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Senate
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S.F. No. 1579 - Department of Health – Technical

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S.F. No. 1579 makes a number of technical changes to the Health Care Administrative Simplification Act; wells and borings; and mortuary science and the disposition of dead bodies.

Sections 1 to 5 (62J.51 and 62J.52) change the name of uniform billing form HCFA 1450 and HCFA 1500 to CMS 1450 and CMS1500.

Sections 6 and 7 (62J.54) make a number of changes regarding the unique identification number for health care provider organizations and for individual health care providers. These sections require health care provider organizations and health care providers that meet the federal definition to obtain a national provider identifier, require small health plans that meet the federal definition to use a national provider identifier, change the term "unique health identifier" to "national provider identifier;" specify the specific providers that need to obtain the national provider identifier; require that the national provider identifier be used on all paper and electronic claims and remittance advice notices; and require that health care provider organizations make their national provider identifier available to other health care providers when it is required to be included on an administrative transaction.

Section 8 (62J.581) changes the effective date for the requirement to use Minnesota uniform remittance advice reports and explanation of benefits document from October 16, 2004, to June 30, 2007.

Sections 9 to 55 make minor changes to chapter 103I (wells and borings). These sections change the term "elevator shaft" to "elevator boring;" change the term "pump hoist" to "hoist;" change the term "applicant" to "representative" when referring to the licensee's representative; and permit the submission of a 7.5 minute series topographic map prepared by the U.S. geographical society.

Sections 56 and 57 (144.221 and 144.225) require death records to be filed with the state registrar and require the registrar to issue a certified death record if a licensed mortician has furnished the registrar with the properly completed attestation.

Sections 58 (149A.93, subdivision 1) requires a licensed mortician to issue a transmit permit before a body is transported.

Section 59 (149.93, subdivision 2) states that a transmit permit is needed when legal and physical custody of the body is transferred; a body is transported by public transportation; or a body is removed from the state.

Section 60 (149.93, subdivision 3) states that a disposition permit is required before a body can be buried, entombed, or cremated and that no disposition permit shall be issued until a fact of death record has been completed.

Section 61 (149A.93, subdivision 4) states that at the place of final disposition legal custody of the body shall pass with the filing of the disposition permit with the person in charge of that place.

Section 62 (149A.93, subdivision 5) requires that when a death occurs outside of the state and the body travels into or through the state, the body must be accompanied by a permit for burial, removal, or other disposition issued in accordance with the laws and rules of the state where the death occurred.

Section 63 (149A.94, subdivision 3) states that no dead human body shall be buried, entombed, or cremated without a disposition permit and that the permit must be filed with the person in charge of the place of final disposition.

Section 64 (149A.96, subdivision 1) states that a disinterment-reinterment permit is issued by the state registrar or a licensed mortician.

Section 65 (149A.96, subdivision 4) states that if the disinterment is opposed, no disinterment-reinterment permit shall be issued until the state registrar or licensed mortician receives a certified copy of a court order that specifically orders the disinterment and reinterment.

Section 66 (149A.96, subdivision 7) states that if the death occurred in the state, the state registrar or licensed mortician must inform the person requesting the disinterment and reinterment of the right to request an amendment to the death record in accordance with Minnesota Rules, chapter 4601.

Section 67 makes a technical change in an effective date.

Section 68 repeals Minnesota Statutes 2004, sections 103I.005, subdivision 13 (definition of limited well/boring sealing contractor); 103I.022 (the use of polyvinyl chloride); and 144.214 (local registrars of vital statistics).

KC:vs

Senators Wergin, Lourey, Kiscaden and Fischbach introduced--

S.F. No. 1579: Referred to the Committee on Health and Family Security.

A bill for an act

relating to health; modifying the Health Care Administrative Simplification Act of 1994; modifying requirements of federal Drug Enforcement Administration registration numbers; modifying provisions for wells, borings, and underground uses; modifying requirements for filing and issuing death records; modifying provisions for disposition of dead bodies; eliminating authority to designate certain morticians; amending Minnesota Statutes 2004, sections 62J.51, subdivisions 17, 18; 62J.52, subdivisions 1, 2, 5; 62J.54, subdivisions 1, 2; 62J.581, subdivision 5; 103I.005, subdivisions 4a, 6, 7, 10, 12, by adding subdivisions; 103I.101, subdivisions 2, 5; 103I.105; 103I.111, subdivisions 1, 3; 103I.115; 103I.205, subdivisions 4, 9; 103I.208, subdivisions 1, 2; 103I.231; 103I.325, subdivision 2; 103I.345, subdivision 2; 103I.401; 103I.501; 103I.505; 103I.525, subdivisions 1, 2, 4, 5, 8, by adding a subdivision; 103I.531, subdivisions 1, 2, 4, 5, 8, by adding a subdivision; 103I.535, subdivisions 1, 2, 4, 5, 7, 8, 9, by adding a subdivision; 103I.541; 103I.545, subdivision 2; 103I.601, subdivisions 4, 9; 144.221, subdivision 1; 144.225, subdivision 7; 149A.93, subdivisions 1, 2, 3, 4, 5; 149A.94, subdivision 3; 149A.96, subdivisions 1, 4, 7; Laws 1998, chapter 316, section 4; repealing Minnesota Statutes 2004, sections 103I.005, subdivision 13; 103I.222; 144.214, subdivision 4.

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

Section 1. Minnesota Statutes 2004, section 62J.51, subdivision 17, is amended to read:

Subd. 17. [UNIFORM BILLING FORM ~~HCFA~~ CMS 1450.] "Uniform billing form ~~HCFA~~ CMS 1450" means the uniform billing form known as the ~~HCFA~~ CMS 1450 or UB92, developed by the National Uniform Billing Committee in 1992 and approved for implementation in October 1993, and any subsequent amendments to the form.

Sec. 2. Minnesota Statutes 2004, section 62J.51, subdivision 18, is amended to read:

Subd. 18. [UNIFORM BILLING FORM ~~HCFA~~ CMS 1500.] "Uniform billing form ~~HCFA~~ CMS 1500" means the 1990 version of the health insurance claim form, ~~HCFA~~ CMS 1500, developed by the National Uniform ~~claims form task force of the federal Health Care Financing Administration~~ Claim Committee and any subsequent amendments to the form.

Sec. 3. Minnesota Statutes 2004, section 62J.52, subdivision 1, is amended to read:

Subdivision 1. [UNIFORM BILLING FORM ~~HCFA~~ CMS 1450.] (a) On and after January 1, 1996, all institutional inpatient hospital services, ancillary services, institutionally owned or operated outpatient services rendered by providers in Minnesota, and institutional or noninstitutional home health services that are not being billed using an equivalent electronic billing format, must be billed using the uniform billing form ~~HCFA~~ CMS 1450, except as provided in subdivision 5.

(b) The instructions and definitions for the use of the uniform billing form ~~HCFA~~ CMS 1450 shall be in accordance with the uniform billing form manual specified by the commissioner. In promulgating these instructions, the commissioner may utilize the manual developed by the National Uniform Billing Committee, as adopted and finalized by the Minnesota Uniform Billing Committee.

(c) Services to be billed using the uniform billing form ~~HCFA~~ CMS 1450 include: institutional inpatient hospital services and distinct units in the hospital such as psychiatric unit services, physical therapy unit services, swing bed (SNF) services, inpatient state psychiatric hospital services, inpatient skilled nursing facility services, home health services (Medicare part A), and hospice services; ancillary services, where benefits are exhausted or patient has no Medicare part A, from hospitals, state psychiatric hospitals, skilled nursing facilities, and home health (Medicare part B); institutional owned or operated outpatient services such as

waivered services, hospital outpatient services, including ambulatory surgical center services, hospital referred laboratory services, hospital-based ambulance services, and other hospital outpatient services, skilled nursing facilities, home health, freestanding renal dialysis centers, comprehensive outpatient rehabilitation facilities (CORF), outpatient rehabilitation facilities (ORF), rural health clinics, and community mental health centers; home health services such as home health intravenous therapy providers, waivered services, personal care attendants, and hospice; and any other health care provider certified by the Medicare program to use this form.

(d) On and after January 1, 1996, a mother and newborn child must be billed separately, and must not be combined on one claim form.

Sec. 4. Minnesota Statutes 2004, section 62J.52, subdivision 2, is amended to read:

Subd. 2. [UNIFORM BILLING FORM ~~HCFA~~ CMS 1500.] (a) On and after January 1, 1996, all noninstitutional health care services rendered by providers in Minnesota except dental or pharmacy providers, that are not currently being billed using an equivalent electronic billing format, must be billed using the health insurance claim form ~~HCFA~~ CMS 1500, except as provided in subdivision 5.

(b) The instructions and definitions for the use of the uniform billing form ~~HCFA~~ CMS 1500 shall be in accordance with the manual developed by the Administrative Uniformity Committee entitled standards for the use of the ~~HCFA~~ CMS 1500 form, dated February 1994, as further defined by the commissioner.

(c) Services to be billed using the uniform billing form ~~HCFA~~ CMS 1500 include physician services and supplies, durable medical equipment, noninstitutional ambulance services, independent ancillary services including occupational therapy, physical therapy, speech therapy and audiology, home infusion therapy, podiatry services, optometry services, mental health licensed professional services, substance abuse licensed professional services, nursing practitioner professional

services, certified registered nurse anesthetists, chiropractors, physician assistants, laboratories, medical suppliers, and other health care providers such as day activity centers and freestanding ambulatory surgical centers.

Sec. 5. Minnesota Statutes 2004, section 62J.52, subdivision 5, is amended to read:

Subd. 5. [STATE AND FEDERAL HEALTH CARE PROGRAMS.] (a) Skilled nursing facilities and ICF/MR services billed to state and federal health care programs administered by the Department of Human Services shall use the form designated by the Department of Human Services.

(b) On and after July 1, 1996, state and federal health care programs administered by the Department of Human Services shall accept the ~~HCFA~~ CMS 1450 for community mental health center services and shall accept the ~~HCFA~~ CMS 1500 for freestanding ambulatory surgical center services.

(c) State and federal health care programs administered by the Department of Human Services shall be authorized to use the forms designated by the Department of Human Services for pharmacy services.

(d) State and federal health care programs administered by the Department of Human Services shall accept the form designated by the Department of Human Services, and the ~~HCFA~~ CMS 1500 for supplies, medical supplies, or durable medical equipment. Health care providers may choose which form to submit.

(e) Personal care attendant and waivered services billed on a fee-for-service basis directly to state and federal health care programs administered by the Department of Human Services shall use either the ~~HCFA~~ CMS 1450 or the ~~HCFA~~ CMS 1500 form, as designated by the Department of Human Services.

Sec. 6. Minnesota Statutes 2004, section 62J.54, subdivision 1, is amended to read:

Subdivision 1. [UNIQUE IDENTIFICATION NUMBER FOR HEALTH CARE PROVIDER ORGANIZATIONS.] (a) Not later than 24 months after the date on which a ~~unique health~~ national provider identifier

~~for-health-care-providers~~ is ~~adopted-or-established~~ made effective under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments), all group purchasers and any health care ~~providers-in-Minnesota~~ provider organization that meets the definition of a health care provider under United States Code, title 42, sections 1320d to 1320d-8, as amended, and regulations adopted thereunder shall use a ~~unique identification number~~ national provider identifier to identify health care provider organizations in Minnesota, according to this section, except as provided in paragraph (b).

(b) Small health plans, as defined by the federal Secretary of Health and Human Services under United States Code, title 42, section 1320d-4 (1996 and subsequent amendments), shall use a ~~unique-identification-number~~ national provider identifier to identify health provider organizations no later than 36 months after the date on which a ~~unique-health~~ national provider identifier ~~for-health-care-providers~~ is ~~adopted-or established~~ made effective under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments).

(c) The ~~unique-health~~ national provider identifier for health care providers ~~adopted-or~~ established by the federal Secretary of Health and Human Services under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments), shall be used as the unique identification number for health care provider organizations in Minnesota under this section.

~~(d)-Provider-organizations-required-to-have-a-unique-health identifier-are:~~

~~(1)-hospitals-licensed-under-chapter-144;~~

~~(2)-nursing-homes-and-hospices-licensed-under-chapter-144A;~~

~~(3)-subacute-care-facilities;~~

~~(4)-individual-providers-organized-as-a-clinic-or-group practice;~~

~~(5)-independent-laboratory,-pharmacy,-surgery,-radiology, or-outpatient-facilities;~~

~~(6)-ambulance-services-licensed-under-chapter-144;~~

~~(7) special transportation services certified under chapter 174; and~~

~~(8) other provider organizations as required by the federal Secretary of Health and Human Services under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments).~~

(d) All health care provider organizations in Minnesota that are eligible to obtain a national provider identifier according to United States Code, title 42, sections 1320d to 1320d-8, as amended, and regulations adopted thereunder shall obtain a ~~unique health~~ national provider identifier from the federal Secretary of Health and Human Services using the process prescribed by the Secretary.

(e) Only the ~~unique health care provider organization~~ national provider identifier shall be used ~~for purposes of~~ to identify health care provider organizations when submitting and receiving paper and electronic claims and remittance advice notices, and in conjunction with other data collection and reporting functions.

(f) Health care provider organizations in Minnesota shall make available their national provider identifier to other health care providers when required to be included in the administrative transactions regulated by United States Code, title 42, sections 1320d to 1320d-8, as amended, and regulations adopted thereunder.

(g) The commissioner of health may contract with the federal Secretary of Health and Human Services or the Secretary's agent to implement this subdivision.

Sec. 7. Minnesota Statutes 2004, section 62J.54, subdivision 2, is amended to read:

Subd. 2. [UNIQUE IDENTIFICATION NUMBER FOR INDIVIDUAL HEALTH CARE PROVIDERS.] (a) Not later than 24 months after the date on which a ~~unique health~~ national provider identifier ~~for health care providers is adopted or established~~ made effective under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments), all group purchasers in

Minnesota and any individual health care ~~providers in Minnesota~~ provider that meets the definition of a health care provider under United States Code, title 42, sections 1320d to 1320d-8, as amended, and regulations adopted thereunder shall use a ~~unique identification number~~ the national provider identifier to identify an individual health care provider in Minnesota, according to this section, except as provided in paragraph (b).

(b) Small health plans, as defined by the federal Secretary of Health and Human Services under United States Code, title 42, section 1320d-4 (1996 and subsequent amendments), shall use a ~~unique identification number~~ the national provider identifier to identify an individual health care provider no later than 36 months after the date on which a ~~unique health~~ national provider identifier for health care providers is ~~adopted or established~~ made effective under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments).

(c) The ~~unique health~~ national provider identifier for health care providers ~~adopted or~~ established by the federal Secretary of Health and Human Services under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments), shall be used as the unique identification number for individual health care providers.

~~(d) Individual providers required to have a unique health identifier are:~~

~~(1) physicians licensed under chapter 147;~~

~~(2) dentists licensed under chapter 150A;~~

~~(3) chiropractors licensed under chapter 148;~~

~~(4) podiatrists licensed under chapter 153;~~

~~(5) physician assistants as defined under section 147A.01;~~

~~(6) advanced practice nurses as defined under section 62A.15;~~

~~(7) doctors of optometry licensed under section 148.57;~~

~~(8) pharmacists licensed under chapter 151;~~

~~(9) individual providers who may bill Medicare for medical and other health services as defined in United States Code;~~

~~title 42, section 1395x(s);~~

~~(10) individual providers who are providers for state and federal health care programs administered by the commissioner of human services; and~~

~~(11) other individual providers as required by the federal Secretary of Health and Human Services under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments).~~

(d) All individual health care providers in Minnesota that are eligible to obtain a national provider identifier according to United States Code, title 42, sections 1320d to 1320d-8, as amended, and regulations adopted thereunder shall obtain a ~~unique health~~ national provider identifier from the federal Secretary of Health and Human Services using the process prescribed by the Secretary.

(e) Only the ~~unique individual health care~~ national provider identifier shall be used ~~for purposes of~~ to identify individual health care providers when submitting and receiving paper and electronic claims and remittance advice notices, and in conjunction with other data collection and reporting functions.

(f) Individual health care providers in Minnesota shall make available their national provider identifier to other health care providers when required to be included in the administrative transactions regulated by United States Code, title 42, sections 1320d to 1320d-8, as amended, and regulations adopted thereunder.

(g) The commissioner of health may contract with the federal Secretary of Health and Human Services or the Secretary's agent to implement this subdivision.

Sec. 8. Minnesota Statutes 2004, section 62J.581, subdivision 5, is amended to read:

Subd. 5. [EFFECTIVE DATE.] The requirements in subdivisions 1 and 2 are effective ~~October 16, 2004~~ June 30, 2007. The requirements in subdivisions 1 and 2 apply regardless of when the health care service was provided to the patient.

[EFFECTIVE DATE.] This section is effective retroactively to October 16, 2004.

Sec. 9. Minnesota Statutes 2004, section 103I.005, is amended by adding a subdivision to read:

Subd. 2a. [CERTIFIED REPRESENTATIVE.] "Certified representative" means a person certified by the commissioner to represent a well contractor, limited well/boring contractor, monitoring well contractor, or elevator boring contractor.

Sec. 10. Minnesota Statutes 2004, section 103I.005, subdivision 4a, is amended to read:

Subd. 4a. [DEWATERING WELL.] "Dewatering well" means a nonpotable well used to lower groundwater levels to allow for construction or use of underground space. A dewatering well does not include:

(1) ~~a well or dewatering well~~ an excavation 25 feet or less in depth for temporary dewatering during construction; or

(2) a well used to lower groundwater levels for control or removal of groundwater contamination.

Sec. 11. Minnesota Statutes 2004, section 103I.005, subdivision 6, is amended to read:

Subd. 6. [ELEVATOR ~~SHAFT~~ BORING.] "Elevator ~~shaft~~ boring" means a bore hole, jack hole, drilled hole, or excavation constructed to install an elevator ~~shaft or~~ hydraulic cylinder.

Sec. 12. Minnesota Statutes 2004, section 103I.005, subdivision 7, is amended to read:

Subd. 7. [ELEVATOR ~~SHAFT~~ BORING CONTRACTOR.] "Elevator ~~shaft~~ boring contractor" means a person with an elevator ~~shaft~~ boring contractor's license issued by the commissioner.

Sec. 13. Minnesota Statutes 2004, section 103I.005, subdivision 10, is amended to read:

Subd. 10. [EXPLORER.] "Explorer" means a person ~~who has the right to drill an exploratory boring~~ with an explorer's license issued by the commissioner.

Sec. 14. Minnesota Statutes 2004, section 103I.005, subdivision 12, is amended to read:

Subd. 12. [LIMITED WELL/BORING CONTRACTOR.] "Limited

well/boring contractor" means a person with a limited well/boring contractor's license issued by the commissioner. Limited well/boring contractor's licenses are issued for constructing, repairing, and sealing vertical heat exchangers; installing, repairing, and modifying pitless units and pitless adaptors, well casings above the pitless unit or pitless adaptor, well screens, or well diameters; constructing, repairing, and sealing drive point wells or dug wells; constructing, repairing, and sealing dewatering wells; sealing wells; and installing well pumps or pumping equipment.

Sec. 15. Minnesota Statutes 2004, section 103I.005, is amended by adding a subdivision to read:

Subd. 20a. [WATER SUPPLY WELL.] "Water supply well" means a well that is not a dewatering well or monitoring well and includes wells used:

(1) for potable water supply;

(2) for irrigation;

(3) for agricultural, commercial, or industrial water supply;

(4) for heating or cooling;

(5) as a remedial well; and

(6) for testing water yield for irrigation, commercial or industrial uses, residential supply, or public water supply.

Sec. 16. Minnesota Statutes 2004, section 103I.101, subdivision 2, is amended to read:

Subd. 2. [DUTIES.] The commissioner shall:

(1) regulate the drilling, construction, modification, repair, and sealing of wells and borings;

(2) examine and license well contractors~~,~~; persons constructing, repairing, and sealing vertical heat exchangers~~,~~; persons modifying or repairing well casings, well screens, or well diameters; persons constructing, repairing, and sealing ~~unconventional wells such as~~ drive point wells or dug wells; persons constructing, repairing, and sealing dewatering wells; persons sealing wells; persons installing well pumps or pumping equipment; and persons excavating or drilling holes for the

installation of elevator ~~shafts~~ borings or hydraulic cylinders;

(3) register and examine monitoring well contractors;

(4) license explorers engaged in exploratory boring and examine individuals who supervise or oversee exploratory boring;

(5) after consultation with the commissioner of natural resources and the Pollution Control Agency, establish standards for the design, location, construction, repair, and sealing of wells~~,-elevator-shafts,~~ and borings within the state; and

(6) issue permits for wells, groundwater thermal devices, vertical heat exchangers, and ~~excavation-for-holes-to-install~~ elevator ~~shafts-or-hydraulic-cylinders~~ borings.

Sec. 17. Minnesota Statutes 2004, section 103I.101, subdivision 5, is amended to read:

Subd. 5. [COMMISSIONER TO ADOPT RULES.] The commissioner shall adopt rules including:

(1) issuance of licenses for:

(i) qualified well contractors, persons modifying or repairing well casings, well screens, or well diameters;

(ii) persons constructing, repairing, and sealing ~~unconventional-wells-such-as~~ drive ~~points~~ point wells or dug wells;

(iii) persons constructing, repairing, and sealing dewatering wells;

(iv) persons sealing wells;

(v) persons installing well pumps or pumping equipment ~~and excavating-holes-for-installing-elevator-shafts-or-hydraulic cylinders; and~~

(vi) persons constructing, repairing, and sealing vertical heat exchangers; and

(vii) persons constructing, repairing, and sealing elevator borings;

(2) issuance of registration for monitoring well contractors;

(3) establishment of conditions for examination and review of applications for license and registration;

(4) establishment of conditions for revocation and

suspension of license and registration;

(5) establishment of minimum standards for design, location, construction, repair, and sealing of wells and borings to implement the purpose and intent of this chapter;

(6) establishment of a system for reporting on wells and borings drilled and sealed;

(7) establishment of standards for the construction, maintenance, sealing, and water quality monitoring of wells in areas of known or suspected contamination;

(8) establishment of wellhead protection measures for wells serving public water supplies;

(9) establishment of procedures to coordinate collection of well and boring data with other state and local governmental agencies;

(10) establishment of criteria and procedures for submission of well and boring logs, formation samples or well or boring cuttings, water samples, or other special information required for and water resource mapping; and

(11) establishment of minimum standards for design, location, construction, maintenance, repair, sealing, safety, and resource conservation related to borings, including exploratory borings as defined in section 103I.005, subdivision 9.

~~Until the commissioner adopts rules under this chapter to replace rules relating to wells and borings that were adopted under chapter 156A, the rules adopted under chapter 156A shall remain in effect.~~

Sec. 18. Minnesota Statutes 2004, section 103I.105, is amended to read:

103I.105 [ADVISORY COUNCIL ON WELLS AND BORINGS.]

(a) The Advisory Council on Wells and Borings is established as an advisory council to the commissioner. The advisory council shall consist of 18 voting members. Of the 18 voting members:

(1) one member must be from the Department of Health, appointed by the commissioner of health;

(2) one member must be from the Department of Natural Resources, appointed by the commissioner of natural resources;

(3) one member must be a member of the Minnesota Geological Survey of the University of Minnesota, appointed by the director;

(4) one member must be a responsible individual for a licensed ~~exploratory borer~~ explorer;

(5) one member must be a certified representative of a licensed elevator ~~shaft~~ boring contractor;

(6) two members must be members of the public who are not connected with the ~~business of exploratory~~ boring or ~~the~~ well drilling industry;

(7) one member must be from the Pollution Control Agency, appointed by the commissioner of the Pollution Control Agency;

(8) one member must be from the Department of Transportation, appointed by the commissioner of transportation;

(9) one member must be from the Board of Water and Soil Resources appointed by its chair;

(10) one member must be a certified representative of a monitoring well contractor;

(11) six members must be residents of this state appointed by the commissioner, who are ~~actively engaged in the well drilling industry~~ certified representatives of licensed well contractors, with not more than two from the seven-county metropolitan area and at least four from other areas of the state who represent different geographical regions; and

(12) one member must be a certified representative of a licensed vertical heat exchanger contractor ~~or be certified by the International Ground Source Heat Pump Association and appointed by the commissioner~~.

(b) An appointee of the well drilling industry may not serve more than two consecutive terms.

(c) The appointees to the advisory council from the well drilling industry must:

(1) have been residents of this state for at least three years before appointment; and

(2) have at least five years' experience in the well drilling business.

(d) The terms of the appointed members and the compensation and removal of all members are governed by section 15.059, except section 15.059, subdivision 5, relating to expiration of the advisory council does not apply.

Sec. 19. Minnesota Statutes 2004, section 103I.111, subdivision 1, is amended to read:

Subdivision 1. [DELEGATION OF DUTIES OF COMMISSIONER.] (a) The commissioner of health may enter into an agreement with a board of health to delegate all or part of the inspection, reporting, and enforcement duties authorized under provisions of this chapter pertaining to permitting, construction, repair, and sealing of wells and elevator ~~shafts~~ borings.

(b) A board of health may delegate its powers and duties to other boards of health within its jurisdiction. An agreement to delegate powers and duties of a board of health must be approved by the commissioner and is subject to subdivision 3.

Sec. 20. Minnesota Statutes 2004, section 103I.111, subdivision 3, is amended to read:

Subd. 3. [PREEMPTION UNLESS DELEGATION.] Notwithstanding any other law, a political subdivision may not regulate the construction, repair, or sealing of wells or ~~elevator shafts~~ borings unless the commissioner delegates authority under subdivisions 1 and 2.

Sec. 21. Minnesota Statutes 2004, section 103I.115, is amended to read:

103I.115 [COMPLIANCE WITH THIS CHAPTER REQUIRED.]

~~(a) Except as provided in paragraph (b),~~ A person may not construct, repair, or seal a well or boring, except as provided under the provisions of this chapter.

~~(b) Until June 30, 1994, this chapter does not apply to dewatering wells 45 feet or less in depth.~~

Sec. 22. Minnesota Statutes 2004, section 103I.205, subdivision 4, is amended to read:

Subd. 4. [LICENSE REQUIRED.] (a) Except as provided in

paragraph (b), (c), ~~or~~ (d), or (e), section 103I.401, subdivision 2, or section 103I.601, subdivision 2, a person may not drill, construct, repair, or seal a well or boring unless the person has a well contractor's license in possession.

(b) A person may construct, repair, and seal a monitoring well if the person:

(1) is a professional engineer ~~registered~~ licensed under sections 326.02 to 326.15 in the branches of civil or geological engineering;

(2) is a hydrologist or hydrogeologist certified by the American Institute of Hydrology;

(3) is a professional ~~engineer registered with the Board of Architecture, Engineering, Land Surveying, Landscape Architecture, and Interior Design~~ geoscientist licensed under sections 326.02 to 326.15;

(4) is a geologist certified by the American Institute of Professional Geologists; or

(5) meets the qualifications established by the commissioner in rule.

A person must register with the commissioner as a monitoring well contractor on forms provided by the commissioner.

(c) A person may do the following work with a limited well/boring contractor's license in possession. A separate license is required for each of the six activities:

(1) installing or repairing well screens or pitless units or pitless adaptors and well casings from the pitless adaptor or pitless unit to the upper termination of the well casing;

(2) constructing, repairing, and sealing drive point wells or dug wells;

(3) installing well pumps or pumping equipment;

(4) sealing wells;

(5) constructing, repairing, or sealing dewatering wells; or

(6) constructing, repairing, or sealing vertical heat exchangers.

(d) A person may construct, repair, and seal an elevator

boring with an elevator boring contractor's license.

~~(d)~~ (e) Notwithstanding other provisions of this chapter requiring a license or registration, a license or registration is not required for a person who complies with the other provisions of this chapter if the person is:

(1) an individual who constructs a well on land that is owned or leased by the individual and is used by the individual for farming or agricultural purposes or as the individual's place of abode; or

(2) an individual who performs labor or services for a contractor licensed or registered under the provisions of this chapter in connection with the construction, sealing, or repair of a well or boring at the direction and under the personal supervision of a contractor licensed or registered under the provisions of this chapter.

Sec. 23. Minnesota Statutes 2004, section 103I.205, subdivision 9, is amended to read:

Subd. 9. [REPORT OF WORK.] Within 30 days after completion or sealing of a well or boring, the person doing the work must submit a verified report to the commissioner containing the information specified by rules adopted under this chapter.

Within 30 days after receiving the report, the commissioner shall send or otherwise provide access to a copy of the report to the commissioner of natural resources, to the local soil and water conservation district where the well is located, and to the director of the Minnesota Geological Survey.

Sec. 24. 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 water supply well, $150, which includes the state core function fee;

(2) for a well sealing, $30 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; and

(3) for construction of a dewatering well, $150, which includes the state core function fee, for each dewatering well except a dewatering project comprising five or more dewatering wells shall be assessed a single fee of $750 for the dewatering wells recorded on the notification.

Sec. 25. 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 water supply well that is not in use under a maintenance permit, $125 annually;

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

(3) for a monitoring well that is unsealed under a maintenance permit, $125 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, 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 per site regardless of the number of monitoring wells located on site;

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

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

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

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

Sec. 26. Minnesota Statutes 2004, section 103I.231, is amended to read:

103I.231 [COMMISSIONER MAY ORDER REPAIRS.]

(a) The commissioner may order a property owner to take remedial measures, including making repairs, reconstructing, or sealing a well or boring according to provisions of this chapter. The order may be issued if the commissioner determines, based on inspection of the water or the well or boring site or an analysis of water from the well or boring, that the well or boring:

(1) is contaminated or may contribute to the spread of contamination;

(2) is required to be sealed under this chapter and has not been sealed according to provisions of this chapter;

(3) is in a state of disrepair so that its continued existence endangers the quality of the groundwater;

(4) is a health or safety hazard; or

(5) is located in a place or constructed in a manner that its continued use or existence endangers the quality of the groundwater.

(b) The order of the commissioner may be enforced in an action to seek compliance brought by the commissioner in the district court of the county where the well or boring is located.

Sec. 27. Minnesota Statutes 2004, section 103I.325, subdivision 2, is amended to read:

Subd. 2. [LIABILITY AFTER SEALING.] The owner of a well or boring is not liable for contamination of groundwater from the well or boring that occurs after the well or boring has been sealed by a licensed contractor in compliance with this chapter if a report of sealing has been filed with the commissioner of health by the contractor who performed the work, and if the owner has not disturbed or disrupted the sealed well or boring.

Sec. 28. Minnesota Statutes 2004, section 103I.345, subdivision 2, is amended to read:

Subd. 2. [EXPENDITURES.] ~~(a)~~ Subject to appropriation by law, money in the account established under subdivision 1 may be

used by the commissioner for sealing wells and borings.

~~(b) In spending money under this subdivision, the commissioner shall give priority to the sealing by July 1, 1997, of all multiaquifer wells and borings entering the Mt. Simon-Hinckley aquifer that the commissioner has authority to seal under section 103I.315, subdivision 2.~~

Sec. 29. Minnesota Statutes 2004, section 103I.401, is amended to read:

103I.401 [ELEVATOR ~~SHAFT~~ BORINGS.]

Subdivision 1. [PERMIT REQUIRED.] (a) A person may not construct an elevator ~~shaft~~ boring until a permit for the hole or excavation is issued by the commissioner.

(b) The elevator ~~shaft~~ boring permit preempts local permits except local building permits, and counties and home rule charter or statutory cities may not require a permit for elevator ~~shaft holes or excavations~~ borings.

Subd. 2. [LICENSE REQUIRED.] A person may not construct an elevator ~~shaft~~ boring unless the person possesses a well contractor's license or an elevator ~~shaft~~ boring contractor's license issued by the commissioner.

Subd. 3. [SEALING.] A well contractor or elevator ~~shaft~~ boring contractor must seal a hole or excavation that is no longer used for an elevator ~~shaft~~ boring. The sealing must be done according to rules adopted by the commissioner.

Subd. 4. [REPORT.] Within 30 days after completion or sealing of ~~a hole or excavation for~~ an elevator ~~shaft~~ boring, the person doing the work must submit a report to the commissioner on forms provided by the commissioner.

Sec. 30. Minnesota Statutes 2004, section 103I.501, is amended to read:

103I.501 [LICENSING AND REGULATION OF WELLS AND BORINGS.]

(a) The commissioner shall regulate and license:

(1) drilling, constructing, and repair of wells;

(2) sealing of wells;

(3) installing of well pumps and pumping equipment;

(4) excavating, drilling, repairing, and sealing ~~of holes~~

~~for the installation~~ of elevator ~~shafts and hydraulic cylinders~~ borings;

(5) construction, repair, and sealing of environmental bore holes; and

(6) construction, repair, and sealing of vertical heat exchangers.

(b) The commissioner shall examine and license well contractors, limited well/boring contractors, and elevator ~~shaft~~ boring contractors, and examine and register monitoring well contractors.

(c) The commissioner shall license explorers engaged in exploratory boring and shall examine persons who supervise or oversee exploratory boring.

Sec. 31. Minnesota Statutes 2004, section 103I.505, is amended to read:

103I.505 [RECIPROCITY OF LICENSES AND REGISTRATIONS.]

Subdivision 1. [RECIPROCITY AUTHORIZED.] The commissioner may issue a license or register a person under this chapter, without giving an examination, if the person is licensed or registered in another state and:

(1) the requirements for licensing or registration under which the well or boring contractor was licensed or registered do not conflict with this chapter;

(2) the requirements are of a standard not lower than that specified by the rules adopted under this chapter; and

(3) equal reciprocal privileges are granted to licensees or registrants of this state.

Subd. 2. [LICENSE FEE REQUIRED.] A well or boring contractor must apply for the license or registration and pay the fees under the provisions of this chapter to receive a license or registration under this section.

Sec. 32. Minnesota Statutes 2004, section 103I.525, subdivision 1, is amended to read:

Subdivision 1. [CERTIFICATION APPLICATION.] (a) A person must file an application and application fee with the commissioner to ~~apply for~~ represent a well ~~contractor's license~~

contractor.

(b) The application must state the applicant's qualifications for ~~the license, the equipment the applicant will use in the contracting~~ certification as a representative, and other information required by the commissioner. The application must be on forms prescribed by the commissioner.

(c) A person may apply as an individual if the person:

(1) is not ~~the licensed well contractor~~ representing a firm, sole proprietorship, partnership, association, corporation, or other entity including the United States government, any interstate body, the state, and an agency, department, or political subdivision of the state; and

(2) meets the well contractor certification and license requirements under ~~provisions of~~ this chapter.

Sec. 33. Minnesota Statutes 2004, section 103I.525, subdivision 2, is amended to read:

Subd. 2. [CERTIFICATION APPLICATION FEE.] The application fee for certification as a ~~well contractor's license~~ representative of a well contractor is $75. The commissioner may not act on an application until the application fee is paid.

Sec. 34. Minnesota Statutes 2004, section 103I.525, is amended by adding a subdivision to read:

Subd. 3a. [ISSUANCE OF CERTIFICATION.] If an applicant meets the experience requirements established by rule and passes the examination as determined by the commissioner, the commissioner shall issue the applicant a certification to represent a well contractor.

Sec. 35. Minnesota Statutes 2004, section 103I.525, subdivision 4, is amended to read:

Subd. 4. [ISSUANCE OF LICENSE.] If ~~an applicant meets the experience requirements established by rule, passes the examination as determined by the commissioner~~ a person employs a certified representative, submits the bond under subdivision 5, and pays the license fee under subdivision 6, the commissioner shall issue a well contractor's license.

Sec. 36. Minnesota Statutes 2004, section 103I.525, subdivision 5, is amended to read:

Subd. 5. [BOND.] (a) As a condition of being issued a well contractor's license, the applicant, except a person applying for an individual well contractor's license, must submit a corporate surety bond for $10,000 approved by the commissioner. The bond must be conditioned to pay the state on ~~unlawful~~ performance of work ~~regulated by~~ in this state that is not in compliance with this chapter ~~in this state~~ or rules adopted under this chapter. The bond is in lieu of other license bonds required by a political subdivision of the state.

(b) From proceeds of the bond, the commissioner may compensate persons injured or suffering financial loss because of a failure of the applicant to ~~properly~~ perform work or duties in compliance with this chapter or rules adopted under this chapter.

Sec. 37. Minnesota Statutes 2004, section 103I.525, subdivision 8, is amended to read:

Subd. 8. [RENEWAL.] (a) A licensee must file an application and a renewal application fee to renew the license by the date stated in the license.

(b) The renewal application fee for a well contractor's license is $250, except the fee for an individual well contractor's license is $75.

(c) The renewal application must include information that the certified representative of the applicant has met continuing education requirements established by the commissioner by rule.

(d) At the time of the renewal, the commissioner must have on file all properly completed well and boring construction reports, well and boring sealing reports, reports of ~~excavations to construct~~ elevator ~~shafts~~ borings, water sample analysis reports, well and boring permits, and well notifications for work conducted by the licensee since the last license renewal.

Sec. 38. Minnesota Statutes 2004, section 103I.531, subdivision 1, is amended to read:

Subdivision 1. [CERTIFICATION APPLICATION.] (a) A person

must file an application and an application fee with the commissioner to ~~apply for~~ represent a limited well/boring ~~contractor's license~~ contractor.

(b) The application must state the applicant's qualifications for the ~~license, the equipment the applicant will use in the contracting~~ certification, and other information required by the commissioner. The application must be on forms prescribed by the commissioner.

Sec. 39. Minnesota Statutes 2004, section 103I.531, subdivision 2, is amended to read:

Subd. 2. [CERTIFICATION APPLICATION FEE.] The application fee for certification as a representative of a limited well/boring ~~contractor's license~~ contractor is $75. The commissioner may not act on an application until the application fee is paid.

Sec. 40. Minnesota Statutes 2004, section 103I.531, is amended by adding a subdivision to read:

Subd. 3a. [ISSUANCE OF CERTIFICATION.] If an applicant meets the experience requirements established by rule and passes the examination as determined by the commissioner, the commissioner shall issue the applicant a certification to represent a limited well/boring contractor.

Sec. 41. Minnesota Statutes 2004, section 103I.531, subdivision 4, is amended to read:

Subd. 4. [ISSUANCE OF LICENSE.] If ~~an applicant meets the experience requirements established in rule, passes the examination as determined by the commissioner~~ a person employs a certified representative, submits the bond under subdivision 5, and pays the license fee under subdivision 6, the commissioner shall issue a limited well/boring contractor's license. If the other conditions of this section are satisfied, the commissioner may not withhold issuance of a dewatering limited license based on the applicant's lack of prior experience under a licensed well contractor.

Sec. 42. Minnesota Statutes 2004, section 103I.531, subdivision 5, is amended to read:

Subd. 5. [BOND.] (a) As a condition of being issued a limited well/boring contractor's license for constructing, repairing, and sealing drive point wells or dug wells, sealing wells or borings, constructing, repairing, and sealing dewatering wells, or constructing, repairing, and sealing vertical heat exchangers, the applicant must submit a corporate surety bond for $10,000 approved by the commissioner. As a condition of being issued a limited well/boring contractor's license for installing or repairing well screens or pitless units or pitless adaptors and well casings from the pitless adaptor or pitless unit to the upper termination of the well casing, or installing well pumps or pumping equipment, the applicant must submit a corporate surety bond for $2,000 approved by the commissioner. The bonds required in this paragraph must be conditioned to pay the state on ~~unlawful~~ performance of work ~~regulated by~~ in this state that is not in compliance with this chapter ~~in this state~~ or rules adopted under this chapter. The bonds are in lieu of other license bonds required by a political subdivision of the state.

(b) From proceeds of a bond required in paragraph (a), the commissioner may compensate persons injured or suffering financial loss because of a failure of the applicant to ~~properly~~ perform work or duties in compliance with this chapter or rules adopted under this chapter.

Sec. 43. Minnesota Statutes 2004, section 103I.531, subdivision 8, is amended to read:

Subd. 8. [RENEWAL.] (a) A person must file an application and a renewal application fee to renew the limited well/boring contractor's license by the date stated in the license.

(b) The renewal application fee for a limited well/boring contractor's license is $75.

(c) The renewal application must include information that the certified representative of the applicant has met continuing education requirements established by the commissioner by rule.

(d) At the time of the renewal, the commissioner must have on file all properly completed well and boring construction

reports, well and boring sealing reports, well and boring permits, ~~vertical heat exchanger permits,~~ water quality sample reports, and well notifications for work conducted by the licensee since the last license renewal.

Sec. 44. Minnesota Statutes 2004, section 103I.535, subdivision 1, is amended to read:

Subdivision 1. [CERTIFICATION APPLICATION.] (a) An individual must file an application and application fee with the commissioner to ~~apply for~~ represent an elevator ~~shaft contractor's license~~ boring contractor.

(b) The application must state the applicant's qualifications for the ~~license, the equipment the applicant will use in the contracting~~ certification, and other information required by the commissioner. The application must be on forms prescribed by the commissioner.

Sec. 45. Minnesota Statutes 2004, section 103I.535, subdivision 2, is amended to read:

Subd. 2. [CERTIFICATION APPLICATION FEE.] The application fee for certification as a representative of an elevator ~~shaft contractor's license~~ boring contractor is $75. The commissioner may not act on an application until the application fee is paid.

Sec. 46. Minnesota Statutes 2004, section 103I.535, is amended by adding a subdivision to read:

Subd. 3a. [ISSUANCE OF CERTIFICATION.] If the applicant meets the experience requirements established by rule and passes the examination as determined by the commissioner, the commissioner shall issue the applicant a certification to represent an elevator boring contractor.

Sec. 47. Minnesota Statutes 2004, section 103I.535, subdivision 4, is amended to read:

Subd. 4. [ISSUANCE OF LICENSE.] If ~~an applicant passes the examination as determined by the commissioner~~ a person employs a certified representative, submits the bond under subdivision 5, and pays the license fee under subdivision 6, the commissioner shall issue an elevator ~~shaft~~ boring contractor's license to the applicant.

Sec. 48. Minnesota Statutes 2004, section 103I.535, subdivision 5, is amended to read:

Subd. 5. [BOND.] (a) As a condition of being issued an elevator ~~shaft~~ boring contractor's license, the applicant must submit a corporate surety bond for $10,000 approved by the commissioner. The bond must be conditioned to pay the state on ~~unlawful~~ performance of work ~~regulated by~~ in this state that is not in compliance with this chapter ~~in this state~~ or rules adopted under this chapter.

(b) From proceeds of the bond, the commissioner may compensate persons injured or suffering financial loss because of a failure of the applicant to ~~properly~~ perform work or duties in compliance with this chapter or rules adopted under this chapter.

Sec. 49. Minnesota Statutes 2004, section 103I.535, subdivision 7, is amended to read:

Subd. 7. [VALIDITY.] An elevator ~~shaft~~ boring contractor's license is valid until the date prescribed in the license by the commissioner.

Sec. 50. Minnesota Statutes 2004, section 103I.535, subdivision 8, is amended to read:

Subd. 8. [RENEWAL.] (a) A person must file an application and a renewal application fee to renew the license by the date stated in the license.

(b) The renewal application fee for an elevator ~~shaft~~ boring contractor's license is $75.

(c) The renewal application must include information that the certified representative of the applicant has met continuing education requirements established by the commissioner by rule.

(d) At the time of renewal, the commissioner must have on file all reports and permits for elevator ~~shaft~~ boring work conducted by the licensee since the last license renewal.

Sec. 51. Minnesota Statutes 2004, section 103I.535, subdivision 9, is amended to read:

Subd. 9. [INCOMPLETE OR LATE RENEWAL.] If a licensee fails to submit all information required for renewal in subdivision 8

or submits the application and information after the required renewal date:

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

(2) the licensee may not conduct activities authorized by the elevator ~~shaft~~ boring contractor's license until the renewal application, renewal application fee, and late fee, and all other information required in subdivision 8 are submitted.

Sec. 52. Minnesota Statutes 2004, section 103I.541, is amended to read:

103I.541 [MONITORING WELL ~~CONTRACTORS~~ CONTRACTOR'S REGISTRATION; REPRESENTATIVE'S CERTIFICATION.]

Subdivision 1. [~~INITIAL~~ REGISTRATION ~~AFTER-JULY-1,-1990.~~] ~~After-July-1,-1990,~~ A person seeking ~~initial~~ registration as a monitoring well contractor must meet examination and experience requirements adopted by the commissioner by rule.

Subd. 2. [VALIDITY.] A monitoring well contractor's registration is valid until the date prescribed in the registration by the commissioner.

Subd. 2a. [CERTIFICATION APPLICATION.] (a) An individual must submit an application and application fee to the commissioner to apply for certification as a representative of a monitoring well contractor ~~registration~~.

(b) The application must be on forms prescribed by the commissioner. The application must state the applicant's qualifications for the ~~registration~~ certification, ~~the-equipment-the-applicant-will-use-in-the-contracting,~~ and other information required by the commissioner.

Subd. 2b. [~~APPLICATION-FEE~~ ISSUANCE OF REGISTRATION.] ~~The application~~ If a person employs a certified representative, submits the bond under subdivision 3, and pays the registration fee of $75 for a monitoring well contractor registration ~~is-$75,~~ the commissioner shall issue a monitoring well contractor registration to the applicant. The fee for an individual registration is $75. The commissioner may not act on an application until the application fee is paid.

Subd. 2c. [CERTIFICATION APPLICATION FEE.] The application

fee for certification as a representative of a monitoring well contractor is $75. The commissioner may not act on an application until the application fee is paid.

Subd. 2d. [EXAMINATION.] After the commissioner has approved an application, the applicant must take an examination given by the commissioner.

Subd. 2e. [ISSUANCE OF CERTIFICATION.] If the applicant meets the experience requirements established by rule and passes the examination as determined by the commissioner, the commissioner shall issue the applicant a certification to represent a monitoring well contractor.

Subd. 3. [BOND.] (a) As a condition of being issued a monitoring well contractor's registration, the applicant must submit a corporate surety bond for $10,000 approved by the commissioner. The bond must be conditioned to pay the state on ~~unlawful~~ performance of work ~~regulated by~~ in this state that is not in compliance with this chapter ~~in this state~~ or rules adopted under this chapter. The bond is in lieu of other license bonds required by a political subdivision of the state.

(b) From proceeds of the bond, the commissioner may compensate persons injured or suffering financial loss because of a failure of the applicant to ~~properly~~ perform work or duties in compliance with this chapter or rules adopted under this chapter.

Subd. 4. [RENEWAL.] (a) A person must file an application and a renewal application fee to renew the registration by the date stated in the registration.

(b) The renewal application fee for a monitoring well contractor's registration is $75.

(c) The renewal application must include information that the certified representative of the applicant has met continuing education requirements established by the commissioner by rule.

(d) At the time of the renewal, the commissioner must have on file all well and boring construction reports, well and boring sealing reports, well permits, and notifications for work conducted by the registered person since the last registration

renewal.

Subd. 5. [INCOMPLETE OR LATE RENEWAL.] If a registered person submits a renewal application after the required renewal date:

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

(2) the registered person may not conduct activities authorized by the monitoring well contractor's registration until the renewal application, renewal application fee, late fee, and all other information required in subdivision 4 are submitted.

Sec. 53. Minnesota Statutes 2004, section 103I.545, subdivision 2, is amended to read:

Subd. 2. [~~PUMP~~ HOIST.] (a) A person may not use a machine such as a ~~pump~~ hoist for an activity requiring a license or registration under this chapter to repair wells or borings, seal wells or borings, or install pumps unless the machine is registered with the commissioner.

(b) A person must apply for the registration on forms prescribed by the commissioner and submit a $75 registration fee.

(c) A registration is valid for one year.

Sec. 54. Minnesota Statutes 2004, section 103I.601, subdivision 4, is amended to read:

Subd. 4. [MAP OF BORINGS.] By ten days before beginning exploratory boring, an explorer must submit to the commissioners of health and natural resources a county road map having a scale of one-half inch equal to one mile, as prepared by the Department of Transportation, or a 7.5 minute series topographic map (1:24,000 scale), as prepared by the United States Geological Survey, showing the location of each proposed exploratory boring to the nearest estimated 40 acre parcel. Exploratory boring that is proposed on the map may not be commenced later than 180 days after submission of the map, unless a new map is submitted.

Sec. 55. Minnesota Statutes 2004, section 103I.601, subdivision 9, is amended to read:

Subd. 9. [SEALING REPORT.] (a) By 30 days after permanent or temporary sealing of an exploratory boring, the explorer must submit a report to the commissioners of health and natural resources.

(b) The report must be on forms provided by the commissioner of health and include:

(1) the location of each drill hole in as large a scale as possible, which is normally prepared as part of the explorer's record;

(2) the type and thickness of overburden and rock encountered;

(3) identification of water bearing formations encountered;

(4) identification of hydrologic conditions encountered;

(5) method of sealing used;

(6) methods of construction and drilling used; and

(7) average scintillometer reading of waste drill cuttings <u>from uranium or other radioactive mineral exploratory borings</u> before backfilling of the recirculation pits.

Sec. 56. Minnesota Statutes 2004, section 144.221, subdivision 1, is amended to read:

Subdivision 1. [WHEN AND WHERE TO FILE.] A death record for each death which occurs in the state shall be filed with the state registrar ~~or local registrar or with a mortician designated pursuant to section 144.214, subdivision 4,~~ within five days after death and prior to final disposition.

Sec. 57. Minnesota Statutes 2004, section 144.225, subdivision 7, is amended to read:

Subd. 7. [CERTIFIED BIRTH OR DEATH RECORD.] (a) The state or local registrar shall issue a certified birth or death record or a statement of no vital record found to an individual upon the individual's proper completion of an attestation provided by the commissioner:

(1) to a person who has a tangible interest in the requested vital record. A person who has a tangible interest is:

(i) the subject of the vital record;

(ii) a child of the subject;

(iii) the spouse of the subject;

(iv) a parent of the subject;

(v) the grandparent or grandchild of the subject;

(vi) the party responsible for filing the vital record;

(vii) the legal custodian or guardian or conservator of the subject;

(viii) a personal representative, by sworn affidavit of the fact that the certified copy is required for administration of the estate;

(ix) a successor of the subject, as defined in section 524.1-201, if the subject is deceased, by sworn affidavit of the fact that the certified copy is required for administration of the estate;

(x) if the requested record is a death record, a trustee of a trust by sworn affidavit of the fact that the certified copy is needed for the proper administration of the trust;

(xi) a person or entity who demonstrates that a certified vital record is necessary for the determination or protection of a personal or property right, pursuant to rules adopted by the commissioner; or

(xii) adoption agencies in order to complete confidential postadoption searches as required by section 259.83;

(2) to any local, state, or federal governmental agency upon request if the certified vital record is necessary for the governmental agency to perform its authorized duties. An authorized governmental agency includes the Department of Human Services, the Department of Revenue, and the United States Immigration and Naturalization Service;

(3) to an attorney upon evidence of the attorney's license;

(4) pursuant to a court order issued by a court of competent jurisdiction. For purposes of this section, a subpoena does not constitute a court order; or

(5) to a representative authorized by a person under clauses (1) to (4).

(b) The state or local registrar shall also issue a certified death record to an individual described in paragraph

(a), clause (1), items (ii) to (vii), if, on behalf of the individual, a licensed mortician ~~designated to receive death records under section 144.214, subdivision 4,~~ furnishes the registrar with a properly completed attestation in the form provided by the commissioner within 180 days of the time of death of the subject of the death record. This paragraph is not subject to the requirements specified in Minnesota Rules, part 4601.2600, subpart 5, item B.

Sec. 58. Minnesota Statutes 2004, section 149A.93, subdivision 1, is amended to read:

Subdivision 1. [PERMITS REQUIRED.] After removal from the place of death to any location where the body is held awaiting final disposition, further transportation of the body shall require a ~~disposition or~~ transit permit issued by ~~the local registrar of the place of death, a subregistrar as defined by Minnesota Rules, part 4600.0100, subpart 5, or, if necessary to avoid delay, the commissioner~~ a licensed mortician. Permits shall contain the information required on the permit form as furnished by the commissioner ~~and shall be signed by the local registrar or subregistrar and the person in legal custody of the body, and, where appropriate, the mortician, intern, or practicum student who embalmed the body, the person in charge of the conveyance in which the body will be moved, or the person in charge of the place of final disposition. Where a funeral establishment name is used in signing a permit, it must be supported by the personal signature of a licensee employed by the funeral establishment.~~

Sec. 59. Minnesota Statutes 2004, section 149A.93, subdivision 2, is amended to read:

Subd. 2. [TRANSIT PERMIT.] A transit permit ~~shall be~~ is required when ~~a body is to be:~~

~~(1) moved within a registration district and~~ legal and physical custody of the body is transferred;

~~(2) removed from a registration district;~~

~~(3) removed from the county where the death occurred;~~

~~(4)~~ a body is transported by public transportation; or

~~(5)~~ (3) a body is removed from the state.

Sec. 60. Minnesota Statutes 2004, section 149A.93, subdivision 3, is amended to read:

Subd. 3. [DISPOSITION PERMIT.] A disposition permit ~~shall~~ be is required before a body can be buried, entombed, or cremated~~, or when a body will be retained for more than five calendar days~~. No disposition permit shall be issued until a fact of death record has been completed ~~or the issuing authority receives firm assurances that the death record will be completed within a reasonable amount of time not to exceed seven calendar days from the issuance of the permit~~.

Sec. 61. Minnesota Statutes 2004, section 149A.93, subdivision 4, is amended to read:

Subd. 4. [POSSESSION OF PERMIT.] Until the body is delivered for final disposition, the disposition permit shall be in possession of the person in physical or legal custody of the body, or attached to the transportation container which holds the body. At the place of final disposition, legal custody of the body shall pass with the filing of the disposition permit with the person in charge of that place~~, the health board authorized under section 145A.04, where local disposition permits are required, or the commissioner where there is no legal entity in charge of the place of final disposition~~.

Sec. 62. Minnesota Statutes 2004, section 149A.93, subdivision 5, is amended to read:

Subd. 5. [DEATH OUTSIDE STATE; DISPOSITION PERMIT.] When a death occurs outside of the state and the body travels into or through this state, the body must be accompanied by a permit for burial, removal, or other disposition issued in accordance with the laws and rules of the state where the death occurred. ~~The properly issued permit from the state where the death occurred shall authorize the transportation of the body into or through this state, but before final disposition in this state, a separate Minnesota disposition permit must be issued and filed, together with the foreign permit, according to subdivision 4.~~

Sec. 63. Minnesota Statutes 2004, section 149A.94,

subdivision 3, is amended to read:

Subd. 3. [PERMIT REQUIRED.] No dead human body shall be buried, entombed, or cremated without ~~the filing of a properly issued~~ disposition permit. The disposition permit must be filed with the person in charge of the place of final disposition. Where a dead human body will be transported out of this state for final disposition, the body must be accompanied by a ~~properly issued disposition~~ transit permit.

Sec. 64. Minnesota Statutes 2004, section 149A.96, subdivision 1, is amended to read:

Subdivision 1. [WRITTEN AUTHORIZATION.] Except as provided in this section, no dead human body or human remains shall be disinterred and reinterred without the written authorization of the person or persons legally entitled to control the body or remains and a disinterment ~~transit~~ reinterment permit properly issued by the ~~local~~ state registrar or ~~subregistrar~~ a licensed mortician. Permits shall contain the information required on the permit form as furnished by the commissioner ~~and shall be signed by the local registrar or subregistrar and the person in legal custody of the body, and, where appropriate, the mortician, intern, or practicum student who embalmed the body, the person in charge of the conveyance in which the body will be moved, or the person in charge of the place of final disposition. Where a funeral establishment name is used in signing a permit, it must be supported by the personal signature of a licensee employed by the funeral establishment.~~

Sec. 65. Minnesota Statutes 2004, section 149A.96, subdivision 4, is amended to read:

Subd. 4. [DISINTERMENT ~~PROCEDURE; REMOVAL FROM DEDICATED CEMETERY~~ OPPOSED.] ~~No dead human body or human remains shall be disinterred and removed from a dedicated cemetery for reinterment elsewhere without a written and notarized authorization from the person or persons with the legal right to control the disposition and a disinterment transit reinterment permit issued by the local registrar or subregistrar. The person or persons requesting the disinterment and reinterment~~

~~must obtain a copy of the death record showing the manner and location of final disposition. The copy of the death record along with written and notarized authorization to disinter and reinter obtained from the person or persons with legal right to control the body as expressed in section 149A.80, and a written and notarized statement of the reasons for requesting disinterment, the manner in which the body or remains will be disinterred and transported, the location of reinterment, and whether there are any known parties who oppose the disinterment shall be submitted to the registrar or a subregistrar in the registration district or county where the body or remains are interred. If the request for disinterment is unopposed, the registrar or subregistrar shall issue a disinterment transit reinterment permit.~~ If the disinterment is opposed, no disinterment-reinterment permit shall ~~issue~~ be issued until the state registrar or ~~subregistrar~~ licensed mortician receives a certified copy of a court order ~~showing reasonable cause to disinter~~ that specifically orders the disinterment and reinterment.

Sec. 66. Minnesota Statutes 2004, section 149A.96, subdivision 7, is amended to read:

Subd. 7. [FILING OF DOCUMENTATION OF DISINTERMENT AND REINTERMENT.] The cemetery where the body or remains were originally interred shall retain a copy of the disinterment ~~transit~~ reinterment permit, the authorization to disinter, ~~the death record~~, and, if applicable, the court order showing reasonable cause to disinter. Until the body or remains are reinterred the original permit and other documentation shall be in the possession of the person in physical or legal custody of the body or remains, or attached to the transportation container which holds the body or remains. At the time of reinterment, the permit and other documentation shall be filed according to the laws, rules, or regulations of the state or country where reinterment occurs. ~~Where the body or remains are to be removed from a dedicated cemetery for reinterment elsewhere, the authority issuing the~~

~~disinterment-transit-reinterment-permit-shall-forward-a photocopy-of-the-issued-permit-to-the-commissioner-to-be-filed with-the-original-death-record.~~ If the death occurred in Minnesota, the state registrar or a licensed mortician shall inform the person requesting the disinterment and reinterment of the right to request an amendment to the death record according to Minnesota Rules, chapter 4601.

Sec. 67. Laws 1998, chapter 316, section 4, is amended to read:

Sec. 4. [EFFECTIVE DATE.]

Sections 1 to 3 are effective 24 months after the date on which a ~~unique-health~~ national provider identifier is ~~adopted-or established~~ made effective under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments).

Sec. 68. [REPEALER.]

Minnesota Statutes 2004, sections 103I.005, subdivision 13; 103I.222; and 144.214, subdivision 4, are repealed.

APPENDIX
Repealed Minnesota Statutes for 05-0137

103I.005 DEFINITIONS.

Subd. 13. **Limited well/boring sealing contractor.** "Limited well/boring sealing contractor" means a person with a limited well/boring sealing contractor's license issued by the commissioner.

103I.222 USE OF POLYVINYL CHLORIDE.

The department shall adopt emergency rules within six months, and permanent rules within one year, of May 25, 1991, designed to allow use of flush threaded polyvinyl chloride casing and screens used for leak detection and monitoring wells at underground or aboveground petroleum storage tank sites.

144.214 LOCAL REGISTRARS OF VITAL STATISTICS.

Subd. 4. **Designated morticians.** The state registrar may designate licensed morticians to receive records of death for filing, to issue burial permits, and to issue permits for the transportation of dead bodies or dead fetuses within a designated territory. The designated morticians shall perform duties as prescribed by rule of the commissioner.

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Senate

State of Minnesota

S.F. No. 899 - Crib Safety

Author: Senator Ellen Anderson

Prepared by: Joan White, Senate Counsel (651/296-3814)

Date: March 29, 2005

Section 1 amends the Department of Human Services licensing act by establishing crib safety standards for licensed child care settings.

Subdivision 1 requires the commissioner to maintain a link from the licensing division to the United States Consumer Product Safety Commission that addresses crib safety information.

Subdivision 2 requires licensed child care providers to maintain certain documentation related to crib safety, effective January 1, 2006.

Subdivision 3 requires the licenseholder to annually check the cribs against the United States Consumer Product Safety Commission Web site and maintain written documentation of the crib review, which must be made available to parents and the commissioner.

Subdivision 4 requires the licenseholder to perform safety inspections of every crib used by or accessible to a child at least monthly, and document the list of requirements in this subdivision. This section also requires the removal of unsafe cribs.

Subdivision 5 requires the commissioner to review the provider's documentation required under this section during routine licensing inspections and when investigating complaints regarding alleged violations of this section.

Subdivision 6 allows the commissioner to issue licensing sanctions or other licensing remedies if the licenseholder does not comply with the requirements under this section.

Section 2 amends the consumer protection; products and sales chapter of law, which is not under the purview of the health and family security committee.

Section 3 is the effective date. Section 1 is effective January 1, 2006.

JW:rdr

A bill for an act

relating to child safety; prohibiting the sale and commercial use of certain cribs; providing enforcement; proposing coding for new law in Minnesota Statutes, chapters 245A; 325F.

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

Section 1. [245A.146] [CRIB USE IN LICENSED CHILD CARE SETTINGS.]

Subdivision 1. [CONSUMER PRODUCT SAFETY WEB LINK.] The commissioner shall maintain a link from the licensing division Web site to the United States Consumer Product Safety Commission Web site that addresses crib safety information.

Subd. 2. [DOCUMENTATION REQUIREMENT FOR LICENSE HOLDERS.] (a) Effective January 1, 2006, all licensed child care providers must maintain the following documentation for every crib used by or that is accessible to any child in care:

(1) the crib's brand name; and

(2) the crib's model number.

(b) Any crib for which the license holder does not have the documentation required under paragraph (a) must not be used by or be accessible to children in care.

Subd. 3. [LICENSE HOLDER CERTIFICATION OF CRIBS.] (a) Annually, from the date printed on the license, all license holders shall check all their cribs' brand names and model numbers against the United States Consumer Product Safety

Commission Web site listing of unsafe cribs.

(b) The license holder shall maintain written documentation to be reviewed on site for each crib showing that the review required in paragraph (a) has been completed, and which of the following conditions applies:

(1) the crib was not identified as unsafe on the United States Consumer Product Safety Commission Web site;

(2) the crib was identified as unsafe on the United States Consumer Product Safety Commission Web site, but the license holder has taken the action directed by the United States Consumer Product Safety Commission to make the crib safe; or

(3) the crib was identified as unsafe on the United States Consumer Product Safety Commission Web site, and the license holder has removed the crib so that it is no longer used by or accessible to children in care.

(c) Documentation of the review completed under this subdivision shall be maintained by the license holder on site and made available to parents of children in care and the commissioner.

Subd. 4. [CRIB SAFETY STANDARDS AND INSPECTION.] (a) On at least a monthly basis, the license holder shall perform safety inspections of every crib used by or that is accessible to any child in care, and must document the following:

(1) no corner posts extend more than 1/16 of an inch;

(2) no spaces between side slats exceed 2.375 inches;

(3) no mattress supports can be easily dislodged from any point of the crib;

(4) no cutout designs are present on end panels;

(5) no heights of the rail and end panel are less than 26 inches when measured from the top of the rail or panel in the highest position to the top of the mattress support in its lowest position;

(6) no heights of the rail and end panel are less than nine inches when measured from the top of the rail or panel in its lowest position to the top of the mattress support in its highest position;

(7) no screws, bolts, or hardware are loose or not secured, and there is no use of woodscrews in components that are designed to be assembled and disassembled by the crib owner;

(8) no sharp edges, points, or rough surfaces are present;

(9) no wood surfaces are rough, splintered, split, or cracked;

(10) there are no tears in mesh of fabric sides in non-full-size cribs;

(11) no mattress pads in non-full-size mesh or fabric cribs exceed one inch; and

(12) no gaps between the mattress and any sides of the crib are present.

(b) Upon discovery of any unsafe condition identified by the license holder during the safety inspection required under paragraph (a), the license holder shall immediately remove the crib so that it is no longer used by or accessible to children in care until necessary repairs are completed or the crib is destroyed.

(c) Documentation of the inspections and actions taken with unsafe cribs required in paragraphs (a) and (b) shall be maintained on site by the license holder and made available to parents of children in care and the commissioner.

Subd. 5. [COMMISSIONER INSPECTION.] During routine licensing inspections, and when investigating complaints regarding alleged violations of this section, the commissioner shall review the provider's documentation required under subdivisions 3 and 4.

Subd. 6. [FAILURE TO COMPLY.] The commissioner may issue a licensing action under section 245A.06 or 245A.07 if a license holder fails to comply with the requirements of this section.

Sec. 2. [325F.171] [CRIB SAFETY.]

Subdivision 1. [DEFINITIONS.] (a) "Commercial user" means any person who deals in cribs or who otherwise by one's occupation holds oneself out as having knowledge or skill peculiar to cribs, or any person who is in the business of remanufacturing, retrofitting, selling, leasing, subletting, or

otherwise placing cribs in the stream of commerce.

(b) "Infant" means any person less than 35 inches tall and less than three years of age.

(c) "Crib" means a bed or containment designed to accommodate an infant.

(d) "Full-size crib" means a full-size crib as defined in the Code of Federal Regulations, title 16, section 1508.3, regarding the requirements for full-size cribs.

(e) "Non-full-size crib" means a non-full-size crib as defined in the Code of Federal Regulations, title 16, section 1509.2, regarding the requirements for non-full-size cribs.

(f) "Place in the stream of commerce" means to sell, offer for sale, give away, offer to give away, or allow to use.

Subd. 2. [UNSAFE CRIBS PROHIBITED.] (a) No commercial user may remanufacture, retrofit, sell, contract to sell or resell, lease, sublet, or otherwise place any unsafe crib in the stream of commerce on or after January 1, 2006.

(b) On or after January 1, 2006, no person operating a hotel, motel, or lodging establishment shall provide any unsafe crib to any guest, either with or without charge, for use during the guest's stay. For the purposes of this paragraph, "hotel," "motel," and "lodging establishment" have the meanings given them in section 157.15.

(c) A crib is presumed to be unsafe for purposes of this section if it does not conform to the standards endorsed or established by the United States Consumer Product Safety Commission, including but not limited to the Code of Federal Regulations, title 16, and ASTM International, as follows:

(1) Code of Federal Regulations, title 16, part 1508, and any regulations adopted to amend or supplement the regulations;

(2) Code of Federal Regulations, title 16, part 1509, and any regulations adopted to amend or supplement the regulations;

(3) Code of Federal Regulations, title 16, part 1303, and any regulations adopted to amend or supplement the regulations;

(4) the following standards and specifications of ASTM International for corner posts of baby cribs and structural

integrity of baby cribs:

(i) ASTM F 966 (corner post standard);

(ii) ASTM F 1169 (structural integrity of full-size baby cribs);

(iii) ASTM F 1822 (non-full-size cribs).

(d) A crib is exempt from the provisions of this section if it is not intended for use by an infant; and at the time of selling, contracting to resell, leasing, subletting or otherwise placing the crib in the stream of commerce, the commercial user attaches a written notice to the crib declaring that it is not intended to be used for an infant and is unsafe for use by an infant. A commercial user who complies with this paragraph is not liable for use of the crib contrary to the notice provided.

Subd. 3. [RETROFITS.] (a) An unsafe crib, as determined under subdivision 2, may be retrofitted if the retrofit has been approved by the United States Consumer Product Safety Commission. A retrofitted crib may be sold if it is accompanied at the time of sale by a notice stating that it is safe to use for a child under three years of age. The commercial user is responsible for ensuring that the notice is present with the retrofitted crib at the time of sale. The notice must include:

(1) a description of the original problem that made the crib unsafe;

(2) a description of the retrofit that explains how the original problem was eliminated and declares that the crib is now safe to use for a child under three years of age; and

(3) the name and address of the commercial user who accomplished the retrofit certifying that the work was done along with the name and model number of the crib.

(b) A retrofit is exempt from this section if:

(1) the retrofit is for a crib that requires assembly by the consumer, the approved retrofit is provided with the product by the commercial user, and the retrofit is accompanied at the time of sale by instructions explaining how to apply the retrofit; or

(2) the seller of a previously unsold product accomplishes

the retrofit prior to sale.

Subd. 4. [EXCEPTION.] A commercial user does not violate this section if the crib placed in the stream of commerce by the commercial user was not included on the consumer product safety commission's list on the day before this placement.

Subd. 5. [PENALTY.] A person who knowingly and willfully violates this section is guilty of a misdemeanor.

Subd. 6. [CUMULATIVE REMEDIES.] Remedies available under this section are in addition to any other remedies or procedures under any other provision of law that may be available to an aggrieved party.

Sec. 3. [EFFECTIVE DATE.]

Section 1 is effective January 1, 2006. Section 2 is effective January 1, 2006, and applies to crimes committed on or after this date.

MINNESOTA CRIB SAFETY ACT
FACT SHEET

- According to the U.S. Consumer Product Safety Commission (CPSC), the use of older, used cribs poses a serious safety hazard to infants and young children. More babies die from injuries associated with cribs than from any other piece of nursery equipment.

- The CPSC estimates that each year 240 Minnesota infants sustain injuries that require hospital treatment as a result of being placed in an unsafe crib. In the last year, four infants in the state died as a result of injuries sustained in cribs. Most injuries and deaths are associated with older, used cribs.

- Older cribs have numerous characteristics that pose safety hazards:
  - Widely spaced crib slats can cause strangulation if a child's body slips through openings between slats.
  - Loose fitting mattresses can cause suffocation if a child's nose or face becomes wedged between the crib and the mattress.
  - Corner posts that extend above the crib rail pose entanglement hazards.
  - Ornamental cut out designs on crib panels can result in strangulation.
  - Mattress supports that are easily dislodged from a crib can result in serious injuries.

- Federal safety standards for cribs have been in place since 1974 under the federal Consumer Product Safety Act. In addition, the CPSC has endorsed voluntary industry crib standards developed by the American Society for Testing and Materials (ASTM). The two sets of safety standards have effectively addressed many of the hazards associated with older cribs. However, while federal and ASTM standards regulate the sale of new cribs, they generally do not apply to the sale or commercial use of second-hand cribs.

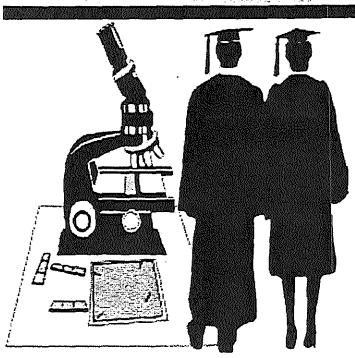
- Most used cribs are safe to use. However, a study by the CPSC found that there are thousands of cribs sold in thrift shops and secondhand furniture stores throughout the U.S. that meet neither the federal nor the ASTM standards. The study estimated that 12% of the thrift shops and secondhand furniture stores in Minnesota sell unsafe cribs. Many parents are not even aware of the potential dangers associated with using secondhand cribs.

- The purpose of the Minnesota Crib Safety Act is to prevent the occurrence of injuries to and deaths of infants resulting from the use of unsafe cribs. The Act will remove unsafe cribs from the secondhand market, ensure that child care facilities and hotels use cribs that meet safety standards, and educate families about how to identify a crib that is safety hazard.

- The Minnesota Crib Safety Act is partially based on model crib safety legislation developed by the CPSC. Currently eleven statesBArizona, Arkansas, California, Colorado, Illinois, Louisiana, Michigan, Oregon, Pennsylvania, Vermont, WashingtonBhave passed laws making it illegal to manufacture or sell new or used baby cribs that do not meet current federal or ASTM safety standards.

State Senator Sandra Pappas

2003 Higher Education Issues



State Budget Shortfall's Impact on Higher Education

In a time of economic downturn like the one that Minnesotans face now, we hear plenty of talk about the need for economic development. Job growth and business growth is of vital importance in the cities, the suburbs and throughout greater Minnesota. In a somewhat contradictory strategy, much of the budget proposed by Governor Pawlenty and his administration seeks to balance the state budget by cutting on of Minnesota's greatest economic development tools, the state's higher education community.

In testimony at the State Capitol and during five recent forays to public and private higher education institutions in different parts of the state, members of the Senate Higher Education Committee have heard testimony from students, administrators, faculty and business leaders. All are concerned about the potential effects Pawlenty's proposed cuts for higher education would have on economic growth and opportunities for higher learning in Minnesota.

But since Gov. Pawlenty has pledged not to raise taxes and not to cut classroom funding for K-12 education, all other items which depend on state dollars are at risk for deep cuts. One of these items is the state's higher education system, which currently accounts for 9% of Minnesota's General Fund tax spending. In February, Governor cut $50 million from the dollars allotted to higher education in the state, meaning that both the University of Minnesota (U of M) system and the Minnesota State Colleges and Universities (MnSCU) system will absorb a $25 million cut between now and June.

Increased Enrollment, Increased Costs

In the near term, higher education costs have increased by $104 million over previous levels. More than half of this increase ($54 million) is due to increased enrollment at colleges and universities throughout the state. As is commonly the case, college enrollments rise during times of economic downturn, since some people who lose their jobs go back to school to pursue advanced degrees, and the lack of businesses recruiting new college graduates prompts many to stay in school for longer periods of time.

Belt Tightening Expected

Although lawmakers on both sides of the aisle stress the importance of higher education as a route toward a better life and toward working our way out of our current economic downturn, Gov. Pawlenty has proposed even deeper cuts and changes in the state's higher education system.

In his 2004-05 budget proposals, the Governor spelled out massive cuts for the U of M and MnSCU systems. He also proposed limiting the amount by which schools can increase their tuition rates, although, under the State Constitution, the Governor has no power to set or control tuition rates at the U of M. Gov. Pawlenty's ideas would force colleges to explore balancing their budgets through such things as deep cuts in financial aid, faculty and staff hiring freezes and wage freezes, faculty and staff reductions and possible campus closings.

Important Phone Numbers and Websites

Financial Aid Information

(651) 642-0567,
www.mheso.state.mn.us

University of Minnesota Information

(612) 625-5000
www.umn.edu

Minnesota State Colleges and Universities Information

888-MnSCU-4-U
(888-667-2848)
or (651) 296-8012
www.mnscu.edu

Minnesota Private College Information

800-PRI-COLL
(800-774-2655)
or (651) 228-9061
www.mnprivate colleges.com

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State	Year Enacted	Applies to Cribs Only	Applies to Children's Products	Applies to Garage Sales	Penalty for Selling an Unsafe Crib	Prohibits Use by Child Care Centers	Prohibits Use by Hotels	Entity Responsible for Public Education
Arizona	?	X			Up to $2,500	X	X	None
Arkansas	2001		X		Up to $1,000	X		Attorney General
California	1994	X			Up to $1,000	X	X	None
Colorado	1998	X			Injunction			Dept. of Public Health and Environment
Illinois	1994		X		?	X		Dept. of Public Health
Louisiana	2001		X		?	X		Dept. of Human Services
Michigan	2000		X		?	X		Dept. of Consumer and Industry Services
Oregon	2001	X		X	Up to $1,000 for commercial seller and $200 for Individuals	X		None
Pennsylvania	2000	X			Up to $1,000		X	Dept. of Health
Vermont	2001		X		Up to $1,000			Dept.of Health
Washington	1996	X				X		None
TOTALS		6	5	1		8	3	

HF 374/SF 377 requires cribs used by licensed child care providers to comply with mandatory standards established in the Code of Federal Regulations (CFR) and voluntary standards established by the American Society for Testing and Materials (ASTM). Licensed child care providers are currently required to comply only with the C.F.R. standards. Below is a table that identifies the source for each of the standards listed in the bill.

Standards for Cribs Used By Child Care Providers in HF 374/SF 377		
Standard	**C.F.R.**	**ASTM**
Corner posts must not extend more than 1/16 inch above the crib's end panels.		ASTM F 966-00
Spaces between crib slats must not be more than 2-3/8 inches	16 C.F.R. Part 1508.4 16 C.F.R. Part 1509.4	
Mattress supports must be firmly attached to corner posts.		ASTM F 1169-99, 7.4 ASTM F 1822-97, 6.3
No cutout designs on the end panels	16 C.F.R. Part 1508.11 16 C.F.R. Part 1509.13	
Appropriate rail height dimensions	16 C.F.R. Part 1508.3	
No loose screws, bolts or hardware*	16 C.F.R. Part 1508.8 16 C.F.R. Part 1509.10	ASTM F 1169-99, 11.1.2 ASTM F 1822-97, 9.2.11.1
No sharp edges, points, rough surfaces or wood surfaces that are not smooth and free from splinters, splits or cracks*	16 C.F.R. Part 1508.7 16 C.F.R. Part 1509.8	ASTM F 1169-99, 11.1.2 ASTM F 1822-97, 5
No tears in mesh or fabric material on a non-full-size crib		ASTM F 1822-97, 7.6-7.7
The mattress pad on a non-full-size mesh/fabric crib must not exceed one inch		ASTM F 1822-97, 5.13.2

Sources: 16 CFR Parts 1508 and 1509; ASTM F966-00, F1169-99, and F1822-97

* C.F.R. and ASTM standards are essentially identical.

TRANSCRIBED TESTIMONY OF RICK TORGERSON | PARENT FROM 2003 SESSION

I'm here to try and convince you to pass this Bill, An crib safty because, An old crib in a daycare took the Life of my son, And changed our life forever.

It's been three year sense that terrible day. Something my wife and I will never forget.

I can't explain what it is like and how it feels, to lose a child.

Children are what this bill is trying to protect. Are your children or grandchildren in a safe crib! Or in a day care. This Law can and will enable you to feel more comfortable leaving them there.

For me its to try an stop this From happening to another family.

To save the Life of one child, and the pain from one family is worth it.

It's hard to talk to people about my son. My wife and I could not live without holding another baby. But with that she could not leave our new baby in a daycare. So she quit working.

The way the Laws are day care's can use old and or Used cribs, that may be unsafe.

Parent of children should be protected From daycare using vary old and out dated equipment. It may Look Just Fine but is simply worn out.

It's Hard to explain what its Like to loose your baby.

For me it's Just as hard Not trying to pervent it from happening again. That would be to Hard to take.

These are children, they can't protect themselves. Laws can and must protect them.

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Senate
State of Minnesota

S.F. No. 639 - Mercury-Free Vaccines

Author: Senator Becky Lourey

Prepared by: Katie Cavanor, Senate Counsel (651/296-3801) KTC

Date: February 1, 2005

S.F. No. 639 prohibits the use of vaccines that contain mercury if a mercury-free vaccine is available.

Section 1 (121A.15, subdivision 3a) makes conforming changes.

Section 2 (145.929) prohibits vaccines that contain mercury from being administered in the state unless a mercury-free vaccine is not manufactured or the provider finds that a mercury-free vaccine is not obtainable by utilizing best efforts because the vaccine is not on the market for sale. This section also states that if a mercury-free vaccine is not available, then a vaccine containing a trace amount of mercury as defined by the United State Food and Drug Administration (FDA) may be administered, and if there is not a mercury-free vaccine or a vaccine with just a trace amount of mercury available, then the vaccine containing the least amount of mercury may be administered.

KC:ph

A bill for an act

relating to health; prohibiting the use of certain vaccines containing mercury or mercury compounds; amending Minnesota Statutes 2004, section 121A.15, subdivision 3a; proposing coding for new law in Minnesota Statutes, chapter 145.

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

Section 1. Minnesota Statutes 2004, section 121A.15, subdivision 3a, is amended to read:

Subd. 3a. [DISCLOSURES REQUIRED.] (a) This paragraph applies to any written information about immunization requirements for enrollment in a school or child care facility that:

(1) is provided to a person to be immunized or enrolling or enrolled in a school or child care facility, or to the person's parent or guardian if the person is under 18 years of age and not emancipated; and

(2) is provided by the Department of Health; the Department of Education; the Department of Human Services; an immunization provider; or a school or child care facility.

Such written information must describe the exemptions from immunizations permitted under subdivision 3, paragraphs (c) and (d). The information on exemptions from immunizations provided according to this paragraph must be in a font size at least equal to the font size of the immunization requirements, in the same font style as the immunization requirements, and on the

same page of the written document as the immunization requirements.

(b) Before immunizing a person, an immunization provider must provide the person, or the person's parent or guardian if the person is under 18 years of age and not emancipated, with the following information in writing:

(1) a list of the immunizations required for enrollment in a school or child care facility;

(2) a description of the exemptions from immunizations permitted under subdivision 3, paragraphs (c) and (d);

(3) a list of additional immunizations currently recommended by the commissioner; and

(4) in accordance with federal law, a copy of the vaccine information sheet from the federal Department of Health and Human Services that lists possible adverse reactions to the immunization to be provided.

(c) The commissioner ~~will~~ shall continue the educational campaign to providers and hospitals on vaccine safety including, but not limited to, information on the vaccine adverse events reporting system (VAERS), the federal vaccine information statements (VIS), and medical precautions and contraindications to immunizations.

(d) The commissioner ~~will~~ shall encourage providers to provide the vaccine information statements at multiple visits and in anticipation of subsequent immunizations.

(e) The commissioner ~~will~~ shall encourage providers to use existing screening for immunization precautions and contraindication materials and make proper use of the vaccine adverse events reporting system (VAERS).

(f) In consultation with groups and people identified in subdivision 12, paragraph (a), clause (1), the commissioner ~~will~~ shall continue to develop and make available patient education materials on immunizations including, but not limited to, contraindications and precautions regarding vaccines.

(g) ~~The commissioner will encourage health care providers to use thimerosal-free vaccines when available~~ Immunization

providers shall comply with section 145.929.

Sec. 2. [145.929] [ELIMINATION OF MERCURY IN VACCINES.]

Subdivision 1. [CITATION.] This section may be cited as the Minnesota Elimination of Mercury in Vaccines Act of 2005.

Subd. 2. [ELIMINATION OF MERCURY.] (a) Effective July 1, 2005, vaccines administered in the state shall not contain any mercury or mercury compounds, including but not limited to thimerosal, unless:

(1) a vaccine containing no mercury is not manufactured;

(2) the provider finds that the mercury-free vaccine is not obtainable by utilizing reasonable efforts, because the vaccine is not on the market for sale; or

(3) a public health emergency has been declared as defined in chapter 12 and the declared public health emergency includes a public vaccination program.

(b) If a mercury-free vaccine is not available according to paragraph (a), then a vaccine containing a trace amount of mercury as defined by the United States Food and Drug Administration may be administered. If neither a mercury-free vaccine nor a vaccine containing a trace amount of mercury is available, then the vaccine containing the least amount of mercury may be administered.

(c) The commissioner of health shall provide to the public contact information for vaccine manufacturers and mercury level content of vaccines through the department's Web site.

Subd. 3. [DRUG MANUFACTURER REPORT.] Drug manufacturers licensed in this state must provide the commissioner of health with an annual status report on the availability of vaccines that are mercury free. For vaccines that are not available without mercury, the report must contain an update on the progress being made to manufacture a mercury-free vaccine, including an anticipated timeline as to when a mercury-free vaccine would be available. The commissioner shall make this report available to the public through the department's Web site.

Sec. 3. [EFFECTIVE DATE.]

Sections 1 and 2 are effective July 1, 2005.

Senator ..... moves to amend the committee engrossment (SCS0639CE1) of S.F. No. 639 as follows:

Page 3, line 10, after "mercury-free" insert "medically recommended"

Page 3, line 12, delete "or"

Page 3, line 13, delete "a public health" and insert "an"

Page 3, line 14, delete "public health"

Page 3, line 15, before the period, insert "; or (4) the vaccine was ordered before May 1, 2005, and administered before May 1, 2006"

SENATE COMMITTEE TESTIMONY ON SF 639
March 17, 2005, St Paul MN
James Nordin, MD, MPH

First, allow me to introduce myself. I am a pediatrician and clinical researcher with over 25 years of experience. I am a member of the HealthPartners Medical Group, a pediatrician with many autistic children in my practice.

My research is largely centered around issues of vaccine safety, primarily trying to prove or disprove theories about potential harm from vaccines. I was involved in both of the studies which proved the risks of the first rotavirus vaccine and resulted in it being withdrawn from the market. So I have looked for and found problems with vaccines before.

I am also chair of the Institute for Clinical Systems Improvement Immunization Work Group. This group produces the evidence based best practices guidelines which govern the practice of the majority of physicians in Minnesota. Because of this, I spend a great deal of time reading the literature on vaccine safety.

As we consider the "Mercury-Free Vaccine Bill" HF 1505 I ask four questions of you.
1) Is the science behind it valid?
2) Will it improve the public health (or make it worse)?
3) Will it have cost impact?
4) What is the best course of action?

Is the science behind this bill valid?

The science behind this bill is badly flawed in several respects.

First, the studies supporting the link between thimerosol and autism and other neurological problems misuse statistical techniques and come to false conclusions. This is especially true of the studies at the core of this argument, those by Geier and Geier. I provided detailed testimony about this to the IOM, which they published verbatim. Even worse, advocates have used the correlations found in these faulty studies to impute cause and effect. This is a logical error. In contrast, numerous large, statistically valid studies have failed to show any link.

Second, while there are some similarities, the neurological problems caused by mercury poisoning are quite different from those caused by autism and it is faulty logic and poor diagnostic judgment to consider them identical.

Third, the form of mercury found in vaccines has a very different fate in the body than the form used in toxicology studies cited by the advocates. It is much more rapidly excreted and is less toxic.

But don't just take my word for it.

The Institute of Medicine (IOM) has considered this. It is a semi-independent institution of the federal government which produces expert opinions on controversial topics. In May of last year a panel of 15 highly respected experts with no connection to vaccines released a report on the effects of vaccines containing thimerosol on autism. They state, "The evidence favors rejection of a causal relationship between thimerosol containing vaccines and autism." The heart of this report is a detailed literature review of all the research which has been done on this topic.

In this report, the IOM references testimony that Michael Goodman and I presented. We discussed the lack of statistical validity of the studies by Geier and Geier showing detrimental effects of thimerosol from vaccines on neurological function of children. The reference is on page 159. On pages 73 through 77 they analyze the many statistical errors committed by the Geiers, quoting the testimony we submitted. This provides the details of the argument about the statistics to those of you who want to study this further.

The IOM goes further than just rejecting the hypothesis that thimerosol from vaccines causes neurological damage. They say that the question is so well settled that scarce resources for research in autism should no longer be used for this question.

Will this bill improve the public health or make it worse? What will be the cost?

Beware unintended consequences. Two parts of this bill have major unintended consequences.

The differentiation of FDA defined "trace" thimerosol from "thimerosol free" is scientifically unjustified, and has major consequences. The amount of thimerosol in "trace" containing vaccines is less than 1/100 of what the subjects in the studies finding no association got. Further, it is less than most breast fed babies get from breast milk. The consequences of this error are substantial.

For some vaccines this bill will result in the supply being cut in half in Minnesota and will likely result in shortages. As you may be aware, there have been shortages of most of the vaccines needed for childhood immunizations over the past 5 years. While the reasons for this are complex and beyond the scope of this discussion, this does indicate the tenuous nature of our vaccine supply. For a couple of vaccines which have two manufacturers, one produces a thimerosol free vaccine and the other a vaccine with trace amounts of thimerosol. If we can only use one, it may result in increases in vaccine preventable diseases such as pertussis and more illness and death.

Another unintended consequence of this bill is a substantial increase in the cost of health care. Many vaccines currently being used will no longer be available in this state and higher priced alternatives will have to be used. Based on average wholesale prices, costs

for immunizing the citizens of our state could go up by more than $1,000,000 per year due to this bill.

Public information obtained from the Minnesota Department of Health shows that the bill to the state of Minnesota for VFC vaccine will be almost $400,000 more per year if this bill is passed. The only cost neutral alternative for the MDH will be to supply less vaccine, resulting directly in more children being inadequately immunized.

The second part of the bill which has major unintended consequences is the lack of age focus of this bill. In spite of advocates only being concerned about the onset of autism in the first years of life, there are no age limits placed on the restrictions on thimerosol in vaccines.

Influenza vaccine is the poster child for this problem. Because of the short production timelines needed every year, most influenza vaccine contains thimerosol, and will continue to do so. (You can fill 10 dose vials which have to have thimerosol at 10 times the rate of single dose vials without preservative, and filling vials is usually the rate limiting step of vaccine manufacture.)

Making it difficult to obtain thimerosol containing influenza vaccine will inevitably reduce the rates of immunization against influenza, especially for high risk and elderly people. In Minnesota alone this will result in hundreds of unnecessary deaths and thousands of unnecessary hospitalizations and millions of unnecessary dollars spent next year due to influenza.

This is also an area of my expertise. At this point I call your attention to a reference in the New England Journal of Medicine, Nichol KL, Nordin J, Mullooly J, Lask R, Fillbrandt K, Iwane M. Influenza vaccination and reduction in hospitalizations for cardiac disease and stroke among the elderly. N Engl J Med. 2003 Apr 3;348(14):1322-32.

Just for an example of the impact of this I am going to hypothesize that this will cause a 30% decrease in the rate of influenza immunization in high risk people in Minnesota.

The data from this publication, and others collected over the years allow us to say that a 30% reduction in influenza immunization among high risk people would result in 200 deaths in Minnesota and 2000 additional hospitalizations. The hospitalizations (at an average of $5000 result in an additional $10,000,000 in direct health care costs for Minnesota, which ultimately you the consumer pay. The indirect costs in terms of sick time and lost productivity and lost years of life are much higher.

Thus in answer to my second and third questions, this bill would worsen the health of Minnesotans while increasing the costs.

What should you do now?

While I believe most of the people involved in this push for "mercury free vaccines" are sincere, they are being misguided by false "experts" and are pushing for something which will harm rather than improve the health of the people of this state. Do you believe the IOM? Do you believe the New England Journal of Medicine? Do you believe all the Minnesota health organizations which have signed on to this position. If you do, I urge you to vote against this bill.

At a minimum this bill needs to go to the finance committee as it is not cost neutral.

These views are endorsed by numerous health care organizations as demonstrated by the letter from the Immunization Action Coalition.

March 16, 2005

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Senator Becky Lourey
Chair, Senate Health and Family Security Committee
Room G-24 Capitol
St. Paul, MN 55155

Re: Senate File 639 – The "Elimination of Mercury in Vaccines" Bill

Dear Chairman Lourey:

On behalf of the Institute for Vaccine Safety at the Johns Hopkins Bloomberg School of Public Health, we would like to voice our opposition to Senate File 639. This bill would prohibit the use of vaccines containing any amount of mercury if a product with a lesser amount or no amount was available. I have read some of the materials that the proponents of this bill are distributing to committee members. These materials include a comment made by me (Neal Halsey) in 1999 and is being used as support for this bill. I would like to clarify my position and provide you with important developments that have occurred in the past 6 years.

In 1999, there was justified concern about the amount of mercury-containing thimerosal preservatives used in the vaccines. We worked with other professionals in academia, the American Academy of Pediatrics, and the U.S. Public Health Service to encourage the removal of thimerosal as a preservative from vaccines administered to young children. Our concern was that the administration of multiple doses of vaccines with this preservative could present a safety issue for very small infants, especially those under six months of age. For some DTaP, hepatitis B and influenza vaccines, however, the manufacturing process included the use of thimerosal during the production process. Manufacturers since have addressed this problem for most infant vaccines by extracting the thimerosal prior to preparation of the final product for sale. This extraction process reduces the amount of thimerosal from approximately 50 micrograms (25 micrograms of ethylmercury) per dose to less than 0.5 micrograms per dose. This small amount of residual thimerosal does not constitute a risk to the health of infants, children, pregnant women or persons of any age.

Mercury toxicity is related to the dose administered. All of us are exposed to low levels of other mercury compounds in food products including many of the fish that are found in Minnesota waters. Public health experts advise women who are pregnant or might get pregnant to restrict consumption of fish that are high in mercury, but they do not advise stopping all fish consumption even though almost all fish contain some mercury. It is not possible to completely eliminate all exposure. The removal of thimerosal as a preservative from vaccines routinely administered to children has removed the theoretical risk that existed in 1999. The trace amounts in some current vaccines do not constitute a health hazard and prohibiting or restricting the administration of vaccines with these trace amounts would be harmful. Under the proposed law, physicians would be required to be absolutely certain that no possible alternative vaccines available, resulting in delays in vaccinating people who are in need of immunizations while they're looking for alternative preparations. Although there will be limited supplies of some vaccines without any thimerosal, there will not be an adequate supply to immunize everyone. This bill poses undue restrictions on individual practitioners and State immunization program personnel that will impair the protection of people through the use of vaccines.

You must know that influenza kills approximately 20,000 people a year in this country, and in epidemic years more than twice as many people may die. Many of these deaths can be prevented with vaccines. The Legislature should not impose an impediment to the delivery of this much-needed vaccine. Also, we might face another major influenza pandemic in the next few years. Some of the new bird influenza viruses kill more than 1/2 of infected people. If a pandemic develops, there will be very little time to develop vaccines and there undoubtedly will be a shortage of influenza vaccine. We definitely will not have enough influenza vaccine with reduced or no thimerosal. Health-care providers should be allowed to engage in decision making with informed patients to balance any theoretical risks from vaccines against the known risks of contracting influenza if they remain unvaccinated.

JOHNS HOPKINS BLOOMBERG SCHOOL of PUBLIC HEALTH

Sincerely,

Neal A. Halsey, MD

Lawrence H. Moulton, PhD

Testimony of Kristen Ehresmann, Section Chief, Immunization, Tuberculosis, and International Health Section, Minnesota Department of Health
Health and Family Security Committee, March 17, 2005
RE: SF639

Thank you Senator Lourey and members of the committee for allowing me to return and testify again. The last time we were short on time and I don't feel that I was able to present MDH's position clearly. Although this bill is well-intentioned, in its current form, it could impair our ability to protect Minnesota's children and adults against influenza, tetanus, pertussis, diphtheria and infringe on the doctor-patient relationship, which is why MDH has serious concerns about this bill.

1. As I stated before, the currently available body of scientific evidence does not support a relationship between thimerosal and autism.

2. I also stated that this legislation is unnecessary because thimerosal has been removed from childhood vaccines. (Manufacturers, themselves, have appropriately and effectively addressed this problem by extracting the thimerosal prior to preparation of the final product for sale. This extraction process drastically reduces the amount of thimerosal to $1/100^{th}$ of its previous levels, from approximately 50 mch per dose to less than 0.5 mcg/per dose).

I would now like to address specifics in the bill that, MDH believes, have not been thoroughly discussed – that is the unintended consequences of this bill.

3. First, I should make it clear when I stated that thimerosal has been removed from childhood vaccines, I was using the FDA definition of "thimerosal free," which includes vaccines that have .25 mcg of thimerosal that is leftover from the production process, which is a Trace amount. Because this bill does not follow the FDA definition, vaccines with a trace amount of thimerosal could not be used, which would have the following consequences.

    a. Cost. The federal Minnesota Vaccines For Children's (VFC) Program pays for vaccines for children who do not have insurance or are underinsured. If MDH was required to only provide the bills definition of thimerosal-free vaccine to all children covered by the VCF program, the number of children that could be vaccinated would decline because there is only a limited amount of funding that the federal government allocates to MN. Based on our estimates, we'd distribute approximately 25,000 fewer doses of Td/DTap vaccine, and in order to maintain the current level of vaccine distribution an additional $400,000 would be needed.

    b. The bill in its current form would also severely limit the choice of vaccines that a private or public provider could buy. For example, this bill would not allow providers to buy the combination DTap-Hep B-IPV vaccine, Pediarix. This very effective vaccine contains a trace amount of thimerosal. As a result a young infant would have to receive more shots to be protected from disease. They would have to get 5 shots instead of 3 shots at one visit. If a parent wanted their child to get Pediarix, they wouldn't have that choice under this bill.

4. The legislation allows a provider to use a vaccine containing thimerosal under certain circumstances, but these circumstances are too limiting.

a. One of the exceptions is if a "public health emergency has been declared as defined in chapter 12 and the declared public health emergency includes a public vaccination program." The threshold to declare an emergency under Chapter 12 is extremely high. It was designed for the state's bioterrorism statute.

b. The vaccine supply is fragile; and it's important to remember that manufacturers supply the whole country. We have seen this distribution problem with the flu and pneumococcal vaccines. The bill's exceptions will not address this problem. The bill states that if a provider finds that the mercury-free is not obtainable by utilizing best efforts, because the vaccine is not on the market for sale, they can use a vaccine with thimerosal. Even though it may be for sale, it may not be immediately available to providers in our state. Would providers then have to defer vaccination. One of the key principles of vaccination is "no missed opportunities." Asking parents to return later leaves kids vulnerable to disease and places an unnecessary burden on the parent. We know that often the most at-risk children, don't come back for a second visit when told to do so. (Both CA and Iowa allow the FDA definition of trace amount.)

5. The population covered is too broad. If proponents of this bill are really concerned about autism, in which onset is at a young age, the bill's focus is too broad. This legislation covers all ages. (Again, it must be pointed out that scientific studies do not support a relationship between thimerosal in vaccines and autism.)

   a. The proponents of the legislation often say that other states have passed this legislation. That is a misleading statement. The two states that have passed similar legislation focus their ban mostly on childhood vaccines (Iowa-under 8 years and California under 3 years and pregnant women); and one state exempts the influenza vaccine from the law. Most of the other states that have proposed related legislation, also only focus on young children.

   b. This week, Dr. Neal Halsey of the John Hopkins School of Public Health, who proponents of this bill often quote in support of their legislation, testified against similar legislation in Maryland. Maryland legislators struck down a proposed thimerosal bill. If Dr. Halsey were here today, he would testify in opposition to the bill.

6. Effective date. The effective date is too soon. Providers will not be able to switch inventory in such a short time frame. Vaccine manufacturing and product licensing is a long and complicated process. Manufacturers have worked as quickly as possible to reduce and/or eliminate thimerosal in vaccines given to children. The remaining vaccines are those typically given to older individuals. A manufacturer cannot just create a new vaccine or change an existing line in a few weeks. Practically speaking, it would be costly for providers who would not be able to use existing inventory -- (*E.g., what if a child has begun a series with pediarix, can they complete it, do they have to start over.*). Both states that passed related legislation had effective dates 1½ to 2 years after the legislation was passed. *(Ca: July 2006, Iowa: January 2006 but exempts flu vaccine)*

7. Lawsuits. Even though encouraging lawsuits was not the stated intent of the legislation, this statute could have that unintended consequence.

- Drug Manufacture Report. You amended the legislation to require MDH to write and post on the Web an annual report on the manufacturer's progress made to manufacture mercury-free vaccines, including an anticipated timeline as to when they will be available. Staff time would be required to collect, track, and put together the required drug manufacture report. It takes away time spent on direct disease prevention activities and the federally required activities specified in the federal grant, which is the only source of immunization program funds. There is no state funding for the immunization program. FYI: We currently have information on our Web site under vaccine safety that links them to the FDA listing of the thimerosal content of all licensed vaccine.

8. The legislation requires the commissioner to provide the public with contact information for vaccine manufacturers and mercury level content of vaccines through the department's Web site. The department already does this.

Finally, I want to note that many legislators have received packets of information from proponents of this bill. MDH has reviewed most of the information legislators have been receiving. We feel that much of the information provided information is misleading and taken out of context of a broader discussion within the science community. However, we feel it would be very time-consuming for us to respond to each point made in all of the handouts. It would take away the already limited time we have from other public health duties/activities. Please contact us is if have any questions regarding these handouts, we will be more than willing to talk to you about them.

Most critically the Department believes that public health policy should be based on well-founded science. Hence, given the current body of scientific evidence, this legislation sends the wrong message. It's sends the message that thimerosal in vaccines is dangerous and it also might fuel people's fear about vaccines in general and keep people from getting vaccinated (creates a barrier that we don't need) and raise the possibility that some Vaccine-preventable diseases may reappear.

MISCELLANEOUS

- It is important to distinguish between people reporting a 'reaction' to vaccine and autism. We know individuals can have bad reactions to medical products, including vaccines. Certain individuals have had reactions to dye used in medical procedures, to antibiotics, as well as other ingredients in medical products. We have not banned the use of these products but rather screen for allergies and history of reaction. This is already being done prior to vaccination.

Jerri Johnson

Evidence of Thimerosal's Toxicity

Minnesota Natural Health Legal Reform Project

Response to Institute of Medicine Report

Of May 18, 2004

In a controversial report of May, 2004, the Institute of Medicine denied that thimerosal, the mercury compound used in vaccines, is linked to autism. However, the IOM revised its focus to autism only, deciding not to comment on whether thimerosal has caused neurodevelopmental disorders in general. Congressman Dave Weldon, MD, a pediatrician, responded, "This revision raises suspicions that this IOM exercise might be more about drawing pre-designed conclusions aimed at restoring public confidence in vaccines, rather than conducting a complete and thorough inquiry into whether or not thimerosal might cause neurodevelopmental disorders."

The IOM report did not rule out thimerosal causing autism in a subset of individuals. The IOM admitted in its report that "the committee cannot rule out, based on the epidemiological evidence, the possibility that vaccines contribute to autism in some small subset or very unusual circumstance."

It is this "small subset" that has been the focus of important biological studies published since the IOM review.

- June 2004 - A study by Dr. Mady Hornig of Columbia University gave low doses of thimerosal to mice. It found that those mice genetically susceptible to autoimmune disorders developed brain damage similar to autism in humans. This animal model showed that the administration of low-dose ethylmercury can lead to behavioral and neurological changes in the brain, reinforcing previous studies showing that a genetic predisposition, in combination with certain environmental triggers, affects risk. (Molecular Psychiatry, June 8, 2004)

- December, 2004 - Dr. Jill James, a former FDA research scientist now at the University of Arkansas for Medical Sciences, published her study showing that autistic children have a severe deficiency in glutathione, which James said is the body's most important detoxifier of metals such as mercury. Autistic children showed a significant impairment in every one of five measurements of the body's ability to maintain glutathione. These findings are strong evidence that if such children were exposed to mercury, they would be much less able to mount an effective defense. In addition, a number of children studied who received supplements such as methyl B12, which restored methionine levels, experienced great improvement in functioning.

These studies indeed identify the "small subgroup" of people at increased risk of harm from mercury. They provide important new evidence that some individuals have reduced ability to detoxify mercury, thus making them vulnerable to even small amounts of mercury exposure.

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MAJOR RESEARCHERS PUBLISHING EVIDENCE SUPPORTING Thimerosal-Neurodevelopmental Disorder Relationship

Dr. James Adams
Mercury Retention in Autistic Children Analyses
Chairman, Department of Materials and Engineering, Arizona State University

Dr. Ruma Banerjee
Thimerosal Neuro-Tissue Culture Analyses
University of Nebraska

Dr. David Baskin
Thimerosal Neuro-Tissue Culture Analyses
Department of Neurosurgery and Anesthesiology, Baylor College of Medicine

Dr. John Bernard
Mercury Retention in Autistic Children Analyses
Director, Nuclear Reactor Laboratory, Massachusetts Institute of Technology

Dr. Richard Deth
Thimerosal Neuro-Tissue Culture Analyses
Department of Pharmaceutical Sciences, School of Pharmacy, Northeastern University

Dr. Mark R. Geier
Epidemiology of Vaccines-Autism, Mercury Retention, Biochemical, & Genetic Analyses in Autistic Children Analyses
President, The Genetic Centers of America

Dr. Sudhir Gupta
Thimerosal Immune-Cell Tissue Culture Analyses
Chief, Basic and Clinical Immunology, Department of Medicine, University of California, Irvine

Dr. Boyd Haley
Thimerosal Neuro-Tissue Culture & Mercury Retention in Autistic Children Analyses
Chairman, Department of Chemistry, University of Kentucky

Dr. Mady Hornig
Thimerosal Mouse Model of Autism
Columbia University

Dr. Joel Mason
Thimerosal Neuro-Tissue Culture Analyses
Tufts University

Dr. Jill James
Thimerosal Neuro-Tissue Culture, Mercury-Biochemical Pathways Analyses in Autistic Children
University of Arkansas

Dr. Walter Spitzer
Epidemiology of Vaccines-Autism
Department of Epidemiology, McGill University

Dr. S Sukumar
Thimerosal Neuro-Tissue Culture Analyses
Johns Hopkins University

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Epidemiology of Vaccines-Autism, Mercury Retention, Biochemical, & Genetic Analyses in Autistic Children Analyses
President, The Genetic Centers of America

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Chief, Basic and Clinical Immunology, Department of Medicine, University of California, Irvine

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SF 639 The Elimination of Mercury in Vaccines

Lourey, Chaudhury, Nienow, Moua, Koeren

Thimerosal breaks down into ethylmercury, a potent neurotoxin

> *"...**ethyl mercury derivatives are virulent neurotoxins** on either acute or chronic exposure..." "They are especially hazardous because of their volatility, their ability to penetrate epithelial & blood-brain barriers & their persistence in vivo."*
>
> *The Clinical Toxicology of Commercial Products*, by Gosselin, Smith and Hodge, 5th edition (1984)
> (Commonly used resource for poison control centers)

The Institute of Medicine report of May, 2004, acknowledged that its epidemiological approach could not pick up adverse effects in a small subset of the population.

> *"The committee cannot rule out, based on the epidemiological evidence, the possibility that vaccines contribute to autism in some small subset."*

This "some small subset" of the population is the exact group identified by scientists as being vulnerable to extremely small amounts of mercury, due to inability to excrete mercury.

- Dr. Jill James showed that autistic children have a deficiency in glutathione, the substance needed to detoxify mercury.
- Dr. James Bradstreet showed that autistic children retain a higher body burden of mercury than healthy children, excreting six times more mercury in response to chelation than healthy children.
- Dr. Richard Deth showed that thimerosal inhibits methylation by interfering with formation of vitamin B12, and that autistic children show improvement when given extra methylB12.
- Dr. Mady Hornig showed that some genetically determined subgroups of mice suffer neurological impairment from minute quantities of thimerosal.

The CDC's own study, on initial analysis, showed that children given mercury-containing vaccines had a seven to eleven times greater risk of autism than children given mercury-free vaccines.

	November relative risk (>25 mcg at one month)	**December relative risk** (>25 mcg at one month)
Autism	7.62	11.35
ADD	3.76	3.96
Sleep disorders	4.98	4.64

(CDC study, cont)

"As for the exposure evaluated at 3 months of age, we found increasing risks of 'neurological developmental disorders' with increasing cumulative exposure to thimerosal... (for) 'developmental speech disorder,' and for 'autism,' 'stuttering' and 'attention deficit disorder.'"

Conclusion: ***"This analysis suggests that in our study population, the risks of tics, ADD, language and speech delays, and developmental delays in general may be increased by exposures to mercury from thimerosal containing vaccines during the first six months of life."*** (Centers for Disease Control and Prevention Study, "Risk of neurologic and renal impairment associated with thimerosal-containing vaccines," Thomas Verstraten, Robert Davis, Frank DeStefano, and the VSD team, June, 2000.)

Independent analysis of the CDC's Vaccine Safety Datalink Database confirmed that mercury in vaccines is related to autism.

"We went to the CDC, and looked at the VSD [Vaccine Safety Data] data. We asked a question: Among children that got a minimum of either three consecutive thimerosal-containing DTaPs or three consecutive thimerosal-free DTaPs, was there a difference in the number of autism cases in the two groups?

We found mega differences. More than 20 times higher. The rate of autism in the children that got more than three doses of thimerosal-containing DTaP vaccines was much, much higher. Almost all the children that have autism in that group were the ones that got the thimerosal-containing DTaP vaccine. The more thimerosal, the greater the cases of autism."

Geier, M and Geier, D., Testimony to Institute of Medicine, Feb, 2004)

The Office of Government Reform's three-year investigation, with over 20 hearings, concluded with a report, Mercury in Medicine, Are we Taking Unnecessary Risks?.

"Upon a thorough review of the scientific literature and internal documents from government and industry, the Committee did in fact find evidence that thimerosal posed a risk. The possible risk for harm from exposure to thimerosal is not "theoretical," but very real and documented in the medical literature."

"Thimerosal used as a preservative in vaccines is likely related to the autism epidemic."

"Mercury in Medicine - Are We Taking Unnecessary Risks?" A Report Prepared by the Staff of the Subcommittee on Human Rights and Wellness Committee on Government Reform, United States House of Representatives, Chairman Congressman Dan Burton, May 2003

A new study published this month with a coauthor from the University of Minnesota shows that the epidemic of autism is not simply a change in diagnostic terms. The epidemic is real. This study found that the sharpest rise in incidence was in children born between 1987 and 1992. We note that this is the very time when six new vaccine doses were added to the immunization schedule, each containing mercury. A child at that time, receiving her regular 6 month immunizations, might have received 62.5 mcg of mercury in one day, 125 times the EPA safe limit for ingestion of methylmercury.

Ensuring that vaccines are mercury-free will strengthen confidence in the immunization program. Many consumers are aware of the toxicity of mercury and do not wish to have a vaccine containing mercury. Ensuring that all mercury-free vaccines will be given will give consumers confidence to go ahead and have the vaccines they wish.

Even if mercury in vaccines caused no harm, this bill is a good idea.

- It will remove barriers to vaccination by removing any risk or appearance of risk.
- It will strengthen public support of immunizations.
- It will show that public health officials are acting aggressively to ensure the safest vaccines possible.
- It will reduce total mercury in the environment.

This bill will ensure that we continually move forward toward mercury-free vaccines. After much forward progress with removing mercury from the regular childhood immunization schedule, the CDC took a giant step backward when it recommended the influenza vaccine for infants and pregnant women, even though the vast majority of flu vaccines given last year contained the full complement of mercury.

Even though thimerosal is being phased out, this bill is still necessary. Without this legislation, thousands of Minnesotans may still receive large amounts of mercury in their flu vaccines and tetanus vaccines, and thousands of children will still receive trace amounts of mercury in their routine immunizations.

This bill will make the shift:

- From trace levels of mercury in routine infant immunizations to mercury-free
- From flu vaccines containing 25 mcg mercury to mercury-free or reduced
- From tetanus boosters with 8 mcg mercury to trace amounts of mercury

Mercury-free versions are now available for every vaccine needed. There is no reason to take the risk of giving mercury-containing vaccines.

Mercury has been banned from vaccines in Denmark, France, Switzerland, Sweden, Russia, Japan, and Canada. Last August, England banned mercury, effective almost immediately.

Iowa and California last year eliminated mercury from vaccines. Fourteen other states are going forward this year with legislation.

If the studies indicating neurological damage from thimerosal are correct, the financial cost to the State of Minnesota is horrendous. The medical costs to the state of caring for individuals with autism are $45,285 per person. In 2002, we spent $115 million for health care for people with autism. Many of these individuals will eventually require full-time residential treatment.

If the studies indicating neurological damage from thimerosal are correct, the personal and societal costs are horrendous. Affected individuals suffer tremendously, and so do their parents, siblings, and grandchildren. Our school classrooms are bursting with children requiring special education. One in six children are now diagnosed with developmental disorders.

The cost of mercury-free vaccines is sometimes higher and sometimes lower. The increased cost of the mercury-free flu vaccine can be more than outweighed by the reduced cost of mercury-free routine DtaP and polio vaccines compared to those containing a trace of mercury.

Cost issues did not prevent us from making the progress we have already made in reducing or eliminating mercury in vaccines. We would never back up and reinstate vaccines with mercury, just because they are cheaper. We need to continue those same steps until our vaccines are completely mercury-free. Ensuring access to the safest possible vaccines is one of the best investments we can make in Minnesota.

INSTITUTE
for
AGRICULTURE
and
TRADE POLICY

Minnesota State Capitol
75 Dr. Martin Luther King Jr. Blvd.
St. Paul, MN 55155-1206

March 25, 2005

Dear Senators:

I am writing to request your support of SF 639, a bill that helps ensure that children will not unnecessarily be exposed to mercury, a potent neurotoxin.

Thimerosal, a common preservative used in vaccines, is nearly 50% ethyl mercury. At the urging of the American Academy of Pediatrics, the Food and Drug Administration and physicians, pharmaceutical manufacturers several years ago began removing this mercury-containing compound from most children's vaccines. However, it is still used in some influenza and tetanus vaccines, commonly given to young children.

This action was prompted by concerns that some infants were receiving excessive doses of mercury early in life. While scientists may debate the narrow question of whether thimerosal has contributed to particular adverse health effects in some children, this question is immaterial to our support for this bill. No one disputes that mercury is toxic to the brain. No one disputes that fetuses and young children, whose brains are still developing, are more vulnerable to injury from mercury exposure. The National Academy of Sciences and the American Medical Association attest to these facts. Given the undisputed toxicity of mercury, it should be common sense that where possible, we ought to avoid unnecessarily exposing children.

This was exactly the sentiment behind the American Academy of Pediatrics urging manufacturers to phase out thimerosal in childhood vaccines. It is the same sentiment behind this legislation. The legislation simply assures that where the option exists to NOT expose children to mercury in vaccines, they will not be exposed.

Immunization of children against common diseases is an important public health intervention that protects children from serious and life-threatening illnesses. This crucial public health tool should not be tainted by fears of mercury. Parents of young children have many decisions to make in protecting their children from possible health risks. If all vaccines were mercury free, parents would not have to think twice about the types of vaccines given to their children.

As a precaution to protect young children, please pass SF 639 and eliminate one more route of exposure to toxic mercury for vulnerable children.

Sincerely,

Kathleen E. Schuler

Kathleen E. Schuler, MPH
Environmental Scientist
612-870-3468
kschuler@iatp.org

IntegraCare
100 2nd St. South, Sartell, MN 56377
Phone 320 251 2600 / Fax 320 251 4763

To Whom It May Concern:

I strongly support vaccination as a method of preventing childhood diseases. I believe we should have the safest vaccines possible for our citizens.

Given the weight of scientific evidence demonstrating that mercury in vaccines can cause serious diseases in a subset of the population that is unable to clear mercury effectively, I strongly support the goal set by the AAP and the USPHS in 1999 to remove mercury from vaccines as soon as possible.

My experience in working with a large number of children with developmental difficulties of all kinds has reinforced in my mind the scientific studies pointing to the concern about thimerosal in vaccines. Many of these children experienced neurological regression shortly following vaccines. Diagnostic studies demonstrate mercury retention in their tissues and many of them have shown striking improvement following therapies to help clear the mercury from their bodies.

It is important that the public continues to have faith in the immunization program, and one of the most important steps we can take is to move quickly to a mercury-free vaccine program in Minnesota.

While it is clear that it is in the best interests of the society to immunize children, it is not clear to many parents that immunizations are the right thing to do for their child. Removing thimerosal from vaccines will remove one more obstacle to the decision of parents to immunize their children.

Thomas A. Sult, MD

Dakota Medical Clinic, PA
Michael Dole, M.D.

Minnesota Representative Laura Brod
G-24 State Capitol
St. Paul, MN 55155

Re: Mercury-Free Vaccine Bill

March 23, 2005

Dear Ms. Lourey,

Thank you for introducing the Mercury-Free Vaccine Bill! As a licensed, practicing family physician in Minnesota, I sincerely believe that there is no excuse for vaccine manufacturers to use mercury containing preservatives in their products.

Everyone agrees that mercury is toxic. Arguments that the amount used in vaccines is acceptable ignore the following realities:

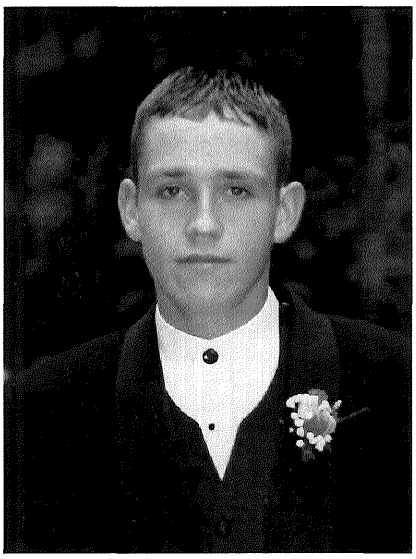
1. A small number of individuals are hypersensitive or allergic to mercury. Even small amounts of mercury will hurt these individuals. At this point, there is no way to test the population to see who is susceptible.
2. Vaccines are not studied for long term adverse events. Therefore the question as to long term consequences of mercury in vaccines has never been studied.
3. Manufactures of mercury preservatives have never done long term studies proving that they are safe.
4. Anecdotal reports of autism-spectrum disorders following vaccinations are increasing. The rates of these devastating disabilities and their costs to our society (let alone to the parents of effected children) rose in parallel with the numbers of vaccines being given.

Given all of the above, we cannot wait for studies to be done on mercury in vaccines. Mercury is a known toxin. Our population and especially our children must be protected.

Sincerely,

Michael Dole, MD

3408 Dakota Avenue South, Saint Louis Park, Minnesota 55416-2312
Tel: (952)924-1053 Fax: (952)924-0254 email: md2@usfamily.net



Ryan Wayne Milley, (Bear)

Senator Becky Lourey, Chair
Senate Health and Family Security Committee
Room G-24 Capitol
St. Paul, MN 55155

Re: Senate File 639

Dear Senator Lourey and Committee Members:

My name is Frankie. I am the mother of an only child who died with a vaccine preventable form of meningitis. He was 18, headed for a pro golf career and college. He became ill on Father's Day 1998 and died the next morning. He went from an earache and a fever, to blood coming from every orifice of his body and finally to death in less than 14 hours. With him went a huge part of our identity, the honor of being the parents at his wedding, our right to ever be called grandma and grandpa and the comfort of a child in our old age. A terrible vaccine preventable disease had taken our son, our life.

The last words Ryan heard were his dad telling him "Daddy loves you baby boy." Ryan's heart stopped and on its own, by the grace of God, it started again and Ryan was able to roll his head in the direction of his dad and mouth the words "I know." Then he died.

Our heart screams everyday for our precious son.

Many people around the world and some here in the U.S. are still being left debilitated or dying from vaccine-preventable diseases such as chickenpox, rubella, meningitis, mumps, pertussis, influenza, hepatitis, diphtheria, typhoid and tetanus, just to name a few. 2004 saw several dozen deaths around the U.S. from pertussis, pneumococcal disease, meningitis and the flu, just to name a few. Diseases we thought long ago were eliminated in our country. One, meningitis, in particular, I have spent seven years of my life working to stop. Epidemics of all of these diseases are in several places in the world. Epidemics are a plane ride away.

In 1992 Denmark, which has one of the highest rates of autism in the word took all Thimerosal out of their vaccines. Today they still have and continue to climb in their higher autism rates. It is

proven that more harmful mercury is found in fish especially tuna. The mercury in Thimerosal is ethyl. Ethyl alcohol is what is in the wine we drink. The mercury in tuna is methyl mercury the same ingredient we find in antifreeze. People in Denmark eat large amounts of fish. Is this a problem/cause? I can't say.

What I can say: We have 50 years of proof vaccines are safe and save lives.

We know lack of meningitis vaccine has caused some of us to lose our children and has left many debilitated. We can't afford this. More important our children can't afford this. It is time we stand up and tell our side and let our voices be heard. We have facts of the truth, vaccines save lives. We have nothing to gain but protecting our children and our future from deadly diseases from the use of vaccines.

Laws such as Senate File 639 will set us all back years. The time wasted to write, hear and pass them will continue to push important life-saving vaccines to the rear again. They will cause a rise in public healthcare cost by purchasing different higher priced vaccines and taking care of outbreaks from disease from lack of vaccine use. As more and more people listen and choose exemptions from vaccines because of unproven propaganda, more debilitation and death will happen.

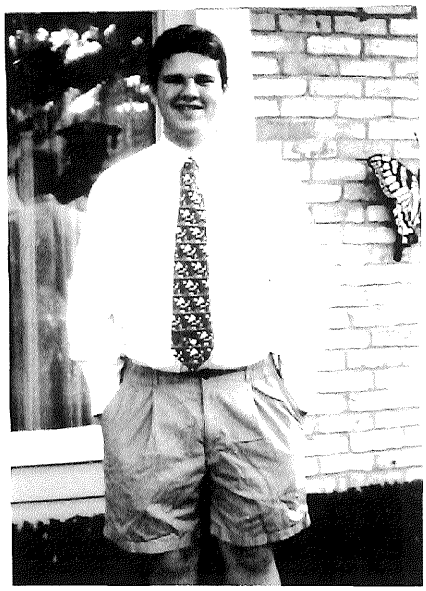
It would be easy to give up. But I will not give up. How many tears must we cry and how many must die before someone listens? Don't leave our children behind, protect them and remember those who have already died from vaccine-preventable diseases.

Make a positive step for public health and, more important, for the lives of your people. VOTE NO on Senate File 639.

Thank You,
In memory of our precious son, Ryan Milley
God has our son and we have His.
Frankie Milley, Ryan's Mom
Texas

For more information on meningitis or to see the damage this disease cause its' victims and their families got to www.meningitis-angels.org

Dear Senator Lourey:


Eddy Bailey, Age 20

On November 12, 2002 my twenty-year old son, Edward Joseph Bailey, **DIED** from a vaccine-preventable disease. Eddy died of Type C meningococcemia, a form of meningitis that invades the bloodstream and decimates all internal organs in a short time span. Eddy died within 16 hours of falling ill. As the paramedics were trying to save his life, he stopped breathing and then his heart stopped.

Eddy and his brother, Brett, received EVERY mandated vaccine because those two boys were and are our very lives, and we as parents wanted to do everything in our power to protect those lives. But we were uneducated about meningococcal disease and did not know that there was a vaccine to protect against this horrible disease.

We sent our son to college at the University of Wisconsin at Madison, where he had earned a full-tuition scholarship for finishing first in his high school class. Eddy had so much to give our world, but this disease **ENDED HIS LIFE**.

My husband and I have worked tirelessly since Eddy's death to educate other parents about this vaccine-preventable disease so that other families do not have to suffer the pain and grief we endure.

The scientific method does **NOT prove** that mercury in vaccines causes autism.

This proposed legislation, Senate File 639, in my opinion will only cause MORE FAMILIES to go through the heartbreaking death or maiming of their children.

I am sure the FAMILY SECURITY COMMITTEE which you chair would not want to cause deaths by discouraging vaccination of our children. I believe this will happen if this legislation is passed.

Please do everything in your power to stop this legislation which will set back the progress scientists have made in order that our children can live meaningful and productive lives.

Death is so final, so permanent, so horrific that there truly are no words to describe what the surviving family members must endure.

I am a teacher at a technical college, and I have had several autistic children in my classes. One young man comes to mind, and his name is Aaron. Aaron is incredibly intelligent, high functioning and capable of loving, but yes, it is different for him in the way that he "connects interpersonally" with others. **But Aaron is ALIVE**!!!! Eddy is DEAD, but his death could have been prevented had we known about the vaccine to protect his life from meningococcal disease.

Please do not support this legislation in your state.

Gail Bailey
731 Glenwood Court
Jefferson, WI 53549
Eddy's Mom

Senator Becky Lourey, Chair
Senate Health & Family Security Committee
Room G24
St Paul, MN 55155

Dear Senator Lourey,

I am writing to you to inform you of the effects of **NOT** vaccinating your children. On February 25, 2004, we lost our beautiful 20 year old daughter, Becky, to meningitis, a very preventable disease. As I helplessly stood by and watched her body deteriorate with every hour, she was gone from us in less than 24 hours.

I have worked in the medical field for over 24 years and I have never seen a disease take an otherwise healthy, strong body and virtually destroy it! I had even asked whether or not Becky needed to be vaccinated against meningitis but because she did not live in the dorms, she was not considered at high risk to a RARE (?) disease. What a horrific mistake!! Every day I live with the fact that I should've known better . . .I should've known how sick she was . . . I should've done something to stop it!! But I could not! Now, I spend my days "preaching" to anyone who will listen to the effects of not vaccinating your children.

Vaccinations are a very important and crucial way to protect our children. We try to protect them from drugs, from bad influences, etc., why would we not protect them from some horrible disease that we have no control over? In reviewing the effects of Thimerosal vs. not vaccinating your child, I can hardly believe that this is an issue. The effects of vaccinating far outweigh the effects of Thimerosal. This law **must** be put into place in order to protect our children from these devastating, mutilating, life-threatening diseases!

I invite you to visit our website and to freely use whatever is there to educate others on the importance of vaccinations.

Thank you for listening.

Dee Dee Werner,
S95 W32805 Hickorywood Trail
Mukwonago, WI 53149
262-363-3057

In Loving Memory of Becky Werner

Senator Becky Lourey, Chair
Senate Health and Family Security Committee
Room G-24 Capitol
St. Paul, MN 55155

Re: Senate File 639

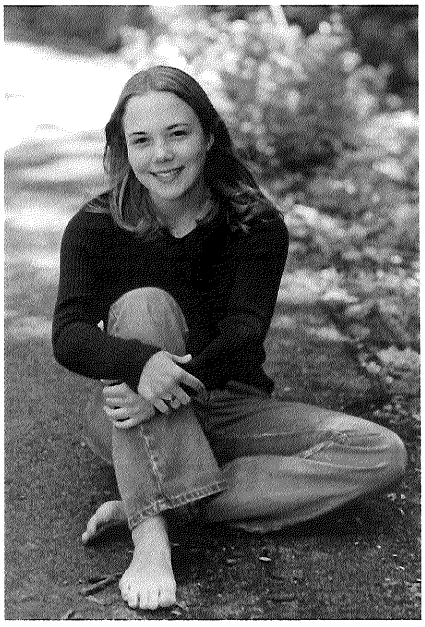
Dear Senator Lourey and Committee Members

I would like to testify about the consequences of **NOT** vaccinating. My daughter, Kris Marx, was a sophomore in college at the great University of Minnesota, became ill with a vaccine-preventable disease, and passed away two days later. You can not imagine the pain and suffering felt by her family, friends and especially her acquaintances at the wonderful University of Minnesota.

Senate File 639 should not be passed. It pushes back very important advances and usages of life-saving vaccines to fight deadly diseases. Please vote no!

Thank you for your consideration.

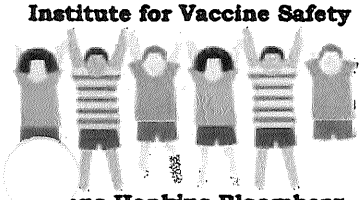
Susan Marx
2914 Nottingham Way
Madison, WI 53713
Phone: 608-271-8966 or 608-249-3322, X12



Kris Marx

March 16, 2005

Institute for Vaccine Safety



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Senator Becky Lourey
Chair, Senate Health and Family Security Committee
Room G-24 Capitol
St. Paul, MN 55155

Re: Senate File 639 – The "Elimination of Mercury in Vaccines" Bill

Dear Chairman Lourey:

On behalf of the Institute for Vaccine Safety at the Johns Hopkins Bloomberg School of Public Health, we would like to voice our opposition to Senate File 639. This bill would prohibit the use of vaccines containing any amount of mercury if a product with a lesser amount or no amount was available. I have read some of the materials that the proponents of this bill are distributing to committee members. These materials include a comment made by me (Neal Halsey) in 1999 and is being used as support for this bill. I would like to clarify my position and provide you with important developments that have occurred in the past 6 years.

In 1999, there was justified concern about the amount of mercury-containing thimerosal preservatives used in the vaccines. We worked with other professionals in academia, the American Academy of Pediatrics, and the U.S. Public Health Service to encourage the removal of thimerosal as a preservative from vaccines administered to young children. Our concern was that the administration of multiple doses of vaccines with this preservative could present a safety issue for very small infants, especially those under six months of age. For some DTaP, hepatitis B and influenza vaccines, however, the manufacturing process included the use of thimerosal during the production process. Manufacturers since have addressed this problem for most infant vaccines by extracting the thimerosal prior to preparation of the final product for sale. This extraction process reduces the amount of thimerosal from approximately 50 micrograms (25 micrograms of ethylmercury) per dose to less than 0.5 micrograms per dose. This small amount of residual thimerosal does not constitute a risk to the health of infants, children, pregnant women or persons of any age.

Mercury toxicity is related to the dose administered. All of us are exposed to low levels of other mercury compounds in food products including many of the fish that are found in Minnesota waters. Public health experts advise women who are pregnant or might get pregnant to restrict consumption of fish that are high in mercury, but they do not advise stopping all fish consumption even though almost all fish contain some mercury. It is not possible to completely eliminate all exposure. The removal of thimerosal as a preservative from vaccines routinely administered to children has removed the theoretical risk that existed in 1999. The trace amounts in some current vaccines do not constitute a health hazard and prohibiting or restricting the administration of vaccines with these trace amounts would be harmful. Under the proposed law, physicians would be required to be absolutely certain that no possible alternative vaccines available, resulting in delays in vaccinating people who are in need of immunizations while they're looking for alternative preparations. Although there will be limited supplies of some vaccines without any thimerosal, there will not be an adequate supply to immunize everyone. This bill poses undue restrictions on individual practitioners and State immunization program personnel that will impair the protection of people through the use of vaccines.

You must know that influenza kills approximately 20,000 people a year in this country, and in epidemic years more than twice as many people may die. Many of these deaths can be prevented with vaccines. The Legislature should not impose an impediment to the delivery of this much-needed vaccine. Also, we might face another major influenza pandemic in the next few years. Some of the new bird influenza viruses kill more than 1/2 of infected people. If a pandemic develops, there will be very little time to develop vaccines and there undoubtedly will be a shortage of influenza vaccine. We definitely will not have enough influenza vaccine with reduced or no thimerosal. Health-care providers should be allowed to engage in decision making with informed patients to balance any theoretical risks from vaccines against the known risks of contracting influenza if they remain unvaccinated.

JOHNS HOPKINS BLOOMBERG SCHOOL of PUBLIC HEALTH

Sincerely,

Neal A. Halsey, MD

Lawrence H. Moulton, PhD

March 29, 2005

Dear Legislator:

Our organizations respectfully wish to state our opposition to the "Mercury-Free Vaccine Bill," SF 639/ HF 1505, introduced in this 2005 session. If enacted, we believe this bill has the potential to do the following:

1. Perpetuate **false and misleading information** about vaccines that would lead both healthcare providers and the public to believe that vaccines containing a mercury-based preservative are not safe. **This is not true.**

The issue of mercury's ill effects on the neurologic development of infants is based on studies of methylmercury and not vaccines. According to the U.S. Environmental Protection Agency, nearly all **methylmercury** exposures in the U.S. occur through eating fish and shellfish. The mercury that is contained in the preservative thimerosal used in some vaccines is known as **ethylmercury**. This issue has been well studied, and there is **no scientific evidence** that ethylmercury in the form of thimerosal in vaccine is any danger to health.

2. Add **more complexity** to our present vaccine delivery system in medical practices, health departments, and anywhere that vaccines are administered to patients for no reason. In some instances, vaccines that have been combined to decrease the number of injections given to children would no longer be an option for providers and parents because the product contains a trace amount of thimerosal, an amount that is nearly immeasurable.

3. Lead to **on-going vaccine shortages** as healthcare providers would need to continually seek mercury-free formulations, which are not widely available for some vaccines. For several vaccines given to children (e.g., influenza, DTaP), only a small portion of the total vaccine supply is available in thimerosal-reduced or thimerosal-free formulations.

4. Lead to **increased costs** for vaccines by the state health department, city and county health departments, private healthcare providers, and ultimately, our patients. Where alternative products without thimerosal are available, they can be as much as 30-45% higher in cost. If additional funding is not available to health departments, services will need to be cut.

While the authors' attempts to reduce mercury exposures in the environment are well intentioned, the unintended consequences of this bill could have devastating results. It is likely that more children and adults will remain unvaccinated and probably lead to increases in vaccine-preventable diseases.

Vaccine manufacturers have revised their manufacturing processes to allow production of mercury-free vaccines as a precautionary measure, despite the absence of evidence of harm, as part of an effort to limit childhood exposure to mercury in all forms. Consequently, thimerosal, containing ethylmercury, has already been eliminated or is present in only trace amounts in vaccines given to young children.

We therefore urge the members of this respected body to oppose this legislation and to help us further our work in protecting our state's children and adults against vaccine-preventable diseases.

Sincerely,

American Academy of Pediatrics, Minnesota Chapter • American Liver Foundation, Minnesota Chapter
Children's Hospitals and Clinics • Immunization Action Coalition
Mayo Clinic • Minnesota Academy of Family Physicians
Minnesota Association of Professionals in Infection Control
Minnesota Chapter, National Association of Pediatric Nurse Practitioners
Minnesota Coalition for Adult Immunization • Minnesota Council of Health Plans
Minnesota Medical Association • Minnesota Pharmacists Association

(See back side of letter for more information)

The organizations listed on the front side of this letter are represented by the individuals indicated below:

Jeffery Schiff, MD, President
American Academy of Pediatrics, Minnesota Chapter

Amy Nelson, Executive Director
American Liver Foundation, Minnesota Chapter

Phil Kibort, MD, Vice President of Medical Affairs
Children's Hospitals and Clinics

Deborah L. Wexler, MD, Executive Director
Immunization Action Coalition, St. Paul

Drs. Gregory A. Poland and Robert M. Jacobson
Mayo Clinic, Rochester

Carol Featherstone, MD, President
Minnesota Academy of Family Physicians

Susan Gustafson, RN, CIC, President-Elect
Minnesota Association of Professionals in Infection Control

Kathleen Eide, RN, CNP, President
Minnesota Chapter, National Association of Pediatric Nurse Practitioners

Kristin L. Nichol, MD, Chair
Minnesota Coalition for Adult Immunization

Julie Brunner, Executive Director
Minnesota Council of Health Plans

Michael Gonzalez-Campoy, MD, President
Minnesota Medical Association

Julie K. Johnson, RPh, Executive Director and CEO
Minnesota Pharmacists Association

Senate Counsel, Research, and Fiscal Analysis

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JO ANNE ZOFF SELLNER
DIRECTOR

Senate

State of Minnesota

S.F. No. 1720 - Children and Family Services and Health and Continuing Care Programs Provisions Technical Modifications

Author: Senator Becky Lourey

Prepared by: Joan White, Senate Counsel (651/296-3814)
David Giel, Senate Research (651/296-7178)

Date: March 28, 2005

S.F. No. 1720 makes technical modifications in laws governing a variety of Department of Human Services programs.

ARTICLE 1
CHILDREN'S AND FAMILY SERVICES

Sections 1 and 2 (13.319, subdivision 3; 13.461, subdivision 29) amend the Data Practices Act specifying child care data jurisdiction between the Commissioners of Human Services and Education.

Sections 3, 5, and 6 (119B.02, subdivision 5; 119B.074; 119B.08, subdivision 1) strike unnecessary references to the Commissioner of Human Services.

Section 4 (119B.035, subdivision 1) specifies that the basic sliding fee pool is up to three percent of the annual "state" appropriation.

Section 7 (119B.09, subdivision 1) clarifies child care assistance eligibility criteria related to household income.

Section 8 (119B.26) updates references to Senate and House committees.

Sections 9 and 10 (256.045, subdivision 6; 256.045, subdivision 7) strike unnecessary references to the Commissioner of Education.

Section 11 (256J.13, subdivision 2) corrects a cross-reference.

Section 12 (256J.21, subdivision 2) updates rule references.

Section 13 (256J.24, subdivision 5) updates the MFIP transitional standard.

Section 14 (256J.561, subdivision 3) modifies the exemption from work activities when a child is born. Current law exempts a participant from the employment services requirement if the child was born within ten months of the caregiver's application for the diversionary work program or MFIP. The bill strikes that language and inserts that the child must not be subject to the family cap.

Section 15 (256J.74, subdivision 1) strikes rule references and updates terminology.

Section 16 (256J.751, subdivision 2) modifies the report to counties with regard to the MFIP work participation rate, which excludes child-only cases and employment and training services exemptions. The bill strikes the reference to employment and training exemptions, which is sunsetting June 30, 2005.

Sections 17 to 21 amend the diversionary work program (DWP).

Section 17 (256J.95, subdivision 2) modifies the definition of "family unit" in the DWP, and inserts a definition for the term "caregiver."

Section 18 (256J.95, subdivision 6) requires the county to screen and requires the applicant to apply for other benefits as required under MFIP.

Section 19 (256J.95, subdivision 11) modifies DWP universal participation by correcting a cross-reference and exempting a caregiver from the work requirements when a child is under 12 weeks of age only if the child is not subject to the family cap under MFIP.

Section 20 (256J.95, subdivision 18) clarifies that a noncompliant DWP participant is not eligible for MFIP or any other TANF cash program for the remainder of the DWP four-month period.

Section 21 (256J.95, subdivision 19) strikes an obsolete reference and clarifies DWP policy related to overpayments and underpayments.

Section 22 (518.6111, subdivision 7) corrects a cross-reference.

Section 23 corrects that statute to reflect language that was adopted by a conference committee last session.

Section 24 is a Revisor instruction.

Section 25 repeals the At-Risk Youth Out-of-Wedlock Pregnancy Prevention Program.

ARTICLE 2
HEALTH CARE AND CONTINUING CARE

Section 1 (256B.04, subdivision 14) states that rate changes under Medical Assistance (MA), General Assistance Medical Care (GAMC), and MinnesotaCare do not, unless otherwise specified, affect payments under competitively bid contracts.

Section 2 (256B.056, subdivision 1c) codifies longstanding rider language requiring adjustments to occur on July 1 in program eligibility to reflect the annual revision of the Federal Poverty Guidelines. This section refers to adjustments in the income standard for MA families with children.

Section 3 (256B.0625, subdivision 5) changes a cross-reference from a rule that has been repealed to the applicable statute.

Section 4 (256B.0625, subdivision 27) deletes certain outdated requirements that must be satisfied in order for organ and tissue transplants to be reimbursed by MA. It also deletes references to an advisory committee on transplants. The statute creating the committee is being repealed in this bill.

Section 5 (256B.0911, subdivision 6) deletes references to the Community Social Services Act (CSSA), which was repealed in 2003. Under this section local long-term care objectives must be included in a home and community-based services quality assurance plan rather than the CSSA plan.

Section 6 (256B.0913, subdivision 13) deletes another reference to the CSSA plan and replaces it with a reference to the home and community-based services quality assurance plan.

Section 7 (256B.092, subdivision 1f) deletes another reference to the CSSA plan.

Section 8 (256B.094, subdivision 8) deletes another reference to the CSSA plan.

Section 9 (256B.0943, subdivision 6) states requirements for services provided under Children's Therapeutic Services and Supports (CTSS).

Section 10 (256B.0943, subdivision 12) clarifies a reference to CTSS service components.

Section 11 (256B.0943, subdivision 13) deletes references to rules that have been repealed and replaces them with the correct references.

Section 12 (256B.503) deletes a requirement that a 1983 law governing case management for persons with mental retardation comply with Minnesota Statutes, chapter 256E. The applicable portions of that chapter have been repealed.

Section 13 (256B.75) corrects a cross-reference.

Section 14 (256D.03, subdivision 3) codifies longstanding rider language requiring adjustments to occur on July 1 in program eligibility to reflect the annual revision of the Federal Poverty Guidelines. This section refers to adjustments in the income standard for GAMC.

Section 15 (256L.01, subdivision 3a) deletes outdated references to coverage for dependent siblings under MinnesotaCare.

Section 16 (256L.04, subdivision 7b) codifies longstanding rider language requiring adjustments to occur on July 1 in program eligibility to reflect the annual revision of the Federal Poverty Guidelines. This section refers to adjustments in the income limits for MinnesotaCare.

Section 17 (626.557, subdivision 12b) amends the statute governing management of data collected and maintained regarding reports of maltreatment of vulnerable adults. This section provides that county social service agencies must maintain private data on individuals but are not required to prepare an investigation memorandum.

Section 18 repeals the following sections:

> **Section 119A.01, subdivision 3:** This subdivision states the purpose for the creation of the Department of Education.
>
> **Section 119A.20, 119A.21, and 119A.22:** These sections establish the abused child program and authorize the Commissioner of Education to make grants to providers that serve abused children.
>
> **Section 119A.35:** This section establishes a council to advise the Commissioner of Education on a variety of child abuse issues and programs.
>
> **Section 119B.21, subdivision 11:** This subdivision creates a task force to advise the Commissioner of Education on child care issues.
>
> **Section 256.014, subdivision 3:** This section requires an annual report to legislative committees on computer systems expenditures.
>
> **Section 256.045, subdivision 3c:** This section creates duties for state human services referees with respect to the Commissioner of Education's former authority over child care programs.
>
> **Section 256B.0629, subdivisions 1, 2, and 4:** This section establishes an advisory committee on organ and tissue transplants and outlines its functions and responsibilities.

Section 256J.95, subdivision 20: This subdivision requires all counties to implement MFIP diversionary work programs by June 30, 2004.

Section 256K.35: This section establishes an at-risk youth out-of-wedlock pregnancy prevention program.

Laws 1998, chapter 407, article, 4, section 63: This section requires an annual report on the cost of adjusting MA income standards and a variety of provider rates by the change in the Consumer Price Index.

ARTICLE 3
MISCELLANEOUS

This article primarily strikes obsolete references to the community social services plan and the children's mental health component of that plan. The 2003 legislature consolidated these funds and several others in the Children's and Community Services Act.

Section 17(252.46, subdivision 10) strikes references to repealed rules.

Section 24 is a Revisor instruction.
JW:rdr

Senator Lourey introduced--

S.F. No. 1720: Referred to the Committee on Health and Family Security.

A bill for an act

relating to human services; making agency technical amendments; changing provisions related to children and family services, health care, and continuing care programs; amending Minnesota Statutes 2004, sections 13.319, subdivision 3; 13.461, by adding a subdivision; 119B.02, subdivision 5; 119B.035, subdivision 1; 119B.074; 119B.08, subdivision 1; 119B.09, subdivision 1; 119B.26; 245.463, subdivision 2; 245.464, subdivision 1; 245.465, subdivision 1; 245.466, subdivisions 1, 5; 245.4661, subdivision 7; 245.483, subdivisions 1, 3; 245.4872, subdivision 2; 245.4873, subdivision 5; 245.4874; 245.4875, subdivisions 1, 5; 245A.16, subdivision 6; 252.24, subdivision 5; 252.282, subdivision 2; 252.46, subdivision 10; 256.045, subdivisions 3, 6, 7; 256B.04, subdivision 14; 256B.056, subdivision 1c; 256B.0625, subdivisions 5, 27; 256B.0911, subdivision 6; 256B.0913, subdivision 13; 256B.092, subdivision 1f; 256B.094, subdivision 8; 256B.0943, subdivisions 6, 12, 13; 256B.503; 256B.75; 256D.03, subdivision 3; 256G.01, subdivision 3; 256J.13, subdivision 2; 256J.21, subdivision 2; 256J.24, subdivision 5; 256J.561, subdivision 3; 256J.74, subdivision 1; 256J.751, subdivision 2; 256J.95, subdivisions 2, 6, 11, 18, 19; 256L.01, subdivision 3a; 256L.04, by adding a subdivision; 256M.30, subdivision 2; 260C.212, subdivision 12; 275.62, subdivision 4; 518.6111, subdivision 7; 626.557, subdivision 12b; 626.5571, subdivision 2; Laws 1997, chapter 245, article 2, section 11, as amended; repealing Minnesota Statutes 2004, sections 119A.01, subdivision 3; 119A.20; 119A.21; 119A.22; 119A.35; 119B.21, subdivision 11; 245.713, subdivisions 2, 4; 245.716; 256.014, subdivision 3; 256.045, subdivision 3c; 256B.0629, subdivisions 1, 2, 4; 256J.95, subdivision 20; 256K.35; 626.5551, subdivision 4; Laws 1998, chapter 407, article 4, section 63.

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

ARTICLE 1

CHILDREN'S AND FAMILY SERVICES

Section 1. Minnesota Statutes 2004, section 13.319,

subdivision 3, is amended to read:

Subd. 3. [PROGRAM SERVICES.] Data on individuals receiving services under certain programs administered by the Department of Education are classified under ~~sections 119A.376, subdivision 4, 119A.44, subdivision 7, and~~ section 119A.50, subdivision 2.

Sec. 2. Minnesota Statutes 2004, section 13.461, is amended by adding a subdivision to read:

Subd. 29. [PROGRAM SERVICES.] Data on individuals receiving services under certain programs administered by the Department of Human Services are classified under sections 119A.376, subdivision 4, and 119A.44, subdivision 7.

Sec. 3. Minnesota Statutes 2004, section 119B.02, subdivision 5, is amended to read:

Subd. 5. [PROGRAM INTEGRITY.] For child care assistance programs under this chapter, the commissioner shall enforce, ~~in cooperation with the commissioner of human services,~~ the requirements for program integrity and fraud prevention investigations under sections 256.046, 256.98, and 256.983.

Sec. 4. Minnesota Statutes 2004, section 119B.035, subdivision 1, is amended to read:

Subdivision 1. [ESTABLISHMENT.] A family in which a parent provides care for the family's infant child may receive a subsidy in lieu of assistance if the family is eligible for or is receiving assistance under the basic sliding fee program. An eligible family must meet the eligibility factors under section 119B.09, except as provided in subdivision 4, and the requirements of this section. Subject to federal match and maintenance of effort requirements for the child care and development fund, the commissioner shall establish a pool of up to three percent of the annual state appropriation for the basic sliding fee program to provide assistance under the at-home infant child care program and for administrative costs associated with the program. At the end of a fiscal year, the commissioner may carry forward any unspent funds under this section to the next fiscal year within the same biennium for assistance under the basic sliding fee program.

Sec. 5. Minnesota Statutes 2004, section 119B.074, is amended to read:

119B.074 [SPECIAL REVENUE ACCOUNT FOR CHILD CARE.]

A child support collection account is established in the special revenue fund for the deposit of collections through the assignment of child support under section 256.741, subdivision 2. The commissioner ~~of human services~~ must deposit all collections made under section 256.741, subdivision 2, in the child support collection account. Money in this account is appropriated to the commissioner for assistance under section 119B.03 and is in addition to other state and federal appropriations.

Sec. 6. Minnesota Statutes 2004, section 119B.08, subdivision 1, is amended to read:

Subdivision 1. [REPORTS.] The commissioner shall specify requirements for reports under the ~~same~~ authority ~~as~~ provided ~~to the commissioner of human services~~ in section 256.01, subdivision 2, paragraph (17).

Sec. 7. Minnesota Statutes 2004, section 119B.09, subdivision 1, is amended to read:

Subdivision 1. [GENERAL ELIGIBILITY REQUIREMENTS FOR ALL APPLICANTS FOR CHILD CARE ASSISTANCE.] (a) Child care services must be available to families who need child care to find or keep employment or to obtain the training or education necessary to find employment and who:

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

(2) ~~have household income below the eligibility levels for MFIP; or~~

~~(3)~~ have household income less than or equal to 175 percent of the federal poverty guidelines, adjusted for family size, at program entry and less than 250 percent of the federal poverty guidelines, adjusted for family size, at program exit.

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

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

Sec. 8. Minnesota Statutes 2004, section 119B.26, is amended to read:

119B.26 [AUTHORITY TO WAIVE REQUIREMENTS DURING DISASTER PERIODS.]

The commissioner may waive requirements under this chapter for up to nine months after the disaster in areas where a federal disaster has been declared under United States Code, title 42, section 5121, et seq., or the governor has exercised authority under chapter 12. The commissioner shall notify the chairs of the ~~senate-Family-and-Early-Childhood-Education-Budget Division,-the-senate-Education-Finance-Committee,-the-house Family-and-Early-Childhood-Education-Finance-Division,-the-house Education-Committee,~~ house and senate committees with jurisdiction over this chapter and the house Ways and Means Committee ten days before the effective date of any waiver granted under this section.

Sec. 9. Minnesota Statutes 2004, section 256.045, subdivision 6, is amended to read:

Subd. 6. [ADDITIONAL POWERS OF THE COMMISSIONER; SUBPOENAS.] (a) The commissioner of human services, or the commissioner of health for matters within the commissioner's jurisdiction under subdivision 3b, ~~or-the-commissioner-of education-for-matters-within-the-commissioner's-jurisdiction under-subdivision-3c,~~ may initiate a review of any action or decision of a county agency and direct that the matter be presented to a state human services referee for a hearing held

under subdivision 3, 3a, 3b, ~~3c,~~ or 4a. In all matters dealing with human services committed by law to the discretion of the county agency, the commissioner's judgment may be substituted for that of the county agency. The commissioner may order an independent examination when appropriate.

(b) Any party to a hearing held pursuant to subdivision 3, 3a, 3b, ~~3c,~~ or 4a may request that the commissioner issue a subpoena to compel the attendance of witnesses and the production of records at the hearing. A local agency may request that the commissioner issue a subpoena to compel the release of information from third parties prior to a request for a hearing under section 256.046 upon a showing of relevance to such a proceeding. The issuance, service, and enforcement of subpoenas under this subdivision is governed by section 357.22 and the Minnesota Rules of Civil Procedure.

(c) The commissioner may issue a temporary order staying a proposed demission by a residential facility licensed under chapter 245A while an appeal by a recipient under subdivision 3 is pending or for the period of time necessary for the county agency to implement the commissioner's order.

Sec. 10. Minnesota Statutes 2004, section 256.045, subdivision 7, is amended to read:

Subd. 7. [JUDICIAL REVIEW.] Except for a prepaid health plan, any party who is aggrieved by an order of the commissioner of human services, or the commissioner of health in appeals within the commissioner's jurisdiction under subdivision 3b, ~~or the commissioner of education for matters within the commissioner's jurisdiction under subdivision 3c,~~ may appeal the order to the district court of the county responsible for furnishing assistance, or, in appeals under subdivision 3b, the county where the maltreatment occurred, by serving a written copy of a notice of appeal upon the commissioner and any adverse party of record within 30 days after the date the commissioner issued the order, the amended order, or order affirming the original order, and by filing the original notice and proof of service with the court administrator of the district court.

Service may be made personally or by mail; service by mail is complete upon mailing; no filing fee shall be required by the court administrator in appeals taken pursuant to this subdivision, with the exception of appeals taken under subdivision 3b. The commissioner may elect to become a party to the proceedings in the district court. Except for appeals under subdivision 3b, any party may demand that the commissioner furnish all parties to the proceedings with a copy of the decision, and a transcript of any testimony, evidence, or other supporting papers from the hearing held before the human services referee, by serving a written demand upon the commissioner within 30 days after service of the notice of appeal. Any party aggrieved by the failure of an adverse party to obey an order issued by the commissioner under subdivision 5 may compel performance according to the order in the manner prescribed in sections 586.01 to 586.12.

Sec. 11. Minnesota Statutes 2004, section 256J.13, subdivision 2, is amended to read:

Subd. 2. [PHYSICAL PRESENCE.] A minor child and a caregiver must live together except as provided in the following paragraphs.

(a) The physical presence requirement is met when a minor child is required to live away from the caregiver's home to meet the need for educational curricula that cannot be met by, but is approved by, the local public school district, the home is maintained for the minor child's return during periodic school vacations, and the caregiver continues to maintain responsibility for the support and care of the minor child.

(b) The physical presence requirement is met when an applicant caregiver or applicant minor child is away from the home due to illness or hospitalization, when the home is maintained for the return of the absent family member, the absence is not expected to last more than six months beyond the month of departure, and the conditions of clause (1), (2), or (3) apply:

(1) when the minor child and caregiver lived together

immediately prior to the absence, the caregiver continues to maintain responsibility for the support and care of the minor child, and the absence is reported at the time of application;

(2) when the pregnant mother is hospitalized or out of the home due to the pregnancy; or

(3) when the newborn child and mother are hospitalized at the time of birth.

(c) The absence of a caregiver or minor child does not affect eligibility for the month of departure when the caregiver or minor child received assistance for that month and lived together immediately prior to the absence. Eligibility also exists in the following month when the absence ends on or before the tenth day of that month. A temporary absence of a caregiver or a minor child which continues beyond the month of departure must not affect eligibility when the home is maintained for the return of the absent family member, the caregiver continues to maintain responsibility for the support and care of the minor child, and one of clauses (1) to (7) applies:

(1) a participant caregiver or participant child is absent due to illness or hospitalization, and the absence is expected to last no more than six months beyond the month of departure;

(2) a participant child is out of the home due to placement in foster care as defined in ~~section~~ sections 260B.007, subdivision 7, and 260C.007, subdivision ~~15~~ 18, when the placement will not be paid under title IV-E of the Social Security Act, and when the absence is expected to last no more than six months beyond the month of departure;

(3) a participant minor child is out of the home for a vacation, the vacation is not with an absent parent, and the absence is expected to last no more than two months beyond the month of departure;

(4) a participant minor child is out of the home due to a visit or vacation with an absent parent, the home of the minor child remains with the caregiver, the absence meets the conditions of this paragraph and the absence is expected to last no more than two months beyond the month of departure;

(5) a participant caregiver is out of the home due to a death or illness of a relative, incarceration, training, or employment search and suitable arrangements have been made for the care of the minor child, or a participant minor child is out of the home due to incarceration, and the absence is expected to last no more than two months beyond the month of departure;

(6) a participant caregiver and a participant minor child are both absent from Minnesota due to a situation described in clause (5), except for incarceration, and the absence is expected to last no more than one month beyond the month of the departure; or

(7) a participant minor child has run away from home, and another person has not made application for that minor child, assistance must continue for no more than two months following the month of departure.

Sec. 12. 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, 9560.0521, and 9560.0650 to 9560.0655, and payments received and used for care and maintenance of a third-party beneficiary who is not a household member;

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

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

(4) all educational assistance, except the county agency must count graduate student teaching assistantships, fellowships, and other similar paid work as earned income and, after allowing deductions for any unmet and necessary

educational expenses, shall count scholarships or grants awarded to graduate students that do not require teaching or research as unearned income;

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

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

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

(ii) federal income tax refunds;

(8)(i) federal earned income credits;

(ii) Minnesota working family credits;

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

(iv) federal or state tax rebates;

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

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

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

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

(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. 13. Minnesota Statutes 2004, section 256J.24, subdivision 5, is amended to read:

Subd. 5. [MFIP TRANSITIONAL STANDARD.] The MFIP transitional standard is based on the number of persons in the assistance unit eligible for both food and cash assistance unless the restrictions in subdivision 6 on the birth of a child apply. The following table represents the transitional standards effective October 1, ~~2003~~ 2004.

Number of Eligible People	Transitional Standard	Cash Portion	Food Portion
1	~~$371~~ $379:	$250	~~$121~~ $129
2	~~$661~~ $675:	$437	~~$224~~ $238
3	~~$852~~ $876:	$532	~~$320~~ $344
4	~~$1,006~~ $1,036:	$621	~~$385~~ $415
5	~~$1,146~~ $1,180:	$697	~~$449~~ $483
6	~~$1,309~~ $1,350:	$773	~~$536~~ $577
7	~~$1,428~~ $1,472:	$850	~~$578~~ $622
8	~~$1,572~~ $1,623:	$916	~~$656~~ $707
9	~~$1,715~~ $1,772:	$980	~~$735~~ $792

10	~~$1,853~~ $1,915:	$1,035	~~$818~~ $880
over 10	add ~~$137~~ $142:	$53	~~$84~~ $89

per additional member.

The commissioner shall annually publish in the State Register the transitional standard for an assistance unit sizes 1 to 10 including a breakdown of the cash and food portions.

Sec. 14. Minnesota Statutes 2004, section 256J.561, subdivision 3, is amended to read:

Subd. 3. [CHILD UNDER 12 WEEKS OF AGE.] (a) A participant who has a natural born child who is less than 12 weeks of age who meets the criteria in clauses (1) and (2) is not required to participate in employment services until the child reaches 12 weeks of age. To be eligible for this provision, the following conditions must be met:

(1) the child ~~must have been born within ten months of the caregiver's application for the diversionary work program or~~ MFIP must not be subject to the provisions of section 256J.24, subdivision 6; and

(2) the assistance unit must not have already used this provision or the previously allowed child under age one exemption. However, an assistance unit that has an approved child under age one exemption at the time this provision becomes effective may continue to use that exemption until the child reaches one year of age.

(b) The provision in paragraph (a) ends the first full month after the child reaches 12 weeks of age. This provision is available only once in a caregiver's lifetime. In a two-parent household, only one parent shall be allowed to use this provision. The participant and job counselor must meet within ten days after the child reaches 12 weeks of age to revise the participant's employment plan.

Sec. 15. Minnesota Statutes 2004, section 256J.74, subdivision 1, is amended to read:

Subdivision 1. [SOCIAL SERVICES.] The county agency shall refer a participant for social services that are offered in the county of financial responsibility according to the criteria

established by that county agency ~~under Minnesota Rules, parts 9550.0010 to 9550.0092~~. A payment issued from federal funds under title XX of the Social Security Act, state funds under the Children and Community ~~Social~~ Services Act, federal or state child welfare funds, or county funds in a payment month must not restrict MFIP eligibility or reduce the monthly assistance payment for that participant.

Sec. 16. Minnesota Statutes 2004, section 256J.751, subdivision 2, is amended to read:

Subd. 2. [QUARTERLY COMPARISON REPORT.] The commissioner shall report quarterly to all counties on each county's performance on the following measures:

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

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

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

(4) federal participation requirements as specified in Title 1 of Public Law 104-193;

(5) median placement wage rate;

(6) caseload by months of TANF assistance;

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

(8) the MFIP work participation rate, defined as the participation requirements specified in title 1 of Public Law 104-193 applied to all MFIP cases except child only cases ~~and cases exempt under section 256J.56~~.

Sec. 17. Minnesota Statutes 2004, section 256J.95, subdivision 2, is amended to read:

Subd. 2. [DEFINITIONS.] The terms used in this section have the following meanings.

(a) "Diversionary Work Program (DWP)" means the program established under this section.

(b) "Employment plan" means a plan developed by the job counselor and the participant which identifies the participant's most direct path to unsubsidized employment, lists the specific steps that the caregiver will take on that path, and includes a timetable for the completion of each step. For participants who request and qualify for a family violence waiver in section 256J.521, subdivision 3, an employment plan must be developed by the job counselor, the participant, and a person trained in domestic violence and follow the employment plan provisions in section 256J.521, subdivision 3. Employment plans under this section shall be written for a period of time not to exceed four months.

(c) "Employment services" means programs, activities, and services in this section that are designed to assist participants in obtaining and retaining employment.

(d) "Family maintenance needs" means current housing costs including rent; manufactured home lot rental costs, or monthly principal, interest, insurance premiums, and property taxes due for mortgages or contracts for deed; association fees required for homeownership; utility costs for current month expenses of gas and electric, garbage, water and sewer; and a flat rate of $35 for telephone services.

(e) "Family unit" means a group of people applying for or receiving DWP benefits together. For the purposes of determining eligibility for this program, the composition of the family unit ~~includes the relationships in~~ is determined according to section 256J.24, subdivisions ~~2 and~~ 1 to 4.

(f) "Minnesota family investment program (MFIP)" means the assistance program as defined in section 256J.08, subdivision 57.

(g) "Personal needs allowance" means an allowance of up to

$70 per month per DWP unit member to pay for expenses such as household products and personal products.

(h) "Work activities" means allowable work activities as defined in section 256J.49, subdivision 13.

(i) "Caregiver" means the caregiver as defined in section 256J.08, subdivision 11.

Sec. 18. Minnesota Statutes 2004, section 256J.95, subdivision 6, is amended to read:

Subd. 6. [INITIAL SCREENING OF APPLICATIONS.] Upon receipt of the application, the county agency must determine if the applicant may be eligible for other benefits as required in sections 256J.09, subdivision 3a, and 256J.28, subdivisions 1 and 5. The county must screen and the applicant must apply for other benefits as required under section 256J.30, subdivision 2. The county must also follow the provisions in section 256J.09, subdivision 3b, clause (2).

Sec. 19. Minnesota Statutes 2004, section 256J.95, subdivision 11, is amended to read:

Subd. 11. [UNIVERSAL PARTICIPATION REQUIRED.] (a) All DWP caregivers, except caregivers who meet the criteria in paragraph (d), are required to participate in DWP employment services. Except as specified in paragraphs (b) and (c), employment plans under DWP must, at a minimum, meet the requirements in section 256J.55, subdivision 1.

(b) A caregiver who is a member of a two-parent family that is required to participate in DWP who would otherwise be ineligible for DWP under subdivision 3 may be allowed to develop an employment plan under section 256J.521, subdivision 2, paragraph (c), that may contain alternate activities and reduced hours.

(c) A participant who is a victim of family violence shall be allowed to develop an employment plan under section 256J.521, subdivision 3. A claim of family violence must be documented by the applicant or participant by providing a sworn statement which is supported by collateral documentation in section 256J.545, paragraph (b).

(d) One parent in a two-parent family unit that has a natural born child under 12 weeks of age is not required to have an employment plan until the child reaches 12 weeks of age unless the family unit has already used the exclusion under section 256J.561, subdivision ~~2~~ 3, or the previously allowed child under age one exemption under section 256J.56, paragraph (a), clause (5).

(e) The provision in paragraph (d) ends the first full month after the child reaches 12 weeks of age. This provision is allowable only once in a caregiver's lifetime and only if the child is not subject to the provisions of section 256J.24, subdivision 6. In a two-parent household, only one parent shall be allowed to use this category.

(f) The participant and job counselor must meet within ten working days after the child reaches 12 weeks of age to revise the participant's employment plan. The employment plan for a family unit that has a child under 12 weeks of age that has already used the exclusion in section 256J.561 or the previously allowed child under age one exemption under section 256J.56, paragraph (a), clause (5), must be tailored to recognize the caregiving needs of the parent.

Sec. 20. Minnesota Statutes 2004, section 256J.95, subdivision 18, is amended to read:

Subd. 18. [REINSTATEMENT FOLLOWING DISQUALIFICATION.] A participant who has been disqualified from the diversionary work program due to noncompliance with employment services may regain eligibility for the diversionary work program by complying with program requirements. A participant who has been disqualified from the diversionary work program due to noncooperation with child support enforcement requirements may regain eligibility by complying with child support requirements under section 256.741. Once a participant has been reinstated, the county shall issue prorated benefits for the remaining portion of the month. A family unit that has been disqualified from the diversionary work program due to noncompliance shall not be eligible for MFIP or any other TANF cash program ~~during the~~

~~period-of-time-the-participant-remains-noncompliant~~ for the remainder of the four-month period. In a two-parent family, both parents must be in compliance before the family unit can regain eligibility for benefits.

Sec. 21. Minnesota Statutes 2004, section 256J.95, subdivision 19, is amended to read:

Subd. 19. [DWP OVERPAYMENTS AND UNDERPAYMENTS.] DWP benefits are subject to overpayments and underpayments. Anytime an overpayment or an underpayment is determined for DWP, the correction shall be calculated using prospective budgeting. Corrections shall be determined based on the policy in section 256J.34, subdivision 1, paragraphs (a), (b), and (c)~~,-and subdivision-3,-paragraph-(b),-clause-(1)~~. ATM errors must be recovered as specified in section 256J.38, subdivision 5. ~~DWP overpayments-are-not-subject-to~~ Cross program recoupment of overpayments cannot be assigned to or from DWP.

Sec. 22. Minnesota Statutes 2004, section 518.6111, subdivision 7, is amended to read:

Subd. 7. [SUBSEQUENT INCOME WITHHOLDING.] (a) This subdivision applies to support orders that do not contain provisions for income withholding.

(b) For cases in which the public authority is providing child support enforcement services to the parties, the income withholding under this subdivision shall take effect without prior judicial notice to the obligor and without the need for judicial or administrative hearing. Withholding shall result when:

(1) the obligor requests it in writing to the public authority;

(2) the obligee or obligor serves on the public authority a copy of the notice of income withholding, