256B, 256D, and 256L.

(b) The measures used for the performance reporting and payment system for medical groups or single-physician practices shall include, but are not limited to, measures of care for asthma, diabetes, hypertension, and coronary artery disease and measures of preventive care services. The measures used for the performance reporting and payment system for inpatient hospitals shall include, but are not limited to, measures of care for acute myocardial infarction, heart failure, and pneumonia, and measures of care and prevention of surgical infections. In the case of a medical group or single-physician practice, the measures used shall be consistent with measures published by nonprofit Minnesota or national organizations that produce and disseminate health care quality measures or evidence-based health care guidelines. In the case of inpatient hospital measures, the commissioner shall appoint the Minnesota Hospital Association and Stratis Health to develop the performance measures to be used for hospital reporting. To enable a consistent measurement process across the community, the commissioner may use measures of care provided for patients in addition to those identified in paragraph (a). The commissioner shall ensure collaboration with other health care reporting

organizations so that the measures described in this section are consistent with those reported by those organizations and used by other purchasers in Minnesota.

(c) For recipients seen on or after January 1, 2007, the commissioner shall provide a performance bonus payment to providers who have achieved certain levels of performance established by the commissioner with respect to the measures or who have achieved certain rates of improvement established by the commissioner with respect to the measures or whose rates of achievement have increased over a previous period, as established by the commissioner. The performance bonus payment may be a fixed dollar amount per patient, paid quarterly or annually, or alternatively payment may be made as a percentage increase over payments allowed elsewhere in statute for the recipients identified in paragraph (a). In order for providers to be eligible for a performance bonus payment under this section, the commissioner may require the providers to submit information in a required format to a health care reporting organization or to cooperate with the information collection procedures of that organization. The commissioner may contract with a reporting organization to assist with the collection of reporting information and to prevent duplication of reporting. The commissioner may limit application of the performance bonus payment system to providers that provide a sufficiently large volume of care to permit adequate statistical precision in the measurement of that care, as established by the commissioner, after consulting with other health care quality reporting organizations.

(d) The performance bonus payments shall be funded with the projected savings in the program costs due to improved results of these measures with the eligible providers.

(e) The commissioner shall publish a description of the proposed performance reporting and payment system for the calendar year beginning January 1, 2007, and each subsequent calendar year, at least three months prior to the beginning of that calendar year.

(f) By April 1, 2007, and annually thereafter, the commissioner shall report through a public Web site the results by medical group, single-physician practice, and hospital of the measures and the performance payments under this section, and shall compare the results by medical group, single-physician practice, and hospital for patients enrolled in public programs to patients enrolled in private health plans. To achieve this reporting, the commissioner may contract with a health care reporting organization that operates a Web site suitable for this purpose.

Sec. 22. Minnesota Statutes 2004, section 256B.0916, is amended by adding a subdivision to read:

Subd. 10. [TRANSITIONAL SUPPORTS ALLOWANCE.] A transitional supports allowance shall be available to all persons under a home and community-based waiver who are moving from a licensed setting to a community setting. "Transitional supports allowance" means a onetime payment of up to $3,000, to cover the costs, not covered by other sources, associated with moving from a licensed setting to a community setting. Covered costs include:

(1) lease or rent deposits;

(2) security deposits;

(3) utilities set-up costs, including telephone;

(4) essential furnishings and supplies; and

(5) personal supports and transports needed to locate and transition to community settings.

[EFFECTIVE DATE.] This section is effective upon federal approval and to the extent approved as a federal waiver amendment.

Sec. 23. [256B.0918] [EMPLOYEE SCHOLARSHIP COSTS AND TRAINING IN ENGLISH AS A SECOND LANGUAGE.]

(a) For the fiscal year beginning July 1, 2005, the commissioner shall provide to each provider listed in paragraph (c) a scholarship reimbursement increase of two-tenths percent of the reimbursement rate for that provider to be used:

(1) for employee scholarships that satisfy the following

requirements:

(i) scholarships are available to all employees who work an average of at least 20 hours per week for the provider, except administrators, department supervisors, and registered nurses; and

(ii) the course of study is expected to lead to career advancement with the provider or in long-term care, including home care or care of persons with disabilities, including medical care interpreter services and social work; and

(2) to provide job-related training in English as a second language.

(b) A provider receiving a rate adjustment under this subdivision with an annualized value of at least $1,000 shall maintain documentation to be submitted to the commissioner on a schedule determined by the commissioner and on a form supplied by the commissioner of the scholarship rate increase received, including:

(1) the amount received from this reimbursement increase;

(2) the amount used for training in English as a second language;

(3) the number of persons receiving the training;

(4) the name of the person or entity providing the training; and

(5) for each scholarship recipient, the name of the recipient, the amount awarded, the educational institution attended, the nature of the educational program, the program completion date, and a determination of the amount spent as a percentage of the provider's reimbursement.

The commissioner shall report to the legislature annually, beginning January 15, 2006, with information on the use of these funds.

(c) The rate increases described in this section shall be provided to home and community-based waivered services for persons with mental retardation or related conditions under section 256B.501; home and community-based waivered services for the elderly under section 256B.0915; waivered services under

community alternatives for disabled individuals under section 256B.49; community alternative care waivered services under section 256B.49; traumatic brain injury waivered services under section 256B.49; nursing services and home health services under section 256B.0625, subdivision 6a; personal care services and nursing supervision of personal care services under section 256B.0625, subdivision 19a; private duty nursing services under section 256B.0625, subdivision 7; day training and habilitation services for adults with mental retardation or related conditions under sections 252.40 to 252.46; alternative care services under section 256B.0913; adult residential program grants under Minnesota Rules, parts 9535.2000 to 9535.3000; semi-independent living services (SILS) under section 252.275, including SILS funding under county social services grants formerly funded under chapter 256I; community support services for deaf and hard-of-hearing adults with mental illness who use or wish to use sign language as their primary means of communication; the group residential housing supplementary service rate under section 256I.05, subdivision 1a; chemical dependency residential and nonresidential service providers under section 254B.03; and intermediate care facilities for persons with mental retardation under section 256B.5012.

(d) These increases shall be included in the provider's reimbursement rate for the purpose of determining future rates for the provider.

Sec. 24. [256B.199] [PAYMENTS REPORTED BY GOVERNMENTAL ENTITIES.]

(a) Hennepin County, Ramsey County, and the University of Minnesota shall annually report to the commissioner by June 1, beginning June 1, 2005, payments to Hennepin County Medical Center, Regions Hospital, and Fairview-University Medical Center respectively made during the previous calendar year that are certified public expenditures that may qualify for reimbursement under federal law. Subject to the reports due June 1, 2005, the amounts for calendar year 2004 are expected to be as follows:

(1) Hennepin County, $60,000,000;

(2) Ramsey County, $27,000,000; and

(3) University of Minnesota, $18,000,000.

(b) Based on these reports, the commissioner shall apply for federal matching funds. These funds are appropriated to the commissioner for the annual payments under section 256.969, subdivision 27.

[EFFECTIVE DATE.] This section is effective the day following final enactment. The commissioner of human services shall submit necessary medical assistance plan amendments to implement this section within 30 days of enactment.

Sec. 25. Minnesota Statutes 2004, section 256B.69, subdivision 4, is amended to read:

Subd. 4. [LIMITATION OF CHOICE.] (a) The commissioner shall develop criteria to determine when limitation of choice may be implemented in the experimental counties. The criteria shall ensure that all eligible individuals in the county have continuing access to the full range of medical assistance services as specified in subdivision 6.

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

(1) persons eligible for medical assistance according to section 256B.055, subdivision 1;

(2) persons eligible for medical assistance due to blindness or disability as determined by the Social Security Administration or the state medical review team, unless:

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

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

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

(4) recipients who are eligible for medical assistance by spending down excess income for medical expenses other than the nursing facility per diem expense;

(5) recipients who receive benefits under the Refugee Assistance Program, established under United States Code, title 8, section 1522(e);

(6) children who are both determined to be severely emotionally disturbed and receiving case management services according to section 256B.0625, subdivision 20;

(7) adults who are both determined to be seriously and persistently mentally ill and received case management services according to section 256B.0625, subdivision 20;

(8) persons eligible for medical assistance according to section 256B.057, subdivision 10; and

(9) persons with access to cost-effective employer-sponsored private health insurance or persons enrolled in ~~an~~ non-Medicare individual health plan determined to be cost-effective according to section 256B.0625, subdivision 15. Children under age 21 who are in foster placement may enroll in the project on an elective basis. Individuals excluded under clauses (1), (6), and (7) may choose to enroll on an elective basis. The commissioner may enroll recipients in the prepaid medical assistance program for seniors who are (1) age 65 and over, and (2) eligible for medical assistance by spending down excess income.

(c) The commissioner may allow persons with a one-month spenddown who are otherwise eligible to enroll to voluntarily enroll or remain enrolled, if they elect to prepay their monthly spenddown to the state.

(d) The commissioner may require those individuals to enroll in the prepaid medical assistance program who otherwise would have been excluded under paragraph (b), clauses (1), (3), and (8), and under Minnesota Rules, part 9500.1452, subpart 2, items H, K, and L.

(e) Before limitation of choice is implemented, eligible individuals shall be notified and after notification, shall be allowed to choose only among demonstration providers. The commissioner may assign an individual with private coverage through a health maintenance organization, to the same health

maintenance organization for medical assistance coverage, if the health maintenance organization is under contract for medical assistance in the individual's county of residence. After initially choosing a provider, the recipient is allowed to change that choice only at specified times as allowed by the commissioner. If a demonstration provider ends participation in the project for any reason, a recipient enrolled with that provider must select a new provider but may change providers without cause once more within the first 60 days after enrollment with the second provider.

(f) An infant born to a woman who is eligible for and receiving medical assistance and who is enrolled in the prepaid medical assistance program shall be retroactively enrolled to the month of birth in the same managed care plan as the mother once the child is enrolled in medical assistance unless the child is determined to be excluded from enrollment in a prepaid plan under this section.

Sec. 26. Minnesota Statutes 2004, section 256D.03, subdivision 4, is amended to read:

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

(1) inpatient hospital services;

(2) outpatient hospital services;

(3) services provided by Medicare certified rehabilitation agencies;

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

(5) equipment necessary to administer insulin and diagnostic supplies and equipment for diabetics to monitor blood sugar level;

(6) eyeglasses and eye examinations provided by a physician or optometrist;

(7) hearing aids;

(8) prosthetic devices;

(9) laboratory and X-ray services;

(10) physician's services;

(11) medical transportation except special transportation;

(12) chiropractic services as covered under the medical assistance program;

(13) podiatric services;

(14) dental services ~~and dentures, subject to the limitations specified in section 256B.0625, subdivision 9~~ as covered under the medical assistance program;

(15) outpatient services provided by a mental health center or clinic that is under contract with the county board and is established under section 245.62;

(16) day treatment services for mental illness provided under contract with the county board;

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

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

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

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

section 148.171;

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

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

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

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

(c) In order to contain costs, the commissioner of human services shall select vendors of medical care who can provide the most economical care consistent with high medical standards and shall where possible contract with organizations on a prepaid capitation basis to provide these services. The commissioner shall consider proposals by counties and vendors for prepaid health plans, competitive bidding programs, block grants, or other vendor payment mechanisms designed to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are provided. Before implementing prepaid programs in counties with a county operated or affiliated public teaching hospital or a hospital or clinic operated by the University of Minnesota, the commissioner shall consider the risks the prepaid program creates for the hospital and allow the county or hospital the opportunity to participate in the program in a manner that reflects the risk of adverse selection and the nature of the patients served by the

hospital, provided the terms of participation in the program are competitive with the terms of other participants considering the nature of the population served. Payment for services provided pursuant to this subdivision shall be as provided to medical assistance vendors of these services under sections 256B.02, subdivision 8, and 256B.0625. For payments made during fiscal year 1990 and later years, the commissioner shall consult with an independent actuary in establishing prepayment rates, but shall retain final control over the rate methodology.

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

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

~~(2) $25 for eyeglasses;~~

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

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

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

~~(e) Co-payments shall be limited to one per day per provider for nonpreventive visits, eyeglasses, and nonemergency visits to a hospital based emergency room. Recipients of general assistance medical care are responsible for all co-payments in this subdivision. The general assistance medical care reimbursement to the provider shall be reduced by the amount of the co-payment, except that reimbursement for prescription drugs shall not be reduced once a recipient has~~

~~reached the $20 per month maximum for prescription drug co-payments. The provider collects the co-payment from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment, except as provided in paragraph (f).~~

~~(f) If it is the routine business practice of a provider to refuse service to an individual with uncollected debt, the provider may include uncollected co-payments under this section. A provider must give advance notice to a recipient with uncollected debt before services can be denied.~~

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

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

~~(i)~~ (f) 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)~~ (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.

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

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

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

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

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

Sec. 27. Minnesota Statutes 2004, section 256D.045, is amended to read:

256D.045 [SOCIAL SECURITY NUMBER REQUIRED.]

To be eligible for general assistance under sections 256D.01 to 256D.21, an individual must provide the individual's Social Security number to the county agency or submit proof that an application has been made. An individual who refuses to provide a Social Security number because of a well-established religious objection as described in Code of Federal Regulations, title 42, section 435.910, may be eligible for general assistance medical care under section 256D.03. The provisions of this section do not apply to the determination of eligibility for emergency general assistance under section 256D.06, subdivision 2. This provision applies to eligible children under the age of 18 effective July 1, 1997.

[EFFECTIVE DATE.] This section is effective August 1, 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) "Gross individual or gross family income" for nonfarm self-employed means income calculated for the six-month period of eligibility using as the baseline the adjusted gross income reported on the applicant's federal income tax form for the previous year and adding back in reported depreciation, carryover loss, and net operating loss amounts that apply to the business in which the family is currently engaged.

(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, or upon HealthMatch implementation, whichever is later.

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

Subdivision 1. [COVERED HEALTH SERVICES.] ~~For-individuals under-section-256L.04,-subdivision-7,-with-income-no-greater than-75-percent-of-the-federal-poverty-guidelines-or-for families-with-children-under-section-256L.04,-subdivision-1,-all subdivisions-of-this-section-apply.~~ "Covered health services" means the health services reimbursed under chapter 256B, with the exception of inpatient hospital services, special education services, private duty nursing services, adult dental care services other than services covered under section 256B.0625, subdivision 9, ~~paragraph-(b),~~ orthodontic services, nonemergency medical transportation services, personal care assistant and case management services, nursing home or intermediate care facilities services, inpatient mental health services, and chemical dependency services. Outpatient mental health services covered under the MinnesotaCare program are limited to diagnostic assessments, psychological testing, explanation of findings, medication management by a physician, day treatment, partial hospitalization, and individual, family, and group psychotherapy.

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

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

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

2005.

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

Subd. 1b. [PREGNANT WOMEN; ELIGIBILITY FOR FULL MEDICAL ASSISTANCE SERVICES.] ~~Beginning January 1, 1999,~~ A pregnant woman ~~who is~~ enrolled in MinnesotaCare ~~when her pregnancy is diagnosed~~ is eligible for coverage of all services provided under the medical assistance program according to chapter 256B retroactive to the date ~~the pregnancy is medically diagnosed~~ of conception. Co-payments totaling $30 or more, paid after the date ~~the pregnancy is diagnosed~~ of conception, shall be refunded.

Sec. 31. Minnesota Statutes 2004, section 256L.03, subdivision 5, is amended to read:

Subd. 5. [CO-PAYMENTS AND COINSURANCE.] (a) Except as provided in paragraphs (b) and (c), the MinnesotaCare benefit plan shall include the following co-payments and coinsurance requirements for all enrollees:

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

(2) $3 per prescription for adult enrollees;

(3) $25 for eyeglasses for adult enrollees; and

(4) 50 percent of the fee-for-service rate for adult dental care services other than preventive care services for persons eligible under section 256L.04, subdivisions 1 to 7, with income equal to or ~~less~~ greater than ~~175~~ 190 percent of the federal poverty guidelines.

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

(c) Paragraph (a), clauses (1) to (4), do not apply to pregnant women and children under the age of 21.

(d) Adult enrollees with family gross income that exceeds 175 percent of the federal poverty guidelines and who are not pregnant shall be financially responsible for the coinsurance amount, if applicable, and amounts which exceed the $10,000 inpatient hospital benefit limit.

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

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

Sec. 32. Minnesota Statutes 2004, section 256L.04, is amended by adding a subdivision to read:

Subd. 1a. [SOCIAL SECURITY NUMBER REQUIRED.] (a) Individuals and families applying for MinnesotaCare coverage must provide a Social Security number.

(b) The commissioner shall not deny eligibility to an otherwise eligible applicant who has applied for a Social Security number and is awaiting issuance of that Social Security number.

(c) Newborns enrolled under section 256L.05, subdivision 3, are exempt from the requirements of this subdivision.

(d) Individuals who refuse to provide a Social Security number because of well-established religious objections are exempt from the requirements of this subdivision. The term "well-established religious objections" has the meaning given in Code of Federal Regulations, title 42, section 435.910.

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

Sec. 33. Minnesota Statutes 2004, section 256L.04, subdivision 2, is amended to read:

Subd. 2. [COOPERATION IN ESTABLISHING THIRD-PARTY LIABILITY, PATERNITY, AND OTHER MEDICAL SUPPORT.] (a) To be eligible for MinnesotaCare, individuals and families must cooperate with the state agency to identify potentially liable third-party payers and assist the state in obtaining third-party payments. "Cooperation" includes, but is not limited to, complying with the notice requirements in section 256B.056, subdivision 9, identifying any third party who may be liable for care and services provided under MinnesotaCare to the enrollee, providing relevant information to assist the state in pursuing a potentially liable third party, and completing forms necessary to recover third-party payments.

(b) A parent, guardian, relative caretaker, or child enrolled in the MinnesotaCare program must cooperate with the Department of Human Services and the local agency in establishing the paternity of an enrolled child and in obtaining medical care support and payments for the child and any other person for whom the person can legally assign rights, in accordance with applicable laws and rules governing the medical assistance program. A child shall not be ineligible for or disenrolled from the MinnesotaCare program solely because the child's parent, relative caretaker, or guardian fails to cooperate in establishing paternity or obtaining medical support.

Sec. 34. Minnesota Statutes 2004, section 256L.04, is amended by adding a subdivision to read:

Subd. 2a. [APPLICATIONS FOR OTHER BENEFITS.] To be eligible for MinnesotaCare, individuals and families must take all necessary steps to obtain other benefits as described in Code of Federal Regulations, title 42, section 435.608. Applicants and enrollees must apply for other benefits within 30 days.

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

Sec. 35. Minnesota Statutes 2004, section 256L.04, subdivision 7, is amended to read:

Subd. 7. [SINGLE ADULTS AND HOUSEHOLDS WITH NO CHILDREN.]

The definition of eligible persons includes all individuals and households with no children who have gross family incomes that are equal to or less than ~~175~~ 190 percent of the federal poverty guidelines.

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

Sec. 36. Minnesota Statutes 2004, section 256L.05, subdivision 3, is amended to read:

Subd. 3. [EFFECTIVE DATE OF COVERAGE.] (a) The effective date of coverage is the first day of the month following the month in which eligibility is approved and the first premium payment has been received. As provided in section 256B.057, coverage for newborns is automatic from the date of birth and must be coordinated with other health coverage. The effective date of coverage for eligible newly adoptive children added to a family receiving covered health services is the ~~date-of-entry into-the-family~~ month of placement. The effective date of coverage for other new ~~recipients~~ members added to the family ~~receiving-covered-health-services~~ is the first day of the month following the month in which ~~eligibility-is-approved-or-at renewal,-whichever-the-family-receiving-covered-health-services prefers~~ the change is reported. All eligibility criteria must be met by the family at the time the new family member is added. The income of the new family member is included with the family's gross income and the adjusted premium begins in the month the new family member is added.

(b) The initial premium must be received by the last working day of the month for coverage to begin the first day of the following month.

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

(d) Notwithstanding any other law to the contrary, benefits under sections 256L.01 to 256L.18 are secondary to a plan of insurance or benefit program under which an eligible person may have coverage and the commissioner shall use cost avoidance

techniques to ensure coordination of any other health coverage for eligible persons. The commissioner shall identify eligible persons who may have coverage or benefits under other plans of insurance or who become eligible for medical assistance.

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

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

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

(b) Beginning October 1, 2004, an enrollee's eligibility must be renewed every six months. The first six-month period of eligibility begins ~~in the month after~~ the month the application is ~~approved~~ received by the commissioner. The effective date of coverage within the first six-month period of eligibility is as provided in subdivision 3. Each new period of eligibility must take into account any changes in circumstances that impact eligibility and premium amount. An enrollee must provide all the information needed to redetermine eligibility by the first day of the month that ends the eligibility period. The premium for the new period of eligibility must be received as provided in section 256L.06 in order for eligibility to continue.

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

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

Subdivision 1. [GENERAL REQUIREMENTS.] (a) Children enrolled in the original children's health plan as of September 30, 1992, children who enrolled in the MinnesotaCare program after September 30, 1992, pursuant to Laws 1992, chapter 549, article 4, section 17, and children who have family gross incomes that are equal to or less than 150 percent of the federal poverty guidelines are eligible without meeting the requirements of subdivision 2 and the four-month requirement in

subdivision 3, as long as they maintain continuous coverage in the MinnesotaCare program or medical assistance. Children who apply for MinnesotaCare on or after the implementation date of the employer-subsidized health coverage program as described in Laws 1998, chapter 407, article 5, section 45, who have family gross incomes that are equal to or less than 150 percent of the federal poverty guidelines, must meet the requirements of subdivision 2 to be eligible for MinnesotaCare.

(b) Families enrolled in MinnesotaCare under section 256L.04, subdivision 1, whose income increases above 275 percent of the federal poverty guidelines, are no longer eligible for the program and shall be disenrolled by the commissioner. Individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose income increases above 175 percent of the federal poverty guidelines are no longer eligible for the program and shall be disenrolled by the commissioner. For persons disenrolled under this subdivision, MinnesotaCare coverage terminates the last day of the calendar month following the month in which the commissioner determines that the income of a family or individual exceeds program income limits.

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

(2) Effective February 1, 2004, notwithstanding paragraph (b), children may remain enrolled in MinnesotaCare if ten percent of their ~~annual~~ gross individual or gross family income as defined in section 256L.01, subdivision 4, is less than the ~~annual~~ premium for a six-month policy with a $500 deductible available through the Minnesota Comprehensive Health Association. Children who are no longer eligible for

MinnesotaCare under this clause shall be given a 12-month notice period from the date that ineligibility is determined before disenrollment. The premium for children remaining eligible under this clause shall be the maximum premium determined under section 256L.15, subdivision 2, paragraph (b).

(d) Effective July 1, 2003, notwithstanding paragraphs (b) and (c), parents are no longer eligible for MinnesotaCare if gross household income exceeds ~~$50,000~~ $25,000 for the six-month period of eligibility.

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

Sec. 39. Minnesota Statutes 2004, section 256L.07, subdivision 3, is amended to read:

Subd. 3. [OTHER HEALTH COVERAGE.] (a) Families and individuals enrolled in the MinnesotaCare program must have no health coverage while enrolled or for at least four months prior to application and renewal. Children enrolled in the original children's health plan and children in families with income equal to or less than 150 percent of the federal poverty guidelines, who have other health insurance, are eligible if the coverage:

(1) lacks two or more of the following:

(i) basic hospital insurance;

(ii) medical-surgical insurance;

(iii) prescription drug coverage;

(iv) dental coverage; or

(v) vision coverage;

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

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

The commissioner may change this eligibility criterion for sliding scale premiums in order to remain within the limits of available appropriations. The requirement of no health coverage does not apply to newborns.

(b) Medical assistance, general assistance medical care, and the Civilian Health and Medical Program of the Uniformed Service, CHAMPUS, or other coverage provided under United States Code, title 10, subtitle A, part II, chapter 55, are not considered insurance or health coverage for purposes of the four-month requirement described in this subdivision.

(c) For purposes of this subdivision, 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.

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

(e) ~~Effective October 1, 2003, applicants who were recipients of medical assistance and had~~ Cost-effective health insurance ~~which~~ that was paid for by medical assistance ~~are exempt from~~ is not considered health coverage for purposes of the four-month requirement under this section, except if the insurance continued after medical assistance no longer considered it cost-effective or after medical assistance closed.

Sec. 40. Minnesota Statutes 2004, section 256L.07, is amended by adding a subdivision to read:

Subd. 5. [VOLUNTARY DISENROLLMENT FOR MEMBERS OF MILITARY.] Notwithstanding section 256L.05, subdivision 3b, MinnesotaCare enrollees who are members of the military and their families, who choose to voluntarily disenroll from the program when one or more family members are called to active duty, may reenroll during or following that member's tour of active duty. Those individuals and families shall be considered to have good cause for voluntary termination under section 256L.06, subdivision 3, paragraph (d). Income and asset increases reported at the time of reenrollment shall be disregarded. All provisions of sections 256L.01 to 256L.18, shall apply to individuals and families enrolled under this subdivision upon six-month renewal.

Sec. 41. Minnesota Statutes 2004, section 256L.12, subdivision 6, is amended to read:

Subd. 6. [CO-PAYMENTS AND BENEFIT LIMITS.] Enrollees are responsible for all co-payments in ~~sections~~ section 256L.03, subdivision 5, ~~and 256L.035,~~ 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.

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

Subd. 2. [SLIDING FEE SCALE TO DETERMINE PERCENTAGE OF MONTHLY GROSS INDIVIDUAL OR FAMILY INCOME.] (a) The commissioner shall establish a sliding fee scale to determine the percentage of monthly gross individual or family income that households at different income levels must pay to obtain coverage through the MinnesotaCare program. The sliding fee scale must be based on the enrollee's monthly gross individual or family income. The sliding fee scale must contain separate tables based on enrollment of one, two, or three or more persons. The sliding fee scale begins with a premium of 1.5 percent of monthly gross individual or family income for individuals or families with incomes below the limits for the medical assistance program for families and children in effect on January 1, 1999, and proceeds through the following evenly spaced steps: 1.8, 2.3, 3.1, 3.8, 4.8, 5.9, 7.4, and 8.8 percent. These percentages are matched to evenly spaced income steps ranging from the medical assistance income limit for families and children in effect on January 1, 1999, to 275 percent of the federal poverty guidelines for the applicable family size, up to a family size of five. The sliding fee scale for a family of five must be used for families of more than five. Effective October 1, 2003, the commissioner shall increase each percentage by 0.5 percentage points for enrollees with income greater than 100 percent but not exceeding 200 percent of the federal poverty guidelines and shall increase each percentage by 1.0 percentage points for families and children with incomes greater than 200

percent of the federal poverty guidelines. The sliding fee scale and percentages are not subject to the provisions of chapter 14. If a family or individual reports increased income after enrollment, premiums shall not be adjusted until eligibility renewal.

(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.

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

(3) The maximum premium is defined as a base charge for one, two, or three or more enrollees so that if all MinnesotaCare cases paid the maximum premium, the total revenue would equal the total cost of MinnesotaCare medical coverage and administration. In this calculation, administrative costs shall be assumed to equal ten percent of the total. The costs of medical coverage for pregnant women and children under age two and the enrollees in these groups shall be excluded from the total. The maximum premium for two enrollees shall be twice the maximum premium for one, and the maximum premium for three or more enrollees shall be three times the maximum premium for one.

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

Sec. 43. Minnesota Statutes 2004, section 256L.15, subdivision 3, is amended to read:

Subd. 3. [EXCEPTIONS TO SLIDING SCALE.] ~~An annual premium of $48 is required for all~~ Children in families with income at or ~~less than~~ below 150 percent of the federal poverty guidelines pay a monthly premium of $4.

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

Sec. 44. [256L.20] [MINNESOTACARE OPTION FOR SMALL EMPLOYERS.]

Subdivision 1. [DEFINITIONS.] (a) For the purpose of this

section, the terms used have the meanings given them.

(b) "Dependent" means an unmarried child under 21 years of age.

(c) "Eligible employer" means a business that employs at least two, but not more than 50, eligible employees, the majority of whom are employed in the state, and includes a municipality that has 50 or fewer employees.

(d) "Eligible employee" means an employee who works at least 20 hours per week for an eligible employer. Eligible employee does not include an employee who works on a temporary or substitute basis or who does not work more than 26 weeks annually.

(e) "Maximum premium" has the meaning given under section 256L.15, subdivision 2, paragraph (b), clause (3).

(f) "Participating employer" means an eligible employer who meets the requirements described in subdivision 3 and applies to the commissioner to enroll its eligible employees and their dependents in the MinnesotaCare program.

(g) "Program" means the MinnesotaCare program.

Subd. 2. [OPTION.] Eligible employees and their dependents may enroll in MinnesotaCare if the eligible employer meets the requirements of subdivision 3. The effective date of coverage is according to section 256L.05, subdivision 3.

Subd. 3. [EMPLOYER REQUIREMENTS.] The commissioner shall establish procedures for an eligible employer to apply for coverage through the program. In order to participate, an eligible employer must meet the following requirements:

(1) agrees to contribute toward the cost of the premium for the employee and the employee's dependents according to subdivision 4;

(2) certifies that at least 75 percent of its eligible employees who do not have other creditable health coverage are enrolled in the program;

(3) offers coverage to all eligible employees and the dependents of eligible employees; and

(4) has not provided employer-subsidized health coverage as

an employee benefit during the previous 12 months, as defined in section 256L.07, subdivision 2, paragraph (c).

Subd. 4. [PREMIUMS.] (a) The premium for MinnesotaCare coverage provided under this section is equal to the maximum premium regardless of the income of the eligible employee.

(b) For eligible employees without dependents with income equal to or less than 175 percent of the federal poverty guidelines and for eligible employees with dependents with income equal to or less than 275 percent of the federal poverty guidelines, the participating employer shall pay 50 percent of the maximum premium for the eligible employee and any dependents, if applicable.

(c) For eligible employees without dependents with income over 175 percent of the federal poverty guidelines and for eligible employees with dependents with income over 275 percent of the federal poverty guidelines, the participating employer shall pay the full cost of the maximum premium for the eligible employee and any dependents, if applicable. The participating employer may require the employee to pay a portion of the cost of the premium so long as the employer pays 50 percent of the cost. If the employer requires the employee to pay a portion of the premium, the employee shall pay the portion of the cost to the employer.

(d) The commissioner shall collect premium payments from participating employers for eligible employees and their dependents who are covered by the program as provided under this section. All premiums collected shall be deposited in the health care access fund.

Subd. 5. [COVERAGE.] The coverage offered to those enrolled in the program under this section must include all health services described under section 256L.03 and all co-payments and coinsurance requirements described under section 256L.03, subdivision 5, apply.

Subd. 6. [ENROLLMENT.] Upon payment of the premium, in accordance with this section and section 256L.06, eligible employees and their dependents shall be enrolled in

MinnesotaCare. For purposes of enrollment under this section, income eligibility limits established under sections 256L.04 and 256L.07, subdivision 1, and asset limits established under section 256L.17 do not apply. The barriers established under section 256L.07, subdivision 2 or 3, do not apply to enrollees eligible under this section. The commissioner may require eligible employees to provide income verification to determine premiums.

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

Sec. 45. Minnesota Statutes 2004, section 549.02, is amended by adding a subdivision to read:

Subd. 3. [LIMITATION.] Notwithstanding subdivisions 1 and 2, where the state agency is named or intervenes as a party to enforce the agency's rights under section 256B.056, the agency shall not be liable for costs to any prevailing defendant.

Sec. 46. Minnesota Statutes 2004, section 549.04, is amended to read:

549.04 [DISBURSEMENTS; TAXATION AND ALLOWANCE.]

Subdivision 1. [GENERALLY.] In every action in a district court, the prevailing party, including any public employee who prevails in an action for wrongfully denied or withheld employment benefits or rights, shall be allowed reasonable disbursements paid or incurred, including fees and mileage paid for service of process by the sheriff or by a private person.

Subd. 2. [LIMITATION.] Notwithstanding subdivision 1, where the state agency is named or intervenes as a party to enforce the agency's rights under section 256B.056, the agency shall not be liable for disbursements to any prevailing defendant.

Sec. 47. [EMPLOYER DISCLOSURE FOR THE MINNESOTA HEALTH CARE PROGRAM.]

Subdivision 1. [DEFINITIONS.] (a) For purposes of this section, the following definitions apply.

(b) "Commissioner" means the commissioner of human services.

(c) "Minnesota health care program" means the prescription

drug program under section 256.955, medical assistance under chapter 256B, general assistance medical care under section 256D.03, subdivision 3, and MinnesotaCare under chapter 256L.

Subd. 2. [REPORT.] (a) By January 15, 2007, for the previous fiscal year, the commissioner shall submit to the legislature a report identifying all employers that employ 50 or more employees who are Minnesota health care program recipients. In determining whether the 50-employee threshold is met, the commissioner shall include all employees employed by an employer and its subsidiaries at all locations within the state. The report shall include the following information:

(1) the name of the employer and, as appropriate, the names of its subsidiaries that employ Minnesota health care program recipients;

(2) the number of Minnesota health care program recipients who are employees of the employer;

(3) the number of Minnesota health care program recipients who are spouses or dependents of employees of the employer; and

(4) the cost to the state of providing health care benefits for these employers' employees and enrolled dependents.

(b) In preparing and publishing the report, the commissioner shall take reasonable precautions to protect the identity of Minnesota health care program recipients:

(1) the report shall include only nonindividually identifiable summary data as defined in section 13.02, subdivision 19;

(2) the commissioner shall employ generally accepted statistical and scientific principles and methods for rendering information as not individually identifiable. The commissioner must determine that there is an insignificant risk that information in the report could be used, alone or in combination with other reasonably available information, to identify any Minnesota health care program recipient; and

(3) the commissioner shall comply with all other applicable privacy and security provisions of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191,

and its corresponding regulations, Code of Federal Regulations, title 45, sections 160, 162, and 164; Minnesota Statutes, chapter 13; section 144.335; and any other applicable state and federal law.

(c) The commissioner shall make the report available to the public on the Department of Human Services' Web site, and shall provide a copy of the report to any member of the public upon request.

Sec. 48. [LIMITING COVERAGE OF HEALTH CARE SERVICES FOR MEDICAL ASSISTANCE, GENERAL ASSISTANCE MEDICAL CARE, AND MINNESOTACARE PROGRAMS.]

Subdivision 1. [PRIOR AUTHORIZATION OF SERVICES.] (a) Effective July 1, 2005, prior authorization is required for the services described in subdivision 2 for reimbursement under chapters 256B, 256D, and 256L.

(b) Prior authorization shall be conducted under the direction of the medical director of the Department of Human Services in conjunction with a medical policy advisory council. To the extent available, the medical director shall use publicly available evidence-based guidelines developed by an independent, nonprofit organization or by the professional association of the specialty that typically provides the service or by a multistate Medicaid evidence-based practice center. If the commissioner does not have a medical director and medical policy director in place, the commissioner shall contract prior authorization to a Minnesota-licensed utilization review organization or to another entity such as a peer review organization eligible to operate in Minnesota.

(c) A prepaid health plan shall use prior authorization for the services described in subdivision 2 unless the prepaid health plan is otherwise using evidence-based practices to address these services.

(d) This section expires July 1, 2007, or when a list is established according to Minnesota Statutes, section 256B.0625, subdivision 46, whichever is earlier.

Subd. 2. [SERVICES REQUIRING PRIOR AUTHORIZATION.] The

following services require prior authorization:

(1) elective outpatient high-technology imaging to include positive emission tomography (PET) scans, magnetic resonance imaging (MRI), computed tomography (CT), and nuclear cardiology;

(2) spinal fusion, unless in an emergency situation related to trauma;

(3) bariatric surgery;

(4) chiropractic visits beyond ten visits;

(5) circumcision; and

(6) orthodontia.

Sec. 49. [ORAL HEALTH CARE SYSTEM PILOT PROJECT START-UP GRANT.]

The commissioner of human services shall issue a request for proposal for a two-year pilot project that shall provide dental services for Minnesota health care program recipients through a new oral health care delivery system. The request for proposal shall be based upon the model designed by the Oral HealthCare Solutions Project. The proposal must demonstrate the capacity to obtain broad community support and to leverage the state's start-up funding by attracting additional public and private funding. The pilot project must include both urban and rural regions of the state, and adhere to the financial and delivery system requirements specified by the commissioner in accordance with the Oral HealthCare Solutions Project design.

Sec. 50. [PLANNING PROCESS FOR MANAGED CARE.]

The commissioner of human services shall develop a planning process for the purposes of implementing at least one additional managed care arrangement to provide medical assistance services, excluding continuing care services, to recipients enrolled in the medical assistance fee-for-service program, effective January 1, 2007. This planning process shall include an advisory committee composed of current fee-for-service consumers, consumer advocates, and providers, as well as representatives of health plans and other provider organizations qualified to provide basic health care services to persons with disabilities. The commissioner shall seek any additional

federal authority necessary to provide basic health care services through contracted managed care arrangements.

Sec. 51. [RATE REDUCTION.]

(a) Effective for the services identified in Minnesota Statutes, section 256B.0625, subdivision 25a, paragraph (c), rendered on or after July 1, 2005, the payment rate shall be reduced by ten percent from the rate in effect on June 30, 2005.

(b) This section shall expire on June 30, 2006, or upon the completion of the prior authorization system required under Minnesota Statutes, section 256B.0625, subdivision 25a, paragraph (b), whichever is later.

Sec. 52. [REPEALER.]

(a) Minnesota Statutes 2004, section 256L.035, is repealed.

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

(b) Minnesota Statutes 2004, section 256B.0631, is repealed.

[EFFECTIVE DATE.] This paragraph is effective January 1, 2006.

ARTICLE 3

HEALTH CARE COST CONTAINMENT

Section 1. Minnesota Statutes 2004, section 62A.65, subdivision 3, is amended to read:

Subd. 3. [PREMIUM RATE RESTRICTIONS.] No individual health plan may be offered, sold, issued, or renewed to a Minnesota resident unless the premium rate charged is determined in accordance with the following requirements:

(a) Premium rates must be no more than 25 percent above and no more than 25 percent below the index rate charged to individuals for the same or similar coverage, adjusted pro rata for rating periods of less than one year. The premium variations permitted by this paragraph must be based only upon health status, claims experience, and occupation. For purposes of this paragraph, health status includes refraining from tobacco use or other actuarially valid lifestyle factors associated with good health, provided that the lifestyle factor

and its effect upon premium rates have been determined by the commissioner to be actuarially valid and have been approved by the commissioner. Variations permitted under this paragraph must not be based upon age or applied differently at different ages. This paragraph does not prohibit use of a constant percentage adjustment for factors permitted to be used under this paragraph.

(b) Premium rates may vary based upon the ages of covered persons only as provided in this paragraph. In addition to the variation permitted under paragraph (a), each health carrier may use an additional premium variation based upon age of up to plus or minus 50 percent of the index rate.

(c) A health carrier may request approval by the commissioner to establish no more than three geographic regions and to establish separate index rates for each region, provided that the index rates do not vary between any two regions by more than 20 percent. Health carriers that do not do business in the Minneapolis/St. Paul metropolitan area may request approval for no more than two geographic regions, and clauses (2) and (3) do not apply to approval of requests made by those health carriers. The commissioner may grant approval if the following conditions are met:

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

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

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

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

(d) Health carriers may use rate cells and must file with the commissioner the rate cells they use. Rate cells must be

based upon the number of adults or children covered under the policy and may reflect the availability of Medicare coverage. The rates for different rate cells must not in any way reflect generalized differences in expected costs between principal insureds and their spouses.

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

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

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

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

(g) The loss ratio must comply with the section 62A.021 requirements for individual health plans.

(h) Notwithstanding paragraphs (a) to (g), the rates must not be approved~~,~~ unless the commissioner has determined that the rates are reasonable. In determining reasonableness, the commissioner shall ~~consider the growth rates applied under section 62J.04, subdivision 1, paragraph (b)~~ apply the premium growth limits established under section 62J.04, subdivision 1b, to the calendar year or years that the proposed premium rate would be in effect, and shall consider actuarially valid changes in risks associated with the enrollee populations~~,~~ and actuarially valid changes as a result of statutory changes in Laws 1992, chapter 549.

Sec. 2. Minnesota Statutes 2004, section 62J.04, is amended by adding a subdivision to read:

Subd. 1b. [PREMIUM GROWTH LIMITS.] (a) For calendar year 2005 and each year thereafter, the commissioner shall set annual premium growth limits for health plan companies. The premium limits set by the commissioner for calendar years 2005 to 2010 shall not exceed the regional Consumer Price Index for urban

consumers for the preceding calendar year plus two percentage points and an additional one percentage point to be used to finance the implementation of the electronic medical record system described under section 62J.565. The commissioner shall ensure that the additional percentage point is being used to provide financial assistance to health care providers to implement electronic medical record systems either directly or through an increase in reimbursement.

(b) For the calendar years beyond 2010, the rate of premium growth shall be limited to the change in the Consumer Price Index for urban consumers for the previous calendar year plus two percentage points. The commissioners of health and commerce shall make a recommendation to the legislature by January 15, 2009, regarding the continuation of the additional percentage point to the growth limit described in paragraph (a). The recommendation shall be based on the progress made by health care providers in instituting an electronic medical record system and in creating a statewide interactive electronic health record system.

(c) The commissioner may add additional percentage points as needed to the premium limit for a calendar year if a major disaster, bioterrorism, or a public health emergency occurs that results in higher health care costs. Any additional percentage points must reflect the additional cost to the health care system directly attributed to the disaster or emergency.

(d) The commissioner shall publish the annual premium growth limits in the State Register by January 31 of the year that the limits are to be in effect.

(e) For the purpose of this subdivision, premium growth is measured as the percentage change in per member, per month premium revenue from the current year to the previous year. Premium growth rates shall be calculated for the following lines of business: individual, small group, and large group. Data used for premium growth rate calculations shall be submitted as part of the cost containment filing under section 62J.38.

(f) For purposes of this subdivision, "health plan company"

has the meaning given in section 62J.041.

(g) A health plan company may reduce reimbursement to providers in order to meet the premium growth limitations required by this section.

Sec. 3. Minnesota Statutes 2004, section 62J.04, subdivision 3, is amended to read:

Subd. 3. [COST CONTAINMENT DUTIES.] The commissioner shall:

(1) establish statewide and regional cost containment goals for total health care spending under this section and collect data as described in sections 62J.38 to 62J.41 to monitor statewide achievement of the cost containment goals and premium growth limits;

(2) divide the state into no fewer than four regions, with one of those regions being the Minneapolis/St. Paul metropolitan statistical area but excluding Chisago, Isanti, Wright, and Sherburne Counties, for purposes of fostering the development of regional health planning and coordination of health care delivery among regional health care systems and working to achieve the cost containment goals;

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

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

(5) undertake health planning responsibilities;

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

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

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

(9) make the cost containment goal and premium growth limit data available to the public in a consumer-oriented manner.

Sec. 4. Minnesota Statutes 2004, section 62J.041, is amended to read:

62J.041 [~~INTERIM~~ HEALTH PLAN COMPANY ~~COST CONTAINMENT GOALS~~ HEALTH CARE EXPENDITURE LIMITS.]

Subdivision 1. [DEFINITIONS.] (a) For purposes of this section, the following definitions apply.

(b) "Health plan company" has the definition provided in section 62Q.01. This definition does not include the state employee health plan offered under chapter 43A.

(c) "~~Total~~ Health care expenditures" means incurred claims or expenditures on health care services~~, administrative expenses, charitable contributions, and all other payments~~ made by health plan companies ~~out of premium revenues~~.

~~(d) "Net expenditures" means total expenditures minus exempted taxes and assessments and payments or allocations made to establish or maintain reserves.~~

~~(e) "Exempted taxes and assessments" means direct payments for taxes to government agencies, contributions to the Minnesota Comprehensive Health Association, the medical assistance provider's surcharge under section 256.9657, the MinnesotaCare~~

~~provider-tax-under-section-295.52,-assessments-by-the-Health Coverage-Reinsurance-Association,-assessments-by-the-Minnesota Life-and-Health-Insurance-Guaranty-Association,-assessments-by the-Minnesota-Risk-Adjustment-Association,-and-any-new assessments-imposed-by-federal-or-state-law.~~

~~(f)~~ "Consumer cost-sharing or subscriber liability" means enrollee coinsurance, co-payment, deductible payments, and amounts in excess of benefit plan maximums.

Subd. 2. [ESTABLISHMENT.] The commissioner of health shall establish ~~cost-containment-goals~~ health care expenditure limits for ~~the-increase-in-net~~ calendar year 2006, and each year thereafter, for health care expenditures by each health plan company ~~for-calendar-years-1994,-1995,-1996,-and-1997.---The-cost containment-goals-must-be-the-same-as-the-annual-cost containment-goals-for-health-care-spending-established-under section-62J.04,-subdivision-1,-paragraph-(b)~~. Health plan companies that are affiliates may elect to meet one combined ~~cost-containment-goal~~ health care expenditure limit. The limits set by the commissioner shall not exceed the premium limits established in section 62J.04, subdivision 1b.

Subd. 3. [DETERMINATION OF EXPENDITURES.] Health plan companies shall submit to the commissioner of health, by April ~~1,-1994,-for-calendar-year-1993;-April-1,-1995,-for-calendar year-1994;-April-1,-1996,-for-calendar-year-1995;-April-1,-1997, for-calendar-year-1996;-and-April-1,-1998,-for-calendar-year 1997~~ of each year beginning 2006, all information the commissioner determines to be necessary to implement this section. The information must be submitted in the form specified by the commissioner. The information must include, but is not limited to, health care expenditures per member per month or cost per employee per month, and detailed information on revenues and reserves. The commissioner, to the extent possible, shall coordinate the submittal of the information required under this section with the submittal of the financial data required under chapter 62J, to minimize the administrative burden on health plan companies. The commissioner may adjust

final expenditure figures for demographic changes, risk selection, changes in basic benefits, and legislative initiatives that materially change health care costs, as long as these adjustments are consistent with the methodology submitted by the health plan company to the commissioner, and approved by the commissioner as actuarially justified. ~~The methodology to be used for adjustments and the election to meet one cost containment goal for affiliated health plan companies must be submitted to the commissioner by September 1, 1994. Community integrated service networks may submit the information with their application for licensure. The commissioner shall also accept changes to methodologies already submitted. The adjustment methodology submitted and approved by the commissioner must apply to the data submitted for calendar years 1994 and 1995. The commissioner may allow changes to accepted adjustment methodologies for data submitted for calendar years 1996 and 1997. Changes to the adjustment methodology must be received by September 1, 1996, and must be approved by the commissioner.~~

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

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

(c) Health plan companies, except those licensed under

chapter 60A to sell accident and sickness insurance under chapter 62A, shall annually before the end of the fourth fiscal quarter provide to the commissioner of health or commerce, as applicable, a projection of the level of reserves the company expects to attain during each quarter of the following fiscal year. These health plan companies shall submit with required quarterly financial statements a calculation of the actual reserve level attained by the company at the end of each quarter including identification of the sources of any significant changes in the reserve level and an updated projection of the level of reserves the health plan company expects to attain by the end of the fiscal year. In cases where the health plan company has been given a certificate to operate a new health maintenance organization under chapter 62D, or been licensed as a community integrated service network under chapter 62N, or formed an affiliation with one of these organizations, the health plan company shall also submit with its quarterly financial statement, total enrollment at the beginning and end of the quarter and enrollment changes within each service area 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.

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

Subd. 5. [NOTICE.] The commissioner of health shall publish in the State Register and make available to the public by July 1, ~~1995~~ 2007, and each year thereafter, a list of all health plan companies that exceeded their ~~cost-containment goal~~ health care expenditure limit for the ~~1994~~ previous calendar year. ~~The commissioner shall publish in the State Register and make available to the public by July 1, 1996, a list of all health plan companies that exceeded their combined cost containment goal for calendar years 1994 and 1995.~~ The commissioner shall notify each health plan company that the commissioner has determined that the health plan company exceeded its ~~cost-containment goal,~~ health care expenditure limit at least 30 days before publishing the list, and shall provide each health plan company ~~with~~ ten days to provide an explanation for exceeding the ~~cost-containment goal~~ health care expenditure limit. The commissioner shall review the explanation and may change a determination if the commissioner determines the explanation to be valid.

Subd. 6. [ASSISTANCE BY THE COMMISSIONER OF COMMERCE.] The commissioner of commerce shall provide assistance to the commissioner of health in monitoring health plan companies regulated by the commissioner of commerce.

Sec. 5. [62J.255] [HEALTH RISK INFORMATION SHEET.]

(a) A health plan company shall provide to each enrollee on an annual basis information on the increased personal health risks and the additional costs to the health care system due to obesity and to the use of tobacco.

(b) The commissioner, in consultation with the Minnesota Medical Association, shall develop an information sheet on the personal health risks of obesity and smoking and on the additional costs to the health care system due to obesity and due to smoking. The information sheet shall be posted on the Minnesota Department of Health's Web site.

(c) When providing the information required in paragraph (a), the health plan company must also provide each enrollee with information on the best practices care guidelines and

quality of care measurement criteria identified in section 62J.43 as well as the availability of this information on the department's Web site.

(d) This section does not apply to health plan companies offering only limited dental or vision plans.

Sec. 6. Minnesota Statutes 2004, section 62J.301, subdivision 3, is amended to read:

Subd. 3. [GENERAL DUTIES.] The commissioner shall:

(1) collect and maintain data which enable population-based monitoring and trending of the access, utilization, quality, and cost of health care services within Minnesota;

(2) collect and maintain data for the purpose of estimating total Minnesota health care expenditures and trends;

(3) collect and maintain data for the purposes of setting cost containment goals and premium growth limits under section 62J.04, and measuring cost containment goal and premium growth limit compliance;

(4) conduct applied research using existing and new data and promote applications based on existing research;

(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

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

(b) The commissioner shall require each group purchaser to submit data on revenue, expenses, and member months, as applicable. Revenue data must distinguish between premium revenue and revenue from other sources and must also include information on the amount of revenue in reserves and changes in reserves. Premium revenue data, information on aggregate enrollment, and data on member months must be broken down to distinguish between individual market, small group market, and large group market. Filings under this section for calendar year 2005 must also include information broken down by individual market, small group market, and large group market for calendar year 2004. Expenditure data must distinguish between costs incurred for patient care and administrative costs. Patient care and administrative costs must include only expenses incurred on behalf of health plan members and must not include the cost of providing health care services for nonmembers at facilities owned by the group purchaser or affiliate. Expenditure data must be provided separately for the following categories and for other categories required by the commissioner: physician services, dental services, other professional services, inpatient hospital services, outpatient hospital services, emergency, pharmacy services and other nondurable medical goods, mental health, and chemical dependency services, other expenditures, subscriber liability, and administrative costs. Administrative costs must include costs for marketing; advertising; overhead; salaries and benefits of central office staff who do not provide direct patient care; underwriting; lobbying; claims processing; provider contracting and credentialing; detection and prevention of payment for fraudulent or unjustified requests for reimbursement or services; clinical quality assurance and other types of medical care quality improvement efforts; concurrent or prospective utilization review as defined in section 62M.02; costs incurred to acquire a hospital, clinic, or health care facility, or the

assets thereof; capital costs incurred on behalf of a hospital or clinic; lease payments; or any other costs incurred pursuant to a partnership, joint venture, integration, or affiliation agreement with a hospital, clinic, or other health care provider. Capital costs and costs incurred must be recorded according to standard accounting principles. The reports of this data must also separately identify expenses for local, state, and federal taxes, fees, and assessments. The commissioner may require each group purchaser to submit any other data, including data in unaggregated form, for the purposes of developing spending estimates, setting spending limits, and monitoring actual spending and costs. In addition to reporting administrative costs incurred to acquire a hospital, clinic, or health care facility, or the assets thereof; or any other costs incurred pursuant to a partnership, joint venture, integration, or affiliation agreement with a hospital, clinic, or other health care provider; reports submitted under this section also must include the payments made during the calendar year for these purposes. The commissioner shall make public, by group purchaser data collected under this paragraph in accordance with section 62J.321, subdivision 5. Workers' compensation insurance plans and automobile insurance plans are exempt from complying with this paragraph as it relates to the submission of administrative costs.

(c) The commissioner may collect information on:

(1) premiums, benefit levels, managed care procedures, and other features of health plan companies;

(2) prices, provider experience, and other information for services less commonly covered by insurance or for which patients commonly face significant out-of-pocket expenses; and

(3) information on health care services not provided through health plan companies, including information on prices, costs, expenditures, and utilization.

(d) All group purchasers shall provide the required data using a uniform format and uniform definitions, as prescribed by the commissioner.

Sec. 8. [62J.82] [CHARGES TO UNINSURED; PROVIDER RECOURSE.]

Subdivision 1. [DEFINITIONS.] (a) For purposes of this section, the terms defined in this subdivision have the meanings given them.

(b) "Covered individual" means an individual who has health plan company or public health care program coverage for health care services.

(c) "CPT code" means a code contained in the most current edition of the Physician's Current Procedural Terminology (CPT) manual published by the American Medical Association and available for purchase through the American Medical Association, Order Department: OP054193, P.O. Box 10950, Chicago, Illinois 60610.

(d) "Dependent" has the meaning given under section 62L.02, subdivision 11.

(e) "Health care service" has the meaning given under section 62J.17, subdivision 2.

(f) "Health plan company" has the meaning given under section 62Q.01, subdivision 4.

(g) "Person" means an individual, corporation, firm, partnership, incorporated or unincorporated association, or any other legal or commercial entity.

(h) "Provider" means a hospital or outpatient surgical center licensed under chapter 144.

(i) "Third-party payer" means a health plan company or a public health care plan or program.

(j) "Uninsured individual" means a person or dependent who does not have health plan company coverage or who is not otherwise covered by a third-party payer.

Subd. 2. [NOTICE TO UNINSURED.] (a) A provider may attempt to obtain from a person or the person's representative information about whether any third-party payer may fully or partially cover the charges for health care services rendered by the provider to the person.

(b) A provider shall inform each person, both orally and in

writing, immediately upon first meeting with that person, or as soon as practicable thereafter, that uninsured individuals will be charged or billed for health care services in amounts that do not exceed the amounts described in subdivision 3.

(c) If, at the time health care services are provided, a person has not provided proof of coverage by a third-party payer or a provider otherwise determines that the person is an uninsured individual, the provider, as part of any billing to the person, shall provide the person with a clear and conspicuous notice that includes:

(1) a statement of charges for health care services rendered by the provider; and

(2) a statement that uninsured individuals will be charged or billed for health care services in amounts that do not exceed the amounts described in subdivision 3.

(d) For purposes of the notice required under paragraph (c), a provider may incorporate the items into the provider's existing billing statements and is not required to develop a separate notice. All communications to a person required by this subdivision must be language appropriate.

Subd. 3. [PROVIDER CHARGES TO THE UNINSURED.] In billing or charging an uninsured individual or the individual's representative for medically necessary health care services, a provider must bill by CPT code, or other billing identifier as may be routinely used for billing that health care service. A provider shall not bill or charge an uninsured individual or the individual's representative more than the amount the provider is paid for that service by the nongovernmental third-party payer that provided the most revenue to the provider during the previous calendar year, plus any applicable cost sharing payments payable by an individual covered by that provider's highest volume plan. After a bill or charge is issued under this subdivision, a provider may not increase the bill or charge.

Subd. 4. [LIMITATIONS.] Notwithstanding any other provision of law, the amounts paid by uninsured individuals for health care services according to subdivision 3 does not

constitute a provider's uniform, published, prevailing, or customary charges, or its usual fees to the general public, for purposes of any payment limit under the Medicare or medical assistance programs or any other federal or state financed health care program.

Subd. 5. [RECOURSE LIMITED.] (a) Providers under agreement with a health plan company or public health care plan or program to provide health care services shall not have recourse against covered individuals, or persons acting on their behalf, for amounts above those specified in the evidence of coverage or other plan or program document as co-payments or coinsurance for health care services. This subdivision applies only to health plans that provide coverage equivalent to or greater than a number two qualified plan described under section 62E.08, and is not limited to the following events:

(1) nonpayment by the health plan company;

(2) insolvency of the health plan company; and

(3) breach of the agreement between the health plan company and the provider.

(b) This subdivision does not limit a provider's ability to seek payment from any person other than the covered individual, the covered individual's guardian or conservator, the covered individual's immediate family members, or the covered individual's legal representative in the event of nonpayment by a health plan company.

Subd. 6. [REMEDIES.] A person may file an action in district court seeking injunctive relief and damages for violations of this section. In any such action, a person may also recover costs and disbursements and reasonable attorney fees.

Subd. 7. [GROUNDS FOR DISCIPLINARY ACTION.] Violations of this section may be grounds for disciplinary or regulatory action against a provider by the appropriate licensing board or agency.

Subd. 8. [AUTHORITY OF ATTORNEY GENERAL.] The attorney general may investigate violations of this section under section

8.31. The attorney general may file an action for violations of this section according to section 8.31 or may pursue other remedies available to the attorney general.

Subd. 9. [INCOME AND ASSET LIMITATIONS.] The provisions of this section shall not apply to uninsured individuals with an annual family income above $125,000.

Sec. 9. Minnesota Statutes 2004, section 62L.08, subdivision 8, is amended to read:

Subd. 8. [FILING REQUIREMENT.] (a) No later than July 1, 1993, and each year thereafter, a health carrier that offers, sells, issues, or renews a health benefit plan for small employers shall file with the commissioner the index rates and must demonstrate that all rates shall be within the rating restrictions defined in this chapter. Such demonstration must include the allowable range of rates from the index rates and a description of how the health carrier intends to use demographic factors including case characteristics in calculating the premium rates.

(b) Notwithstanding paragraph (a), the rates shall not be approved~~,~~ unless the commissioner has determined that the rates are reasonable. In determining reasonableness, the commissioner shall ~~consider the growth rates applied under section 62J.04, subdivision 1, paragraph (b)~~ apply the premium growth limits established under section 62J.04, subdivision 1b, to the calendar year or years that the proposed premium rate would be in effect, and shall consider actuarially valid changes in risk associated with the enrollee population, and actuarially valid changes as a result of statutory changes in Laws 1992, chapter 549. ~~For premium rates proposed to go into effect between July 1, 1993 and December 31, 1993, the pertinent growth rate is the growth rate applied under section 62J.04, subdivision 1, paragraph (b), to calendar year 1994.~~

ARTICLE 4

LONG-TERM CARE AND CONTINUING CARE

Section 1. Minnesota Statutes 2004, section 144A.073, is amended by adding a subdivision to read:

Subd. 3c. [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 under this section in 2002 for a moratorium exception project may reduce the number of single rooms from 46 to 42 and may reduce the common space by more than five percent.

Sec. 2. Minnesota Statutes 2004, section 144A.073, subdivision 10, is amended to read:

Subd. 10. [EXTENSION OF APPROVAL OF MORATORIUM EXCEPTION.] Notwithstanding subdivision 3, the commissioner of health shall extend project approval for an additional ~~18~~ 36 months for any proposed exception to the nursing home licensure and certification moratorium if the proposal was approved under this section between July 1, 2001, and June 30, 2003.

Sec. 3. Minnesota Statutes 2004, section 252.291, is amended by adding a subdivision to read:

Subd. 2b. [EXCEPTION FOR BROWN COUNTY FACILITY.] (a) The commissioner shall authorize and grant a new license under chapter 245A to a new intermediate care facility for persons with mental retardation under the following circumstances:

(1) the new facility replaces an existing six-bed intermediate care facility for the mentally retarded located in Brown County that has been operating since June 1982;

(2) the new facility is located on an already purchased parcel of land; and

(3) the new facility is handicapped accessible.

(b) The medical assistance payment rate for the new facility shall be the higher of the rate specified in paragraph (c) or as otherwise provided by law.

(c) The new facility shall be considered a newly established facility for rate-setting purposes and shall be eligible for the investment per bed limit specified in section 256B.501, subdivision 11, paragraph (c), and the interest expense limitation specified in section 256B.501, subdivision 11, paragraph (d). Notwithstanding section 256B.5011, the newly established facility's initial payment rate shall be set according to Minnesota Rules, part 9553.0075, and shall not be subject to the provisions of section 256B.501, subdivision 5b.

(d) During the construction of the new facility, Brown County shall work with residents, families, and service providers to explore all service options open to current residents of the facility.

Sec. 4. Minnesota Statutes 2004, section 256B.0621, subdivision 2, is amended to read:

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

(1) "home care service recipients" means those individuals receiving the following services under section 256B.0627: skilled nursing visits, home health aide visits, private duty nursing, personal care assistants, or therapies provided through a home health agency;

(2) "home care targeted case management" means the provision of targeted case management services for the purpose of assisting home care service recipients to gain access to needed services and supports so that they may remain in the community;

(3) "institutions" means hospitals, consistent with Code of Federal Regulations, title 42, section 440.10; regional treatment center inpatient services, consistent with section 245.474; nursing facilities; and intermediate care facilities for persons with mental retardation;

(4) "relocation targeted case management" ~~means~~ includes the provision of both county targeted case management and public or private vendor service coordination services for the purpose

of assisting recipients to gain access to needed services and supports if they choose to move from an institution to the community. Relocation targeted case management may be provided during the last 180 consecutive days of an eligible recipient's institutional stay; and

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

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

Subd. 3. [ELIGIBILITY.] The following persons are eligible for relocation targeted case management or home ~~care-targeted~~ care targeted case management:

(1) medical assistance eligible persons residing in institutions who choose to move into the community are eligible for relocation targeted case management services; and

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

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

Subd. 4. [RELOCATION TARGETED COUNTY CASE MANAGEMENT PROVIDER QUALIFICATIONS.] (a) A relocation targeted county case management provider is an enrolled medical assistance provider who is determined by the commissioner to have all of the following characteristics:

(1) the legal authority to provide public welfare under sections 393.01, subdivision 7; and 393.07; or a federally recognized Indian tribe;

(2) the demonstrated capacity and experience to provide the components of case management to coordinate and link community resources needed by the eligible population;

(3) the administrative capacity and experience to serve the target population for whom it will provide services and ensure

quality of services under state and federal requirements;

(4) the legal authority to provide complete investigative and protective services under section 626.556, subdivision 10; and child welfare and foster care services under section 393.07, subdivisions 1 and 2; or a federally recognized Indian tribe;

(5) a financial management system that provides accurate documentation of services and costs under state and federal requirements; and

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

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

(c) A relocation targeted county case management provider may subcontract with another provider to deliver relocation targeted case management services. Subcontracted providers must demonstrate the ability to provide the services outlined in subdivision 6, and have a procedure in place that notifies the recipient and the recipient's legal representative of any conflict of interest if the contracted targeted case management provider also provides, or will provide, the recipient's services and supports. Counties must require that contracted providers must provide information on all conflicts of interest and obtain the recipient's informed consent or provide the recipient with alternatives.

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

Subd. 5. [HOME CARE TARGETED CASE MANAGEMENT AND RELOCATION SERVICE COORDINATION PROVIDER QUALIFICATIONS.] ~~The following qualifications and certification standards must be met by~~ Providers of home care targeted case management and relocation service coordination must meet the qualifications under subdivision 4 for county vendors or the following qualifications and certification standards for private vendors.

(a) The commissioner must certify each provider of home care targeted case management and relocation service

coordination before enrollment. The certification process shall examine the provider's ability to meet the requirements in this subdivision and other state and federal requirements of this service.

(b) ~~A~~ Both home care targeted case management ~~provider is an~~ providers and relocation service coordination providers are enrolled medical assistance ~~provider~~ providers who ~~has~~ have a minimum of a bachelor's degree or a license in a health or human services field, or comparable training and two years of experience in human services, and ~~is~~ have been determined by the commissioner to have all of the following characteristics:

(1) the demonstrated capacity and experience to provide the components of case management to coordinate and link community resources needed by the eligible population;

(2) the administrative capacity and experience to serve the target population for whom it will provide services and ensure quality of services under state and federal requirements;

(3) a financial management system that provides accurate documentation of services and costs under state and federal requirements;

(4) the capacity to document and maintain individual case records under state and federal requirements; ~~and~~

(5) the capacity to coordinate with county administrative functions;

(6) have no financial interest in the provision of out-of-home residential services to persons for whom targeted case management or relocation service coordination is provided; and

(7) if a provider has a financial interest in services other than out-of-home residential services provided to persons for whom targeted case management or relocation service coordination is also provided, the county must determine each year that:

(i) any possible conflict of interest is explained annually at a face-to-face meeting and in writing and the person provides written informed consent consistent with section 256B.77,

subdivision 2, paragraph (p); and

(ii) information on a range of other feasible service provider options has been provided.

(c) The State of Minnesota, a county board, or agency acting on behalf of a county board shall not be liable for damages, injuries, or liabilities sustained because of services provided to a client by a private service coordination vendor.

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

Subd. 6. [ELIGIBLE SERVICES.] (a) Services eligible for medical assistance reimbursement as targeted case management include:

(1) assessment of the recipient's need for targeted case management services and for persons choosing to relocate, the county must provide service coordination provider options at the first contact and upon request;

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

(3) routine contact or communication with the recipient, recipient's family, primary caregiver, legal representative, substitute care provider, service providers, or other relevant persons identified as necessary to the development or implementation of the goals of the individual service plan;

(4) coordinating referrals for, and the provision of, case management services for the recipient with appropriate service providers, consistent with section 1902(a)(23) of the Social Security Act;

(5) coordinating and monitoring the overall service delivery and engaging in advocacy as needed to ensure quality of services, appropriateness, and continued need;

(6) completing and maintaining necessary documentation that supports and verifies the activities in this subdivision;

(7) ~~traveling~~ assisting individuals in order to access

needed services, including travel to conduct a visit with the recipient or other relevant person necessary to develop or implement the goals of the individual service plan; and

(8) coordinating with the institution discharge planner in the 180-day period before the recipient's discharge.

(b) Relocation targeted county case management includes services under paragraph (a), clauses (1), (2), and (4). Relocation service coordination includes services under paragraph (a), clauses (3) and (5) to (8). Home care targeted case management includes services under paragraph (a), clauses (1) to (8).

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

Subd. 7. [TIME LINES.] The following time lines must be met for assigning a case manager:

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

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

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

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

(i) meet the provider requirements under subdivision 4 that

are not waived by the commissioner;

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

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

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

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

(b) For home care targeted case management, an eligible recipient must be assigned a case manager within 20 working days of requesting a case manager from a home care targeted case management provider, as defined in subdivision 5.

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

Subd. 2. [SKILLED AND INTERMEDIATE NURSING CARE.] Medical assistance covers skilled nursing home services and services of intermediate care facilities, including training and habilitation services, as defined in section 252.41, subdivision 3, for persons with mental retardation or related conditions who are residing in intermediate care facilities for persons with mental retardation or related conditions. Medical assistance must not be used to pay the costs of nursing care provided to a patient in a swing bed as defined in section 144.562, unless (a) the facility in which the swing bed is located is eligible as a sole community provider, as defined in Code of Federal Regulations, title 42, section 412.92, or the facility is a public hospital owned by a governmental entity with 15 or fewer licensed acute care beds; (b) the Centers for Medicare and Medicaid Services approves the necessary state plan amendments; (c) the patient was screened as provided by law; (d) the patient no longer requires acute care services; and (e) no nursing home beds are available within 25 miles of the facility. <u>The</u>

commissioner shall exempt a facility from compliance with the sole community provider requirement in clause (a) if, as of January 1, 2004, the facility had an agreement with the commissioner to provide medical assistance swing bed services. Medical assistance also covers up to ten days of nursing care provided to a patient in a swing bed if: (1) the patient's physician certifies that the patient has a terminal illness or condition that is likely to result in death within 30 days and that moving the patient would not be in the best interests of the patient and patient's family; (2) no open nursing home beds are available within 25 miles of the facility; and (3) no open beds are available in any Medicare hospice program within 50 miles of the facility. The daily medical assistance payment for nursing care for the patient in the swing bed is the statewide average medical assistance skilled nursing care per diem as computed annually by the commissioner on July 1 of each year.

[EFFECTIVE DATE.] This section is effective the day following final enactment and applies to medical assistance payments for swing bed services provided on or after March 5, 2005.

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

Subd. 19c. [PERSONAL CARE.] Medical assistance covers personal care assistant services provided by an individual who is qualified to provide the services according to subdivision 19a and section 256B.0627, where the services are ~~prescribed~~ determined to be medically necessary by a physician, provided in accordance with a service plan ~~of treatment,~~ and are supervised by the recipient or a qualified professional. The physician's determination of medical necessity for personal care assistant services shall be documented on a form approved by the commissioner and include the diagnosis or condition of the person that results in a need for personal care assistant services and be updated either when the person's medical condition requires a change or at least annually if the medical need for personal care services is ongoing.

"Qualified professional" means a mental health professional as defined in section 245.462, subdivision 18, or 245.4871, subdivision 27; or a registered nurse as defined in sections 148.171 to 148.285, or a licensed social worker as defined in section 148B.21. As part of the assessment, the county public health nurse will assist the recipient or responsible party to identify the most appropriate person to provide supervision of the personal care assistant. The qualified professional shall perform the duties described in Minnesota Rules, part 9505.0335, subpart 4.

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

Subdivision 1. [DEFINITION.] (a) "Activities of daily living" includes eating, toileting, grooming, dressing, bathing, transferring, mobility, and positioning.

(b) "Assessment" means a review and evaluation of a recipient's need for home care services conducted in person. Assessments for private duty nursing shall be conducted by a registered private duty nurse. Assessments for home health agency services shall be conducted by a home health agency nurse. Assessments for personal care assistant services shall be conducted by the county public health nurse or a certified public health nurse under contract with the county. A face-to-face assessment must include: documentation of health status, determination of need, evaluation of service effectiveness, identification of appropriate services, service plan development or modification, coordination of services, referrals and follow-up to appropriate payers and community resources, completion of required reports, recommendation of service authorization, and consumer education. Once the need for personal care assistant services is determined under this section, the county public health nurse or certified public health nurse under contract with the county is responsible for communicating this recommendation to the commissioner and the recipient. A face-to-face assessment for personal care assistant services is conducted on those recipients who have

never had a county public health nurse assessment. A face-to-face assessment must occur at least annually or when there is a significant change in the recipient's condition or when there is a change in the need for personal care assistant services. A service update may substitute for the annual face-to-face assessment when there is not a significant change in recipient condition or a change in the need for personal care assistant service. A service update or review for temporary increase includes a review of initial baseline data, evaluation of service effectiveness, redetermination of service need, modification of service plan and appropriate referrals, update of initial forms, obtaining service authorization, and on going consumer education. Assessments for medical assistance home care services for mental retardation or related conditions and alternative care services for developmentally disabled home and community-based waivered recipients may be conducted by the county public health nurse to ensure coordination and avoid duplication. Assessments must be completed on forms provided by the commissioner within 30 days of a request for home care services by a recipient or responsible party.

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

(d) "Complex and regular private duty nursing care" means:

(1) complex care is private duty nursing provided to recipients who are ventilator dependent or for whom a physician has certified that were it not for private duty nursing the recipient would meet the criteria for inpatient hospital intensive care unit (ICU) level of care; and

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

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

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

(g) "Instrumental activities of daily living" includes meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communication by telephone and other media, and getting around and participating in the community.

(h) "Medically necessary" has the meaning given in Minnesota Rules, parts 9505.0170 to 9505.0475.

(i) "Personal care assistant" means a person who:

(1) is at least 18 years old, except for persons 16 to 18 years of age who participated in a related school-based job training program or have completed a certified home health aide competency evaluation;

(2) is able to effectively communicate with the recipient and personal care provider organization;

(3) effective July 1, 1996, has completed one of the training requirements as specified in Minnesota Rules, part 9505.0335, subpart 3, items A to D;

(4) has the ability to, and provides covered personal care assistant services according to the recipient's care plan, responds appropriately to recipient needs, and reports changes in the recipient's condition to the supervising qualified professional or physician;

(5) is not a consumer of personal care assistant services; ~~and~~

(6) maintains daily written records detailing:

(i) the actual services provided to the recipient; and

(ii) the amount of time spent providing the services; and

(7) is subject to criminal background checks and procedures specified in chapter 245C.

(j) "Personal care provider organization" means an organization enrolled to provide personal care assistant services under the medical assistance program that complies with the following:

(1) owners who have a five percent interest or more, and managerial officials are subject to a background study as provided in chapter 245C. This applies to currently enrolled personal care provider organizations and those agencies seeking enrollment as a personal care provider organization. An organization will be barred from enrollment if an owner or managerial official of the organization has been convicted of a crime specified in chapter 245C, or a comparable crime in another jurisdiction, unless the owner or managerial official meets the reconsideration criteria specified in chapter 245C;

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

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

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

(k) "Responsible party" means an individual who is capable of providing the support necessary to assist the recipient to live in the community, is at least 18 years old, actively participates in planning and directing of personal care assistant services, and is not the personal care assistant. The responsible party must be accessible to the recipient and the personal care assistant when personal care services are being

provided and monitor the services at least weekly according to the plan of care. The responsible party must be identified at the time of assessment and listed on the recipient's service agreement and care plan. Responsible parties who are parents of minors or guardians of minors or incapacitated persons may delegate the responsibility to another adult who is not the personal care assistant during a temporary absence of at least 24 hours but not more than six months. The person delegated as a responsible party must be able to meet the definition of responsible party, except that the delegated responsible party is required to reside with the recipient only while serving as the responsible party. The delegated responsible party is not required to reside with the recipient while serving as the responsible party if adequate supervision and monitoring are provided for as part of the person's individual service plan under a home and community-based waiver program or in conjunction with a home care targeted case management service provider or other case manager. The responsible party must assure that the delegate performs the functions of the responsible party, is identified at the time of the assessment, and is listed on the service agreement and the care plan. Foster care license holders may be designated the responsible party for residents of the foster care home if case management is provided as required in section 256B.0625, subdivision 19a. For persons who, as of April 1, 1992, are sharing personal care assistant services in order to obtain the availability of 24-hour coverage, an employee of the personal care provider organization may be designated as the responsible party if case management is provided as required in section 256B.0625, subdivision 19a.

(l) "Service plan" means a written description of the services needed based on the assessment developed by the nurse who conducts the assessment together with the recipient or responsible party. The service plan shall include a description of the covered home care services, frequency and duration of services, and expected outcomes and goals. The recipient and

the provider chosen by the recipient or responsible party must be given a copy of the completed service plan within 30 calendar days of the request for home care services by the recipient or responsible party.

(m) "Skilled nurse visits" are provided in a recipient's residence under a plan of care or service plan that specifies a level of care which the nurse is qualified to provide. These services are:

(1) nursing services according to the written plan of care or service plan and accepted standards of medical and nursing practice in accordance with chapter 148;

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

(3) assessments performed only by a registered nurse; and

(4) teaching and training the recipient, the recipient's family, or other caregivers requiring the skills of a registered nurse or licensed practical nurse.

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

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

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

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

(c) The amount and type of services authorized shall be based on an assessment of the recipient's needs in these areas:

(1) bowel and bladder care;

(2) skin care to maintain the health of the skin;

(3) repetitive maintenance range of motion, muscle strengthening exercises, and other tasks specific to maintaining a recipient's optimal level of function;

(4) respiratory assistance;

(5) transfers and ambulation;

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

(7) turning and positioning;

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

(9) application and maintenance of prosthetics and orthotics;

(10) cleaning medical equipment;

(11) dressing or undressing;

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

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

(14) assisting, monitoring, or prompting the recipient to complete the services in clauses (1) to (13);

(15) redirection, monitoring, and observation that are medically necessary and an integral part of completing the personal care assistant services described in clauses (1) to (14);

(16) redirection and intervention for behavior, including observation and monitoring;

(17) interventions for seizure disorders, including monitoring and observation if the recipient has had a seizure that requires intervention within the past three months;

(18) tracheostomy suctioning using a clean procedure if the procedure is properly delegated by a registered nurse. Before this procedure can be delegated to a personal care assistant, a

registered nurse must determine that the tracheostomy suctioning can be accomplished utilizing a clean rather than a sterile procedure and must ensure that the personal care assistant has been taught the proper procedure; and

(19) incidental household services that are an integral part of a personal care service described in clauses (1) to (18). For purposes of this subdivision, monitoring and observation means watching for outward visible signs that are likely to occur and for which there is a covered personal care service or an appropriate personal care intervention. For purposes of this subdivision, a clean procedure refers to a procedure that reduces the numbers of microorganisms or prevents or reduces the transmission of microorganisms from one person or place to another. A clean procedure may be used beginning 14 days after insertion.

(d) The personal care assistant services that are not eligible for payment are the following:

(1) services ~~not ordered by the physician~~ provided without a physician's 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 commissioner's designee.

(e) The recipient or responsible party may choose to supervise the personal care assistant or to have a qualified professional, as defined in section 256B.0625, subdivision 19c, provide the supervision. As required under section 256B.0625, subdivision 19c, the county public health nurse, as a part of the assessment, will assist the recipient or responsible party to identify the most appropriate person to provide supervision of the personal care assistant. Health-related delegated tasks performed by the personal care assistant will be under the supervision of a qualified professional or the direction of the recipient's physician. If the recipient has a qualified professional, Minnesota Rules, part 9505.0335, subpart 4, applies.

(f) In order to be paid for personal care services, personal care provider organizations, and personal care choice providers are required:

(1) to maintain a recipient file for each recipient for whom services are being billed that contains:

(i) the current physician's determination of medical necessity as required by section 256B.0625, subdivision 19c;

(ii) the service plan, including the monthly authorized hours, or flexible use plan;

(iii) the care plan, signed by the recipient and the qualified professional, if required or designated, detailing the personal care services to be provided;

(iv) documentation, on a form approved by the commissioner and signed by the personal care assistant, specifying the day,

month, year, arrival, and departure times, with AM and PM notation, for all services provided to the recipient. The form must include a notice that it is a federal crime to provide false information on personal care service billings for medical assistance payment; and

(v) all notices to the recipient regarding personal care service use exceeding authorized hours; and

(2) to communicate, by telephone if available, and in writing, with the recipient or the responsible party about the schedule for use of authorized hours and to notify the recipient and the county public health nurse in advance and as soon as possible, on a form approved by the commissioner, if the monthly number of hours authorized is likely to be exceeded for the month.

(g) The commissioner shall establish an ongoing audit process for potential fraud and abuse for personal care assistant services. The audit process must include, at a minimum, a requirement that the documentation of hours of care provided be on a form approved by the commissioner and include the personal care assistant's signature attesting that the hours shown on each bill were provided by the personal care assistant on the dates and the times specified.

Sec. 14. Minnesota Statutes 2004, section 256B.0627, subdivision 5, is amended to read:

Subd. 5. [LIMITATION ON PAYMENTS.] Medical assistance payments for home care services shall be limited according to this subdivision.

(a) [LIMITS ON SERVICES WITHOUT PRIOR AUTHORIZATION.] A recipient may receive the following home care services during a calendar year:

(1) up to two face-to-face assessments to determine a recipient's need for personal care assistant services;

(2) one service update done to determine a recipient's need for personal care assistant services; and

(3) up to nine skilled nurse visits.

(b) [PRIOR AUTHORIZATION; EXCEPTIONS.] All home care

services above the limits in paragraph (a) must receive the commissioner's prior authorization, except when:

(1) the home care services were required to treat an emergency medical condition that if not immediately treated could cause a recipient serious physical or mental disability, continuation of severe pain, or death. The provider must request retroactive authorization no later than five working days after giving the initial service. The provider must be able to substantiate the emergency by documentation such as reports, notes, and admission or discharge histories;

(2) the home care services were provided on or after the date on which the recipient's eligibility began, but before the date on which the recipient was notified that the case was opened. Authorization will be considered if the request is submitted by the provider within 20 working days of the date the recipient was notified that the case was opened;

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

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

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

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

(d) [ASSESSMENT AND SERVICE PLAN.] Assessments under section 256B.0627, subdivision 1, paragraph (a), shall be conducted initially, and at least annually thereafter, in person with the recipient and result in a completed service plan using forms specified by the commissioner. Within 30 days of

recipient or responsible party request for home care services, the assessment, the service plan, and other information necessary to determine medical necessity such as diagnostic or testing information, social or medical histories, and hospital or facility discharge summaries shall be submitted to the commissioner. Notwithstanding the provisions of section 256B.0627, subdivision 12, the commissioner shall maximize federal financial participation to pay for public health nurse assessments for personal care services. For personal care assistant services:

(1) The amount and type of service authorized based upon the assessment and service plan will follow the recipient if the recipient chooses to change providers.

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

(3) To continue to receive personal care assistant services after the first year, the recipient or the responsible party, in conjunction with the public health nurse, may complete a service update on forms developed by the commissioner according to criteria and procedures in subdivision 1.

(e) [PRIOR AUTHORIZATION.] The commissioner, or the commissioner's designee, shall review the assessment, service update, request for temporary services, request for flexible use option, service plan, and any additional information that is submitted. The commissioner shall, within 30 days after receiving a complete request, assessment, and service plan, authorize home care services as follows:

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

(2) [PERSONAL CARE ASSISTANT SERVICES.] (i) All personal care assistant services and supervision by a qualified professional, if requested by the recipient, must be prior authorized by the commissioner or the commissioner's designee except for the assessments established in paragraph (a). The amount of personal care assistant services authorized must be based on the recipient's home care rating. A child may not be found to be dependent in an activity of daily living if because of the child's age an adult would either perform the activity for the child or assist the child with the activity and the amount of assistance needed is similar to the assistance appropriate for a typical child of the same age. Based on medical necessity, the commissioner may authorize:

(A) up to two times the average number of direct care hours provided in nursing facilities for the recipient's comparable case mix level; or

(B) up to three times the average number of direct care hours provided in nursing facilities for recipients who have complex medical needs or are dependent in at least seven activities of daily living and need physical assistance with eating or have a neurological diagnosis; or

(C) up to 60 percent of the average reimbursement rate, as of July 1, 1991, for care provided in a regional treatment center for recipients who have Level I behavior, plus any inflation adjustment as provided by the legislature for personal

care service; or

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

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

(F) a reasonable amount of time for the provision of supervision by a qualified professional of personal care assistant services, if a qualified professional is requested by the recipient or responsible party.

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

(iii) The home care rating shall be determined by the commissioner or the commissioner's designee based on information submitted to the commissioner by the county public health nurse on forms specified by the commissioner. The home care rating shall be a combination of current assessment tools developed under sections 256B.0911 and 256B.501 with an addition for seizure activity that will assess the frequency and severity of seizure activity and with adjustments, additions, and clarifications that are necessary to reflect the needs and conditions of recipients who need home care including children and adults under 65 years of age. The commissioner shall establish these forms and protocols under this section and shall use an advisory group, including representatives of recipients,

providers, and counties, for consultation in establishing and revising the forms and protocols.

(iv) A recipient shall qualify as having complex medical needs if the care required is difficult to perform and because of recipient's medical condition requires more time than community-based standards allow or requires more skill than would ordinarily be required and the recipient needs or has one or more of the following:

(A) daily tube feedings;

(B) daily parenteral therapy;

(C) wound or decubiti care;

(D) postural drainage, percussion, nebulizer treatments, suctioning, tracheotomy care, oxygen, mechanical ventilation;

(E) catheterization;

(F) ostomy care;

(G) quadriplegia; or

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

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

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

(B) physical injury to other people; or

(C) destruction of property.

(vi) Time authorized for personal care relating to Level I behavior in subclause (v), items (A) to (C), shall be based on the predictability, frequency, and amount of intervention required.

(vii) A recipient shall qualify as having Level II behavior if the recipient exhibits on a daily basis one or more of the following behaviors that interfere with the completion of personal care assistant services under subdivision 4, paragraph (a):

(A) unusual or repetitive habits;

(B) withdrawn behavior; or

(C) offensive behavior.

(viii) A recipient with a home care rating of Level II behavior in subclause (vii), items (A) to (C), shall be rated as comparable to a recipient with complex medical needs under subclause (iv). If a recipient has both complex medical needs and Level II behavior, the home care rating shall be the next complex category up to the maximum rating under subclause (i), item (B).

(3) [PRIVATE DUTY NURSING SERVICES.] All private duty nursing services shall be prior authorized by the commissioner or the commissioner's designee. Prior authorization for private duty nursing services shall be based on medical necessity and cost-effectiveness when compared with alternative care options. The commissioner may authorize medically necessary private duty nursing services in quarter-hour units when:

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

(ii) the cares are outside of the scope of services that can be provided by a home health aide or personal care assistant.

The commissioner may authorize:

(A) up to two times the average amount of direct care hours provided in nursing facilities statewide for case mix classification "K" as established by the annual cost report submitted to the department by nursing facilities in May 1992;

(B) private duty nursing in combination with other home care services up to the total cost allowed under clause (2);

(C) up to 16 hours per day if the recipient requires more nursing than the maximum number of direct care hours as established in item (A) and the recipient meets the hospital admission criteria established under Minnesota Rules, parts 9505.0501 to 9505.0540.

The commissioner may authorize up to 16 hours per day of medically necessary private duty nursing services or up to 24 hours per day of medically necessary private duty nursing

services until such time as the commissioner is able to make a determination of eligibility for recipients who are cooperatively applying for home care services under the community alternative care program developed under section 256B.49, or until it is determined by the appropriate regulatory agency that a health benefit plan is or is not required to pay for appropriate medically necessary health care services. Recipients or their representatives must cooperatively assist the commissioner in obtaining this determination. Recipients who are eligible for the community alternative care program may not receive more hours of nursing under this section than would otherwise be authorized under section 256B.49.

(4) [VENTILATOR-DEPENDENT RECIPIENTS.] If the recipient is ventilator-dependent, the monthly medical assistance authorization for home care services shall not exceed what the commissioner would pay for care at the highest cost hospital designated as a long-term hospital under the Medicare program. For purposes of this clause, home care services means all services provided in the home that would be included in the payment for care at the long-term hospital. "Ventilator-dependent" means an individual who receives mechanical ventilation for life support at least six hours per day and is expected to be or has been dependent for at least 30 consecutive days.

(f) [PRIOR AUTHORIZATION; TIME LIMITS.] The commissioner or the commissioner's designee shall determine the time period for which a prior authorization shall be effective <u>and, if flexible use has been requested, whether to allow the flexible use option</u>. If the recipient continues to require home care services beyond the duration of the prior authorization, the home care provider must request a new prior authorization. Under no circumstances, other than the exceptions in paragraph (b), shall a prior authorization be valid prior to the date the commissioner receives the request or for more than 12 months. A recipient who appeals a reduction in previously authorized home care services may continue previously authorized services, other

than temporary services under paragraph (h), pending an appeal under section 256.045. The commissioner must provide a detailed explanation of why the authorized services are reduced in amount from those requested by the home care provider.

(g) [APPROVAL OF HOME CARE SERVICES.] The commissioner or the commissioner's designee shall determine the medical necessity of home care services, the level of caregiver according to subdivision 2, and the institutional comparison according to this subdivision, the cost-effectiveness of services, and the amount, scope, and duration of home care services reimbursable by medical assistance, based on the assessment, primary payer coverage determination information as required, the service plan, the recipient's age, the cost of services, the recipient's medical condition, and diagnosis or disability. The commissioner may publish additional criteria for determining medical necessity according to section 256B.04.

(h) [PRIOR AUTHORIZATION REQUESTS; TEMPORARY SERVICES.] The agency nurse, the independently enrolled private duty nurse, or county public health nurse may request a temporary authorization for home care services by telephone. The commissioner may approve a temporary level of home care services based on the assessment, and service or care plan information, and primary payer coverage determination information as required. Authorization for a temporary level of home care services including nurse supervision is limited to the time specified by the commissioner, but shall not exceed 45 days, unless extended because the county public health nurse has not completed the required assessment and service plan, or the commissioner's determination has not been made. The level of services authorized under this provision shall have no bearing on a future prior authorization.

(i) [PRIOR AUTHORIZATION REQUIRED IN FOSTER CARE SETTING.] Home care services provided in an adult or child foster care setting must receive prior authorization by the department according to the limits established in paragraph (a).

The commissioner may not authorize:

(1) home care services that are the responsibility of the foster care provider under the terms of the foster care placement agreement and administrative rules;

(2) personal care assistant services when the foster care license holder is also the personal care provider or personal care assistant unless the recipient can direct the recipient's own care, or case management is provided as required in section 256B.0625, subdivision 19a;

(3) personal care assistant services when the responsible party is an employee of, or under contract with, or has any direct or indirect financial relationship with the personal care provider or personal care assistant, unless case management is provided as required in section 256B.0625, subdivision 19a; or

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

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

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

(b) The recipient or responsible party, together with the

case manager, if the recipient has case management services, and the county public health nurse, shall determine whether flexible use is an appropriate option based on the needs, abilities, preferences, and history of service use of the recipient or responsible party, and if appropriate, must ensure that the allocation of hours covers the ongoing needs of the recipient over an entire year divided into two six-month periods of flexible use.

(c) If prior authorized, recipients may use their approved hours flexibly within the service authorization period for medically necessary covered services specified in the assessment required in subdivision 1. The flexible use of authorized hours does not increase the total amount of authorized hours available to a recipient as determined under subdivision 5. The commissioner shall not authorize additional personal care assistant services to supplement a service authorization that is exhausted before the end date under a flexible service use plan, unless the county public health nurse determines a change in condition and a need for increased services is established.

~~(b)~~ (d) The personal care provider organization and the recipient or responsible party~~,-together-with-the-provider,~~ must ~~work-to-monitor-and-document-the-use-of-authorized-hours-and ensure-that-a-recipient-is-able-to-manage-services-effectively throughout-the-authorized-period.--Upon-request-of-the-recipient or-responsible-party,-the-provider-must-furnish-regular-updates to-the-recipient-or-responsible-party-on-the-amount-of-personal care-assistant-services-used~~ develop a written month-to-month plan of the projected use of personal care assistant services that is part of the care plan and ensures:

(1) that the health and safety needs of the recipient will be met;

(2) that the total annual authorization will not be used before the end of the authorization period; and

(3) monthly monitoring will be conducted of hours used as a percentage of the authorized amount.

(e) The provider shall notify the recipient, the case

manager, if the recipient has case management services, and the county public health nurse in advance and as soon as possible, on a form approved by the commissioner, if the monthly amount of hours authorized is likely to be exceeded for the month.

(f) The commissioner shall provide written notice to the provider, the recipient or responsible party, the county case manager, if the recipient has case management services, and the county public health nurse, when a flexible use recipient exceeds the personal care service authorization for the month by an amount determined by the commissioner. If the use of hours exceeds the monthly service authorization by the amount determined by the commissioner for two months during any three-month period, the commissioner shall notify the recipient and the county public health nurse that the flexible use authorization will be revoked beginning the following month. The revocation will not become effective if, within ten working days of the commissioner's notice of flexible use revocation, the county public health nurse requests prior authorization for an increase in the service authorization and continuation of the flexible use option, or the recipient appeals and assistance pending appeal is ordered. The commissioner shall determine whether to approve the increase and continued flexible use.

(g) The recipient or responsible party may stop the flexible use of hours by notifying the provider and county public health nurse in writing.

(h) The recipient or responsible party may appeal the commissioner's action according to section 256.045. The denial or revocation of the flexible use option shall not affect the recipient's authorized level of personal care assistant services as determined under subdivision 5.

Sec. 16. Minnesota Statutes 2004, section 256B.0627, is amended by adding a subdivision to read:

Subd. 18. [OVERSIGHT OF ENROLLED PERSONAL CARE ASSISTANT SERVICES PROVIDERS.] The commissioner may request from providers documentation of compliance with laws, rules, and policies governing the provision of personal care assistant services. A

personal care assistant service provider must provide the requested documentation to the commissioner within ten business days of the request. Failure to provide information to demonstrate substantial compliance with laws, rules, or policies may result in suspension, denial, or termination of the provider agreement.

Sec. 17. Minnesota Statutes 2004, section 256B.15, subdivision 1, is amended to read:

Subdivision 1. [POLICY, APPLICABILITY, PURPOSE, AND CONSTRUCTION; DEFINITION.] (a) It is the policy of this state that individuals or couples, either or both of whom participate in the medical assistance program, use their own assets to pay their share of the total cost of their care during or after their enrollment in the program according to applicable federal law and the laws of this state. The following provisions apply:

(1) subdivisions 1c to 1k shall not apply to claims arising under this section which are presented under section 525.313;

(2) the provisions of subdivisions 1c to 1k expanding the interests included in an estate for purposes of recovery under this section give effect to the provisions of United States Code, title 42, section 1396p, governing recoveries, but do not give rise to any express or implied liens in favor of any other parties not named in these provisions;

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

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

(5) a deceased recipient's life estate and joint tenancy interests continued under this section shall be owned by the remaindermen or surviving joint tenants as their interests may appear on the date of the recipient's death. They shall not be merged into the remainder interest or the interests of the

surviving joint tenants by reason of ownership. They shall be subject to the provisions of this section. Any conveyance, transfer, sale, assignment, or encumbrance by a remainderman, a surviving joint tenant, or their heirs, successors, and assigns shall be deemed to include all of their interest in the deceased recipient's life estate or joint tenancy interest continued under this section; and

(6) the provisions of subdivisions 1c to 1k continuing a recipient's joint tenancy interests in real property after the recipient's death do not apply to a homestead owned of record, on the date the recipient dies, by the recipient and the recipient's spouse as joint tenants with a right of survivorship. Homestead means the real property occupied by the surviving joint tenant spouse as their sole residence on the date the recipient dies and classified and taxed to the recipient and surviving joint tenant spouse as homestead property for property tax purposes in the calendar year in which the recipient dies. For purposes of this exemption, real property the recipient and their surviving joint tenant spouse purchase solely with the proceeds from the sale of their prior homestead, own of record as joint tenants, and qualify as homestead property under section 273.124 in the calendar year in which the recipient dies and prior to the recipient's death shall be deemed to be real property classified and taxed to the recipient and their surviving joint tenant spouse as homestead property in the calendar year in which the recipient dies. The surviving spouse, or any person with personal knowledge of the facts, may provide an affidavit describing the homestead property affected by this clause and stating facts showing compliance with this clause. The affidavit shall be prima facie evidence of the facts it states.

(b) The commissioner shall release liens arising under notices of potential claims under this section and medical assistance liens under sections 514.980 to 514.985, against life estates and jointly owned interests a remainderman or surviving joint tenant has in farm and income-producing property the

deceased recipient owned of record on the date of the recipient's death under the following conditions:

(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:

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

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

(iii) all of the land is classified and taxed as class 2a agricultural land under section 273.13, subdivision 23, paragraph (a), for property tax purposes; and

(2) the income-producing 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:

(i) no part of the property is classified or taxed as homestead property for property tax purposes, provided that if the property is classified and taxed as both homestead and nonhomestead property, the portion of the property classified and taxed as nonhomestead property shall be considered to satisfy this requirement;

(ii) all of the property is classified and taxed as class 1c property under section 273.13, subdivision 22, paragraph (c), except that part of the class 1c property that is a dwelling occupied as a homestead; class 3a or 3b commercial or industrial property under section 273.13, subdivision 24; or as class 4a or 4c property classified under section 273.13, subdivision 25, paragraphs (a) and (d), for property tax purposes; and

(iii) the business, profession, or occupation in which the real property is used is the primary business, profession, or

occupation of the remainderman or surviving joint tenant and the real property is used solely for that business, profession, or occupation. A primary business, profession, or occupation is one the ongoing operation of which provides at least 65 percent of a person's gross income for federal income tax purposes for the calendar year.

(c) For purposes of this section, "medical assistance" includes the medical assistance program under this chapter and the general assistance medical care program under chapter 256D ~~and~~ but does not include the alternative care program for nonmedical assistance recipients under section 256B.0913.

[EFFECTIVE DATE.] The amendments in this section relating to the alternative care program are effective retroactively from July 1, 2003, and apply to the estates of decedents who die on or after that date. The remaining amendments in this section are effective July 1, 2005, and apply to the estates of decedents who die on or after that date.

Sec. 18. Minnesota Statutes 2004, section 256B.15, subdivision 1a, is amended to read:

Subd. 1a. [ESTATES SUBJECT TO CLAIMS.] If a person receives any medical assistance hereunder, on the person's death, if single, or on the death of the survivor of a married couple, either or both of whom received medical assistance, or as otherwise provided for in this section, the total amount paid for medical assistance rendered for the person and spouse shall be filed as a claim against the estate of the person or the estate of the surviving spouse in the court having jurisdiction to probate the estate or to issue a decree of descent according to sections 525.31 to 525.313.

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

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

(b) the person resided in a medical institution for six months or longer, received services under this chapter,

excluding alternative care, and, at the time of institutionalization or application for medical assistance, whichever is later, the person could not have reasonably been expected to be discharged and returned home, as certified in writing by the person's treating physician. For purposes of this section only, a "medical institution" means a skilled nursing facility, intermediate care facility, intermediate care facility for persons with mental retardation, nursing facility, or inpatient hospital; or

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

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

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

Subd. 2. [LIMITATIONS ON CLAIMS.] The claim shall include only the total amount of medical assistance rendered after age

55 or during a period of institutionalization described in subdivision 1a, clause (b), and the total amount of general assistance medical care rendered, and shall not include interest. Claims that have been allowed but not paid shall bear interest according to section 524.3-806, paragraph (d). A claim against the estate of a surviving spouse who did not receive medical assistance, for medical assistance rendered for the predeceased spouse, is limited to the value of the assets of the estate that were marital property or jointly owned property at any time during the marriage. ~~Claims for alternative care shall be net of all premiums paid under section 256B.0913, subdivision 12, on or after July 1, 2003, and shall be limited to services provided on or after July 1, 2003.~~

[EFFECTIVE DATE.] This section is effective retroactively from July 1, 2003, for decedents dying on or after that date.

Sec. 20. Minnesota Statutes 2004, section 256B.431, is amended by adding a subdivision to read:

Subd. 41. [NURSING FACILITY RATE INCREASES FOR SEPTEMBER 1, 2005, AND JULY 1, 2006.] (a) For the rate period beginning September 1, 2005, and the rate year beginning July 1, 2006, the commissioner shall make available to each nursing facility reimbursed under this section or section 256B.434 an adjustment equal to two percent of the total operating payment rate.

(b) Money resulting from the rate adjustment under paragraph (a) must be used to increase wages and benefits and pay associated costs for employees, except management fees, the administrator, and central office staff. Except as provided in paragraph (c), money received by a facility as a result of the rate adjustment provided in paragraph (a) must be used only for wage, benefit, and staff increases implemented on or after the effective date of the rate increase each year, and must not be used for increases implemented prior to that date.

(c) With respect only to the September 1, 2005, rate increase, a hospital-attached nursing facility that incurred costs for salary and employee benefit increases first provided after July 1, 2003, may count those costs towards the amount

required to be spent on salaries and benefits under paragraph (b). These costs must be reported to the commissioner in the form and manner specified by the commissioner.

(d) Nursing facilities may apply for the rate adjustment under paragraph (a). The application must be made to the commissioner and contain a plan by which the nursing facility will distribute the funds according to paragraph (b). For nursing facilities in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative constitutes the plan. A negotiated agreement may constitute the plan only if the agreement is finalized after the date of enactment of all increases for the rate year and signed by both parties prior to submission to the commissioner. The commissioner shall review the plan to ensure that the rate adjustments are used as provided in paragraph (b). To be eligible, a facility must submit its distribution plan by December 31 each year. If a facility's distribution plan is effective after the first day of the applicable rate period that the funds are available, the rate adjustments are effective the same date as the facility's plan.

(e) A copy of the approved distribution plan must be made available to all employees by giving each employee a copy or by posting a copy in an area of the nursing facility to which all employees have access. If an employee does not receive the wage and benefit adjustment described in the facility's approved plan and is unable to resolve the problem with the facility's management or through the employee's union representative, the employee may contact the commissioner at an address or telephone number provided by the commissioner and included in the approved plan.

Sec. 21. Minnesota Statutes 2004, section 256B.431, is amended by adding a subdivision to read:

Subd. 42. [SINGLE-BED ROOM PAYMENT RATE.] (a) Beginning July 1, 2005, the operating payment rate for nursing facilities reimbursed under this section or section 256B.434 shall be

increased by five percent multiplied by the ratio of the number of new single-bed rooms created divided by the number of active beds on July 1, 2005, for each bed closure that results in the creation of a single-bed room after July 1, 2005.

(b) A nursing facility is prohibited from discharging residents for purposes of establishing single-bed rooms. A nursing facility must retain a statement from any resident discharged to another nursing facility between July 1, 2005, and December 31, 2007, signed by the resident or the resident's designated responsible party, certifying the resident requests to move and is under no coercion to be discharged. This signed statement must be witnessed and signed by the local ombudsman. The commissioner shall assess a monetary penalty of $5,000 per occurrence against any nursing facility determined to have discharged a resident for purposes of establishing single-bed rooms.

(c) If after the date of enactment of this section and before December 31, 2007, more than 4,000 nursing home beds are removed from service, a portion of the appropriation for nursing homes shall be transferred to the alternative care program. The amount of this transfer shall equal the number of beds removed from service less 4,000, multiplied by the average monthly per-person cost for alternative care, multiplied by 12, and further multiplied by .3.

(d) Savings that result from bed closures on or after July 1, 2005, that do not result in the establishment of single-bed rooms and exceed the number of closures included in the February 2005 forecast shall not cancel to the general fund but are appropriated to the commissioner for the medical assistance costs of nursing home moratorium exceptions approved by the commissioner of health under section 144A.073. The commissioner of health, in consultation with the commissioner of human services, shall publish a request for proposals under section 144A.073, subdivision 2, when, in the determination of the commissioner of health, sufficient funds are available under this paragraph. Money appropriated to the commissioner of human

services under this paragraph shall not cancel and shall be available until expended.

(e) For the rate year beginning July 1, 2005, the amount nursing facilities receive for medically necessary single-bed rooms under Minnesota Rules, part 9549.0070, subpart 3, shall be up to 114.365 percent of the established total payment rate for the resident. For the rate year beginning July 1, 2006, the amount nursing facilities receive for medically necessary single-bed rooms under Minnesota Rules, part 9549.0070, subpart 3, shall be up to 114.75 percent of the established total payment rate for the resident. For the rate years beginning on or after July 1, 2007, the single-bed payment rate shall be up to 115 percent of the established total payment rate for the resident.

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

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

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

(c) A nursing facility's case mix payment rates for the second and subsequent years of a facility's contract under this section are the previous rate year's contract payment rates plus an inflation adjustment and, for facilities reimbursed under this section or section 256B.431, an adjustment to include the cost of any increase in Health Department licensing fees for the facility taking effect on or after July 1, 2001. The index for the inflation adjustment must be based on the change in the Consumer Price Index-All Items (United States City average) (CPI-U) forecasted by the commissioner of finance's national

economic consultant, as forecasted in the fourth quarter of the calendar year preceding the rate year. The inflation adjustment must be based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined. For the rate years beginning on July 1, 1999, July 1, 2000, July 1, 2001, July 1, 2002, July 1, 2003, ~~and~~ July 1, 2004, July 1, 2005, and July 1, 2006, this paragraph shall apply only to the property-related payment rate, except that adjustments to include the cost of any increase in Health Department licensing fees taking effect on or after July 1, 2001, shall be provided. In determining the amount of the property-related payment rate adjustment under this paragraph, the commissioner shall determine the proportion of the facility's rates that are property-related based on the facility's most recent cost report.

(d) The commissioner shall develop additional incentive-based payments of up to five percent above the standard contract rate for achieving outcomes specified in each contract. The specified facility-specific outcomes must be measurable and approved by the commissioner. The commissioner may establish, for each contract, various levels of achievement within an outcome. After the outcomes have been specified the commissioner shall assign various levels of payment associated with achieving the outcome. Any incentive-based payment cancels if there is a termination of the contract. In establishing the specified outcomes and related criteria the commissioner shall consider the following state policy objectives:

(1) improved cost effectiveness and quality of life as measured by improved clinical outcomes;

(2) successful diversion or discharge to community alternatives;

(3) decreased acute care costs;

(4) improved consumer satisfaction;

(5) the achievement of quality; or

(6) any additional outcomes proposed by a nursing facility that the commissioner finds desirable.

Sec. 23. Minnesota Statutes 2004, section 256B.434, is amended by adding a subdivision to read:

Subd. 4f. [RATE INCREASE EFFECTIVE JULY 1, 2005.] For the rate year beginning July 1, 2005, a facility in Ramsey County licensed for 180 beds shall have its operating payment rate as determined under this section and in effect on June 30, 2005, increased by $2.49. The increase under this subdivision shall be included in the facility's total payment rates for the purposes of determining future rates under this section or any other section.

Sec. 24. Minnesota Statutes 2004, section 256B.440, is amended by adding a subdivision to read:

Sub. 4. [CONTINUED SYSTEM DEVELOPMENT.] (a) The commissioner shall continue developmental work on a new nursing home reimbursement system and present recommendations for a new system to the legislature by January 15, 2006. The new system shall comply with subdivisions 1 and 2.

(b) Nursing facilities shall continue to file, and the commissioner shall continue to collect and audit, annual cost reports under the conditions specified in subdivision 3.

(c) Notwithstanding any contrary provisions of chapter 16C, the commissioner may, within the limits of appropriations specifically available for this purpose, extend contracts previously negotiated for consulting work on development of the new reimbursement system.

Sec. 25. Minnesota Statutes 2004, section 256B.5012, is amended by adding a subdivision to read:

Subd. 6. [ICF/MR RATE INCREASES BEGINNING SEPTEMBER 1, 2005, AND JULY 1, 2006.] (a) For the rate periods beginning September 1, 2005, and July 1, 2006, the commissioner shall make available to each facility reimbursed under this section an adjustment to the total operating payment rate of two percent.

(b) Money resulting from the rate adjustment under paragraph (a) must be used to increase wages and benefits and pay associated costs for employees, except for administrative and central office employees. Money received by a facility as a

result of the rate adjustment provided in paragraph (a) must be used only for wage, benefit, and staff increases implemented on or after the effective date of the rate increase each year, and must not be used for increases implemented prior to that date.

(c) For each facility, the commissioner shall make available an adjustment using the percentage specified in paragraph (a) multiplied by the total payment rate, excluding the property-related payment rate, in effect on the preceding day. The total payment rate shall include the adjustment provided in section 256B.501, subdivision 12.

(d) A facility whose payment rates are governed by closure agreements, receivership agreements, or Minnesota Rules, part 9553.0075, is not eligible for an adjustment otherwise granted under this subdivision.

(e) A facility may apply for the payment rate adjustment provided under paragraph (a). The application must be made to the commissioner and contain a plan by which the facility will distribute the funds according to paragraph (b). For facilities in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative constitutes the plan. A negotiated agreement may constitute the plan only if the agreement is finalized after the date of enactment of all rate increases for the rate year. The commissioner shall review the plan to ensure that the payment rate adjustment per diem is used as provided in this subdivision. To be eligible, a facility must submit its plan by December 31 each year. If a facility's plan is effective for its employees after the first day of the applicable rate period that the funds are available, the payment rate adjustment per diem is effective the same date as its plan.

(f) A copy of the approved distribution plan must be made available to all employees by giving each employee a copy or by posting it in an area of the facility to which all employees have access. If an employee does not receive the wage and benefit adjustment described in the facility's approved plan and

is unable to resolve the problem with the facility's management or through the employee's union representative, the employee may contact the commissioner at an address or telephone number provided by the commissioner and included in the approved plan.

Sec. 26. Minnesota Statutes 2004, section 256B.69, subdivision 23, is amended to read:

Subd. 23. [ALTERNATIVE INTEGRATED LONG-TERM CARE SERVICES; ELDERLY AND DISABLED PERSONS.] (a) The commissioner may implement demonstration projects to create alternative integrated delivery systems for acute and long-term care services to elderly persons and persons with disabilities as defined in section 256B.77, subdivision 7a, that provide increased coordination, improve access to quality services, and mitigate future cost increases. The commissioner may seek federal authority to combine Medicare and Medicaid capitation payments for the purpose of such demonstrations. Medicare funds and services shall be administered according to the terms and conditions of the federal waiver and demonstration provisions. For the purpose of administering medical assistance funds, demonstrations under this subdivision are subject to subdivisions 1 to 22. The provisions of Minnesota Rules, parts 9500.1450 to 9500.1464, apply to these demonstrations, with the exceptions of parts 9500.1452, subpart 2, item B; and 9500.1457, subpart 1, items B and C, which do not apply to persons enrolling in demonstrations under this section. An initial open enrollment period may be provided. Persons who disenroll from demonstrations under this subdivision remain subject to Minnesota Rules, parts 9500.1450 to 9500.1464. When a person is enrolled in a health plan under these demonstrations and the health plan's participation is subsequently terminated for any reason, the person shall be provided an opportunity to select a new health plan and shall have the right to change health plans within the first 60 days of enrollment in the second health plan. Persons required to participate in health plans under this section who fail to make a choice of health plan shall not be randomly assigned to health plans under these demonstrations.

Notwithstanding section 256L.12, subdivision 5, and Minnesota Rules, part 9505.5220, subpart 1, item A, if adopted, for the purpose of demonstrations under this subdivision, the commissioner may contract with managed care organizations, including counties, to serve only elderly persons eligible for medical assistance, elderly and disabled persons, or disabled persons only. For persons with primary diagnoses of mental retardation or a related condition, serious and persistent mental illness, or serious emotional disturbance, the commissioner must ensure that the county authority has approved the demonstration and contracting design. Enrollment in these projects for persons with disabilities shall be voluntary. The commissioner shall not implement any demonstration project under this subdivision for persons with primary diagnoses of mental retardation or a related condition, serious and persistent mental illness, or serious emotional disturbance, without approval of the county board of the county in which the demonstration is being implemented.

(b) Notwithstanding chapter 245B, sections 252.40 to 252.46, 256B.092, 256B.501 to 256B.5015, and Minnesota Rules, parts 9525.0004 to 9525.0036, 9525.1200 to 9525.1330, 9525.1580, and 9525.1800 to 9525.1930, the commissioner may implement under this section projects for persons with developmental disabilities. The commissioner may capitate payments for ICF/MR services, waivered services for mental retardation or related conditions, including case management services, day training and habilitation and alternative active treatment services, and other services as approved by the state and by the federal government. Case management and active treatment must be individualized and developed in accordance with a person-centered plan. Costs under these projects may not exceed costs that would have been incurred under fee-for-service. Beginning July 1, 2003, and until two years after the pilot project implementation date, subcontractor participation in the long-term care developmental disability pilot is limited to a nonprofit long-term care system providing ICF/MR services, home

and community-based waiver services, and in-home services to no more than 120 consumers with developmental disabilities in Carver, Hennepin, and Scott Counties. The commissioner shall report to the legislature prior to expansion of the developmental disability pilot project. This paragraph expires two years after the implementation date of the pilot project.

(c) Before implementation of a demonstration project for disabled persons, the commissioner must provide information to appropriate committees of the house of representatives and senate and must involve representatives of affected disability groups in the design of the demonstration projects.

(d) A nursing facility reimbursed under the alternative reimbursement methodology in section 256B.434 may, in collaboration with a hospital, clinic, or other health care entity provide services under paragraph (a). The commissioner shall amend the state plan and seek any federal waivers necessary to implement this paragraph.

(e) Notwithstanding section 256B.0621, health plans providing services under this section are responsible for home care targeted case management and relocation targeted case management. Services must be provided according to the terms of the waivers and contracts approved by the federal government.

Sec. 27. [501B.895] [PUBLIC HEALTH CARE PROGRAMS AND CERTAIN TRUSTS.]

(a) It is the public policy of this state that individuals use all available resources to pay for the cost of long-term care services, as defined in section 256B.0595, before turning to Minnesota health care program funds, and that trust instruments should not be permitted to shield available resources of an individual or an individual's spouse from such use. Any irrevocable inter-vivos trust or any legal instrument, device, or arrangement similar to an irrevocable inter-vivos trust created on or after July 1, 2005, containing assets or income of an individual or an individual's spouse, including those created by a person, court, or administrative body with legal authority to act in place of, at the direction of, upon

the request of, or on behalf of the individual or individual's spouse, becomes revocable by operation of law for the sole purpose of a state or local human services agency determination on an application by the individual or the individual's spouse for payment of long-term care services through a Minnesota public health care program under chapter 256. For purposes of this section, any inter-vivos trust and any legal instrument, device, or arrangement similar to an inter-vivos trust:

(1) shall be deemed to be located in and subject to the laws of this state; and

(2) is created as of the date it is fully executed by or on behalf of all of the settlors or others.

(b) For purposes of this section, a legal instrument, device, or arrangement similar to an irrevocable inter-vivos trust means any instrument, device, or arrangement which involves a grantor who transfers or whose property is transferred by another including, but not limited to, any court, administrative body, or anyone else with authority to act on their behalf or at their direction, to an individual or entity with fiduciary, contractual, or legal obligations to the grantor or others to be held, managed, or administered by the individual or entity for the benefit of the grantor or others. These legal instruments, devices, or other arrangements are irrevocable inter-vivos trusts for purposes of this section.

(c) In the event of a conflict between this section and the provisions of an irrevocable trust created on or after July 1, 2005, this section shall control.

(d) This section does not apply to trusts that qualify as supplemental needs trusts under section 501B.89 or to trusts meeting the criteria of United States Code, title 42, section 1396p (d)(4)(a) and (c) for purposes of eligibility for medical assistance.

(e) This section applies to all trusts first created on or after July 1, 2005, and to all interests in real or personal property regardless of the date on which the interest was created, reserved, or acquired.

Sec. 28. Minnesota Statutes 2004, section 514.981, subdivision 6, is amended to read:

Subd. 6. [TIME LIMITS; CLAIM LIMITS; LIENS ON LIFE ESTATES AND JOINT TENANCIES.] (a) A medical assistance lien is a lien on the real property it describes for a period of ten years from the date it attaches according to section 514.981, subdivision 2, paragraph (a), except as otherwise provided for in sections 514.980 to 514.985. The agency may renew a medical assistance lien for an additional ten years from the date it would otherwise expire by recording or filing a certificate of renewal before the lien expires. The certificate shall be recorded or filed in the office of the county recorder or registrar of titles for the county in which the lien is recorded or filed. The certificate must refer to the recording or filing data for the medical assistance lien it renews. The certificate need not be attested, certified, or acknowledged as a condition for recording or filing. The registrar of titles or the recorder shall file, record, index, and return the certificate of renewal in the same manner as provided for medical assistance liens in section 514.982, subdivision 2.

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

(c) Notwithstanding any law or rule to the contrary, the provisions in clauses (1) to (7) apply if a life estate subject

to a medical assistance lien ends according to its terms, or if a medical assistance recipient who owns a life estate or any interest in real property as a joint tenant that is subject to a medical assistance lien dies.

(1) The medical assistance recipient's life estate or joint tenancy interest in the real property shall not end upon the recipient's death but shall merge into the remainder interest or other interest in real property the medical assistance recipient owned in joint tenancy with others. The medical assistance lien shall attach to and run with the remainder or other interest in the real property to the extent of the medical assistance recipient's interest in the property at the time of the recipient's death as determined under this section.

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

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

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

(5) Subdivision 5, paragraph (a), clause (4), paragraph (b), clauses (1) and (2); and subdivision 6, paragraph (b), do not apply to medical assistance liens which attach to interests in real property as provided under this subdivision.

(6) The continuation of a medical assistance recipient's life estate or joint tenancy interest in real property after the medical assistance recipient's death for the purpose of recovering medical assistance provided for in sections 514.980 to 514.985 modifies common law principles holding that these interests terminate on the death of the holder.

(7) Notwithstanding any law or rule to the contrary, no release, satisfaction, discharge, or affidavit under section 256B.15 shall extinguish or terminate the life estate or joint tenancy interest of a medical assistance recipient subject to a lien under sections 514.980 to 514.985 on the date the recipient dies.

(8) The provisions of clauses (1) to (7) do not apply to a homestead owned of record, on the date the recipient dies, by the recipient and the recipient's spouse as joint tenants with a right of survivorship. Homestead means the real property occupied by the surviving joint tenant spouse as their sole residence on the date the recipient dies and classified and taxed to the recipient and surviving joint tenant spouse as homestead property for property tax purposes in the calendar year in which the recipient dies. For purposes of this exemption, real property the recipient and their surviving joint tenant spouse purchase solely with the proceeds from the sale of their prior homestead, own of record as joint tenants, and qualify as homestead property under section 273.124 in the calendar year in which the recipient dies and prior to the recipient's death shall be deemed to be real property classified and taxed to the recipient and their surviving joint tenant spouse as homestead property in the calendar year in which the recipient dies. The surviving spouse, or any person with personal knowledge of the facts, may provide an affidavit describing the homestead property affected by this clause and stating facts showing compliance with this clause. The affidavit shall be prima facie evidence of the facts it states.

(d) The commissioner shall release liens arising under notices of potential claims under section 256B.15 and medical

assistance liens under sections 514.980 to 514.985, against life estates and jointly owned interests a remainderman or surviving tenant has in farm and income-producing property the deceased recipient owned of record on the date of the recipient's death under the following conditions:

(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:

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

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

(iii) all of the land is classified and taxed as class 2a agricultural land under section 273.13, subdivision 23, paragraph (a), for property tax purposes; and

(2) the income-producing 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:

(i) no part of the property is classified or taxed as homestead property for property tax purposes, provided that if the property is classified and taxed as both homestead and nonhomestead property, the portion of the property classified and taxed as nonhomestead property shall be considered to satisfy this requirement;

(ii) all of the property is classified and taxed as class 1c property under section 273.13, subdivision 22, paragraph (c), except that part of the class 1c property that is a dwelling occupied as a homestead; class 3a or 3b commercial or industrial property under section 273.13, subdivision 24; or as class 4a or 4c property classified under section 273.13, subdivision 25,

paragraphs (a) and (d), for property tax purposes; and

(iii) the business, profession, or occupation in which the real property is used is the primary business, profession, or occupation of the remainderman or surviving joint tenant and the real property is used solely for that business, profession, or occupation. A primary business, profession, or occupation is one the ongoing operation of which provides at least 65 percent of a person's gross income for federal income tax purposes for the calendar year.

[EFFECTIVE DATE.] This section is effective July 1, 2005, and applies to the estates of decedents who die on or after that date.

Sec. 29. Minnesota Statutes 2004, section 524.3-805, is amended to read:

524.3-805 [CLASSIFICATION OF CLAIMS.]

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

(1) costs and expenses of administration;

(2) reasonable funeral expenses;

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

(4) reasonable and necessary medical, hospital, or nursing home expenses of the last illness of the decedent, including compensation of persons attending the decedent, ~~a claim filed under section 256B.15 for recovery of expenditures for alternative care for nonmedical assistance recipients under section 256B.0913,~~ and including a claim filed pursuant to section 256B.15;

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

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

(7) all other claims.

(b) No preference shall be given in the payment of any claim over any other claim of the same class, and a claim due

and payable shall not be entitled to a preference over claims not due, except that if claims for expenses of the last illness involve only claims filed under section ~~256B.15 for recovery of expenditures for alternative care for nonmedical assistance recipients under section 256B.0913,~~ section 246.53 for costs of state hospital care and claims filed under section 256B.15, ~~claims filed to recover expenditures for alternative care for nonmedical assistance recipients under section 256B.0913 shall have preference over claims filed under both sections 246.53 and other claims filed under section 256B.15, and.~~ Claims filed under section 246.53 have preference over claims filed under section 256B.15 ~~for recovery of amounts other than those for expenditures for alternative care for nonmedical assistance recipients under section 256B.0913~~.

[EFFECTIVE DATE.] This section is effective retroactively from July 1, 2003, for decedents dying on or after that date.

Sec. 30. [COMMUNITY SERVICES PROVIDER RATE INCREASES.]

(a) The commissioner of human services shall increase reimbursement rates by two percent for the rate period beginning September 1, 2005, and the rate year beginning July 1, 2006, effective for services rendered on or after those dates.

(b) The two percent annual rate increase described in this section must be provided to:

(1) home and community-based waivered services for persons with mental retardation or related conditions under Minnesota Statutes, section 256B.501;

(2) home and community-based waivered services for the elderly under Minnesota Statutes, section 256B.0915;

(3) waivered services under community alternatives for disabled individuals under Minnesota Statutes, section 256B.49;

(4) community alternative care waivered services under Minnesota Statutes, section 256B.49;

(5) traumatic brain injury waivered services under Minnesota Statutes, section 256B.49;

(6) nursing services and home health services under Minnesota Statutes, section 256B.0625, subdivision 6a;

(7) personal care services and nursing supervision of personal care services under Minnesota Statutes, section 256B.0625, subdivision 19a;

(8) private duty nursing services under Minnesota Statutes, section 256B.0625, subdivision 7;

(9) day training and habilitation services for adults with mental retardation or related conditions under Minnesota Statutes, sections 252.40 to 252.46;

(10) alternative care services under Minnesota Statutes, section 256B.0913;

(11) adult residential program grants under Minnesota Rules, parts 9535.2000 to 9535.3000;

(12) adult and family community support grants under Minnesota Rules, parts 9535.1700 to 9535.1760;

(13) the group residential housing supplementary service rate under Minnesota Statutes, section 256I.05, subdivision 1a;

(14) adult mental health integrated fund grants under Minnesota Statutes, section 245.4661;

(15) semi-independent living services under Minnesota Statutes, section 252.275, including SILS funding under county social services grants formerly funded under Minnesota Statutes, chapter 256I;

(16) community support services for deaf and hard-of-hearing adults with mental illness who use or wish to use sign language as their primary means of communication; and

(17) living skills training programs for persons with intractable epilepsy who need assistance in the transition to independent living.

(c) Providers that receive a rate increase under this section shall use the additional revenue to increase wages and benefits and pay associated costs for employees, except for management fees, the administrator, and central office staffs.

(d) For public employees, the increase for wages and benefits for certain staff is available and pay rates shall be increased only to the extent that they comply with laws governing public employees collective bargaining. Money

received by a provider for pay increases under this section may be used only for increases implemented on or after the first day of the rate period in which the increase is available and must not be used for increases implemented prior to that date.

(e) A copy of the provider's plan for complying with paragraph (c) must be made available to all employees by giving each employee a copy or by posting a copy in an area of the provider's operation to which all employees have access. If an employee does not receive the adjustment, if any, described in the plan and is unable to resolve the problem with the provider, the employee may contact the employee's union representative. If the employee is not covered by a collective bargaining agreement, the employee may contact the commissioner at a telephone number provided by the commissioner and included in the provider's plan.

Sec. 31. [CONSUMER-DIRECTED COMMUNITY SUPPORTS METHODOLOGY.]

For persons using the home and community-based waiver for persons with developmental disabilities whose Consumer-Directed Community Supports budgets were reduced by the October 2004, state-set budget methodology, the commissioner of human services must allow exceptions to exceed the state-set budget formula up to the daily average cost during calendar year 2004 or for persons who graduated from school during 2004, the average daily cost during July through December 2004, less one-half of case management and home modifications over $5,000 when the individual's county of financial responsibility determines that:

(1) necessary alternative services will cost the same or more than the person's current budget; and

(2) administrative expenses or provider rates will result in less hours of needed staffing for the person than under the Consumer-Directed Community Supports option. Any exceptions the county grants must be within the county's allowable aggregate amount for the home and community-based waiver for persons with developmental disabilities.

Sec. 32. [COSTS ASSOCIATED WITH PHYSICAL ACTIVITIES.]

The expenses allowed for adults under the Consumer-Directed Community Supports option shall include costs at the lowest rate available, considering daily, monthly, semiannual, annual, or membership rates, including transportation, associated with physical exercise or other physical activities to maintain or improve the person's health and functioning.

Sec. 33. [WAIVER AMENDMENT.]

The commissioner of human services shall submit an amendment to the Centers for Medicare and Medicaid Services consistent with sections 29 and 30 by August 1, 2005.

Sec. 34. [INDEPENDENT EVALUATION AND REVIEW OF UNALLOWABLE ITEMS.]

The commissioner of human services shall include in the independent evaluation of the Consumer-Directed Community Supports option provided through the home and community-based services waivers for persons with disabilities under 65 years of age:

(1) provision for ongoing, regular participation by stakeholder representatives through June 30, 2007;

(2) recommendations on whether changes to the unallowable items should be made to meet the health, safety, or welfare needs of participants in the Consumer-Directed Community Supports option within the allowed budget amounts. The recommendations on allowable items shall be provided to the senate and house of representatives committees with jurisdiction over human services policy and finance issues by January 15, 2006; and

(3) a review of the statewide caseload changes for the disability waiver programs for persons under 65 years of age that occurred since the state-set budget methodology implementation on October 1, 2004, and recommendations on the fiscal impact of the budget methodology on use of the Consumer-Directed Community Supports option.

Sec. 35. [IMMUNITY; REFUNDS BARRED.]

(a) The commissioner of human services, county agencies, and elected officials and their employees are immune from all

liability for any action taken implementing those portions of Laws 2003, First Special Session chapter 14, that extend medical assistance lien policies to include the alternative care program, as those laws existed at the time the action was taken.

(b) The legislature expressly intends that none of the recoveries of alternative care payments the state or a local agency made under Minnesota Statutes, sections 514.991 to 514.995, as they existed prior to the effective date of this amendment, shall be refunded or repaid.

[EFFECTIVE DATE.] This section is effective retroactively from August 1, 2003.

Sec. 36. [EXPIRATION DATE.]

Section 31 shall expire on the date the commissioner of human services implements a new consumer-directed community supports budget methodology that is based on reliable and accurate information about the services and supports intensity needs of persons using the option and that adequately accounts for the increased costs of adults who graduate from school and need services funded by the waiver during the day.

Sec. 37. [REPEALER.]

Minnesota Statutes 2004, sections 514.991; 514.992; 514.993; 514.994; and 514.995, are repealed retroactively from July 1, 2003.

Sec. 38. [EFFECTIVE DATE.]

Sections 31 and 32 are effective upon federal approval of the waiver amendment in section 33. Sections 33 and 34 are effective the day following final enactment.

ARTICLE 5

MENTAL AND CHEMICAL HEALTH

Section 1. Minnesota Statutes 2004, section 62J.692, subdivision 3, is amended to read:

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

(1) is funded, in part, by patient care revenues;

(2) occurs in patient care settings that face increased financial pressure as a result of competition with nonteaching patient care entities; and

(3) emphasizes primary care or specialties that are in undersupply in Minnesota.

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

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

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

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

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

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

those training sites that host 0.5 FTE or more eligible trainees for a program may be included in the program's application; and

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

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

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

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

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

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

Sec. 2. Minnesota Statutes 2004, section 244.054, is amended to read:

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

Subdivision 1. [OFFER TO DEVELOP PLAN.] The commissioner of human services, in collaboration with the commissioner of corrections, shall offer to develop a discharge plan for community-based services for every offender with serious and persistent mental illness, as defined in section 245.462, subdivision 20, paragraph (c), and every offender who has had a diagnosis of mental illness and would otherwise be eligible for case management services under section 245.462, subdivision 20, paragraph (c), but for the requirement that the offender be

hospitalized or in residential treatment, who is being released from a correctional facility. If an offender is being released pursuant to section 244.05, the offender may choose to have the discharge plan made one of the conditions of the offender's supervised release and shall follow the conditions to the extent that services are available and offered to the offender.

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:

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

(2) at least 75 days before the offender is due to be discharged, the offender's ~~designated agent~~ discharge planner 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 community where the offender expects to reside following discharge, and inform the department of the offender's impending discharge and the planned date of the offender's return to the community; determine whether the county or a designated contracted provider will provide case management services to the offender; refer the offender to the case management services provider; and confirm that the case management services provider will have opened the offender's case prior to the offender's discharge; and

(iii) ~~refer the offender to appropriate staff in the county human services department in the community where the offender expects to reside following discharge, for enrollment of the offender if eligible in medical assistance or general assistance medical care, using special procedures established by process~~

~~and Department of Human Services bulletin~~ assist the offender in filling out an application for medical assistance, general assistance medical care, or MinnesotaCare and submit the application for eligibility determination to the commissioner. The commissioner shall determine an offender's eligibility no more than 45 days, or no more than 60 days if the offender's disability status must be determined, from the date that the application is received by the department. The effective date of eligibility for the health care program shall be no earlier than the date of the offender's release. If eligibility is approved, the commissioner shall mail a Minnesota health care program membership card to the facility in which the offender resides and transfer the offender's case to MinnesotaCare operations within the department or the appropriate county human services agency in the county where the offender expects to reside following release for ongoing case management;

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

(4) at least 30 days before discharge, the offender's ~~designated agent~~ discharge planner shall convene a predischarge assessment and planning meeting of key staff from the programs in which the offender has participated while in the correctional facility, the offender, the supervising agent, and the mental health case management services provider assigned to the offender. At the meeting, attendees shall provide background information and continuing care recommendations for the offender, including information on the offender's risk for relapse; current medications, including dosage and frequency; therapy and behavioral goals; diagnostic and assessment information, including results of a chemical dependency evaluation; confirmation of appointments with a psychiatrist and other program staff in the community; a relapse prevention plan;

continuing care needs; needs for housing, employment, and finance support and assistance; and recommendations for successful community integration, including chemical dependency treatment or support if chemical dependency is a risk factor. Immediately following this meeting, the offender's ~~designated agent~~ discharge planner shall summarize this background information and continuing care recommendations in a written 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;

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

(7) upon discharge, the offender's ~~designated agent~~ discharge planner shall ensure that the offender leaves the correctional facility with at least a ten-day supply of all 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~~ 60-day supply of all necessary medications, and must be able to be refilled once for one additional 30-day supply.

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

Sec. 3. Minnesota Statutes 2004, section 245.4885, subdivision 1, is amended to read:

Subdivision 1. [~~SCREENING-REQUIRED~~ ADMISSION CRITERIA.] The county board shall, prior to admission, except in the case of emergency admission, ~~screen~~ determine the needed level of care for all children referred for treatment of severe emotional disturbance ~~to~~ in a treatment foster care setting, residential treatment facility, or informally admitted to a regional treatment center if public funds are used to pay for the services. The county board shall also ~~screen~~ determine the needed level of care for all children admitted to an acute care hospital for treatment of severe emotional disturbance if public funds other than reimbursement under chapters 256B and 256D are used to pay for the services. ~~If-a-child-is-admitted-to-a residential-treatment-facility-or-acute-care-hospital-for emergency-treatment-or-held-for-emergency-care-by-a-regional treatment-center-under-section-253B.05,-subdivision-1,-screening must-occur-within-three-working-days-of-admission.~~ ~~Screening~~ The level of care determination shall determine whether the proposed treatment:

(1) is necessary;

(2) is appropriate to the child's individual treatment needs;

(3) cannot be effectively provided in the child's home; and

(4) provides a length of stay as short as possible consistent with the individual child's need.

When a ~~screening~~ level of care determination is conducted, the county board may not determine that referral or admission to a treatment foster care setting, residential treatment facility, or acute care hospital is not appropriate solely because services were not first provided to the child in a less restrictive setting and the child failed to make progress toward or meet treatment goals in the less restrictive setting. ~~Screening-shall-include-both~~ The level of care determination must be based on a diagnostic assessment ~~and~~ that includes a functional assessment which evaluates family, school,

and community living situations; and an assessment of the child's need for care out of the home using a validated tool which assesses a child's functional status and assigns an appropriate level of care. The validated tool must be approved by the commissioner of human services. If a diagnostic assessment ~~or~~ including a functional assessment has been completed by a mental health professional within the past 180 days, a new diagnostic ~~or functional~~ assessment need not be completed unless in the opinion of the current treating mental health professional the child's mental health status has changed markedly since the assessment was completed. The child's parent shall be notified if an assessment will not be completed and of the reasons. A copy of the notice shall be placed in the child's file. Recommendations developed as part of the ~~screening~~ level of care determination process shall include specific community services needed by the child and, if appropriate, the child's family, and shall indicate whether or not these services are available and accessible to the child and family.

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

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

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

An alternate review process may be approved by the commissioner if the county board demonstrates that an alternate review process has been established by the county board and the times of review, persons responsible for the review, and review

criteria are comparable to the standards in clauses (1) to (4).

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

Sec. 4. Minnesota Statutes 2004, section 245.4885, is amended by adding a subdivision to read:

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

Sec. 5. Minnesota Statutes 2004, section 245.4885, subdivision 2, is amended to read:

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

~~(1) mental health professionals or mental health practitioners are unavailable to provide this service; and~~

~~(2) services are provided by a designated person with training in human services who receives clinical supervision from a mental health professional.~~

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

Sec. 6. Minnesota Statutes 2004, section 245.4661, is amended by adding a subdivision to read:

Subd. 8. [SUPPORTIVE HOUSING AND OTHER COMMUNITY SERVICES

FOR INDIVIDUALS TRANSITIONING FROM ANOKA-METRO REGIONAL TREATMENT CENTER.] The commissioner, through agreements with counties and in consultation with providers of supportive housing with services and others, shall transition individuals who are currently at Anoka-Metro Regional Treatment Center into the community, who are ready to be discharged or who are at imminent risk of admission. The commissioner shall expand the adult mental health initiative pilot projects under section 245.4661 to provide appropriate, thorough, flexible, and sufficient services that may include supportive housing with services, assertive community treatment, case management, and other community supports for individuals with a mental illness who:

(1) are at imminent risk of being admitted to, or are ready to be discharged or have recently been discharged from, a regional treatment center, community hospital, or residential treatment program; and

(2) have no appropriate housing available or lack the resources necessary to access permanent housing.

Sec. 7. Minnesota Statutes 2004, section 245.4661, is amended by adding a subdivision to read:

Subd. 9. [BED CLOSING.] The commissioner shall close 25 beds at the Anoka-Metro Regional Treatment Center by January 1, 2007, and an additional 25 beds by January 1, 2008, or after sufficient alternative services have been developed. The commissioner shall transfer state savings resulting from these bed closures into appropriate accounts in accordance with subdivision 10 to pay for the ongoing provision of the alternative services in subdivision 8 and for expansion of contract beds under section 256.9693. No individual will be involuntarily discharged under this subdivision if appropriate community services are not available to support the individual.

Sec. 8. Minnesota Statutes 2004, section 245.4661, is amended by adding a subdivision to read:

Subd. 10. [BUDGET FLEXIBILITY.] The commissioner may make budget transfers that do not increase the state share of costs

to effectively implement the restructuring of adult mental health services.

Sec. 9. Minnesota Statutes 2004, section 245.4661, is amended by adding a subdivision to read:

Subd. 11. [COUNTY ELIGIBILITY.] The commissioner may approve funding for services under subdivision 8 in accordance with subdivisions 9 and 10 for a county or group of counties that:

(1) agrees to outcome-based performance criteria that includes a reduction in utilization of regional treatment center inpatient services through provision of quality services that meet individual needs;

(2) agrees to the collection and submission of data necessary to measure progress towards the criteria in clause (1) and measurement of any resulting state or county savings;

(3) agrees to reinvest in the services defined in subdivision 8 an amount equal to the ten percent county share of regional treatment center services for the fiscal year ending June 30, 2004, applied against the bed utilization reduction in clause (1); and

(4) agrees to develop a supportive housing program that insures the delivery of employment services, supportive services, housing and health care for eligible individuals, or agrees to contract with an existing integrated program.

Sec. 10. Minnesota Statutes 2004, section 254B.03, subdivision 4, is amended to read:

Subd. 4. [DIVISION OF COSTS.] Except for services provided by a county under section 254B.09, subdivision 1, or services provided under section 256B.69 or 256D.03, subdivision 4, paragraph (b), or when the primary drug problem is amphetamine or methamphetamine abuse or dependence, the county shall, out of local money, pay the state for 15 percent of the cost of chemical dependency services, including those services provided to persons eligible for medical assistance under chapter 256B and general assistance medical care under chapter 256D. Counties may use the indigent hospitalization levy for treatment

and hospital payments made under this section. Fifteen percent of any state collections from private or third-party pay, less 15 percent of the cost of payment and collections, must be distributed to the county that paid for a portion of the treatment under this section. If all funds allocated according to section 254B.02 are exhausted by a county and, except for treatment provided for amphetamine or methamphetamine abuse or dependence, the county has met or exceeded the base level of expenditures under section 254B.02, subdivision 3, the county shall pay the state for 15 percent of the costs paid by the state under this section, unless the payment is for treatment of amphetamine or methamphetamine abuse of dependence. The commissioner may refuse to pay state funds for services to persons not eligible under section 254B.04, subdivision 1, if the county financially responsible for the persons has exhausted its allocation.

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

Sec. 11. Minnesota Statutes 2004, section 256B.0622, subdivision 2, is amended to read:

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

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

(b) "Intensive residential rehabilitative mental health services" means short-term, time-limited services provided in a residential setting to recipients who are in need of more restrictive settings and are at risk of significant functional deterioration if they do not receive these services. Services

are designed to develop and enhance psychiatric stability, personal and emotional adjustment, self-sufficiency, and skills to live in a more independent setting. Services must be directed toward a targeted discharge date with specified client outcomes and must be consistent with the Fairweather Lodge treatment model as defined in paragraph (a), and other evidence-based practices.

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

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

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

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

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

Sec. 13. Minnesota Statutes 2004, section 256B.0625, is amended by adding a subdivision to read:

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

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

Subd. 48. [PSYCHIATRIC CONSULTATION TO PRIMARY CARE PRACTITIONERS.] Effective January 1, 2006, medical assistance covers consultation provided by a psychiatrist via telephone, e-mail, facsimile, or other means of communication to primary care practitioners, including pediatricians. The need for consultation and the receipt of the consultation must be documented in the patient record maintained by the primary care practitioner. If the patient consents, and subject to federal limitations and data privacy provisions, the consultation may be provided without the patient present.

Sec. 15. [256B.0946] [TREATMENT FOSTER CARE.]

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

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

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

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

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

Subd. 2. [DETERMINATION OF CLIENT ELIGIBILITY.] A client's eligibility to receive treatment foster care under this section

shall be determined by a diagnostic assessment, an evaluation of level of care needed, and development of an individual treatment plan, as defined in paragraphs (a) to (c).

(a) The diagnostic assessment must:

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

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

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

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

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

(c) The individual treatment plan must be:

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

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

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

(4) signed by the client or, if appropriate, by the

client's parent or other person authorized by statute to consent to mental health services for the client.

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

(1) a county;

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

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

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

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

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

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

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

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

foster care provider;

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

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

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

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

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

Sec. 16. [256B.0947] [TRANSITIONAL YOUTH INTENSIVE REHABILITATIVE MENTAL HEALTH SERVICES.]

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

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

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

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

(c) "Treatment team" means all staff who provide services to recipients under this section. At a minimum, this includes

the clinical supervisor, mental health professionals, mental health practitioners, mental health behavioral aides, and a school representative familiar with the recipient's individual education plan (IEP) if applicable.

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

(1) is age 16 or 17;

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

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

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

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

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

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

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

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

and 6.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) the cost for similar services in the local trade area;

(2) actual costs incurred by entities providing the services;

(3) the intensity and frequency of services to be provided to each recipient;

(4) the degree to which recipients will receive services other than services under this section; and

(5) the costs of other services that will be separately reimbursed.

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

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

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

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

Subd. 9. [PROVIDER ENROLLMENT; RATE SETTING FOR COUNTY-OPERATED ENTITIES.] Counties that employ their own staff to provide services under this section shall apply directly to the commissioner for enrollment and rate setting. In this case, a county contract is not required and the commissioner shall perform the program review and rate setting duties which would otherwise be required of counties under this section.

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

Sec. 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~~

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

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

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

Sec. 18. Minnesota Statutes 2004, section 256D.03, subdivision 4, is amended to read:

Subd. 4. [GENERAL ASSISTANCE MEDICAL CARE; SERVICES.] (a)(i) For a person who is eligible under subdivision 3, paragraph (a), clause (2), item (i), general assistance medical

care covers, except as provided in paragraph (c):

(1) inpatient hospital services;

(2) outpatient hospital services;

(3) services provided by Medicare certified rehabilitation agencies;

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

(5) equipment necessary to administer insulin and diagnostic supplies and equipment for diabetics to monitor blood sugar level;

(6) eyeglasses and eye examinations provided by a physician or optometrist;

(7) hearing aids;

(8) prosthetic devices;

(9) laboratory and X-ray services;

(10) physician's services;

(11) medical transportation except special transportation;

(12) chiropractic services as covered under the medical assistance program;

(13) podiatric services;

(14) dental services and dentures, subject to the limitations specified in section 256B.0625, subdivision 9;

(15) outpatient services provided by a mental health center or clinic that is under contract with the county board and is established under section 245.62;

(16) day treatment services for mental illness provided under contract with the county board;

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

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

(19) medical equipment not specifically listed in this paragraph when the use of the equipment will prevent the need

for costlier services that are reimbursable under this subdivision;

(20) services performed by a certified pediatric nurse practitioner, a certified family nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological nurse practitioner, a certified neonatal nurse practitioner, or a certified geriatric nurse practitioner in independent practice, if (1) the service is otherwise covered under this chapter as a physician service, (2) the service provided on an inpatient basis is not included as part of the cost for inpatient services included in the operating payment rate, and (3) the service is within the scope of practice of the nurse practitioner's license as a registered nurse, as defined in section 148.171;

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

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

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

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

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

(c) In order to contain costs, the commissioner of human

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

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

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

(2) $25 for eyeglasses;

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

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

(5) 50 percent coinsurance on restorative dental services.

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

(f) If it is the routine business practice of a provider to refuse service to an individual with uncollected debt, the provider may include uncollected co-payments under this section. A provider must give advance notice to a recipient with uncollected debt before services can be denied.

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

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

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

(j) The conditions of payment for services under this

subdivision are the same as the conditions specified in rules adopted under chapter 256B governing the medical assistance program, unless otherwise provided by statute or rule.

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

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

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

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

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

Sec. 19. Minnesota Statutes 2004, section 256D.44, subdivision 5, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) Payment for nonrecurring special needs must be allowed for necessary home repairs or necessary repairs or replacement of household furniture and appliances using the payment standard of the AFDC program in effect on July 16, 1996, for these expenses, as long as other funding sources are not available.

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

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

(e) A fee of ten percent of the recipient's gross income or $25, whichever is less, is allowed for representative payee services provided by an agency that meets the requirements under SSI regulations to charge a fee for representative payee

services. This special need is available to all recipients of Minnesota supplemental aid regardless of their living arrangement.

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

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

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

Subdivision 1. [COVERED HEALTH SERVICES.] For individuals under section 256L.04, subdivision 7, with income no greater than 75 percent of the federal poverty guidelines or for families with children under section 256L.04, subdivision 1, all subdivisions of this section apply. "Covered health services" means the health services reimbursed under chapter 256B, with the exception of inpatient hospital services, special education services, private duty nursing services, adult dental care services other than services covered under section 256B.0625, subdivision 9, paragraph (b), orthodontic services, nonemergency medical transportation services, personal care assistant and

case management services, nursing home or intermediate care facilities services, inpatient mental health services, and chemical dependency services. Outpatient mental health services covered under the MinnesotaCare program are limited to diagnostic assessments, psychological testing, explanation of findings, mental health telemedicine, psychiatric consultation, medication management by a physician, day treatment, partial hospitalization, and individual, family, and group psychotherapy.

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

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

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

Sec. 21. [641.155] [DISCHARGE PLANS; OFFENDERS WITH SERIOUS AND PERSISTENT MENTAL ILLNESS.]

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

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

(1) providing assistance in filling out an application for medical assistance, general assistance medical care, or MinnesotaCare;

(2) making a referral for case management as outlined under

section 245.467, subdivision 4;

(3) providing assistance in obtaining a state photo identification;

(4) securing a timely appointment with a psychiatrist or other appropriate community mental health providers; and

(5) providing prescriptions for a 30-day supply of all necessary medications.

Sec. 22. [PRIORITY IN JANITORIAL CONTRACTS.]

When awarding contracts to provide the janitorial services for the new Department of Human Services and Department of Health buildings, the commissioner of administration shall give priority to supported work vendors.

ARTICLE 6

FAMILY SUPPORT

Section 1. Minnesota Statutes 2004, section 119B.011, is amended by adding a subdivision to read:

Subd. 23. [WORK PARTICIPATION RATE ENHANCEMENT PROGRAM.] "Work participation rate enhancement program" means the program established under section 256J.575.

Sec. 2. Minnesota Statutes 2004, section 119B.05, subdivision 1, is amended to read:

Subdivision 1. [ELIGIBLE PARTICIPANTS.] Families eligible for child care assistance under the MFIP child care program are:

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

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

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

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

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

(6) families who are participating in services or activities that are included in an approved family stabilization plan under section 256J.575;

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

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

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

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

(b) For households with adjusted gross income equal to or greater than 100 percent of federal poverty guidelines, the parental contribution shall be computed by applying the following schedule of rates to the adjusted gross income of the natural or adoptive parents:

(1) if the adjusted gross income is equal to or greater than 100 percent of federal poverty guidelines and less than 175 percent of federal poverty guidelines, the parental contribution is $4 per month;

(2) if the adjusted gross income is equal to or greater than 175 percent of federal poverty guidelines and less than or equal to 375 percent of federal poverty guidelines, the parental contribution shall be determined using a sliding fee scale established by the commissioner of human services which begins

at one percent of adjusted gross income at 175 percent of federal poverty guidelines and increases to 7.5 percent of adjusted gross income for those with adjusted gross income up to 375 percent of federal poverty guidelines;

(3) if the adjusted gross income is greater than 375 percent of federal poverty guidelines and less than 675 percent of federal poverty guidelines, the parental contribution shall be 7.5 percent of adjusted gross income;

(4) if the adjusted gross income is equal to or greater than 675 percent of federal poverty guidelines and less than 975 percent of federal poverty guidelines, the parental contribution shall be ten percent of adjusted gross income; and

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

If the child lives with the parent, the annual adjusted gross income is reduced by $2,400 prior to calculating the parental contribution. If the child resides in an institution specified in section 256B.35, the parent is responsible for the personal needs allowance specified under that section in addition to the parental contribution determined under this section. The parental contribution is reduced by any amount required to be paid directly to the child pursuant to a court order, but only if actually paid.

(c) The household size to be used in determining the amount of contribution under paragraph (b) includes natural and adoptive parents and their dependents, including the child receiving services. Adjustments in the contribution amount due to annual changes in the federal poverty guidelines shall be implemented on the first day of July following publication of the changes.

(d) For purposes of paragraph (b), "income" means the adjusted gross income of the natural or adoptive parents determined according to the previous year's federal tax form, except, effective retroactive to July 1, 2003, taxable capital gains to the extent the funds have been used to purchase a

home and funds from early withdrawn qualified retirement accounts under the Internal Revenue Code shall not be counted as income.

(e) The contribution shall be explained in writing to the parents at the time eligibility for services is being determined. The contribution shall be made on a monthly basis effective with the first month in which the child receives services. Annually upon redetermination or at termination of eligibility, if the contribution exceeded the cost of services provided, the local agency or the state shall reimburse that excess amount to the parents, either by direct reimbursement if the parent is no longer required to pay a contribution, or by a reduction in or waiver of parental fees until the excess amount is exhausted.

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

(g) Parents of a minor child who do not live with each other shall each pay the contribution required under paragraph (a)~~.---An-amount-equal-to-the-annual~~, except that a court-ordered child 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 by an additional five percent if the local agency determines that insurance coverage is available but not obtained for the child. For purposes of this section, "available" means the insurance is a benefit of employment for a family member at an annual cost of no more than five percent of the family's annual income. For purposes of this section, "insurance" means health

and accident insurance coverage, enrollment in a nonprofit health service plan, health maintenance organization, self-insured plan, or preferred provider organization.

Parents who have more than one child receiving services shall not be required to pay more than the amount for the child with the highest expenditures. There shall be no resource contribution from the parents. The parent shall not be required to pay a contribution in excess of the cost of the services provided to the child, not counting payments made to school districts for education-related services. Notice of an increase in fee payment must be given at least 30 days before the increased fee is due.

(i) The contribution under paragraph (b) shall be reduced by $300 per fiscal year if, in the 12 months prior to July 1:

(1) the parent applied for insurance for the child;

(2) the insurer denied insurance;

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

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

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

A parent who has requested a reduction in the contribution amount under this paragraph shall submit proof in the form and manner prescribed by the commissioner or county agency, including, but not limited to, the insurer's denial of insurance, the written letter or complaint of the parents, court documents, and the written response of the insurer approving insurance. The determinations of the commissioner or county agency under this paragraph are not rules subject to chapter 14.

(j) Within the available appropriation for the biennium beginning July 1, 2005, the commissioner shall modify the contribution amount under paragraph (a), giving priority to reducing the parental contribution for the lowest income

parents. Notwithstanding paragraphs (a) to (i), the commissioner shall implement the new parental fee formula as soon as possible and request that the changes be codified in the next legislative session.

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

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

(b) For the purposes of this section, "American Indian child" means a person from birth to 18 years of age who is a tribal member or eligible for membership in one of the tribes chosen for the project under this subdivision and who is residing on the reservation of that tribe.

(c) In order to qualify for an American Indian child

welfare project, a tribe must:

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

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

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

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

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

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

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

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

(2) family preservation;

(3) facilitative, supportive, and reunification services;

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

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

(e) When a tribe has initiated a project and has been approved by the commissioner to assume child welfare responsibilities for American Indian children of that tribe under this section, the affected county social service agency is relieved of responsibility for responding to reports of abuse and neglect under section 626.556 for those children during the time the tribal project is in effect and receiving funding for the project. The commissioner shall work with tribes and affected counties to develop procedures for data collection, evaluation, and clarification of the ongoing role and financial responsibilities of the county and tribe for child welfare services prior to initiation of the project. Children who have

not been identified by the tribe as participating in the project shall remain the responsibility of the county. Nothing in this section changes the responsibilities of the county law enforcement agency or court services.

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

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

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

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

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

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

under Code of Federal Regulations, title 45, section 263.5.

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

Subd. 65. [PARTICIPANT.] "Participant" means a person who is currently receiving cash assistance or the food portion available through MFIP. A person who fails to withdraw or access electronically any portion of the person's cash and food assistance payment by the end of the payment month, who makes a written request for closure before the first of a payment month and repays cash and food assistance electronically issued for that payment month within that payment month, or who returns any uncashed assistance check and food coupons and withdraws from the program is not a participant. A person who withdraws a cash or food assistance payment by electronic transfer or receives and cashes an MFIP assistance check or food coupons and is subsequently determined to be ineligible for assistance for that period of time is a participant, regardless whether that assistance is repaid. The term "participant" includes the caregiver relative and the minor child whose needs are included in the assistance payment. A person in an assistance unit who does not receive a cash and food assistance payment because the case has been suspended from MFIP is a participant. A person who receives cash payments under the diversionary work program under section 256J.95 is a participant. A person who receives cash payments under the work participation rate enhancement program under section 256J.575 is a participant.

Sec. 7. Minnesota Statutes 2004, section 256J.21, subdivision 2, is amended to read:

Subd. 2. [INCOME EXCLUSIONS.] The following must be excluded in determining a family's available income:

(1) payments for basic care, difficulty of care, and clothing allowances received for providing family foster care to children or adults under Minnesota Rules, parts 9545.0010 to 9545.0260 and 9555.5050 to 9555.6265, and payments received and used for care and maintenance of a third-party beneficiary who is not a household member;

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

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

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

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

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

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

(ii) federal income tax refunds;

(8)(i) federal earned income credits;

(ii) Minnesota working family credits;

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

(iv) federal or state tax rebates;

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

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

(11) reimbursements for medical expenses that cannot be

paid by medical assistance;

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

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

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

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

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

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

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

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

(20) Minnesota supplemental aid, including retroactive payments;

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

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

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

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

(25) rent rebates;

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

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

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

(31) reverse mortgages;

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

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

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

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

(36) benefits from the Trade Act of 1974, United States 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);

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

(40) security and utility deposit refunds;

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

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

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

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

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

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

Sec. 8. Minnesota Statutes 2004, section 256J.521, subdivision 1, is amended to read:

Subdivision 1. [ASSESSMENTS.] (a) For purposes of MFIP employment services, assessment is a continuing process of gathering information related to employability for the purpose of identifying both participant's strengths and strategies for coping with issues that interfere with employment. The job counselor must use information from the assessment process to develop and update the employment plan under subdivision 2 or 3,

as appropriate, ~~and~~ to determine whether the participant qualifies for a family violence waiver including an employment plan under subdivision 3, and to determine whether the participant should be referred to the work participation rate enhancement program under section 256J.575.

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

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

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

(3) the results of a mental and chemical health screening tool designed by the commissioner and results of the brief screening tool for special learning needs. Screening tools for mental and chemical health and special learning needs must be approved by the commissioner and may only be administered by job counselors or county staff trained in using such screening tools. The commissioner shall work with county agencies to develop protocols for referrals and follow-up actions after screens are administered to participants, including guidance on how employment plans may be modified based upon outcomes of certain screens. Participants must be told of the purpose of the screens and how the information will be used to assist the participant in identifying and overcoming barriers to employment. Screening for mental and chemical health and special learning needs must be completed by participants who are unable to find suitable employment after six weeks of job search under subdivision 2, paragraph (b), and participants who are determined to have barriers to employment under subdivision 2, paragraph (d). Failure to complete the screens will result in

sanction under section 256J.46; and

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

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

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

Sec. 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:

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

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

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

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

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

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

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

Sec. 10. [256J.575] [WORK PARTICIPATION RATE ENHANCEMENT 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.

(b) The goal of this program is to stabilize and improve

the lives of families at risk of long-term welfare dependency or family instability due to employment barriers such as physical disability, mental disability, age, and caring for a disabled household member. WORK PREP provides services to promote and support families to achieve the greatest possible degree of self-sufficiency. Counties may provide supportive and other allowable services funded by the MFIP consolidated fund under section 256J.626 to eligible participants.

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

(a) The "work participation rate enhancement program" means the program established under this section.

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

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

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

(1) obtaining and retaining unsubsidized employment;

(2) family stability;

(3) economic stability; and

(4) barrier reduction.

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

Subd. 3. [ELIGIBILITY.] (a) The following MFIP or DWP participants are eligible for the program under this section:

(1) a participant identified under section 256J.561,

subdivision 2, paragraph (d), who has or is eligible for an employment plan developed under section 256J.521, subdivision 2, paragraph (c);

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

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

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

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

Subd. 4. [UNIVERSAL PARTICIPATION.] All caregivers must participate in family stabilization services as defined in subdivision 2.

Subd. 5. [CASE MANAGEMENT; FAMILY STABILIZATION PLANS; COORDINATED SERVICES.] (a) The county agency shall provide family stabilization services to families through a case management model. A case manager shall be assigned to each participating family within 30 days after the family begins to receive financial assistance as a participant of the work participation rate enhancement program. The case manager, with the full involvement of the family, shall recommend, and the county agency shall establish and modify as necessary, a family stabilization plan for each participating family.

(b) The family stabilization plan shall include:

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

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

(3) an identification of the services, supports, education,

training, and accommodations needed to overcome any barriers to enable the family to achieve self-sufficiency and to fulfill each caregiver's personal and family responsibilities.

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

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

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

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

(4) services required by the plan are unavailable; or

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

(d) Family stabilization plans under this section shall be written for a period of time not to exceed six months.

Subd. 6. [COOPERATION WITH PROGRAM REQUIREMENTS.] (a) To be eligible, a participant must comply with paragraphs (b) to (f).

(b) Participants shall engage in family stabilization plan activities listed in clause (1) or (2) for the number of hours per week that the activities are scheduled and available, unless good cause exists for not doing so, as defined in section 256J.57, subdivision 1:

(1) in single-parent families with no children under six years of age, the case manager and the participant must develop a family stabilization plan that includes 30 to 35 hours per week of activities; and

(2) in single-parent families with a child under six years

of age, the case manager and the participant must develop a family stabilization plan that includes 20 to 35 hours per week of activities.

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

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

(e) Participants who have not increased their participation in work activities sufficient to meet the federal participation requirements of TANF may request a referral to the MFIP program and assignment to a job counselor after 12 months in the program.

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

Subd. 7. [SANCTIONS.] (a) The financial assistance grant of a participating family shall be reduced, according to section 256J.46, if a participating adult fails without good cause to comply or continue to comply with the family stabilization plan requirements in this subdivision, unless compliance has been excused under subdivision 6, paragraph (f).

(b) Given the purpose of the work participation rate enhancement program in this section and the nature of the underlying family circumstances that act as barriers to both

employment and full compliance with program requirements, sanctions are appropriate only when it is clear that there is both ability to comply and willful noncompliance on the part of the participant.

(c) Prior to the imposition of a sanction, the county agency must review the participant's case to determine if the family stabilization plan is still appropriate and meet with the participants face-to-face. The participant may bring an advocate to the face-to-face meeting. If a face-to-face meeting is not conducted, the county agency must send the participant a written notice that includes the information required under clause (1):

(1) during the face-to-face meeting, the county agency must:

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

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

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

(iv) explain the consequences of continuing noncompliance;

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

(vi) inform the participant of the right to appeal under section 256J.40; and

(2) if the lack of an identified activity or service can explain the noncompliance, the county must work with the participant to provide the identified activity.

(d) After the requirements of paragraph (c) are met and prior to imposition of a sanction, the county agency shall provide a notice of intent to sanction under section 256J.57,

subdivision 2, and, when applicable, a notice of adverse action as provided in section 256J.31.

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

Sec. 11. [256J.621] [WORK PARTICIPATION BONUS.]

Upon exiting the diversionary work program (DWP) or upon terminating MFIP cash assistance with earnings, a participant who is employed and working 24 hours a week may be eligible for transitional assistance of $50 per month to assist in meeting the family's basic needs as the participant continues to move toward self-sufficiency.

To be eligible for a transitional assistance payment, the participant must not receive MFIP cash assistance or diversionary work program assistance during the month and must be employed an average of at least 24 hours a week. Transitional assistance shall be available for a maximum of nine months from the date the participant exited the diversionary work program or terminated MFIP cash assistance.

The commissioner shall establish policies and develop forms to verify eligibility for transitional assistance. The forms must contain all data elements required to meet federal TANF reporting requirements.

Expenditures on the transitional assistance program shall be state-funded and treated as segregated funds under the state's TANF maintenance of effort requirement. Months in which a participant receives transitional assistance under this section shall not count toward the participant's MFIP 60-month time limit.

This section shall take effect if federal law changes the TANF work participation rates that states must meet and the commissioner determines that implementation of this program will enhance Minnesota's TANF work participation rates.

Sec. 12. Minnesota Statutes 2004, section 256J.626, subdivision 1, is amended to read:

Subdivision 1. [CONSOLIDATED FUND.] The consolidated fund is established to support counties and tribes in meeting their

duties under this chapter. Counties and tribes must use funds from the consolidated fund to develop programs and services that are designed to improve participant outcomes as measured in section 256J.751, subdivision 2, and to provide case management services to participants of the work participation rate enhancement program. Counties may use the funds for any allowable expenditures under subdivision 2. Tribes may use the funds for any allowable expenditures under subdivision 2, except those in clauses (1) and (6).

Sec. 13. Minnesota Statutes 2004, section 256J.626, subdivision 2, is amended to read:

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

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

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

(3) direct and administrative costs of staff to deliver employment services for MFIP ~~or~~, the diversionary work program, or the 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;

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

(5) cost of work supports including tools, clothing, boots,

and other work-related expenses;

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

(7) services to parenting and pregnant teens;

(8) supported work;

(9) wage subsidies;

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

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

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

(13) services to help families participating in the work participation rate enhancement program achieve the greatest possible degree of self-sufficiency.

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

Sec. 14. Minnesota Statutes 2004, section 256J.626, subdivision 3, is amended to read:

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

risk of receiving MFIP or diversionary work program.

Sec. 15. Minnesota Statutes 2004, section 256J.626, subdivision 4, is amended to read:

Subd. 4. [COUNTY AND TRIBAL BIENNIAL SERVICE AGREEMENTS.] (a) Effective January 1, 2004, and each two-year period thereafter, each county and tribe must have in place an approved biennial service agreement related to the services and programs in this chapter. In counties with a city of the first class with a population over 300,000, the county must consider a service agreement that includes a jointly developed plan for the delivery of employment services with the city. Counties may collaborate to develop multicounty, multitribal, or regional service agreements.

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

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

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

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

(4) strategies the county or tribe will pursue under the work participation rate enhancement program; and

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

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

(d) The service agreement must be submitted to the

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

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

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

Sec. 16. Minnesota Statutes 2004, section 256J.626, subdivision 7, is amended to read:

Subd. 7. [PERFORMANCE BASE FUNDS.] (a) Beginning calendar year 2005, each county and tribe will be allocated ~~95~~ 100 percent of their initial calendar year allocation. Counties and tribes will be allocated additional funds from federal TANF bonus funds the state receives based on performance as follows:

(1) for calendar year 2005, a county or tribe that achieves a 30 percent rate or higher on the MFIP participation rate under section 256J.751, subdivision 2, clause (8), as averaged across the four quarterly measurements for the most recent year for which the measurements are available, will receive an additional allocation ~~equal to 2.5 percent of its initial allocation~~ to be determined by the commissioner based upon available funds; and

(2) for calendar year 2006, a county or tribe that achieves a 40 percent rate or a five percentage point improvement over the previous year's MFIP participation rate under section 256J.751, subdivision 2, clause (8), as averaged across the four quarterly measurements for the most recent year for which the measurements are available, will receive an additional allocation ~~equal to 2.5 percent of its initial allocation~~ to be determined by the commissioner based upon available funds; and

(3) for calendar year 2007, a county or tribe that achieves a 50 percent rate or a five percentage point improvement over

the previous year's MFIP participation rate under section 256J.751, subdivision 2, clause (8), as averaged across the four quarterly measurements for the most recent year for which the measurements are available, will receive an additional allocation ~~equal to 2.5 percent of its initial allocation~~ to be determined by the commissioner based upon available funds; and

(4) for calendar year 2008 and yearly thereafter, a county or tribe that achieves a 50 percent MFIP participation rate under section 256J.751, subdivision 2, clause (8), as averaged across the four quarterly measurements for the most recent year for which the measurements are available, will receive an additional allocation ~~equal to 2.5 percent of its initial allocation~~ to be determined by the commissioner based upon available funds; and

(5) for calendar years 2005 and thereafter, a county or tribe that performs above the top of its range of expected performance on the three-year self-support index under section 256J.751, subdivision 2, clause (7), in both measurements in the preceding year will receive an additional allocation ~~equal to five percent of its initial allocation~~ to be determined by the commissioner based upon available funds; or

(6) for calendar years 2005 and thereafter, a county or tribe that performs within its range of expected performance on the three-year self-support index under section 256J.751, subdivision 2, clause (7), in both measurements in the preceding year, or above the top of its range of expected performance in one measurement and within its expected range of performance in the other measurement, will receive an additional allocation ~~equal to 2.5 percent of its initial allocation~~ to be determined by the commissioner based upon available funds.

(b) Funds remaining unallocated after the performance-based allocations in paragraph (a) are available to the commissioner for innovation projects under subdivision 5.

~~(c) (1) 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.~~

~~(2) If after the application of clause (1) funds remain insufficient to meet county and tribal allocations under paragraph (a), the commissioner must proportionally reduce the allocation of each county and tribe with respect to their maximum allocation available under paragraph (a).~~

Sec. 17. Minnesota Statutes 2004, section 256J.95, subdivision 3, is amended to read:

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

(1) child only cases;

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

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

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

(5) a caregiver age 60 or over;

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

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

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

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

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

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

(d) Newly arrived refugees and asylees as defined in Code of Federal Regulations, title 45, chapter IV, section 400.2, who have arrived in the United States within the last two months shall be exempt from mandatory participation in the diversionary work program and may enroll directly into the MFIP program.

[EFFECTIVE DATE.] This section (256J.95, subdivision 3) is effective the day following final enactment.

Sec. 18. Minnesota Statutes 2004, section 256J.95, subdivision 9, is amended to read:

Subd. 9. [PROPERTY AND INCOME LIMITATIONS.] The asset limits and exclusions in section 256J.20 apply to applicants and recipients of DWP. All payments, unless excluded in section 256J.21, must be counted as income to determine eligibility for the diversionary work program. The county shall treat income as outlined in section 256J.37~~,--except-for-subdivision-3a~~. The initial income test and the disregards in section 256J.21, subdivision 3, shall be followed for determining eligibility for the diversionary work program.

Sec. 19. [REPEALER.]

Minnesota Statutes 2004, section 256J.37, subdivisions 3a and 3b, are repealed effective July 1, 2005.

ARTICLE 7

MISCELLANEOUS

Section 1. [151.52] [MANUFACTURER PRICE REPORT.]

Subdivision 1. [REPORT.] All drug manufacturers registered

or licensed to do business in this state shall, on a quarterly basis, report by National Drug Code the following pharmaceutical pricing criteria to the commissioner of human services for each of their drugs: average wholesale price, wholesale acquisition cost, average manufacturer price as defined in United States Code, title 42, chapter 7, subchapter XIX, section 1396r-8(k), and best price as defined in United States Code, title 42, chapter 7, subchapter XIX, section 1396r-8(c)(1)(C). The calculation of average wholesale price and wholesale acquisition cost shall be the net of all volume discounts, prompt payment discounts, chargebacks, short-dated product discounts, cash discounts, free goods, rebates, and all other price concessions or incentives provided to a purchaser that result in a reduction in the ultimate cost to the purchaser. When reporting average wholesale price, wholesale acquisition cost, average manufacturer price, and best price, manufacturers shall also include a detailed description of the methodology by which the prices were calculated. When a manufacturer reports average wholesale price, wholesale acquisition cost, average manufacturer price, or best price, the president or chief executive officer of the manufacturer shall certify on a form provided by the commissioner of human services, that the reported prices are accurate. Any information reported under this section shall be classified as nonpublic data under section 13.02, subdivision 9. Notwithstanding the classification of data in this section and subdivision 2, the Minnesota Attorney General's Office, the federal Centers for Medicare and Medicaid Services or another law enforcement agency may access and obtain copies of the data required under this section and use that data for law enforcement purposes.

Subd. 2. [PENALTIES AND REMEDIES.] The attorney general may pursue the penalties and remedies available to the attorney general under section 8.31 against any manufacturer who violates this section.

Sec. 2. [151.55] [CANCER DRUG REPOSITORY PROGRAM.]

Subdivision 1. [DEFINITIONS.] (a) For the purposes of this

section, the terms defined in this subdivision have the meanings given.

(b) "Board" means the Board of Pharmacy.

(c) "Cancer drug" means a prescription drug that is used to treat:

(1) cancer or the side effects of cancer; or

(2) the side effects of any prescription drug that is used to treat cancer or the side effects of cancer.

(d) "Cancer drug repository" means a medical facility or pharmacy that has notified the board of its election to participate in the cancer drug repository program.

(e) "Cancer supply" or "supplies" means prescription and nonprescription cancer supplies needed to administer a cancer drug.

(f) "Dispense" has the meaning given in section 151.01, subdivision 30.

(g) "Distribute" means to deliver, other than by administering or dispensing.

(h) "Medical facility" means an institution defined in section 144.50, subdivision 2.

(i) "Medical supplies" means any prescription and nonprescription medical supply needed to administer a cancer drug.

(j) "Pharmacist" has the meaning given in section 151.01, subdivision 3.

(k) "Pharmacy" means any pharmacy registered with the Board of Pharmacy according to section 151.19, subdivision 1.

(l) "Practitioner" has the meaning given in section 151.01, subdivision 23.

(m) "Prescription drug" means a legend drug as defined in section 151.01, subdivision 17.

(n) "Side effects of cancer" means symptoms of cancer.

(o) "Single-unit-dose packaging" means a single-unit container for articles intended for administration as a single dose, direct from the container.

(p) "Tamper-evident unit dose packaging" means a container

within which a drug is sealed so that the contents cannot be opened without obvious destruction of the seal.

Subd. 2. [ESTABLISHMENT.] The Board of Pharmacy shall establish and maintain a cancer drug repository program, under which any person may donate a cancer drug or supply for use by an individual who meets the eligibility criteria specified under subdivision 4. Under the program, donations may be made on the premises of a medical facility or pharmacy that elects to participate in the program and meets the requirements specified under subdivision 3.

Subd. 3. [REQUIREMENTS FOR PARTICIPATION BY PHARMACIES AND MEDICAL FACILITIES.] (a) To be eligible for participation in the cancer drug repository program, a pharmacy or medical facility must be licensed and in compliance with all applicable federal and state laws and administrative rules.

(b) Participation in the cancer drug repository program is voluntary. A pharmacy or medical facility may elect to participate in the cancer drug repository program by submitting the following information to the board, in a form provided by the board:

(1) the name, street address, and telephone number of the pharmacy or medical facility;

(2) the name and telephone number of a pharmacist who is employed by or under contract with the pharmacy or medical facility, or other contact person who is familiar with the pharmacy's or medical facility's participation in the cancer drug repository program; and

(3) a statement indicating that the pharmacy or medical facility meets the eligibility requirements under paragraph (a) and the chosen level of participation under paragraph (c).

(c) A pharmacy or medical facility may fully participate in the cancer drug repository program by accepting, storing, and dispensing or administering donated drugs and supplies, or may limit its participation to only accepting and storing donated drugs and supplies. If a pharmacy or facility chooses to limit its participation, the pharmacy or facility shall distribute any

donated drugs to a fully participating cancer drug repository in accordance with subdivision 8.

(d) A pharmacy or medical facility may withdraw from participation in the cancer drug repository program at any time upon notification to the board. A notice to withdraw from participation may be given by telephone or regular mail.

Subd. 4. [INDIVIDUAL ELIGIBILITY REQUIREMENTS.] Any Minnesota resident who is diagnosed with cancer is eligible to receive drugs or supplies under the cancer drug repository program. Drugs and supplies shall be dispensed or administered according to the priority given under subdivision 6, paragraph (d).

Subd. 5. [DONATIONS OF CANCER DRUGS AND SUPPLIES.] (a) Any one of the following persons may donate legally obtained cancer drugs or supplies to a cancer drug repository, if the drugs or supplies meet the requirements under paragraph (b) or (c) as determined by a pharmacist who is employed by or under contract with a cancer drug repository:

(1) an individual who is 18 years old or older; or

(2) a pharmacy, medical facility, drug manufacturer, or wholesale drug distributor, if the donated drugs have not been previously dispensed.

(b) A cancer drug is eligible for donation under the cancer drug repository program only if the following requirements are met:

(1) the donation is accompanied by a cancer drug repository donor form described under paragraph (d) that is signed by the person making the donation or that person's authorized representative;

(2) the drug's expiration date is at least six months later than the date that the drug was donated;

(3) the drug is in its original, unopened, tamper-evident unit dose packaging that includes the drug's lot number and expiration date. Single-unit dose drugs may be accepted if the single-unit-dose packaging is unopened; and

(4) the drug is not adulterated or misbranded.

(c) Cancer supplies are eligible for donation under the cancer drug repository program only if the following requirements are met:

(1) the supplies are not adulterated or misbranded;

(2) the supplies are in their original, unopened, sealed packaging; and

(3) the donation is accompanied by a cancer drug repository donor form described under paragraph (d) that is signed by the person making the donation or that person's authorized representative.

(d) The cancer drug repository donor form must be provided by the board and shall state that to the best of the donor's knowledge the donated drug or supply has been properly stored and that the drug or supply has never been opened, used, tampered with, adulterated, or misbranded. The board shall make the cancer drug repository donor form available on the Department of Health's Web site.

(e) Controlled substances and drugs and supplies that do not meet the criteria under this subdivision are not eligible for donation or acceptance under the cancer drug repository program.

(f) Drugs and supplies may be donated on the premises of a cancer drug repository to a pharmacist designated by the repository. A drop box may not be used to deliver or accept donations.

(g) Cancer drugs and supplies donated under the cancer drug repository program must be stored in a secure storage area under environmental conditions appropriate for the drugs or supplies being stored. Donated drugs and supplies may not be stored with nondonated inventory.

Subd. 6. [DISPENSING REQUIREMENTS.] (a) Drugs and supplies must be dispensed by a licensed pharmacist pursuant to a prescription by a practitioner or may be dispensed or administered by a practitioner in accordance with the requirements of chapter 151 and within the practitioner's scope of practice.

(b) Cancer drugs and supplies shall be visually inspected by the pharmacist or practitioner before being dispensed or administered for adulteration, misbranding, and date of expiration. Drugs or supplies that have expired or appear upon visual inspection to be adulterated, misbranded, or tampered with in any way may not be dispensed or administered.

(c) Before a cancer drug or supply may be dispensed or administered to an individual, the individual must sign a cancer drug repository recipient form provided by the board acknowledging that the individual understands the information stated on the form. The form shall include the following information:

(1) that the drug or supply being dispensed or administered has been donated and may have been previously dispensed;

(2) that a visual inspection has been conducted by the pharmacist or practitioner to ensure that the drug has not expired, has not been adulterated or misbranded, and is in its original, unopened packaging; and

(3) that the dispensing pharmacist, the dispensing or administering practitioner, the cancer drug repository, the state Department of Health, and any other participant of the cancer drug repository program cannot guarantee the safety of the drug or supply being dispensed or administered and that the pharmacist or practitioner has determined that the drug or supply is safe to dispense or administer based on the accuracy of the donor's form submitted with the donated drug or supply and the visual inspection required to be performed by the pharmacist or practitioner before dispensing or administering. The board shall make the cancer drug repository form available on the Department of Health's Web site.

(d) Drugs and supplies shall only be dispensed or administered to individuals who meet the eligibility requirements in subdivision 4 and in the following order of priority:

(1) individuals who are uninsured;

(2) individuals who are enrolled in medical assistance,

general assistance medical care, MinnesotaCare, Medicare, or other public assistance health care; and

(3) all other individuals who are otherwise eligible under subdivision 4 to receive drugs or supplies from a cancer drug repository.

Subd. 7. [HANDLING FEES.] A cancer drug repository may charge the individual receiving a drug or supply a handling fee of no more than 250 percent of the medical assistance program dispensing fee for each cancer drug or supply dispensed or administered.

Subd. 8. [DISTRIBUTION OF DONATED CANCER DRUGS AND SUPPLIES.] (a) Cancer drug repositories may distribute drugs and supplies donated under the cancer drug repository program to other repositories if requested by a participating repository.

(b) A cancer drug repository that has elected not to dispense donated drugs or supplies shall distribute any donated drugs and supplies to a participating repository upon request of the repository.

(c) If a cancer drug repository distributes drugs or supplies under paragraph (a) or (b), the repository shall complete a cancer drug repository donor form provided by the board. The completed form and a copy of the donor form that was completed by the original donor under subdivision 5 shall be provided to the fully participating cancer drug repository at the time of distribution.

Subd. 9. [RESALE OF DONATED DRUGS OR SUPPLIES.] Donated drugs and supplies may not be resold.

Subd. 10. [RECORD-KEEPING REQUIREMENTS.] (a) Cancer drug repository donor and recipient forms shall be maintained for at least five years.

(b) A record of destruction of donated drugs and supplies that are not dispensed under subdivision 6 shall be maintained by the dispensing repository for at least five years. For each drug or supply destroyed, the record shall include the following information:

(1) the date of destruction;

(2) the name, strength, and quantity of the cancer drug destroyed;

(3) the name of the person or firm that destroyed the drug; and

(4) the source of the drugs or supplies destroyed.

Subd. 11. [LIABILITY.] A medical facility or pharmacy participating in the program, a pharmacist dispensing a drug or supply pursuant to the program, a practitioner dispensing or administering a drug or supply pursuant to the program, or the 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 or supply that causes injury to or the death of an individual to whom the cancer drug or supply is dispensed or administered and no disciplinary action shall be taken against a pharmacist or practitioner so long as the drug or supply is donated, accepted, distributed, and dispensed or administered in accordance with the requirements of this section. This immunity does not apply if the act or omission involves reckless, wanton, or intentional misconduct or malpractice unrelated to the quality of the donated cancer drug or supply.

Sec. 3. Minnesota Statutes 2004, section 241.01, is amended by adding a subdivision to read:

Subd. 10. [PURCHASING FOR PRESCRIPTION DRUGS.] In accordance with section 241.021, subdivision 4, the commissioner may contract with a separate entity to purchase prescription drugs for persons confined in institutions under the control of the commissioner. Local governments may participate in this purchasing pool in order to purchase prescription drugs for those persons confined in local correctional facilities in which the local government has responsibility for providing health care. If any county participates, the commissioner shall appoint a county representative to any committee convened by the commissioner for the purpose of establishing a drug formulary to be used for state and local correctional facilities.

Sec. 4. Minnesota Statutes 2004, section 256.741, subdivision 4, is amended to read:

Subd. 4. [EFFECT OF ASSIGNMENT.] Assignments in this section take effect upon a determination that the applicant is eligible for public assistance. The amount of support assigned under this subdivision may not exceed the total amount of public assistance issued or the total support obligation, whichever is less. Child care support collections made according to an assignment under subdivision 2, paragraph (c), must be deposited, subject to any limitations of federal law, ~~by the commissioner of human services in the child support collection account in the special revenue fund and appropriated to the commissioner of education for child care assistance under section 119B.03. These collections are in addition to state and federal funds appropriated to the child care~~ in the general fund.

Sec. 5. [256.957] [HEALTH CARE QUALITY IMPROVEMENT ACCOUNT.]

A health care quality improvement account is established in the general fund.

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

Subd. 13e. [PAYMENT RATES.] (a) The basis for determining the amount of payment shall be the lower of the actual acquisition costs of the drugs plus a fixed dispensing fee; the maximum allowable cost set by the federal government or by the commissioner plus the fixed dispensing fee; or the usual and customary price charged to the public. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The pharmacy dispensing fee shall be $3.65, except that the dispensing fee for intravenous solutions which must be compounded by the pharmacist shall be $8 per bag, $14 per bag for cancer chemotherapy products, and $30 per bag for total parenteral nutritional products dispensed in one liter quantities, or $44 per bag for total parenteral nutritional products dispensed in quantities greater than one liter. Actual

acquisition cost includes quantity and other special discounts except time and cash discounts. The actual acquisition cost of a drug shall be estimated by the commissioner, at average wholesale price minus 11.5 percent, except that where a drug has had its wholesale price reduced as a result of the actions of the National Association of Medicaid Fraud Control Units, the estimated actual acquisition cost shall be the reduced average wholesale price, without the 11.5 percent deduction. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to, but no higher than, the maximum amount paid by other third-party payors in this state who have maximum allowable cost programs. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

(b) An additional dispensing fee of $.30 may be added to the dispensing fee paid to pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities when a unit dose blister card system, approved by the department, is used. Under this type of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National Drug Code (NDC) from the drug container used to fill the blister card must be identified on the claim to the department. The unit dose blister card containing the drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider will be required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse. Over-the-counter medications must be dispensed in the manufacturer's unopened package. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply.

(c) Whenever a generically equivalent product is available, payment shall be on the basis of the actual acquisition cost of the generic drug, or on the maximum allowable cost established by the commissioner.

(d) The basis for determining the amount of payment for

drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the provider, the average wholesale price minus five percent, or the maximum allowable cost set by the federal government under United States Code, title 42, chapter 7, section 1396r-8(e), and Code of Federal Regulations, title 42, section 447.332, or by the commissioner under paragraphs (a) to (c).

(e) The commissioner may consider the prices reported under section 151.47, subdivision 1, paragraph (g), when determining reimbursement payments under this subdivision.

Sec. 7. Minnesota Statutes 2004, section 295.582, is amended to read:

295.582 [AUTHORITY.]

Subdivision 1. [WHOLESALE DRUG DISTRIBUTOR TAX.] (a) A hospital, surgical center, or health care provider that is subject to a tax under section 295.52, or a pharmacy that has paid additional expense transferred under this section by a wholesale drug distributor, may transfer additional expense generated by section 295.52 obligations on to all third-party contracts for the purchase of health care services on behalf of a patient or consumer. Nothing shall prohibit a pharmacy from transferring the additional expense generated under section 295.52 to a pharmacy benefits manager. The additional expense transferred to the third-party purchaser or a pharmacy benefits manager must not exceed the tax percentage specified in section 295.52 multiplied against the gross revenues received under the third-party contract, and the tax percentage specified in section 295.52 multiplied against co-payments and deductibles paid by the individual patient or consumer. The expense must not be generated on revenues derived from payments that are excluded from the tax under section 295.53. All third-party purchasers of health care services including, but not limited to, third-party purchasers regulated under chapter 60A, 62A, 62C, 62D, 62H, 62N, 64B, 65A, 65B, 79, or 79A, or under section 471.61 or 471.617, and pharmacy benefits managers must pay the transferred expense in addition to any payments due under

existing contracts with the hospital, surgical center, pharmacy, or health care provider, to the extent allowed under federal law. A third-party purchaser of health care services includes, but is not limited to, a health carrier or community integrated service network that pays for health care services on behalf of patients or that reimburses, indemnifies, compensates, or otherwise insures patients for health care services. For purposes of this section, a pharmacy benefits manager means an entity that performs pharmacy benefits management. A third-party purchaser or pharmacy benefits manager shall comply with this section regardless of whether the third-party purchaser or pharmacy benefits manager is a for-profit, not-for-profit, or nonprofit entity. A wholesale drug distributor may transfer additional expense generated by section 295.52 obligations to entities that purchase from the wholesaler, and the entities must pay the additional expense. Nothing in this section limits the ability of a hospital, surgical center, pharmacy, wholesale drug distributor, or health care provider to recover all or part of the section 295.52 obligation by other methods, including increasing fees or charges.

(b) 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).

(d) If the commissioner responsible for regulating the third-party purchaser finds at any time that the third-party purchaser has not complied with paragraph (a), the commissioner may take enforcement action against a third-party purchaser

which is subject to the commissioner's regulatory jurisdiction and which does not allow a hospital, surgical center, pharmacy, or provider to pass-through the tax. The commissioner may by order fine or censure the third-party purchaser or revoke or suspend the certificate of authority or license of the third-party purchaser to do business in this state if the commissioner finds that the third-party purchaser has not complied with this section. The third-party purchaser may appeal the commissioner's order through a contested case hearing in accordance with chapter 14.

Subd. 2. [AGREEMENT.] A contracting agreement between a third-party purchaser or a pharmacy benefits manager and a resident or nonresident pharmacy registered under chapter 151, may not prohibit:

(1) a pharmacy that has paid additional expense transferred under this section by a wholesale drug distributor from exercising its option under this section to transfer such additional expenses generated by the section 295.52 obligations on to the third-party purchaser or pharmacy benefits manager; or

(2) a pharmacy that is subject to tax under section 295.52, subdivision 4, from exercising its option under this section to recover all or part of the section 295.52 obligations from the third-party purchaser or a pharmacy benefits manager.

Sec. 8. [LANGUAGE INTERPRETER SERVICES STUDY.]

The commissioner of commerce, in consultation with the commissioners of health, human services, and employee relations, and representatives of health plan companies, health care providers, and limited-English-speaking communities, and communities that communicate through sign language shall study and make recommendations on providing language interpreter services to limited-English-speaking patients and patients who communicate through sign language in order to facilitate the provision of health care services by health care providers and health care facilities. The recommendations shall include:

(1) ways to address the needed availability of professional interpreter services;

(2) an accreditation system for language interpreters, including appropriate standards for education, training, and credentialing; and

(3) criteria for determining financial responsibility for providing interpreter services to patients, including the responsible parties for arranging interpreter services and for reimbursement for these services.

The commissioner of commerce shall submit these recommendations to the legislature by January 15, 2006.

Sec. 9. [REBATE REVENUE RECAPTURE.]

Any money received by the state from a drug manufacturer due to errors in the pharmaceutical pricing used by the manufacturer in determining the prescription drug rebate shall be deposited in the health care quality improvement account established in Minnesota Statutes, section 256.957.

Sec. 10. [REPEALER.]

Minnesota Statutes 2004, section 119B.074, is repealed.

ARTICLE 8

APPROPRIATIONS

Section 1. [HEALTH AND HUMAN SERVICES APPROPRIATIONS.]

The sums in the columns marked "APPROPRIATIONS" are added to, or, if shown in parentheses, are subtracted from the appropriations to the specified agencies in 2005 S.F. No. 1879, article 5, if enacted. The appropriations are from the general fund, unless another fund is named, and are available for the fiscal year indicated for each purpose. The figures "2006" and "2007," where used in this article, mean that the additions to or subtractions from the appropriations listed under them are for the fiscal year ending June 30, 2006, or June 30, 2007, respectively. The "first year" is fiscal year 2006. The "second year" is fiscal year 2007. The "biennium" is fiscal years 2006 and 2007.

SUMMARY BY FUND

	2006	2007	BIENNIAL TOTAL
General	$ 48,398,000	$ 78,851,000	$ 127,250,000
State Government Special Revenue	7,001,000	12,625,000	19,626,000
Health Care Access	39,339,000	57,519,000	96,858,000
Federal TANF	(3,033,000)	14,817,000	11,784,000
Lottery Prize Fund	400,000	400,000	800,000

TOTAL	$ 92,105,000	$ 164,212,000	$ 256,318,000

	APPROPRIATIONS Available for the Year Ending June 30	
	2006	2007
Sec. 2. COMMISSIONER OF HUMAN SERVICES		
Subdivision 1. Total Appropriation	$ 83,181,000	$ 148,602,000
Summary by Fund		
General	46,545,000	75,936,000
Health Care Access	39,269,000	57,449,000
Federal TANF	(3,033,000)	14,817,000
Lottery Cash Flow	400,000	400,000

[ADMINISTRATIVE REDUCTION.] The general fund appropriation in this section includes a department-wide administrative reduction of $6,885,000 the first year and $7,201,000 the second year. The commissioner shall ensure that any staff reductions made under this paragraph comply with Minnesota Statutes, section 43A.046.

[REDUCED TANF TRANSFER.] Notwithstanding Laws 2000, chapter 488, article 8, section 2, subdivision 6, with respect to TANF funds used as refinancing for the state share of the child support pass-through under Minnesota Statutes, section 256.741, subdivision 15, and notwithstanding Minnesota Statutes, section 290.0671, subdivision 6a, with respect to the TANF-funded expansion of the Minnesota working family credit, the commissioner shall reduce the combined amount of the TANF funds transferred to the commissioner of revenue for deposit in the general fund by $11,160,000 in fiscal year 2006 and by $7,000,000 in fiscal year 2007 and subsequent years. Notwithstanding section 5, this paragraph shall not expire.

[TANF TRANSFER TO FEDERAL CHILD CARE AND DEVELOPMENT FUND.] The following amounts are appropriated to the commissioner for the purposes of MFIP transition year child care under Minnesota Statutes, section 119B.05; $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 commissioner shall authorize the transfer of sufficient TANF funds to the federal child care and development fund to meet this appropriation and

shall ensure that all transferred funds are expended according to the federal child care and development fund regulations. Notwithstanding section 5, this paragraph expires June 30, 2009.

Subd. 2. Agency Management

	Summary by Fund	
General	(158,000)	(231,000)
Health Care Access	1,623,000	1,701,000

The amounts that may be spent from the appropriation for each purpose are as follows:

(a) Financial Operations

General	424,000	424,000
Health Care Access	152,000	183,000

[ADMINISTRATIVE BASE ADJUSTMENT - WEB PAYMENT.] The health care access fund base is increased by $28,000 in fiscal year 2008 and $61,000 in fiscal year 2009 for fees associated with web-based payment collections.

(b) Legal and Regulation Operations

General	(5,208,000)	(5,482,000)
Health Care Access	75,000	75,000

(c) Information Technology Operations

General	4,626,000	4,827,000
Health Care Access	1,396,000	1,443,000

Subd. 3. Revenue and Pass-Through

Federal TANF	(17,712,000)	(6,312,000)

Subd. 4. Basic Health Care Grants

	Summary by Fund	
General	4,916,000	18,513,000
Health Care Access	30,843,000	51,903,000

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) MinnesotaCare Grants

Health Care Access	30,843,000	51,903,000

(b) MA Basic Health Care Grants - Families and Children

4,385,000	12,062,000

[GREATER MINNESOTA HOSPITAL PAYMENT

ADJUSTMENT.] Of the general fund appropriation, $400,000 each year is for greater Minnesota payment adjustments under Minnesota Statutes, section 256.969, subdivision 26, for admissions occurring on or after July 1, 2005.

(c) Notwithstanding section 5, these provisions shall not expire.

(d) MA Basic Health Care Grants - Elderly and Disabled

(62,000) (838,000)

(e) General Assistance Medical Care Grants

3,092,000 9,266,000

(f) Health Care Grants - Other Assistance

(2,500,000) (1,978,000)

Subd. 5. Health Care Management

Summary by Fund

General	4,663,000	4,411,000
Health Care Access	6,803,000	3,845,000

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) Health Care Administration

General	4,206,000	4,157,000
Health Care Access	4,353,000	3,152,000

(b) Health Care Operations

General	457,000	254,000
Health Care Access	2,450,000	693,000

Subd. 6. State-Operated Services

22,682,000 6,796,000

[EVIDENCE-BASED PRACTICE FOR METHAMPHETAMINE TREATMENT.] Of the general fund appropriation, $300,000 each year is to support development of evidence-based practices for the treatment of methamphetamine abuse at the state-operated services chemical dependency program in Willmar. These funds shall be used to support research on evidence-based practices for the treatment of methamphetamine abuse, dissemination of the results of the evidence-based practice research statewide, and creation of training for addiction counselors specializing in the treatment of methamphetamine abuse.

Subd. 7. Continuing Care Grants

Summary by Fund

General	11,536,000	38,301,000
Lottery Prize Fund	400,000	400,000

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) Aging and Adult Service Grant

3,000 10,000

(b) Deaf and Hard-of-Hearing Service Grants

10,000 33,000

(c) Mental Health Grants

General	1,024,000	1,888,000
Lottery Prize Fund	400,000	400,000

[TASK FORCE ON COLLABORATIVE SERVICES.] The commissioner, in collaboration with the commissioner of education, shall create a task force to discuss collaboration between schools and mental health providers to: promote colocation and integrated services; identify barriers to collaboration; develop a model contract; and identify examples of successful collaboration. The task force shall 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, 2006.

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.

[ALTERNATIVES TO ANOKA-METRO REGIONAL TREATMENT CENTER.] Of this 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

section 5, this paragraph shall not expire.

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

(3,562,000) (4,171,000)

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

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

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

(e) Medical Assistance Long-Term Care Facilities Grants

1,536,000 16,340,000

[RATE ADJUSTMENTS UNDER NEW NURSING FACILITY REIMBURSEMENT SYSTEM.] Of this appropriation, $12,992,000 the second year is to adjust nursing facility rates in order to facilitate the transition from the current ratesetting system to the system developed under Minnesota Statutes, section 256B.440.

[NURSING HOME MORATORIUM EXCEPTIONS.]

Of this appropriation, $300,000 the first year is to the commissioner for the medical assistance costs of moratorium exceptions approved by the commissioner of health under Minnesota Statutes, section 144A.073.

[ICF/MR DOWNSIZING.] Of this appropriation, $600,000 the first year is for rate adjustments for intermediate care facilities for persons with mental retardation that are downsizing.

(f) Alternative Care Grants

10,131,000 18,774,000

(g) Chemical Dependency Entitlement Grants

2,144,000 4,762,000

(h) Other Continuing Care

250,000 665,000

Subd. 8. Continuing Care Management

534,000 430,000

Subd. 9. Economic Support Grants

Summary by Fund

General	2,106,000	7,456,000
Federal TANF	14,679,000	21,129,000

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) Minnesota Family Investment Program

General	-0-	3,740,000
Federal TANF	13,783,000	19,898,000

(b) MFIP Child Care Assistance Grants

General	-0-	(3,740,000)
Federal TANF	756,000	1,091,000

(c) Children Services Grants

1,124,000 6,074,000

(d) Children and Community Services Grants

General Fund	3,000	11,000
Federal TANF	140,000	140,000

(e) Minnesota Supplemental Aid Grants

118,000 363,000

(f) Group Residential Housing Grants

111,000 258,000

(g) Other Children's and Economic Assistance Grants

750,000 750,000

[NEW CHANCE PROGRAM.] Of the TANF appropriation, $140,000 each year is to the commissioner for a grant to the new chance program. The new chance program shall provide comprehensive services through a private, nonprofit agency to young parents in Hennepin County who have dropped out of school and are receiving public assistance. The program administrator shall report annually to the commissioner on skills development, education, job training, and job placement outcomes for program participants.

[TRANSITIONAL HOUSING.] Of this appropriation, $750,000 each year is to the commissioner for the transitional housing program established in the 2005 Environment, Agriculture, and Economic Development omnibus appropriations bill.

Subd. 10. Children and Economic Assistance Management

267,000 261,000

Sec. 3. COMMISSIONER OF HEALTH

Subdivision 1. Total Appropriation	6,757,000	13,604,000
Summary by Fund		
General	1,853,000	2,915,000
State Government Special Revenue	4,834,000	10,619,000
Health Care Access	70,000	70,000

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

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

(c) The commissioner shall increase all fees levied by the commissioner a pro rata amount in order to generate revenue of $712,000 the first year and $1,808,000 the second year. These amounts shall be deposited in the

general fund. This paragraph shall not apply to fees paid by occupational therapists.

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

Subd. 2. Health Improvement

Summary by Fund

General	645,000	(154,000)
State Government Special Revenue	335,000	335,000
Health Care Access	70,000	70,000

[TANF CARRYFORWARD.] Any unexpended 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 cancel but is available for the second year.

Subd. 3. Policy Quality and Compliance

Summary by Fund

State Government Special Revenue	770,000	770,000

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

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

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

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

(2) encourage screening and testing for HIV; and

(3) connect individuals to public

health and health care resources. The grants must be awarded to collaborative efforts that bring together nonprofit community-based groups with demonstrated experience in addressing the public health, health care, and social service needs of African-born communities.

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

Subd. 4. Health Protection

Summary by Fund

State Government		
Special Revenue	3,729,000	9,514,000

Subd. 5. Administrative Support Services

1,208,000 3,069,000

Sec. 4. HEALTH-RELATED BOARDS

Subdivision 1. Total Appropriation	2,167,000	2,006,000

Summary by Fund

State Government		
Special Revenue	2,167,000	2,006,000

[STATE GOVERNMENT SPECIAL REVENUE FUND.] The appropriations in this section are from the state government special revenue fund, except where noted.

[NO SPENDING IN EXCESS OF REVENUES.] The commissioner of finance shall not permit the allotment, encumbrance, or expenditure of money appropriated in this section in excess of the anticipated biennial revenues or accumulated surplus revenues from fees collected by the boards. Neither this provision nor Minnesota Statutes, section 214.06, applies to transfers from the general contingent account.

Subd. 2. Board of Dentistry

Summary by Fund

State Government		
Special Revenue	150,000	-0-

[ORAL HEALTH PILOT PROJECT.] Of this appropriation, $150,000 the first year is to be transferred to the commissioner of human services for an oral health care system pilot project.

Subd. 3. Board of Nursing

1,563,000 1,407,000

[MINNESOTA CENTER OF NURSING.] (a) Of this appropriation, $500,000 in fiscal year 2006 is to be used as start-up funding to establish a Minnesota Center of Nursing. The goals of the center shall be to:

(1) maintain information on the current and projected supply and demand of nurses through the collection and analysis of data on the nursing workforce;

(2) develop a strategic statewide plan for the nursing workforce;

(3) convene work groups of stakeholders to examine issues and make recommendations regarding factors affecting nursing education, recruitment, and retention;

(4) promote recognition, reward, and renewal activities for nurses in Minnesota; and

(5) provide consultation, technical assistance, and data on the nursing workforce to the legislature.

(b) The board shall report to the legislature by January 15, 2007, on the Center of Nursing's progress, the center's collaboration efforts with other organizations and governmental entities, and the activities conducted by the center in achieving the goals outlined.

[TRANSFERS FROM SPECIAL REVENUE FUND.] The following transfers shall be made as directed from the state government special revenue fund:

(a) $938,000 the first year and $1,207,000 the second year shall be transferred to the commissioner of human services for the long-term care and home and community-based care employee scholarship program.

(b) $125,000 the first year and $200,000 the second year shall be transferred to the health professional education loan forgiveness program account for loan forgiveness for nurses under Minnesota Statutes, section 144.1501. This appropriation shall become part of base level funding for the commissioner for the biennium beginning July 1, 2007. Notwithstanding section 5, this paragraph expires on June 30, 2009.

Subd. 4. Board of Pharmacy

499,000 499,000

[RURAL PHARMACY PROGRAM.] Of this

appropriation, $200,000 each year shall be transferred to the commissioner of health for the rural pharmacy planning and transition grant program under Minnesota Statutes, section 144.1476. Of this transferred amount, $20,000 each year may be retained by the commissioner for related administrative costs. This appropriation shall become part of base level funding for the commissioner for the biennium beginning July 1, 2007. Notwithstanding section ..., this paragraph expires on June 30, 2009.

[PHARMACIST LOAN FORGIVENESS.] $200,000 each year shall be transferred to the health professional education loan forgiveness program account for loan forgiveness for pharmacists under Minnesota Statutes, section 144.501. This appropriation shall become part of base level funding for the commissioner for the biennium beginning July 1, 2007. Notwithstanding section ..., this 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.

(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.

Subd. 5. Board of Social Work

105,000 100,000

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

Sec. 5. [SUNSET OF UNCODIFIED LANGUAGE.]

All uncodified language in this article expires on June 30, 2007, unless a different expiration date is explicit.

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State of Minnesota

S.F. No. XXXX - Short Summary of Health and Human Services Omnibus Appropriations Bill

Author: Senator Linda Berglin

Prepared by: David Giel, Senate Research (296-7178)
Katie Cavanor, Senate Counsel (296-3801)
Joan White, Senate Counsel (296-3814)

Date: April 26, 2005

Article 1
Health Department

This article establishes a state trauma system. It increases fees for vital statistics, drinking water, well management, plumbing, food management, food, beverage and lodging and lab certification. It increases fees for hospitals and outpatient surgical centers for the adverse health care reporting system. It establishes new plumbing and inspection requirements. It expands the number of days of swing bed nursing home care that can be provided by Critical Access Hospitals. The article also establishes a rural pharmacy planning and transition grant program. It adds to the loan forgiveness program nurse educators, pharmacists who agree to practice in rural areas, and medical residents who agree to specialize in pediatric psychiatry. It also lowers the level of venous blood lead level required for a lead assessment to be conducted. It establishes a cervical cancer elimination study, a clinical trial work group to look at health plan coverage for routine care associated with clinical trials, and an interagency work group on childhood obesity.

Article 2
Health Care – Department of Human Services

This article establishes an annual non-Medical Assistance (MA) payment to certain hospitals, financed with federal matching funds expected to be earned on certified public expenditures reported by certain hospitals. It strengthens MA third-party collection processes. It also makes a number of changes to the state health care programs by restoring MinnesotaCare benefits to single adults without children, restoring dental benefits, and eliminating copayments. The article also establishes

a performance reporting and quality improvement payment system for providers who meet certain levels of performance. It establishes a prior authorization requirement for certain identified services and requires that a list of services be developed that are determined not to be medically effective. The article also reestablishes the prescription drug discount program ensuring individuals with no prescription drug coverage the ability to purchase drugs at the MA rate. It expands MA coverage to include medication therapy management care. It clarifies the HIV health care access program. It also allows members of the military to voluntarily disenroll from MinnesotaCare and to reenroll without penalty. It permits small employers to purchase health care coverage for their employees through MinnesotaCare. It requires a report from employers on the number of employees who are receiving coverage under state health care programs. It provides start-up money to the commissioner for an oral health care system pilot project.

Article 3
Health Care Cost Containment

This article establishes premium growth limits and health care expenditure limits. It also requires health plan companies to provide enrollees with health risk information on tobacco use and obesity. It also places limits on hospital billings for services to uninsured individuals.

Article 4
Long-Term Care and Continuing Care

This article strengthens oversight of the personal care assistant (PCA) program. It repeals the 2003 legislation establishing Alternative Care program liens and exempts, effective July 1, 2005, certain family farms and income-producing property from the 2003 changes regarding liens on life estates and joint tenancies. It provides two percent COLAs for employees of nursing facilities, intermediate care facilities, and a variety of community-based services. It creates an incentive to establish single-bed nursing facility rooms by closing beds. It suspends the automatic inflationary increase for APS nursing facilities for two years. It establishes rate increases for a very small number of individual facilities and extends previously granted moratorium exceptions by 18 months for certain nursing facilities. It establishes state policy that trusts should not be permitted to shield available resources from use and should be accessed before a person applies for state health care programs.

Article 5
Mental and Chemical Health

This article includes provisions dealing with offenders with mental illness who are being released from a correctional facility; requires that beds be closed at the Anoka-Metro Regional Treatment Center, and a sufficient number of alternative services be developed, including supportive housing and services; clarifies that methamphetamine treatment is part of the treatment available under the chemical dependency treatment fund services; expands medical assistance coverage, subject to federal approval, to include treatment foster care, transitional youth intensive rehabilitative mental health services, mental health telemedicine, and psychiatric consultation to primary care practitioners; and creates a county share for treatment foster care costs.

Article 6
Family Support

This article establishes the Work Participation Rate Enhancement Program; modifies the parental contribution for parents whose children are receiving Medical Assistance services without regard to income; authorizes American Indian Child Welfare Projects; modifies the work requirement for MFIP recipients who are in school; allows certain newly arrived refugees and asylees to enroll directly in MFIP, and repeals two MFIP provisions dealing with rental subsidies and Supplemental Security Income.

Article 7
Miscellaneous

This article requires drug manufacturers to provide the Commissioner of Human Services with pharmaceutical pricing information. It also establishes a cancer drug repository program. It clarifies the provider tax pass through requirement for pharmacy benefit managers. Finally, it requires a study of language interpreter services.

Article 8
Appropriations

This article makes appropriations for the departments of health and human services and a number of health-related boards and includes budget-related riders.

/cs

BILLS INCLUDED IN THE HEALTH AND HUMAN SERVICES OMNIBUS APPROPRIATIONS BILL

SF #	Author	Topic
23	Solon	Drug manufacturer price reporting
24	Solon	Cervical cancer elimination study
65	Berglin	Health care reform
127	Wiger	Ramsey County nursing facility rate increase
227	Solon	Cancer drug repository program
254	Berglin	Parental contributions, MFIP, liens
255	Berglin	Repeal MinnesotaCare limited benefit set
695	Koering	MinnesotaCare definition of gross income
769	Berglin	New Chance Program
795	Higgins	Language interpreter services
828	Lourey	Employer disclosure by public program recipients
884	Kubly	Nursing home moratorium project extension
908	Lourey	Donated dental services
968	Dibble	AIDS prevention for African-born persons
973	Lourey	MA coverage for medication therapy management
984	Lourey	Programs for persons with disabilities
1000	Berglin	Inmate discharge planning
1028	Berglin	Discharge of offenders with mental illness
1101	Bakk	Swing beds
1115	Fischbach	Plumbing licensure
1118	Larson	Nursing home moratorium project extension
1122	Solon	Rural hospital DRG payments
1162	Berglin	Medical Fairness Act
1163	Berglin	RN loan forgiveness
1266	Rosen	Critical Access Hospitals
1279	Dibble	Antihemophilic drugs
1297	Saxhaug	Nursing home moratorium project extension
1313	LeClair	DHS budget bill
1395	Foley	Anoka RTC alternatives
1520	Dille	MFIP diversionary work program
1567	Kubly	Rural pharmacy grant and loan
1589	Frederickson	Relocation of Brown County ICF/MR
1706	Higgins	Task force on mental health collaboration
1817	Berglin	MFIP work hours for students
1836	Hottinger	HIV health care access program
1837	Lourey	DHS health care policy
1864	Higgins	Center of Nursing
1872	Lourey	Lead risk assessment
1955	Berglin	MFIP work participation rate enhancement
1979	Berglin	Non-MA hospital payment
2003	Berglin	Employee COLAs, waiver limits, bed closures
2232	Belanger	Nursing home moratorium project extension

Note: all or a portion of these bills are included in the omnibus bill

Prepared by Senate Counsel, Research, and Fiscal Analysis, April 26, 2005

Trkg. Line	Gov Rec / Bill Ref	Fund	BACT	DESCRIPTION	GOVERNOR'S RECOMMENDATION FY 2006	FY 2007	FY 06-07	FY 2008	FY 2009	FY 08-09	SENATE POSITION - SF 1879 FY 2006	FY 2007	FY 06-07	FY 2008	FY 2009	FY 08-09	SENATE POSITION - HHS OMNIBUS BUDGET BILL FY 2006	FY 2007	FY 06-07	FY 2008	FY 2009	FY 08-09	SENATE TOTAL POSITION FY 06-07	FY 08-09
NET FISCAL IMPACT: DIRECT APPROPRIATIONS +/- NON-DEDICATED REVENUE																								
	Note: Increases in non-dedicated revenues are shown as negatives in this tracking																							
1																								
2		TOTAL - ALL AGENCIES			(100,436)	(174,073)	(274,509)	(125,618)	(105,623)	(231,241)	(38,521)	(52,457)	(90,978)	(29,551)	(27,848)	(57,399)	101,737	158,052	259,790	208,674	245,168	453,842	168,812	396,443
3		GF		General Fund	(257,231)	(374,027)	(631,258)	(362,744)	(364,524)	(727,268)	(38,521)	(52,457)	(90,978)	(29,551)	(27,848)	(57,399)	65,933	84,557	150,491	122,185	160,959	283,144	59,513	225,745
4		SGSR		State Government Special Revenue Fund	1,153	(487)	666	1,323	1,232	2,555	0	0	0	0	0	0	1,608	2,959	4,567	2,156	1,389	3,545	4,567	3,545
5		HCAF		Health Care Access Fund	155,642	200,441	356,083	235,803	257,669	493,472	0	0	0	0	0	0	36,829	55,319	92,148	81,454	96,683	178,137	92,148	178,137
6		TANF		Federal TANF	0	0	0	0	0	0	0	0	0	0	0	0	(3,033)	14,817	11,784	2,479	(14,263)	(11,784)	11,784	(11,784)
7		LOTT		Lottery Prize Fund	0	0	0	0	0	0	0	0	0	0	0	0	400	400	800	400	400	800	800	800
8		OTH		Other Funds	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
9																								
10																				313	39	352		
11																								
12		HUMAN SERVICES TARGET - DIRECT APPROPRIATIONS																						
13				Target			276,198												150,500					
14				Proposals			276,198												150,491					
15				Over/(Under) Target			0												(10)					
16																								
17		HCAF FUND BALANCE																						
18				February 2005 Forecast	81,819	204,563		469,758	771,320		81,819	204,563		469,758	771,320		82,619	207,663		475,558	780,420			
19				Investment income change (cumulative, per DOF)	(1,275)	(6,889)		(21,726)	(50,220)		0	0		0	0		(918)	(2,721)		(8,100)	(21,042)			
20				Non-DHS proposals (cumulative, per DOF)	(930)	(40)		1,160	2,880		800	3,100		5,800	9,100		0	0		0	0			
21				Provider tax transfers (cumulative, per DOF)	49,413	102,072		161,513	203,800		0	0		0	0		0	0		0	0			
22				End of year balance transfers (cumulative, per DOF)	26,615	56,377		6,377	(43,623)		0	0		0	0		0	0		0	0			
23				DHS Proposals (cumulative)	(165,642)	(356,083)		(591,886)	(849,555)		0	0		0	0		(36,829)	(92,148)		(173,602)	(270,285)			
24				Ending Balance	0	0		15,196	34,602		82,619	207,663		475,558	780,420		44,872	112,794		293,856	489,093			
25				HealthMatch Reserve													44,000	88,000		88,000	88,000			
26				Balance after Reserve													872	24,794		205,856	401,093			
27																								
28		FEDERAL TANF BALANCE																						
29				February 2004 Forecast	51,849	33,477		14,263	0		51,849	33,477		14,263	0		51,849	33,477		14,283	0			
30				Proposals (cumulative)	0	0		0	0		0	0		0	0		3,033	(11,784)		(14,283)	0			
31				Ending Balance	51,849	33,477		14,263	0		51,849	33,477		14,263	0		54,882	21,693		0	0			
32																								
33																								
34																								
35		DEPARTMENT OF HUMAN SERVICES			(101,185)	(175,013)	(276,198)	(128,368)	(108,282)	(236,650)	(38,521)	(52,457)	(90,978)	(29,551)	(27,848)	(57,399)	99,554	154,522	254,077	205,948	243,209	449,157	163,099	391,756
36		GF		General Fund	(256,827)	(375,454)	(632,281)	(364,171)	(365,951)	(730,122)	(38,521)	(52,457)	(90,978)	(29,551)	(27,848)	(57,399)	65,428	84,056	149,485	121,685	160,459	282,144	58,507	224,745
37		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
38		HCAF		Health Care Access Fund	155,642	200,441	356,083	235,803	257,669	493,472	0	0	0	0	0	0	36,759	55,249	92,008	81,384	96,613	177,997	92,008	177,997
39		TANF		Federal TANF	0	0	0	0	0	0	0	0	0	0	0	0	(3,033)	14,817	11,784	2,479	(14,263)	(11,784)	11,784	(11,784)
40		LOTT		Lottery Prize Fund	0	0	0	0	0	0	0	0	0	0	0	0	400	400	800	400	400	800	800	800
41		OTH		Other Funds	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
42																								
43																				313	39	352		
44																								
45		DEPARTMENT OF HEALTH			749	940	1,689	2,750	2,659	5,409	0	0	0	0	0	0	(134)	1,524	1,390	1,952	1,110	3,062	1,390	3,062
46		GF		General Fund	(404)	1,427	1,023	1,427	1,427	2,854	0	0	0	0	0	0	505	501	1,006	500	500	1,000	1,006	1,000
47		SGSR		State Government Special Revenue Fund	1,153	(487)	666	1,323	1,232	2,555	0	0	0	0	0	0	(709)	953	244	1,382	540	1,922	244	1,922
48		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
49		TANF		Federal TANF	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
50		OTH		Other Funds	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
51																								
52																								
53																								
54		VETERANS NURSING HOMES BOARD			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
55		GF		General Fund	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
56		OTH		Other Funds	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
57																								
58																								
59																								
60		HEALTH RELATED BOARDS			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
61		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
62		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
63		OTH		Other Funds	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
64																								
65																								
66																								
67		EMERGENCY MEDICAL SERVICES BOARD			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
68		GF		General Fund	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Trkg. Line	Gov Rec / Bill Ref	Fund	BACT	DESCRIPTION	GOVERNOR'S RECOMMENDATION						SENATE POSITION - SF 1879						SENATE POSITION - HHS OMNIBUS BUDGET BILL						SENATE TOTAL POSITION	
					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 2006	FY 2007	FY 06-07	FY 2008	FY 2009	FY 08-09	FY 06-07	FY 08-09
69		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
70		OTH		Other Funds	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
71																								
72																								
73																								
74		COUNCIL ON DISABILITY			0	0	0	0	0	0	0	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	0	0	0	0	0	0
76		OTH		Other Funds	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
77																								
78																								
79																								
80		OMBUDSMAN FOR MENTAL HEALTH AND MENTAL RETARDATION			0	0	0	0	0	0	0	0	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	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
83																								
84																								
85																								
86		OMBUDSMAN FOR FAMILIES			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
87		GF		General Fund	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
88		OTH		Other Funds	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
89																								
129																								
130																								
131		***DEPARTMENT OF HUMAN SERVICES***																						
132																								
133																								
134	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
135		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
136		HCAF	13	HCAF operations	1,396	1,443	2,839	1,443	1,443	2,886	0	0	0	0	0	0	1,396	1,443	2,839	1,443	1,443	2,886	2,839	2,886
137		GF	13	Major systems operations	1,430	1,488	2,918	1,488	1,488	2,976	0	0	0	0	0	0	1,430	1,488	2,918	1,488	1,488	2,976	2,918	2,976
138		GF	REV1	Administrative ffp	(1,243)	(1,312)	(2,555)	(1,312)	(1,312)	(2,624)	0	0	0	0	0	0	(1,243)	(1,312)	(2,555)	(1,312)	(1,312)	(2,624)	(2,555)	(2,624)
139		HCAF	REV1	Administrative ffp	(559)	(577)	(1,136)	(577)	(577)	(1,154)	0	0	0	0	0	0	(559)	(577)	(1,136)	(577)	(577)	(1,154)	(1,136)	(1,154)
140																								
141	Rider	GENERAL FUND 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)
142		GF	11	Across the board admin reduction	0	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)
143		GF	REV1	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
144																								
145	Page 8	MEETING STATUTORY REQUIREMENTS FOR LICENSING			325	264	589	264	264	528	0	0	0	0	0	0	493	432	924	432	297	728	924	728
146		AND BACKGROUND STUDIES																						
147																								
148		*Licensing Performnace Standards*			*313*	*269*	*582*	*269*	*269*	*538*	*0*	*0*	*0*	*0*	*0*	*0*	*314*	*270*	*583*	*270*	*135*	*404*	583	404
149		GF	11	Administration (13 FTEs)	1,045	898	1,943	898	898	1,796	0	0	0	0	0	0	523	449	972	449	449	898	972	898
150		GF	REV1	Administrative ffp	(418)	(359)	(777)	(359)	(359)	(718)	0	0	0	0	0	0	(209)	(180)	(389)	(180)	(180)	(359)	(389)	(359)
151		GF	REV2	Increase licensing fees	(314)	(270)	(584)	(270)	(270)	(540)	0	0	0	0	0	0	0	0	0	0	(135)	(135)	0	(135)
152																								
153		*Fund Umbrella Rule Implementation*			*100*	*83*	*183*	*83*	*83*	*166*	*0*	*0*	*0*	*0*	*0*	*0*	*100*	*83*	*183*	*83*	*83*	*166*	183	166
154		GF	11	Administration (2 FTEs)	167	138	305	138	138	276	0	0	0	0	0	0	167	138	305	138	138	276	305	276
155		GF	REV1	Administrative ffp	(67)	(55)	(122)	(55)	(55)	(110)	0	0	0	0	0	0	(67)	(55)	(122)	(55)	(55)	(110)	(122)	(110)
156																								
157		*Increase Background 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
158		DED	REV	Increase fees to $20 (PCPO, SNSA, court appted guardian)	(167)	(167)	(334)	(167)	(167)	(334)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
159		DED	11	Operating deficit (direct & indirect)	167	167	334	167	167	334	0	0	0	0	0	0	0	0	0	0	0	0	0	0
160		GF	11	Operating deficit (direct & indirect)													167	167	334	167	167	334		
161		GF	REV1	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)
162																								
163	Page 11	MEETING STATUTORY REQUIREMENTS FOR ADMINISTRATIVE			608	505	1,113	505	505	1,010	0	0	0	0	0	0	419	505	924	505	505	1,010	924	1,010
164		FAIR HEARINGS									0	0		0	0									
165		GF	11	Administration (11 FTEs)	1,013	842	1,855	842	842	1,684	0	0	0	0	0	0	698	842	1,540	842	842	1,684	1,540	1,684
166		GF	REV1	Administrative ffp	(405)	(337)	(742)	(337)	(337)	(674)	0	0	0			0	(279)	(337)	(616)	(337)	(337)	(674)	(616)	(674)
167																								
168	Page 13	AMERICAN INDIAN CHILD WELFARE PROJECT			0	4,838	4,838	4,838	4,838	9,676	0	0	0	0	0	0	0	4,596	4,596	4,596	4,596	9,192	4,596	9,192
169		GF	26	Children's services grants	0	4,838	4,838	4,838	4,838	9,676	0	0	0	0	0	0	0	4,838	4,838	4,838	4,838	9,676	4,838	9,676
170		GF	REV2	County share 5% of total costs	0	0	0	0	0	0	0	0	0	0	0	0	0	(242)	(242)	(242)	(242)	(484)	(242)	(484)
171																								
172																								
173	Page 14	ADJUST APPROPRIATION 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
174		AND RELATIVE CUSTODY ASSISTANCE																						
175		GF	26	Adoption assistance	(526)	(449)	(975)	1,704	3,861	5,565	(526)	(449)	(975)	1,704	3,861	5,565	0	0	0	0	0	0	(975)	5,565
176		GF	26	Relative custody assistance	(814)	(1,042)	(1,856)	(204)	647	443	(814)	(1,042)	(1,856)	(204)	647	443	0	0	0	0	0	0	(1,856)	443
177																								

Trkg. Line	Gov Rec / Bill Ref	Fund	BACT	DESCRIPTION	GOVERNOR'S RECOMMENDATION						SENATE POSITION - SF 1879						SENATE POSITION - HHS OMNIBUS BUDGET BILL						SENATE TOTAL POSITION	
					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 2006	FY 2007	FY 06-07	FY 2008	FY 2009	FY 08-09	FY 06-07	FY 08-09
178	Page 15	**PREVENT HOMELESSNESS FOR YOUNG ADULTS**			1,125	1,122	2,247	1,122	1,122	2,244	0	0	0	0	0	0	1,125	1,122	2,247	1,122	1,122	2,244	2,247	2,244
179		**TRANSITIONING FROM LONG-TERM FOSTER CARE**																						
180		GF	26	Demonstration project: transition planning with supportive housing	1,085	1,085	2,170	1,085	1,085	2,170	0	0	0	0	0	0	1,085	1,085	2,170	1,085	1,085	2,170	2,170	2,170
181		GF	35	Staff to administer/coordinate demonstration programs (1 fte)	72	66	138	66	66	132	0	0	0	0	0	0	72	66	138	66	66	132	138	132
182		GF	REV1	Administrative ffp	(32)	(29)	(61)	(29)	(29)	(58)	0	0	0	0	0	0	(32)	(29)	(61)	(29)	(29)	(58)	(61)	(58)
183																								
184	Page 17	**ADDRESS HOMELESSNESS WITH SUPPORTIVE HOUSING**			5,000	5,000	10,000	5,000	5,000	10,000	0	0	0	0	0	0	0	0	0	0	0	0	0	0
185		**SERVICES GRANTS**																						
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	0	0	0	0	0	0
187																								
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
189		GF	27	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	(50,000)	0
190																								
191	Page 19	**FREEZE MAXIMUM RATES PAID FOR CHILD CARE ASSISTANCE**			(32,330)	(35,859)	(68,189)	(34,709)	(33,045)	(67,754)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
192		GF	22	MFIP child care assistance grants	(22,289)	(30,318)	(52,607)	(31,348)	(32,039)	(63,387)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
193		GF	23	BSF child care assistance	(10,041)	(5,591)	(15,632)	(3,361)	(1,006)	(4,367)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
194		GF	36	MAXIS-MEC[2]	0	50	50	0	0	0	0	0	0	0	0	0			0			0	0	0
195																								
196	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	0
197		GF	10	Financial operations	424	424	848	424	424	848	0	0	0	0	0	0	424	424	848	424	424	848	848	848
198		GF	11	Legal & regulatory operations	123	123	246	123	123	246	0	0	0	0	0	0	123	123	246	123	123	246	246	246
199		GF	13	Technical operations	60	60	120	60	60	120	0	0	0	0	0	0	60	60	120	60	60	120	120	120
200		GF	35	Children & economic assistance administration	195	195	390	195	195	390	0	0	0	0	0	0	195	195	390	195	195	390	390	390
201		GF	REV1	Administrative ffp	(802)	(802)	(1,604)	(802)	(802)	(1,604)	0	0	0	0	0	0	(802)	(802)	(1,604)	(802)	(802)	(1,604)	(1,604)	(1,604)
202		DED	10	Financial operations	(424)	(424)	(848)	(424)	(424)	(848)	0	0	0	0	0	0	(424)	(424)	(848)	(424)	(424)	(848)	(848)	(848)
203		DED	11	Legal & regulatory operations	(123)	(123)	(246)	(123)	(123)	(246)	0	0	0	0	0	0	(123)	(123)	(246)	(123)	(123)	(246)	(246)	(246)
204		DED	13	Technical operations	(60)	(60)	(120)	(60)	(60)	(120)	0	0	0	0	0	0	(60)	(60)	(120)	(60)	(60)	(120)	(120)	(120)
205		DED	35	Children & economic assistance administration	(195)	(195)	(390)	(195)	(195)	(390)	0	0	0	0	0	0	(195)	(195)	(390)	(195)	(195)	(390)	(390)	(390)
206		DED	REV3	Agency indirect costs - dedicated revenue	802	802	1,604	802	802	1,604	0	0	0	0	0	0	802	802	1,604	802	802	1,604	1,604	1,604
207																								
208	Page 21	**FINALIZE 2003 SESSION TANF REFINANCING**			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
209		TANF	15	Increase TANF transfer to MFIP child care	6,692	3,192	9,884	3,192	3,192	6,384	0	0	0	0	0	0	0	0	0	0	0	0	0	0
210		TANF	15	Reduce undesignated TANF refinancing	(6,692)	(3,192)	(9,884)	(3,192)	(3,192)	(6,384)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
211		GF	22	Decrease general fund for MFIP child care	(6,692)	(3,192)	(9,884)	(3,192)	(3,192)	(6,384)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
212		GF	REV2	Reduce non-dedicated revenue to general fund	6,692	3,192	9,884	3,192	3,192	6,384	0	0	0	0	0	0	0	0	0	0	0	0	0	0
213		DED	22	MFIP child care assistance grants	6,692	3,192	9,884	3,192	3,192	6,384	0	0	0	0	0	0	0	0	0	0	0	0	0	0
214		DED	REV3	Federal grants - dedicated revenue	(6,692)	(3,192)	(9,884)	(3,192)	(3,192)	(6,384)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
215																								
216	SF 254	**REPEAL MFIP PENALTIES**			0	0	0	0	0	0	0	0	0	0	0	0	13,430	14,614	28,044	14,527	14,310	28,837	28,044	28,837
217		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)
218		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
219		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)
220		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
221		TANF	20	Subsidized housing penalty	0	0	0	0	0	0	0	0	0	0	0	0	3,238	3,524	6,762	3,502	3,450	6,952	6,762	6,952
222		TANF	20	SSI penalty	0	0	0	0	0	0	0	0	0	0	0	0	10,192	11,090	21,282	11,025	10,860	21,885	21,282	21,885
223																								
224	SF 1955	**MFIP WORK PARTICIPATION RATE ENHANCEMENT INITIATIVE**			0	0	0	0	0	0	0	0	0	0	0	0	63	8,638	8,701	8,638	8,638	17,276	8,701	17,276
225		TANF	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
226		TANF	20	Work participation bonus	0	0	0	0	0	0	0	0	0	0	0	0	0	6,876	6,876	6,876	6,876	13,752	6,876	13,752
227		TANF	20	DWP bonus	0	0	0	0	0	0	0	0	0	0	0	0	0	1,699	1,699	1,699	1,699	3,398	1,699	3,398
228		TANF	15	TANF to Childcare Development Fund - 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
229		TANF	20	MFIP/DWP Grants - 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)
230		GF	20	MFIP/DWP Grants - 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
231		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)
232																								
233	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
234		**REFUGEES AND ASYLEES**																						
235		TANF	20	MFIP/DWP grants	0	0	0	0	0	0	0	0	0	0	0	0	163	134	297	134	134	268	297	268
236																								
237	SF 1817	**REDUCE WEEKLY WORK HOURS REQUIRED FOR MFIP PARTICIPANTS**			0	0	0	0	0	0	0	0	0	0	0	0	127	252	379	251	248	499	379	499
238		**FOR APPROVED POST-SECONDARY EDUCATION PROGRAM**																						
239		TANF	20	MFIP/DWP grants	0	0	0	0	0	0	0	0	0	0	0	0	127	252	379	251	248	499	379	499
240																								
241	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
242		TANF	22	Transitional year service costs	0	0	0	0	0	0	0	0	0	0	0	0	255	404	659	426	449	875	659	875
243		TANF	22	Administration	0	0	0	0	0	0	0	0	0	0	0	0	13	20	33	22	23	45	33	45
244																								
245	SF XXXX	**DECREASE CO-PAYS FOR MFIP/TY CHILD CARE**			0	0	0	0	0	0	0	0	0	0	0	0	488	667	1,155	657	655	1,312	1,155	1,312

Trkg. Line	Gov Rec / Bill Ref	Fund	BACT	DESCRIPTION	GOVERNOR'S RECOMMENDATION FY 2006	FY 2007	FY 06-07	FY 2008	FY 2009	FY 08-09	SENATE POSITION - SF 1879 FY 2006	FY 2007	FY 06-07	FY 2008	FY 2009	FY 08-09	SENATE POSITION - HHS OMNIBUS BUDGET BILL FY 2006	FY 2007	FY 06-07	FY 2008	FY 2009	FY 08-09	SENATE TOTAL POSITION FY 06-07	FY 08-09
246		TANF	22	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
247		TANF	22	County Administrative Allowance	0	0	0	0	0	0	0	0	0	0	0	0	23	32	55	31	31	62	55	62
248																								
249	SF 769	**APPROPRIATION FOR NEW CHANCE PROGRAM**			**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**140**	**140**	**280**	**280**	**280**	**560**	**280**	**560**
250		TANF	27	Appropriation	0	0	0	0	0	0	0	0	0	0	0	0	140	140	280	280	280	560	280	560
251																								
252		**GENERAL FUND MFIP FINANCING**			**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
253		GF	20	Finance MFIP 08/09	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	12,284	28,808	41,072	0	41,072
254		TANF	20	Finance MFIP 08/09																(12,284)	(28,808)	(41,072)	0	(41,072)
255																								
256	SF XXXX	**APPRORIATION FOR TRANSITIONAL HOUSING**			**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**750**	**750**	**1,500**	**750**	**750**	**1,500**	**1,500**	**1,500**
257		GF	32	Appropriation - Other children and economic assistance grants	0	0	0	0	0	0	0	0	0	0	0	0	750	750	1,500	750	750	1,500	1,500	1,500
258																								
259	Page 22	**MEDICARE MODERNIZATION ACT CHANGES**			**(3,374)**	**(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**	**0**	**0**	**(21,429)**	**(27,620)**
260		GF	44	Adjust PDP to forecast	(4,720)	(9,803)	(14,523)	(9,898)	(9,554)	(19,452)	(4,720)	(9,803)	(14,523)	(9,898)	(9,554)	(19,452)	0	0	0	0	0	0	(14,523)	(19,452)
261		GF	44	Transform PDP 1/1/06	(2,253)	(4,007)	(6,260)	(3,912)	(4,256)	(8,168)	(2,253)	(4,007)	(6,260)	(3,912)	(4,256)	(8,168)	0	0	0	0	0	0	(6,260)	(8,168)
262		GF	REV2	Transform PDP 1/1/06 - residual rebate revenue	(252)	(394)	(646)	0	0	0	(252)	(394)	(646)	0	0	0	0	0	0	0	0	0	(646)	0
263		GF	70	Aging grants (enrollment & assistance)	4,988	3,417	8,405	3,417	3,417	6,834	0	0	0	0	0	0	0	0	0	0	0	0	0	0
264		GF	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	0	0	0
265		GF	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	0	0	0
266		GF	70	Aging grants (offset request with one-time fed supplement to SHIP)	(259)	0	(259)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
267		GF	85	Administration (3 ftes)	350	307	657	307	307	614	0	0	0	0	0	0	0	0	0	0	0	0	0	0
268		GF	50	Administration (ftes / FY 2006-09: 1, 7, 6, 6)	76	501	577	501	501	1,002	0	0	0	0	0	0	0	0	0	0	0	0	0	0
269		GF	36	MAXIS costs	12	0	12	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
270		GF	51	MMIS costs	175	0	175	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
271		GF	51	HealthMatch	0	1,000	1,000	1,000	1,000	2,000	0	0	0	0	0	0	0	0	0	0	0	0	0	0
272		GF	REV1	Administrative ffp	(170)	(323)	(493)	(323)	(323)	(646)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
273																								
274	Page 25	**COST EFFECTIVE 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)**
275																								
276		***Selective Distribution of Specialty Pharmaceuticals***			***(133)***	***(205)***	***(338)***	***(228)***	***(248)***	***(476)***	***(133)***	***(205)***	***(338)***	***(228)***	***(248)***	***(476)***	***0***	***0***	***0***	***0***	***0***	***0***	**(338)**	**(476)**
277		GF	41	MA families and children	(17)	(39)	(56)	(43)	(45)	(88)	(17)	(39)	(56)	(43)	(45)	(88)	0	0	0	0	0	0	(56)	(88)
278		GF	42	MA elderly and disabled	(117)	(151)	(268)	(170)	(189)	(359)	(117)	(151)	(268)	(170)	(189)	(359)	0	0	0	0	0	0	(268)	(359)
279		GF	43	GAMC	(7)	(15)	(22)	(15)	(14)	(29)	(7)	(15)	(22)	(15)	(14)	(29)	0	0	0	0	0	0	(22)	(29)
280		GF	44	PDP	(6)	(8)	(14)	(7)	(8)	(15)	(6)	(8)	(14)	(7)	(8)	(15)	0	0	0	0	0	0	(14)	(15)
281		GF	51	MMIS costs	8	0	8	0	0	0	8	0	8	0	0	0	0	0	0	0	0	0	8	0
282		GF	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
283																								
284		***Hemophilia Blood 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)**
285		GF	41	MA families and children	(47)	(105)	(152)	(117)	(125)	(242)	(47)	(105)	(152)	(117)	(125)	(242)	0	0	0	0	0	0	(152)	(242)
286		GF	42	MA elderly and disabled	(321)	(412)	(733)	(465)	(518)	(983)	(321)	(412)	(733)	(465)	(518)	(983)	0	0	0	0	0	0	(733)	(983)
287		GF	51	MMIS costs	7	0	7	0	0	0	7	0	7	0	0	0	0	0	0	0	0	0	7	0
288		GF	51	HealthMatch small effect	18	0	18	0	0	0	18	0	18	0	0	0	0	0	0	0	0	0	18	0
289																								
290		***Align Payment for Administered Drugs With Medicare Rates***			***(451)***	***(502)***	***(953)***	***(552)***	***(607)***	***(1,159)***	***(451)***	***(502)***	***(953)***	***(552)***	***(607)***	***(1,159)***	***0***	***0***	***0***	***0***	***0***	***0***	**(953)**	**(1,159)**
291		GF	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)
292		GF	42	MA elderly and disabled	(339)	(373)	(712)	(410)	(451)	(861)	(339)	(373)	(712)	(410)	(451)	(861)	0	0	0	0	0	0	(712)	(861)
293		GF	43	GAMC	(34)	(38)	(72)	(41)	(45)	(86)	(34)	(38)	(72)	(41)	(45)	(86)	0	0	0	0	0	0	(72)	(86)
294		GF	51	MMIS costs	5	0	5	0	0	0	5	0	5	0	0	0	0	0	0	0	0	0	5	0
295																								
296		***Reduce Pharmacy Payments to AWP Minus 14%***			***(5,182)***	***(3,635)***	***(8,797)***	***(4,061)***	***(4,429)***	***(8,490)***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	0	0
297		GF	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
298		GF	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
299		GF	43	GAMC	(254)	(267)	(521)	(271)	(253)	(524)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
300		GF	44	PDP	(224)	(140)	(364)	(131)	(140)	(271)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
301		GF	44	Interaction with Medicare Modernization Act Changes - Page 22	112	140	252	131	140	271	0	0	0	0	0	0	0	0	0	0	0	0	0	0
302																								
303		***Prior Authorization 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)**
304		GF	41	MA families and children	(231)	(257)	(488)	(258)	(271)	(529)	(231)	(257)	(488)	(258)	(271)	(529)	0	0	0	0	0	0	(488)	(529)
305		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)
306		GF	43	GAMC	(95)	(100)	(195)	(101)	(95)	(196)	(95)	(100)	(195)	(101)	(95)	(196)	0	0	0	0	0	0	(195)	(196)
307		GF	44	PDP	(84)	(53)	(137)	(44)	(47)	(91)	(84)	(53)	(137)	(44)	(47)	(91)	0	0	0	0	0	0	(137)	(91)
308		GF	44	Interaction with "Medicare Modernization Act Changes" proposal - Page 22	42	53	95	44	47	91	42	53	95	44	47	91	0	0	0	0	0	0	95	91
309																								
310	SF 65	**PRESCRIPTION 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)**
311		GF	45	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
312		GF	REV2	General Fund transfer in - savings in SGSR account	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(909)	(113)	(1,022)	0	(1,022)
313		DED	REV2	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
314		DED	REV3	Special revenue fund rebate revenue	0	0	0	0	0	0	0	0	0	0	0	0	0	(320)	(320)	(2,870)	(4,725)	(7,595)	(320)	(7,595)

Trkg. Line	Gov Rec / Bill Ref	Fund	BACT	DESCRIPTION	GOVERNOR'S RECOMMENDATION						SENATE POSITION - SF 1879						SENATE POSITION - HHS OMNIBUS BUDGET BILL						SENATE TOTAL POSITION	
					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 2006	FY 2007	FY 06-07	FY 2008	FY 2009	FY 08-09	FY 06-07	FY 08-09
315		DED	45	Special revenue fund transfer out	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	909	113	1,022	0	1,022
316		DED	45	Special revenue fund other expenses	0	0	0	0	0	0	0	0	0	0	0	0	0	1,342	1,342	2,274	4,651	6,925	1,342	6,925
317																								
318	Page 24A			**DEDICATE GAMC 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)**
319		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
320		DED	REV3	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
321		GF	REV2	GAMC rebates	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)
322																								
323	Rider			**PDP GRANT ACCOUNT REDUCTION**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(2,500)**	**(3,000)**	**(5,500)**	**0**	**0**	**0**	**(5,500)**	**0**
324		GF	45	Prescription Drug Program	0	0	0	0	0	0	0	0	0			0	(2,500)	(3,000)	(5,500)	0	0	0	(5,500)	0
325																								
326	SF 973			**MA COVERAGE FOR MEDICATION THERAPY MANAGEMENT SERVICES**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**40**	**(124)**	**(84)**	**(250)**	**(321)**	**(571)**	**(84)**	**(571)**
327		GF	50	Rx Service costs - admin.	0	0	0	0	0	0	0	0	0	0	0	0	59	272	331	389	389	777	331	777
328		GF	42	MA elderly and disabled - effect on other services	0	0	0	0	0	0	0	0	0	0	0	0	(36)	(426)	(461)	(639)	(710)	(1,348)	(461)	(1,348)
329		GF	50	Adminstrative costs													0	50	50	0	0		50	0
330		GF	50	Contract for evaluation	0	0	0	0	0	0	0	0	0	0	0	0	29	0	29	0	0	0	29	0
331		GF	REV1	Adminstrative ffp	0	0	0	0	0	0	0	0	0	0	0	0	(12)	(20)	(32)	0	0	0	(32)	0
332																								
333	Page 28			**5% REDUCTION TO HOSPITAL RATES**	**(17,323)**	**(38,178)**	**(55,501)**	**(43,157)**	**(47,282)**	**(90,439)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
334		GF	41	MA families and children	(7,117)	(18,528)	(25,645)	(21,623)	(23,887)	(45,510)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
335		GF	42	MA elderly and disabled	(4,997)	(8,278)	(13,275)	(9,283)	(10,121)	(19,404)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
336		GF	43	GAMC	(3,290)	(7,635)	(10,925)	(8,876)	(9,684)	(18,560)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
337		HCAF	40	MinnesotaCare	(2,106)	(4,237)	(6,343)	(3,773)	(3,968)	(7,741)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
338		HCAF	40	Interaction with "Restructure HC Prog. Eligibility" proposal - Page 29 / MNCare reduction	812	1,551	2,363	1,564	1,651	3,215	0	0	0	0	0	0	0	0	0	0	0	0	0	0
339		GF	41	Interaction with "Restructure HC Prog. Eligibility" proposal - Page 29 / MNCare shift to MA	53	349	402	150	23	173	0	0	0	0	0	0	0	0	0	0	0	0	0	0
340		GF	42	Interaction with "Restructure HC Prog. Eligibility" proposal - Page 29 / MNCare shift to MA	(20)	(71)	(91)	(94)	(114)	(208)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
341		GF	43	Interaction with "Restructure HC Prog. Eligibility" proposal - Page 29 / MNCare shift to GAMC	(658)	(1,329)	(1,987)	(1,222)	(1,182)	(2,404)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
342																								
343	SF 1122			**MA & GAMC INPATIENT HOSPITAL RATE INCREASE FOR 16 DRGS FOR**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**400**	**400**	**800**	**400**	**400**	**800**	**800**	**800**
344				**HOSPITALS IN NON-METRO COUNTIES**																				
345		GF	41	MA families and children	0	0	0	0	0	0	0	0	0	0	0	0	181	181	362	181	181	362	362	362
346		GF	42	MA elderly and disabled	0	0	0	0	0	0	0	0	0	0	0	0	146	146	292	146	146	292	292	292
347		GF	43	GAMC	0	0	0	0	0	0	0	0	0	0	0	0	73	73	146	73	73	146	146	146
348																								
349	Page 29			**RESTRUCTURE 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**
350		HCAF	11	Legal & regulatory operations	438	0	438	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
351		HCAF	REV1	Administrative ffp	(174)	0	(174)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
352		HCAF	40	Eliminate MNCare	(86,258)	(89,445)	(175,703)	(84,431)	(90,972)	(175,403)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
353		GF	41	Shift to MA F&C	(3,575)	(18,568)	(22,143)	(4,796)	(368)	(5,164)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
354		GF	42	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	0	0	0
355		GF	43	Shift to GAMC	30,754	27,193	57,947	12,693	11,201	23,894	0	0	0	0	0	0	0	0	0	0	0	0	0	0
356		GF	43	GAMC spenddown / eliminate GHO	19,998	35,632	55,628	38,759	40,094	78,853	0	0	0	0	0	0	0	0	0	0	0	0	0	0
357		GF	38	MAXIS	12	0	12	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
358		HCAF	51	MMIS	26	0	26	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
359		HCAF	51	HealthMatch - 4 month delay	1,262	0	1,262	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
360																								
361	SF 255			**REPEAL MINNESOTACARE LIMITED BENEFIT SET/$5000 CAP**	**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**
362		HCAF	40	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
363																								
364	SF 255			**INCREASE MINNESOTACARE ELIGIBLITY FOR ADULTS W/OUT CHILDREN TO 190% FPG**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**469**	**9,030**	**9,499**	**11,019**	**12,163**	**23,182**	**9,499**	**23,182**
365		HCAF	40	MinnesotaCare Grants	0	0	0	0	0	0	0	0	0	0	0	0	469	9,030	9,499	11,019	12,163	23,182	9,499	23,182
366																								
367	SF 695			**ELIMINATE 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**
368		HCAF	50	MinnesotaCare Grants - administration	0	0	0	0	0	0	0	0	0	0	0	0	0	45	45	16	17	33	45	33
369		HCAF	40	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
370		HCAF	40	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
371		HCAF	40	Healthmatch effect	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
372																								
373	SF 908			**REPEAL $500 DENTAL CAP FROM MA, GAMC, & MINNESOTACARE**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**835**	**1,439**	**2,274**	**1,583**	**1,709**	**3,292**	**2,274**	**3,292**
374		GF	41	MA families and children	0	0	0	0	0	0	0	0	0	0	0	0	458	831	1,289	921	993	1,914	1,289	1,914
375		GF	42	MA elderly and disabled	0	0	0	0	0	0	0	0	0	0	0	0	335	535	870	583	631	1,214	870	1,214
376		GF	43	GAMC	0	0	0	0	0	0	0	0	0	0	0	0	26	52	78	59	63	122	78	122
377		HCAF	40	MinnesotaCare Grants - families and children	0	0	0	0	0	0	0	0	0	0	0	0	12	17	29	18	20	38	29	38
378		HCAF	40	MinnesotaCare Grants - adults without children	0	0	0	0	0	0	0	0	0	0	0	0	4	4	8	2	2	4	8	4
379																								
380	SF 65			**ELIMINATE CO-PAYS FOR MA AND GAMC**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**7,563**	**19,218**	**26,781**	**21,778**	**23,553**	**45,331**	**26,781**	**45,331**
381		GF	41	MA families and children	0	0	0	0	0	0	0	0	0	0	0	0	2,736	7,633	10,369	8,495	9,194	17,689	10,369	17,689
382		GF	41	MA elderly and disabled	0	0	0	0	0	0	0	0	0	0	0	0	1,612	2,002	3,614	2,214	2,412	4,626	3,614	4,626
383		GF	43	GAMC	0	0	0	0	0	0	0	0	0	0	0	0	3,215	9,583	12,798	11,069	11,947	23,016	12,798	23,016
384																								

Trkg. Line	Gov Rec / Bill Ref	Fund	BACT	DESCRIPTION	GOVERNOR'S RECOMMENDATION FY 2006	FY 2007	FY 06-07	FY 2008	FY 2009	FY 08-09	SENATE POSITION - SF 1879 FY 2006	FY 2007	FY 06-07	FY 2008	FY 2009	FY 08-09	SENATE POSITION - HHS OMNIBUS BUDGET BILL FY 2006	FY 2007	FY 06-07	FY 2008	FY 2009	FY 08-09	SENATE TOTAL POSITION FY 06-07	FY 08-09
385	SF 65			**MINNESOTACARE 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
386		HCAF	40	MinnesotaCare Grants	0	0	0	0	0	0	0	0	0	0	0	0	589	6,552	7,141	9,824	10,931	20,755	7,141	20,755
387		HCAF	50	Admin- policy and program costs	0	0	0	0	0	0	0	0	0	0	0	0	133	78	211	0	0	0	211	0
388		HCAF	51	Admin - operations	0	0	0	0	0	0	0	0	0	0	0	0	297	693	990	506	447	953	990	953
389		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	0	2,103	0
390		HCAF	REV1	Administrative ffp													(53)	(31)	(84)	0	0	0	(84)	0
391		HCAF	REV1	Administrative ffp													(119)	(277)	(396)	(202)	(179)	(381)	(396)	(381)
392																								
393	SF 828			**REPORT ON EMPLOYERS AND MINNESOTA HEALTH CARE PROGRAMS**	0	0	0	0	0	0	0	0	0	0	0	0	202	0	202	0	0	0	202	0
394		GF	50	Administrative cost for study - 4 ftes	0	0	0	0	0	0	0	0	0	0	0	0	302	0	302	0	0	0	302	0
395		GF	51	Systems/operations							0	0		0	0		35	0	35	0	0	0	35	0
396		GF	REV1	Administrative ffp	0	0	0	0	0	0	0	0	0	0	0	0	(135)	0	(135)	0	0	0	(135)	0
397																								
398	Page 30			**BETTER MANAGE HEALTH CARE COSTS**	2,558	(833)	1,725	(1,517)	(3,070)	(4,587)	(691)	(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)
399																								
400				***Better Address Fraud and Abuse***	*131*	*(425)*	*(294)*	*(932)*	*(1,400)*	*(2,332)*	*0*	*0*	*0*	*0*	*0*	*0*	*131*	*(425)*	*(294)*	*(932)*	*(1,400)*	*(2,332)*	(294)	(2,332)
401		GF	42	MA FFS (SIRS activity)	(117)	(468)	(585)	(936)	(1,404)	(2,340)	0	0	0	0	0	0	(117)	(468)	(585)	(936)	(1,404)	(2,340)	(585)	(2,340)
402		GF	51	Administration (SIRS - 3 FTEs)	279	234	513	234	234	468	0	0	0	0	0	0	279	234	513	234	234	468	513	468
403		GF	REV1	Administrative ffp	(112)	(94)	(206)	(94)	(94)	(188)	0	0	0	0	0	0	(112)	(94)	(206)	(94)	(94)	(188)	(206)	(188)
404		GF	51	MMIS - SIRS analytical tools	120	20	140	20	20	40	0	0	0	0	0	0	120	20	140	20	20	40	140	40
405		GF	REV2	MA recoveries	(39)	(117)	(156)	(156)	(156)	(312)	0	0	0	0	0	0	(39)	(117)	(156)	(156)	(156)	(312)	(156)	(312)
406																								
407				***Comply With Federal Program Integrity Requirements***	*1,244*	*1,016*	*2,260*	*1,012*	*1,006*	*2,018*	*0*	*0*	*0*	*0*	*0*	*0*	*1,468*	*1,151*	*2,619*	*1,152*	*1,145*	*2,297*	2,619	2,297
408		GF	50	Administration (PERM 7 FTEs, MEQC - 7 FTEs)	1,606	1,351	2,957	1,351	1,351	2,702	0	0	0	0	0	0	1,606	1,351	2,957	1,351	1,351	2,702	2,957	2,702
409		GF	REV1	Administrative ffp	(642)	(540)	(1,182)	(540)	(540)	(1,080)	0	0	0	0	0	0	(642)	(540)	(1,182)	(540)	(540)	(1,080)	(1,182)	(1,080)
410		HCAF	11	Appeals for fraud prevention activity (1 fte)	75	75	150	75	75	150	0	0	0	0	0	0	75	75	150	75	75	150	150	150
411		HCAF	REV1	Administrative ffp	(30)	(30)	(60)	(30)	(30)	(60)	0	0	0	0	0	0	(30)	(30)	(60)	(30)	(30)	(60)	(60)	(60)
412		HCAF	40	MnCare - Fraud Prevention	(43)	(96)	(139)	(95)	(102)	(197)	0	0	0	0	0	0	(43)	(96)	(139)	(95)	(102)	(197)	(139)	(197)
413		HCAF	50	Administration (FPI - 5 FTEs)	505	380	885	380	380	760	0	0	0	0	0	0	505	380	885	380	380	760	885	760
414		HCAF	REV1	Administrative ffp	(202)	(152)	(354)	(152)	(152)	(304)	0	0	0	0	0	0	(202)	(152)	(354)	(152)	(152)	(304)	(354)	(304)
415		HCAF	50	Administration (quality control - 4 FTEs)	332	272	604	272	272	544	0	0	0	0	0	0	332	272	604	272	272	544	604	544
416		HCAF	REV1	Administrative ffp	(133)	(109)	(242)	(109)	(109)	(218)	0	0	0	0	0	0	(133)	(109)	(242)	(109)	(109)	(218)	(242)	(218)
417		HCAF	40	Interaction with "Restructure HC Prog. Eligibility" proposal - Page 29 / MnCare - Fraud Prev.	18	40	58	35	36	71	0	0	0	0	0	0	0	0	0	0	0	0	0	0
418		HCAF	50	Interaction with "Restructure HC Prog. Eligibility" proposal - Page 29 / Admin (FPI - (3) FTEs)	(319)	(224)	(543)	(224)	(224)	(448)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
419		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	0	0	0	0	0	0
420		HCAF	50	Interaction with "Restructure HC Prog. Eligibility" proposal - Page 29 / Admin (QC - (1) FTEs)	(83)	(68)	(151)	(68)	(68)	(136)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
421		HCAF	REV1	Interaction with "Restructure HC Prog. Eligibility" proposal - Page 29 / Administrative ffp	33	27	60	27	27	54	0	0	0	0	0	0	0	0	0	0	0	0	0	0
422																								
423				***Recover Uncompensated Transfers of Income and Assets - In SF 1879***	*(96)*	*(144)*	*(240)*	*(192)*	*(192)*	*(384)*	*(96)*	*(144)*	*(240)*	*(192)*	*(192)*	*(384)*	*0*	*0*	*0*	*0*	*0*	*0*	(240)	(384)
424		GF	42	MA elderly and disabled	(96)	(144)	(240)	(192)	(192)	(384)	(96)	(144)	(240)	(192)	(192)	(384)			0			0	(240)	(384)
425																								
426				***Recover From Estates Assets Held in Irrevocable Trusts or Annuities***	*36*	*(124)*	*(88)*	*(404)*	*(459)*	*(863)*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	0	0
427		GF	51	Administration (1 fte)	60	60	120	60	60	120	0	0	0	0	0	0	0	0	0	0	0	0	0	0
428		GF	REV2	AC recoveries	0	(10)	(10)	(40)	(45)	(85)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
429		GF	REV2	MA recoveries	0	(150)	(150)	(400)	(450)	(850)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
430		GF	REV1	Administrative ffp	(24)	(24)	(48)	(24)	(24)	(48)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
431																								
432				***Make Trust Available***	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*(676)*	*(3,371)*	*(4,047)*	*(6,487)*	*(14,777)*	*(23,264)*	(4,047)	(23,264)
433		GF	72	MA Long Term Care Facilities Grants	0	0	0	0	0	0	0	0	0	0	0	0	(439)	(2,192)	(2,631)	(5,300)	(8,815)	(14,115)	(2,631)	(14,115)
434		GF	73	MA recoveries	0	0	0	0	0	0	0	0	0	0	0	0	(87)	(505)	(592)	(1,390)	(2,637)	(4,027)	(592)	(4,027)
435		GF	42	Administrative ffp	0	0	0	0	0	0	0	0	0	0	0	0	(150)	(674)	(824)	(1,797)	(3,325)	(5,122)	(824)	(5,122)
436																								
437				***Implement Intensive Medical Care Management***	*337*	*(225)*	*112*	*(225)*	*(225)*	*(450)*	*0*	*0*	*0*	*0*	*0*	*0*	*337*	*(225)*	*112*	*(225)*	*(225)*	*(450)*	112	(450)
438		GF	42	MA FFS	(563)	(1,125)	(1,688)	(1,125)	(1,125)	(2,250)	0	0	0	0	0	0	(563)	(1,125)	(1,688)	(1,125)	(1,125)	(2,250)	(1,688)	(2,250)
439		GF	50	Administrative contract	1,500	1,500	3,000	1,500	1,500	3,000	0	0	0	0	0	0	1,500	1,500	3,000	1,500	1,500	3,000	3,000	3,000
440		GF	REV1	Administrative ffp	(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)
441																								
442				***Improve Cost Effectiveness of Coverage - In SF 1879***	*(595)*	*(1,931)*	*(2,526)*	*(2,914)*	*(3,960)*	*(6,874)*	*(595)*	*(1,931)*	*(2,526)*	*(2,914)*	*(3,960)*	*(6,874)*	*0*	*0*	*0*	*0*	*0*	*0*	(2,526)	(6,874)
443		GF	50	Medical director's salary and benefits (1 fte)	200	188	388	188	188	376	200	188	388	188	188	376	0	0	0	0	0	0	388	376
444		GF	50	Staff costs to support medical policy function (1 ftes)	87	75	162	75	75	150	87	75	162	75	75	150	0	0	0	0	0	0	162	150
445		GF	50	Evidence based practice center subscription fee	50	42	92	42	42	84	50	42	92	42	42	84	0	0	0	0	0	0	92	84
446		GF	41	MA families and children ffs	(249)	(655)	(904)	(969)	(1,291)	(2,260)	(249)	(655)	(904)	(969)	(1,291)	(2,260)	0	0	0	0	0	0	(904)	(2,260)
447		GF	42	MA elderly and disabled ffs	(465)	(1,222)	(1,687)	(1,788)	(2,411)	(4,199)	(465)	(1,222)	(1,687)	(1,788)	(2,411)	(4,199)	0	0	0	0	0	0	(1,687)	(4,199)
448		GF	43	GAMC ffs	(93)	(237)	(330)	(340)	(441)	(781)	(93)	(237)	(330)	(340)	(441)	(781)	0	0	0	0	0	0	(330)	(781)
449		GF	51	MMIS costs	10	0	10	0	0	0	10	0	10	0	0	0	0	0	0	0	0	0	10	0
450		GF	REV1	Administrative ffp	(135)	(122)	(257)	(122)	(122)	(244)	(135)	(122)	(257)	(122)	(122)	(244)	0	0	0	0	0	0	(257)	(244)
451																								
452				***Improve Health Care Enrollment Process***	*1,431*	*915*	*2,346*	*2,036*	*2,039*	*4,075*	*0*	*0*	*0*	*0*	*0*	*0*	*2,080*	*1,426*	*3,506*	*2,673*	*1,796*	*4,469*	3,506	4,469
453		HCAF	50	Administration costs	3,383	2,377	5,760	4,454	2,994	7,448	0	0	0	0	0	0	3,383	2,377	5,760	891	599	1,490	5,760	1,490
454		HCAF	51	MMIS costs	50	0	50	0	0	0	0	0	0	0	0	0	50	0	50	0	0	0	50	0

Trkg. Line	Gov Rec / Bill Ref	Fund	BACT	DESCRIPTION	GOVERNOR'S RECOMMENDATION FY 2006	FY 2007	FY 06-07	FY 2008	FY 2009	FY 08-09	SENATE POSITION - SF 1879 FY 2006	FY 2007	FY 06-07	FY 2008	FY 2009	FY 08-09	SENATE POSITION - HHS OMNIBUS BUDGET BILL FY 2006	FY 2007	FY 06-07	FY 2008	FY 2009	FY 08-09	SENATE TOTAL POSITION FY 06-07	FY 08-09
455		HCAF	REV1	Administrative ffp	(1,353)	(951)	(2,304)	(1,782)	(1,198)	(2,980)	0	0	0	0	0	0	(1,353)	(951)	(2,304)	(356)	(240)	(596)	(2,304)	(596)
456		GF	50	Administration costs							0	0	0	0	0	0	0	0	0	3,563	2,395	5,958	0	5,958
457		GF	REV1	Administrative ffp							0	0	0	0	0	0	0	0	0	(1,425)	(958)	(2,383)	0	(2,383)
458		HCAF	50	Interaction with "Restructure HC Prog. Eligibility" proposal - Page 29 / Admin costs	(1,081)	(852)	(1,933)	(1,061)	405	(656)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
459		HCAF	51	Interaction with "Restructure HC Prog. Eligibility" proposal - Page 29 / MMIS costs	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
460		HCAF	REV1	Interaction with "Restructure HC Prog. Eligibility" proposal - Page 29 / Administrative ffp	432	341	773	425	(162)	263	0	0	0	0	0	0	0	0	0	0	0	0	0	0
461																								
462																								
463				***Increase Use of Web Payment Method***	***70***	***85***	***155***	***102***	***121***	***223***	***0***	***0***	***0***	***0***	***0***	***0***	***91***	***110***	***201***	***132***	***158***	***290***	**201**	**290**
464		HCAF	10	Financial management - admin fee	152	183	335	220	263	483	0	0	0	0	0	0	152	183	335	220	263	483	335	483
465		HCAF	REV1	Administrative ffp	(61)	(73)	(134)	(88)	(105)	(193)	0	0	0	0	0	0	(61)	(73)	(134)	(88)	(105)	(193)	(134)	(193)
466		HCAF	10	Interaction with "Restructure HC Prog. Eligibility" proposal - Page 29 / Admin costs	(35)	(42)	(77)	(51)	(61)	(112)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
467		HCAF	REV1	Interaction with "Restructure HC Prog. Eligibility" proposal - Page 29 / Administrative ffp	14	17	31	21	24	45	0	0	0	0	0	0	0	0	0	0	0	0	0	0
468																								
469	SF 65			**PRIOR AUTHORIZATION OF CERTAIN HEALTH CARE SERVICES**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(1,369)**	**(3,163)**	**(4,532)**	**(3,253)**	**(3,243)**	**(6,496)**	**(4,532)**	**(6,496)**
470		GF	41	MA families and children - managed care	0	0	0	0	0	0	0	0	0	0	0	0	(410)	(1,112)	(1,522)	(1,157)	(1,163)	(2,320)	(1,522)	(2,320)
471		GF	42	MA elderly and disabled -managed care	0	0	0	0	0	0	0	0	0	0	0	0	(301)	(723)	(1,024)	(729)	(734)	(1,463)	(1,024)	(1,463)
472		GF	43	GAMC -managed care	0	0	0	0	0	0	0	0	0	0	0	0	(85)	(269)	(354)	(292)	(294)	(586)	(354)	(586)
473		GF	41	MA families and children - ffs	0	0	0	0	0	0	0	0	0	0	0	0	(126)	(183)	(309)	(197)	(191)	(388)	(309)	(388)
474		GF	42	MA elderly and disabled - ffs	0	0	0	0	0	0	0	0	0	0	0	0	(369)	(533)	(902)	(575)	(588)	(1,163)	(902)	(1,163)
475		GF	43	GAMC - ffs	0	0	0	0	0	0	0	0	0	0	0	0	(137)	(188)	(325)	(188)	(170)	(356)	(325)	(356)
476		GF	13	MMIS systems	0	0	0	0	0	0	0	0	0	0	0	0	22	0	22	0	0	0	22	0
477		GF	50	Administration	0	0	0	0	0	0	0	0	0	0	0	0	503	503	1,006	503	503	1,006	1,006	1,006
478		GF	REV1	Administrative ffp				0	0	0	0	0	0	0	0		(201)	(201)	(402)	(201)	(201)	(402)	(402)	(402)
479		HCAF	40	MinnesotaCare - Families with Children	0	0	0	0	0	0	0	0	0	0	0	0	(162)	(269)	(431)	(233)	(235)	(468)	(431)	(468)
480		HCAF	40	MinnesotaCare - Adults w/o Children	0	0	0	0	0	0	0	0	0	0	0	0	(103)	(188)	(291)	(188)	(170)	(356)	(291)	(356)
481																								
482																								
483	SF 254			**REDUCE MEDICAL ASSISTANCE LIENS ON INCOME PRODUCING PROPERTY**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1,832**	**1,864**	**3,696**	**1,864**	**1,864**	**3,728**	**3,696**	**3,728**
484		GF	72	Cost of MA retroactive repayments	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
485		GF	REV2	Reduced MA recoveries	0	0	0	0	0	0	0	0	0	0	0	0	1,832	1,864	3,696	1,864	1,864	3,728	3,696	3,728
486																								
487	SF 254			**ELIMINATE ALTERNATIVE CARE LIENS AND CLAIMS AGAINST ESTATES**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**9,958**	**17,063**	**27,021**	**17,068**	**17,043**	**34,111**	**27,021**	**34,111**
488		GF	71	AC caseload effect	0	0	0	0	0	0	0	0	0	0	0	0	9,168	16,263	25,431	16,268	16,243	32,511	25,431	32,511
489		GF	71	Cost of AC retroactive repayments	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
490		GF	REV2	Cost of reduced AC Recoveries	0	0	0	0	0	0	0	0	0	0	0	0	790	800	1,590	800	800	1,600	1,590	1,600
491																								
492	Page 37			**REFINANCE HEALTH CARE PROGRAMS**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
493		GF	43	GAMC forecast	(192,707)	(350,175)	(542,882)	(399,652)	(429,156)	(828,808)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
494		HCAF	43	GAMC forecast	192,707	350,175	542,882	399,652	429,156	828,808	0	0	0	0	0	0	0	0	0	0	0	0	0	0
495		GF	REV2	Move HMO surcharge to HCAF	0	24,378	24,378	26,000	26,000	52,000	0	0	0	0	0	0	0	0	0	0	0	0	0	0
496		HCAF	REV2	Move HMO surcharge to HCAF	0	(24,378)	(24,378)	(26,000)	(26,000)	(52,000)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
497		GF	REV2	Move hospital surcharge to HCAF	0	88,500	88,500	95,000	95,000	190,000	0	0	0	0	0	0	0	0	0	0	0	0	0	0
498		HCAF	REV2	Move hospital surcharge to HCAF	0	(88,500)	(88,500)	(95,000)	(95,000)	(190,000)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
499		GF	43	GAMC - other proposals	(46,319)	(53,204)	(99,523)	(40,586)	(39,581)	(80,167)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
500		HCAF	43	GAMC - other proposals	46,319	53,204	99,523	40,586	39,581	80,167	0	0	0	0	0	0	0	0	0	0	0	0	0	0
501																								
502	SF 984			**ALLOW PRIVATE VENDORS TO PROVIDE RELOCATION SERVICE COORDINATION**	**0**	**0**	**0**	**0**	**0**		**0**	**0**	**0**	**0**	**0**	**0**	**21**	**(175)**	**(154)**	**(587)**	**(979)**	**(1,566)**	**(154)**	**(1,566)**
503		GF	42	MA elderly and disabled	0	0	0	0	0	0	0	0	0	0	0	0	0	45	45	45	45	90	45	90
504		GF	72	MA long term care facilities grants	0	0	0	0	0	0	0	0	0	0	0	0	0	(790)	(790)	(2,140)	(3,426)	(5,566)	(790)	(5,566)
505		GF	73	MA Waivers 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
506		GF	85	Admin.	0	0	0	0	0	0	0	0	0	0	0	0	35	35	70	35	35	70	70	70
507		GF	REV1	Administrative ffp	0	0	0	0	0	0	0	0	0	0	0	0	(14)	(14)	(28)	(14)	(14)	(28)	(28)	(28)
508																								
509	Page 41			**MANAGE CASELOAD GROWTH IN HOME AND COMMUNITY**	**(13,761)**	**(38,945)**	**(52,706)**	**(31,449)**	**(11,394)**	**(42,843)**	**(1,405)**	**(7,102)**	**(8,507)**	**(11,394)**	**(11,394)**	**(22,788)**	**0**	**0**	**0**	**0**	**0**	**0**	**(8,507)**	**(11,394)**
510		**BASED WAIVERS**																						
511		GF	73	CADI waiver: 95 per month with MH exception	(10,346)	(26,229)	(36,575)	(16,209)	0	(16,209)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
512		GF	73	TBI waiver limits: 150 per year	(5,099)	(13,575)	(18,674)	(8,860)	0	(8,860)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
513		GF	73	MR/RC waiver - reduced diversions: 50 div's per year for emergencies	(1,756)	(8,877)	(10,633)	(14,242)	(14,242)	(28,484)	(1,756)	(8,877)	(10,633)	(14,242)	(14,242)	(28,484)	0	0	0	0	0	0	(10,633)	(28,484)
514		GF	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
515																								
516	Page 41			**MANAGE CASELOAD GROWTH IN HOME AND COMMUNITY**	**0**	**0**	**0**	**0**	**0**		**0**	**0**	**0**	**0**	**0**	**0**	**(11,842)**	**(29,513)**	**(41,355)**	**(17,523)**	**1,139**	**(16,384)**	**(41,355)**	**(16,384)**
517		**BASED WAIVERS - 10% INCREASE OVER CURRENT CAPS**																						
518		GF	73	CADI waiver: 105 per month with MH exception	0	0	0	0	0	0	0	0	0	0	0	0	(10,021)	(24,797)	(34,818)	(14,965)	0	(14,965)	(34,818)	(14,965)
519		GF	73	TBI waiver limits: 165 per year	0	0	0	0	0	0	0	0	0	0	0	0	(4,958)	(12,982)	(17,940)	(8,362)	0	(8,362)	(17,940)	(8,362)
520		GF	73	MR/RC waiver - Governor's rec accepted in S1879. Ominbus bill allows 75 div's per year	0	0	0	0	0	0	0	0	0	0	0	0	176	888	1,064	1,424	1,424	2,848	1,064	2,848
521		GF	73	MA offset	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
522		GF	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)
523																								

Trkg. Line	Gov Rec / Bill Ref	Fund	BACT	DESCRIPTION	GOVERNOR'S RECOMMENDATION						SENATE POSITION - SF 1879						SENATE POSITION - HHS OMNIBUS BUDGET BILL						SENATE TOTAL POSITION	
					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 2006	FY 2007	FY 06-07	FY 2008	FY 2009	FY 08-09	FY 06-07	FY 08-09
524	SF 65			**REFORM USE OF PCA SERVICES**	0	0	0	0	0	0	0	0	0	0	0	0	(1,557)	(4,523)	(6,080)	(4,957)	(5,323)	(10,280)	(6,080)	(10,280)
525		GF	73	MA LTC Waivers and Home Care Grants	0	0	0	0	0	0	0	0	0	0	0	0	(2,876)	(6,148)	(9,024)	(6,613)	(7,070)	(13,683)	(9,024)	(13,683)
526		GF	72	MA LTC Facilities Grants	0	0	0	0	0	0	0	0	0	0	0	0	288	615	903	661	707	1,368	903	1,368
527		GF	42	MA elderly and disabled	0	0	0	0	0	0	0	0	0	0	0	0	756	794	1,550	840	884	1,724	1,550	1,724
528		GF	85	Continuing Care Management	0	0	0	0	0	0	0	0	0	0	0	0	459	360	819	259	260	519	819	519
529		GF	REV1	Administrative ffp	0	0	0	0	0	0			0	0	0	0	(184)	(144)	(328)	(104)	(104)	(208)	(328)	(208)
530																								
531	SF 254			**RESTRUCTURE TEFRA PARENTAL FEE SCHEDULE - FORMULA TO BE DEVELOPED**	0	0	0	0	0	0	0	0	0	0	0	0	1,500	1,500	3,000	1,500	1,500	3,000	3,000	3,000
532		GF	REV2	TEFRA parental fees decrease	0	0	0	0	0	0	0	0	0	0	0	0	1,500	1,500	3,000	1,500	1,500	3,000	3,000	3,000
533																								
534	SF1589			**BROWN COUNTY ICF/MR REALLOCATION AUTHORITY**	0	0	0	0	0	0	0	0	0	0	0	0	0	115	115	125	125	250	115	250
535		GF	72	MA LTC Facilities Grants	0	0	0	0	0	0	0	0	0			0	0	115	115	125	125	250	115	250
536																								
537	SF 1101			**MODIFY SWING BED SERVICES REQUIREMENTS**	0	0	0	0	0	0	0	0	0	0	0	0	4	4	8	4	4	8	8	8
538		GF	72	MA LTC Facilities Grants	0	0	0	0	0	0	0	0	0			0	4	4	8	4	4	8	8	8
539																								
540	RIDER			**EXTEND EXISTING NURSING FACILITY MORITORIUM EXCEPTIONS FOR 18 MONTHS**	0	0	0	0	0	0	0	0	0	0	0	0	(405)	(675)	(1,080)	0	0	0	(1,080)	0
541		GF	72	MA LTC Facilities Grants	0	0	0	0	0	0	0	0	0	0	0	0	(405)	(675)	(1,080)	0	0	0	(1,080)	0
542																								
543	SF XXXX			**NURSING HOME MORITORIUM EXCEPTION FUND**	0	0	0	0	0	0	0	0	0	0	0	0	300	0	300	0	0	0	300	0
544		GF	72	MA LTC Facilities Grants	0	0	0	0	0	0	0	0	0	0	0	0	300	0	300	0	0	0	300	0
545																								
546	SF 127			**RAMSEY COUNTY NURSING FACILITY MA RATE INCREASE**	0	0	0	0	0	0	0	0	0	0	0	0	51	51	102	51	51	102	102	102
547		GF	72	MA LTC Facilities Grants	0	0	0	0	0	0	0	0	0	0	0	0	51	51	102	51	51	102	102	102
548																								
549	SF XXXX			**ICF/MR DOWNSIZING AND CONSTRUCTION FUND**	0	0	0	0	0	0	0	0	0	0	0	0	600	0	600	0	0	0	600	0
550		GF	72	MA LTC Facilities Grants	0	0	0	0	0	0	0	0	0	0	0	0	600	0	600	0	0	0	600	0
551																								
552	SF 254			**DRUG PRICE REPORTING**	0	0	0	0	0	0	0	0	0	0	0	0	0	(9)	(9)	(9)	(9)	(18)	(9)	(18)
552		GF	50	Administrative costs	0	0	0	0	0	0	0	0	0	0	0	0	122	108	230	108	108	216	230	216
553		GF	REV1	Administrative FFP	0	0	0	0	0	0	0	0	0	0	0	0	(48)	(43)	(91)	(43)	(43)	(86)	(91)	(86)
554		GF	REV2	Increased wholesale drug manufacturers license fees - transfer from Board of Pharmacy	0	0	0	0	0	0	0	0	0	0	0	0	(74)	(74)	(148)	(74)	(74)	(148)	(148)	(148)
555																								
552	SF 2003			**NURSING FACILITY TRANSFORMATION**	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(197)	(292)	(489)	0	(489)
553		GF	72	Increase single bed rate 5%	0	0	0	0	0	0	0	0	0	0	0	0	211	83	294	(114)	(209)	(323)	294	(323)
554		GF	72	Reduce medically necessary single bed rate	0	0	0	0	0	0	0	0	0	0	0	0	(211)	(83)	(294)	(83)	(83)	(166)	(294)	(166)
555																								
556	SF XXXX			**LONG TERM CARE AND HOME AND COMMUNITY BASED PROVIDERS 2% AND 2%**	0	0	0	0	0	0	0	0	0	0	0	0	20,394	56,505	76,899	64,425	69,418	133,843	76,899	133,843
557				**RATE INCREASE IN FY06 AND FY07 (APS RATE SUSPENDED FY06-FY07)**																				
558		GF	73	MA LTC waivers and home care grants	0	0	0	0	0	0	0	0	0	0	0	0	11,034	32,152	43,186	37,907	41,661	79,568	43,186	79,568
559		GF	73	Interaction with waiver caps	0	0	0	0	0	0	0	0	0	0	0		(233)	(1,296)	(1,529)	(1,255)	(578)	(1,833)	(1,529)	(1,833)
560		GF	72	MA LTC facilities grants	0	0	0	0	0	0	0	0	0	0	0	0	7,558	19,186	26,744	20,005	19,859	39,864	26,744	39,864
561		GF	42	MA basic health care elderly and disabled	0	0	0	0	0	0	0	0	0	0	0	0	123	1,141	1,264	1,940	2,608	4,548	1,264	4,548
562		GF	41	MA basic health care families and children	0	0	0	0	0	0	0	0	0	0	0	0	2	5	7	6	6	12	7	12
563		GF	43	GAMC basic health care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
564		GF	71	Alternative care grants	0	0	0	0	0	0	0	0	0	0	0	0	856	2,382	3,238	2,603	2,606	5,209	3,238	5,209
565		GF	30	GRH grants	0	0	0	0	0	0	0	0	0	0	0	0	163	431	594	450	450	900	594	900
566		GF	74	Adult mental health grants	0	0	0	0	0	0	0	0	0	0	0	0	598	1,652	2,250	1,803	1,803	3,606	2,250	3,606
567		GF	26	Children mental health grants	0	0	0	0	0	0	0	0	0	0	0	0	39	151	190	169	169	338	190	338
568		GF	78	DD community support grants	0	0	0	0	0	0	0	0	0	0	0	0	91	282	373	308	308	616	373	616
569		GF	27	Community social services grants	0	0	0	0	0	0	0	0	0	0	0	0	3	10	13	11	11	22	13	22
570		GF	75	Deaf and hard of hearing Grants	0	0	0	0	0	0	0	0	0	0	0	0	9	31	40	31	31	62	40	62
571		GF	70	Aging and adult services grants	0	0	0	0	0	0	0	0	0	0	0	0	3	10	13	10	10	20	13	20
572		GF	76	State share of CD Tier I	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
573		GF	78	Consumer support grants	0	0	0	0	0	0	0	0	0	0	0	0	148	368	516	437	474	911	516	911
574																								
575																								
576	Page 39			**NURSING FACILITY QUALITY AND RATE REFORM**	(800)	(2,495)	(3,295)	620	(1,009)	(389)	0	0	0	0	0	0	(6,553)	0	(6,553)	0	0	0	(6,553)	0
577		GF	72	Suspend automatic COLA for contract NFs	(6,553)	(12,992)	(19,545)	(19,818)	(26,291)	(46,109)	0	0	0	0	0	0	(6,553)	(12,992)	(19,545)	0	0	0	(19,545)	0
578		GF	72	2% flexible funding increase - effective 10/01/05	5,753	8,529	14,282	8,574	8,566	17,140	0	0	0	0	0	0	0	0	0	0	0	0	0	0
579		GF	72	VBR minor effects - effective 10/01/06	0	(532)	(532)	161	1,007	1,168	0	0	0	0	0	0	0	0	0	0	0	0	0	0
580		GF	72	Partial hold harmless/safety net - effective 10/01/07	0	2,500	2,500	2,500	1,000	3,500	0	0	0	0	0	0	0	0	0	0	0	0	0	0
581		GF	72	Faster phase-in for high quality NFs - effective 10/01/07	0	0	0	3,000	2,000	5,000	0	0	0	0	0	0	0	0	0	0	0	0	0	0
582		GF	72	Increase staffing levels - effective 10/01/07	0	0	0	6,203	12,709	18,912	0	0	0	0	0	0	0	0	0	0	0	0	0	0
583		GF	72	Admin for design of new nf rate system	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
584		GF	72	Administrative ffp	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
585		GF	72	One time appropriation in FY07 for implementation of new nf rate system	0	0	0	0	0	0	0	0	0	0	0	0	0	12,992	12,992	0	0	0	12,992	0
586																								
587	SF 65			**LONG TERM CARE AND HOME AND COMMUNITY BASED EMPLOYEE SCHOLARSHIPS**	0	0	0	0	0	0	0	0	0	0	0	0	938	1,208	2,146	2,597	2,782	5,379	2,146	5,379
588		GF	73	MA LTC waivers and home care grants	0	0	0	0	0	0	0	0	0	0	0	0	1,380	1,797	3,177	1,942	2,092	4,034	3,177	4,034

Trkg. Line	Gov Rec / Bill Ref	Fund	BACT	DESCRIPTION	GOVERNOR'S RECOMMENDATION						SENATE POSITION - SF 1879						SENATE POSITION - HHS OMNIBUS BUDGET BILL						SENATE TOTAL POSITION	
					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 2006	FY 2007	FY 06-07	FY 2008	FY 2009	FY 08-09	FY 06-07	FY 08-09
589		GF	72	MA LTC facilities grants	0	0	0	0	0	0	0	0	0	0	0	0	132	141	273	131	122	253	273	253
590		GF	42	MA basic health care elderly and disabled	0	0	0	0	0	0	0	0	0	0	0	0	16	60	76	96	129	225	76	225
591		GF	41	MA basic health care families and children	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
592		GF	43	GAMC basic health care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
593		GF	71	Alternative care grants	0	0	0	0	0	0	0	0	0	0	0	0	107	129	236	129	129	258	236	258
594		GF	30	GRH grants	0	0	0	0	0	0	0	0	0	0	0	0	20	22	42	22	22	44	42	44
595		GF	74	Adult mental health grants	0	0	0	0	0	0	0	0	0	0	0	0	78	91	167	91	91	182	167	182
596		GF	26	Children mental health grants	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
597		GF	78	DD community support grants	0	0	0	0	0	0	0	0	0	0	0	0	11	15	26	15	15	30	26	30
598		GF	27	Community social services grants	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1	1	2	1	2
599		GF	75	Deaf and hard of hearing Grants	0	0	0	0	0	0	0	0	0	0	0	0	1	2	3	2	2	4	3	4
600		GF	70	Aging and adult services grants	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
601		GF	76	State share of CD Tier I	0	0	0	0	0	0	0	0	0	0	0	0	105	136	241	147	158	305	241	305
602		GF	78	Consumer support grants	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
603		GF	85	Continuing Care Management - admin costs	0	0	0	0	0	0	0	0	0	0	0	0	35	35	70	35	35	70	70	70
604		GF	REV1	Administrative ffp	0	0	0	0	0	0	0	0	0	0	0	0	(14)	(14)	(28)	(14)	(14)	(28)	(28)	(28)
605		GF	13	MMIS Systems Costs	0	0	0	0	0	0	0	0	0	0	0	0	7	0	7	0	0	0	7	0
606		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
607																								
608	SF 1395			**COMMUNITY ALTERNATIVES FOR ANOKA REGIONAL TREATMENT CENTER**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**295**	**279**	**574**	**626**	**592**	**1,218**	**574**	**1,218**
609		GF	29	Minnesota Supplemental Aid Grants	0	0	0	0	0	0	0	0	0	0	0	0	118	363	481	494	502	996	481	996
610		GF	30	Group Residential Housing Grants	0	0	0	0	0	0	0	0	0	0	0	0	(72)	(195)	(267)	(248)	(248)	(496)	(267)	(496)
611		GF	41	MA elderly and disabled	0	0	0	0	0	0	0	0	0	0	0	0	(101)	(55)	(156)	134	134	268	(156)	268
612		GF	43	GAMC	0	0	0	0	0	0	0	0	0	0	0	0	0	15	15	31	31	62	15	62
613		GF	74	Mental Health Grants	0	0	0	0	0	0	0	0	0	0	0	0	350	145	495	1,203	2,116	3,319	495	3,319
614		GF	90	State Operated Services	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(1,250)	(2,444)	(3,694)	0	(3,694)
615		GF	REV2	Decrease in county share payments to Anoka RTC						0	0	0	0	0	0	0	0	0	0	250	489	739	0	739
616		HCAF	40	MNCare without FFP	0	0	0	0	0	0	0	0	0	0	0	0	0	6	6	12	12	24	6	24
617																								
618	Page 43			**SOS FORENSIC 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**
619		GF	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
620		GF	REV2	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)
621																								
622	Page 44A			**STATE OPERATED 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**
623		GF	90	SOS appropriated services - operating costs	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
624																								
625	SF 1000			**DISCHARGE PLANNING FOR MENTALLY ILL OFFENDERS**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**173**	**173**	**124**	**100**	**224**	**173**	**224**
626		GF	50	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
627		GF	72	Administrative ffp	0	0	0	0	0	0	0	0	0	0	0	0	0	(115)	(115)	(82)	(66)	(148)	(115)	(148)
628																								
629	Page 45			**IMPROVE MENTAL HEALTH COVERAGE**	**205**	**3,201**	**3,406**	**4,724**	**6,228**	**10,952**	**0**	**0**	**0**	**0**	**0**	**0**	**205**	**2,064**	**2,269**	**3,217**	**4,266**	**7,483**	**2,269**	**7,483**
630		GF	41	MA F&C - treatment foster care benefit	0	2,274	2,274	3,014	3,922	6,936	0	0	0	0	0	0	0	2,274	2,274	3,014	3,922	6,936	2,274	6,936
631		GF	41	MA F&C - pysch case consultation-children	33	130	163	163	163	326	0	0	0	0	0	0	33	130	163	163	163	326	163	326
632		GF	42	MA E&D - pysch case consultation-adults	98	390	488	488	488	976	0	0	0	0	0	0	98	390	488	488	488	976	488	976
633		GF	41	MA F&C - assertive community treatment benefit	0	356	356	1,008	1,604	2,612	0	0	0	0	0	0	0	356	356	1,008	1,604	2,612	356	2,612
634		GF	50	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
635		GF	REV1	Administrative FFP	(34)	(34)	(68)	(34)	(34)	(68)	0	0	0	0	0	0	(34)	(34)	(68)	(34)	(34)	(68)	(68)	(68)
636		GF	51	MMIS costs	5	0	5	0	0	0	0	0	0	0	0	0	5	0	5	0	0	0	5	0
637		GF	51	HealthMatch small effect	18	0	18	0	0	0	0	0	0	0	0	0	18	0	18	0	0	0	18	0
638		GF	REV2	County share 25% of total costs	0	0	0	0	0	0	0	0	0	0	0	0	0	(1,137)	(1,137)	(1,507)	(1,962)	(3,469)	(1,137)	(3,469)
639																								
640	SF 1706			**COLLABORATION BETWEEN SCHOOLS AND MENTAL HEALTH PROVIDERS STUDY**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**5**	**0**	**5**	**0**	**0**	**0**	**5**	**0**
641		GF	85	Appropriation	0	0	0	0	0	0	0	0	0	0	0	0	5	0	5	0	0	0	5	0
642																								
643	Rider			**COMPULSIVE GAMBLING GRANT PROGRAM**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**400**	**400**	**800**	**400**	**400**	**800**	**800**	**800**
644		LOTT	74	Appropriation	0	0	0	0	0	0	0	0	0	0	0	0	400	400	800	400	400	800	800	800
645																								
646	Page 47			**EXPAND METHAMPHETAMINE TREATMENT CAPACITY**	**300**	**300**	**600**	**300**	**300**	**600**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
647				**FOR WOMEN WITH CHILDREN**																				
648		GF	77	Methamphetamine treatment grants	300	300	600	300	300	600	0	0	0	0	0	0	0	0	0	0	0	0	0	0
649																								
650	Rider			**METHAMPHETAMINE EVIDENCE-BASED TREATMENT, WILLMAR**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**300**	**300**	**600**	**300**	**300**	**600**	**600**	**600**
651		GF	90	Methamphetamine treatment grants	0	0	0	0	0	0	0	0	0	0	0	0	300	300	600	300	300	600	600	600
652																								
653	SF XXXX			**TRAINING AND GRANT PROGRAM TO EXTEND CHEMICAL DEPENDENCY TREATMENT FOR**	**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**
654				**METHAMPHETEMINE ADDICTION FOR UP TO SIX MONTHS**																				
655		GF	78	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
656																								
657																								
658																								

Trkg. Line	Gov Rec / Bill Ref	Fund	BACT	DESCRIPTION	GOVERNOR'S RECOMMENDATION FY 2006	FY 2007	FY 06-07	FY 2008	FY 2009	FY 08-09	SENATE POSITION - SF 1879 FY 2006	FY 2007	FY 06-07	FY 2008	FY 2009	FY 08-09	SENATE POSITION - HHS OMNIBUS BUDGET BILL FY 2006	FY 2007	FY 06-07	FY 2008	FY 2009	FY 08-09	SENATE TOTAL POSITION FY 06-07	FY 08-09
659	***DEPARTMENT OF HEALTH***																							
660																								
661																								
662	Page 9			**ELIMINATE SUICIDE PREVENTION GRANTS**	(983)	(983)	(1,966)	(983)	(983)	(1,966)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
663		GF	1	Suicide prevention grants	(983)	(983)	(1,966)	(983)	(983)	(1,966)			0	0	0	0	0	0	0	0	0	0	0	0
664																								
665	Page 9			**ELIMINATE DENTAL LOAN FORGIVENESS PROGRAM**	(560)	(560)	(1,120)	(560)	(560)	(1,120)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
666		GF	1	Dental loan forgiveness grants	(560)	(560)	(1,120)	(560)	(560)	(1,120)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
667																								
668	Page 10 A			**STATE TRAUMA SYSTEM**	382	352	734	352	352	704	0	0	0	0	0	0	0	0	0	0	0	0	0	0
669		GF	1	State Trauma System	382	352	734	352	352	704	0	0	0	0	0	0	382	352	734	352	352	704	734	704
670		GF	REV	Increase Hospital License Fees	0	0	0	0	0	0	0	0	0	0	0	0	(382)	(352)	(734)	(352)	(352)	(704)	(734)	(704)
671																								
672	Page 23			**ELIMINATE OFFICE 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
673		GF	2	Eliminate office of complimentary and alternative practice	(65)	(65)	(130)	(65)	(65)	(130)			0	0	0	0	0	0	0	0	0	0	0	0
674																								
675	Page 24			**INCREASE VITAL RECORDS ACTIVITY**	(316)	(416)	(732)	384	384	768	0	0	0	0	0	0	0	0	0	0	0	0	0	0
676		SGSR	2	Increase 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
677		SGSR	REV	Increase fees	(1,420)	(1,420)	(2,840)	(1,420)	(1,420)	(2,840)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
678		SGSR	REV	Increase base fee for certified copy of a record by $1 ($8 to $9)	0	0	0	0	0	0	0	0			0	0	(600)	(600)	(1,200)	(600)	(600)	(1,200)	(1,200)	(1,200)
679		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)
680																								
681	Page 23			**OCCUPATIONAL THERAPY LICENSE FEE SUSPENSION**	254	254	508	254	254	508	0	0	0	0	0	0	0	0	0	0	0	0	0	0
682		SGSR	REV	Fee holiday - decrease revenues	254	254	508	254	254	508	0	0	0	0	0	0	0	0	0	0	0	0	0	0
683																								
684	Page 17			**METH LAB REMEDIATION**	100	100	200	100	100	200	0	0	0	0	0	0	0	0	0	0	0	0	0	0
685		GF	3	Meth lab remediation - technical assistance to local units of government	100	100	200	100	100	200	0	0	0	0	0	0			0			0	0	0
686																								
687	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
688		SGSR	3	Increase appropriation for drinking water protection program	381	635	1,016	1,570	1,570	3,140	0	0	0	0	0	0	381	635	1,016	1,570	1,570	3,140	1,016	3,140
689		SGSR	REV	Increase drinking water connectin fee from $5.21 to $8.36	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)
690																								
691	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
692		SGSR	3	Increase appropriation for well management program	356	601	957	601	601	1,202	0	0	0	0	0	0	356	601	957	601	601	1,202	957	1,202
693		SGSR	REV	Increase variety of well management fees	0	(551)	(551)	(551)	(551)	(1,102)	0	0	0	0	0	0	0	(551)	(551)	(551)	(551)	(1,102)	(551)	(1,102)
694																								
695	Page 19			**PLUMBING PROGRAM**	255	255	510	255	255	510	0	0	0	0	0	0	255	255	510	255	255	510	510	510
696		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
697		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
698																								
699	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)
700		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
701		SGSR	REV	Fee increase for food manager's certification from $15 to $28	(91)	(91)	(182)	(91)	(91)	(182)	0	0	0	0	0	0	(91)	(91)	(182)	(91)	(91)	(182)	(182)	(182)
702																								
703	Page 14			**FOOD, BEVERAGE AND LODGING PROGRAM FEE**	226	226	452	226	226	452	0	0	0	0	0	0	226	226	452	226	226	452	452	452
704		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	0	1,552	1,552	3,104	1,552	1,552	3,104	3,104	3,104
705		SGSR	REV	Increase license fee for food, beverage and lodging establishments	(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)
706																								
707	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
708		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
709		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)
710																								
711	Page 8			**OPERATIONS SUPPORT - DIVISION MANAGEMENT**	(200)	(200)	(400)	(200)	(200)	(400)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
712		GF	1	Reallocation to pay for increased rent for new lab building	(200)	(200)	(400)	(200)	(200)	(400)	0	0	0	0	0	0			0			0	0	0
713																								
714	Page 8			**OPERATIONS SUPPORT - DENTAL HEALTH PROGRAM**	(72)	(72)	(144)	(72)	(72)	(144)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
715		GF	1	Reallocation to pay for increased rent for new lab building	(72)	(72)	(144)	(72)	(72)	(144)	0	0	0	0	0	0			0			0	0	0
716																								
717	Page 8			**OPERATIONS SUPPORT - OFFICE OF STATE REGISTRAR**	(140)	(140)	(280)	(140)	(140)	(280)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
718		GF	1	Reallocation to pay for increased rent for new lab building	(140)	(140)	(280)	(140)	(140)	(280)	0	0	0	0	0	0			0			0	0	0
719																								
717	Page 8			**OPERATIONS SUPPORT - RADIATION CONTROL**	(21)	(21)	(42)	(21)	(21)	(42)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
718		GF	1	Reallocation to pay for increased rent for new lab building	(21)	(21)	(42)	(21)	(21)	(42)	0	0	0	0	0	0			0			0	0	0
719																								
720	Page 8			**OPERATIONS SUPPORT - EH MANAGEMENT**	(19)	(19)	(38)	(19)	(19)	(38)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
721		GF	1	Reallocation to pay for increased rent for new lab building	(19)	(19)	(38)	(19)	(19)	(38)	0	0	0	0	0	0			0			0	0	0
722																								
720	Page 8			**OPERATIONS SUPPORT - VACCINE OUTBREAK FUND**	(34)	(34)	(68)	(34)	(34)	(68)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
721		GF	1	Reallocation to pay for increased rent for new lab building	(34)	(34)	(68)	(34)	(34)	(68)	0	0	0	0	0	0			0			0	0	0
722																								

Trkg. Line	Gov Rec / Bill Ref	Fund	BACT	DESCRIPTION	GOVERNOR'S RECOMMENDATION FY 2006	FY 2007	FY 06-07	FY 2008	FY 2009	FY 08-09	SENATE POSITION - SF 1879 FY 2006	FY 2007	FY 06-07	FY 2008	FY 2009	FY 08-09	SENATE POSITION - HHS OMNIBUS BUDGET BILL FY 2006	FY 2007	FY 06-07	FY 2008	FY 2009	FY 08-09	SENATE TOTAL POSITION FY 06-07	FY 08-09
711	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**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
712		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
713		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)
714		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	(712)	(1,808)	(2,520)	(1,808)	(1,808)	(3,616)	(2,520)	(3,616)
715		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)
716		GF	5	*Operations support - library support - reallocation within BACT - [non-add]*	(188)	(188)	(376)	(188)	(188)	(376)	0	0	0	0	0	0	(188)	(188)	(376)	(188)	(188)	(376)	(376)	(376)
717		GF	5	*Operations support - F & FM (inventory management) - reallocation within BACT - [non-add]*	(124)	(124)	(248)	(124)	(124)	(248)	0	0	0	0	0	0	(124)	(124)	(248)	(124)	(124)	(248)	(248)	(248)
718		GF	5	*Operations support - communications office - reallocation within BACT - [non-add]*	(50)	(50)	(100)	(50)	(50)	(100)	0	0	0	0	0	0	(50)	(50)	(100)	(50)	(50)	(100)	(100)	(100)
719		GF	5	*Operations support - HR - reallocation within BACT - [non-add]*	(188)	(188)	(376)	(188)	(188)	(376)	0	0	0	0	0	0	(188)	(188)	(376)	(188)	(188)	(376)	(376)	(376)
720		GF	5	*Operations support - F & FM (federal grants support) reallocation within BACT - [non-add]*	(50)	(50)	(100)	(50)	(50)	(100)	0	0	0	0	0	0	(50)	(50)	(100)	(50)	(50)	(100)	(100)	(100)
721		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
722		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
723		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
724		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
725		GF	5	Reallocation from operations support - radiation control reduction	21	21	42	21	21	42	0	0	0	0	0	0	21	21	42	21	21	42	42	42
726		GF	5	Reallocation from operations support - EH management	19	19	38	19	19	38	0	0	0	0	0	0	19	19	38	19	19	38	38	38
727		GF	5	Reallocation from 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
728																								
729	Page 8			**ADVERSE HEALTH EVENT REPORTING**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
730		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
731		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)
732																								
733	SF 1115			**PLUMBERS LICENSING AND INSPECTION REQUIREMENTS**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(1,924)**	**1,278**	**(646)**	**697**	**(54)**	**643**	**(646)**	**643**
734		SGSR	3	Salary and fringes	0	0	0	0	0	0	0	0	0	0	0	0	537	761	1,298	761	761	1,522	1,298	1,522
735		SGSR	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
736		SGSR	REV	Increase Public, Commercial and Industrial Fees						0	0	0	0	0	0	0	(2,866)	(4,950)	(7,816)	(5,531)	(6,282)	(11,813)	(7,816)	(11,813)
737																								
738	SF 908			**DONATED DENTAL PROGRAM**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**70**	**70**	**140**	**70**	**70**	**140**	**140**	**140**
739		HCAF	1	Appropriation	0	0	0	0	0	0	0	0	0	0	0	0	70	70	140	70	70	140	140	140
740																								
741	SF 65			**INTER-AGENCY WORK GROUP ON CHILDHOOD OBESITY**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**5**	**1**	**6**	**0**	**0**	**0**	**6**	**0**
742		GF	1	Interagency workgroup meetings	0	0	0	0	0	0	0	0	0	0	0	0	5	1	6	0	0	0	6	0
743																								
744	SF XXXX			**FAMILY PLANNING GRANTS APPROPRIATION FOR GREATER MN CLINICS**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**500**	**500**	**1,000**	**500**	**500**	**1,000**	**1,000**	**1,000**
745		GF	1	Appropriation	0	0	0	0	0	0	0	0	0	0	0	0	500	500	1,000	500	500	1,000	1,000	1,000
746																								
747																								
748																								
749																								
774																								
775	***HEALTH-RELATED BOARDS***																							
776																								
777																								
778	SF1567			**BOARD OF PHARMACY - 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**
779				**PRESERVATION GRANT PROGRAM - LOAN FORGIVENESS**	0	0		0																
780		SGSR	09	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
781		SGSR	09	Appropriation for MDH Rural Pharmacist Loan Forgiveness Program													200	200	400	200	200	400		
782																								
783	SF 227			**BOARD OF PHARMACY - CANCER DRUG REPOSITORY PROGRAM**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**25**	**25**	**50**	**25**	**25**	**50**	**50**	**50**
784		SGSR	09	Administration - .5 fte	0	0	0	0	0	0	0	0	0	0	0	0	25	25	50	25	25	50	50	50
785																								
786	SF 23			**BOARD OF PHARMACY - PHARMACEUTICAL PRICE REPORTING**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**74**	**74**	**148**	**74**	**74**	**148**	**148**	**148**
787		SGSR	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
788																								
789	Rider			**BOARD OF NURSING - 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**
790				**HOME AND COMMUNITY BASED EMPLOYEE SCHOLARSHIPS**																				
791		SGSR	06	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	0
792																								
793	SF 1183			**BOARD OF NURSING - 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**
794				**LOAN FORGIVENESS PROGRAM**																				
795		SGSR	06	Appropriation for health professional loan forgiveness program	0	0	0	0	0	0	0	0	0	0	0	0	125	200	325	275	350	625	325	625
796																								
793	Rider			**BOARD OF NURSING - APPROPRIATION FOR CENTER FOR EXCELLENCE**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**500**	**0**	**500**	**0**	**0**	**0**	**500**	**0**
794		SGSR	06	Appropriation	0	0	0	0	0	0				0	0	0	500	0	500	0	0	0	500	0
795																								
796	SF XXXX			**BOARD OF SOCIAL WORK - OFFICE MENTAL HEALTH PRACTICE APPROPRIATION**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**105**	**100**	**205**	**0**	**0**	**0**	**205**	**0**
797		SGSR	13	Appropriation	0	0	0	0	0	0	0	0	0	0	0	0	105	100	205	0	0	0	205	0
798																								
799	SF XXXX			**BOARD OF DENTISTRY - DENTAL ACCESS PROGRAM START-UP**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**150**	**0**	**150**	**0**	**0**	**0**	**150**	**0**
800		SGSR	02	Appropriation	0	0	0	0	0	0	0	0	0	0	0	0	150	0	150	0	0	0	150	0

ATTACHMENT "A"

Sec. 7. Minnesota Statutes 2004, section 256B.0625, subdivision 13e, as amended by 2005 S.F. No. 1879, article 13, section 7, subdivision 13e, if enacted, is amended to read:

Subd. 13e. [PAYMENT RATES.] (a) The basis for determining the amount of payment shall be the lower of the actual acquisition costs of the drugs plus a fixed dispensing fee; the maximum allowable cost set by the federal government or by the commissioner plus the fixed dispensing fee; or the usual and customary price charged to the public. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The pharmacy dispensing fee shall be $3.65, except that the dispensing fee for intravenous solutions which must be compounded by the pharmacist shall be $8 per bag, $14 per bag for cancer chemotherapy products, and $30 per bag for total parenteral nutritional products dispensed in one liter quantities, or $44 per bag for total parenteral nutritional products dispensed in quantities greater than one liter. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. The actual acquisition cost of a drug shall be estimated by the commissioner, at average wholesale price minus 11.5 percent, except that where a drug has

had its wholesale price reduced as a result of the actions of the National Association of Medicaid Fraud Control Units, the estimated actual acquisition cost shall be the reduced average wholesale price, without the 11.5 percent deduction. The actual acquisition cost of antihemophilic factor drugs shall be estimated at the average wholesale price minus 30 percent. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to, but no higher than, the maximum amount paid by other third-party payors in this state who have maximum allowable cost programs. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

(b) An additional dispensing fee of $.30 may be added to the dispensing fee paid to pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities when a unit dose blister card system, approved by the department, is used. Under this type of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National Drug Code (NDC) from the drug container used to fill the blister card must be identified on the claim to the department. The unit dose blister card containing the drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider will be required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse. Over-the-counter medications must be dispensed in the manufacturer's unopened package. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply.

(c) Whenever a generically equivalent product is available, payment shall be on the basis of the actual acquisition cost of the generic drug, or on the maximum allowable cost established by the commissioner.

(d) The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the provider or the

amount established for Medicare by the United States Department of Health and Human Services pursuant to title XVIII, section 1847a of the federal Social Security Act.

(e) The commissioner may negotiate lower reimbursement rates for specialty pharmacy products than the rates specified in paragraph (a). The commissioner may require individuals enrolled in the health care programs administered by the department to obtain specialty pharmacy products from providers with whom the commissioner has negotiated lower reimbursement rates. Specialty pharmacy products are defined as those used by a small number of recipients or recipients with complex and chronic diseases that require expensive and challenging drug regimens. Examples of these conditions include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of cancer. Specialty pharmaceutical products include injectable and infusion therapies, biotechnology drugs, high-cost therapies, and therapies that require complex care. The commissioner shall consult with the formulary committee to develop a list of specialty pharmacy products subject to this paragraph. In consulting with the formulary committee in developing this list, the commissioner shall take into consideration the population served by special pharmacy products, the current delivery system 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.

ATTACHMENT "B"

04/26/05 [COUNSEL] KC BL1031

Senator ..... moves to amend S.F. No. .... as follows:

Page .., after line .., insert:

"Sec. ... Minnesota Statutes 2004, section 62Q.37, subdivision 7, is amended to read:

Subd. 7. [HUMAN SERVICES.] (a) The commissioner of human services shall implement this section in a manner that is consistent with applicable federal laws and regulations and that avoids the duplication of review activities performed by a nationally recognized independent organization.

(b) By December 31 of each year, the commissioner shall submit to the legislature a written report identifying the number of audits performed by a nationally recognized independent organization that were accepted, partially accepted, or rejected by the commissioner under this section. The commissioner shall provide the rationale for partial acceptance or rejection. If the rationale for the partial acceptance or rejection was based on the commissioner's determination that the standards used in the audit were not equivalent to state law, regulation, or contract requirement, the report must document the variances between the audit standards and the applicable state requirements."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

ATTACHMENT "C"

04/24/05 [COUNSEL] KC BL1015

Senator ..... moves to amend S.F. No. .... as follows:

Page .., after line .., insert:

"Sec. .. [62J.83] [PROVIDER COST DISCLOSURE.]

Subdivision 1. [REPORT; AVAILABILITY.] (a) Each health care provider, as defined by section 62J.03, subdivision 8, shall report annually to the commissioner of health, in a form and manner specified by the commissioner, the following:

(1) the average and median allowable charge from private third-party payers for the 20 services or procedures most commonly performed;

(2) the average and median payment rates for those services and procedures for medical assistance; and

(3) the average and median payment rates for private pay individuals.

(b) This information shall be available to the public:

(1) through the health care provider; and

(2) through the commissioner on agency Web sites, including minnesotahealthinfo.com.

Subd. 2. [COMPARABILITY.] The commissioner may contract with one or more private, nonprofit organizations to make this information available in an easily understood format that promotes comparisons by integrated health care systems, individual practice groups, single-provider practices, specialty groups, and hospitals.

Subd. 3. [DETERMINATION OF MOST COMMON PROCEDURES.] The commissioner may specify the 20 most common procedures by specialty, provider type, or other suitable categories."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly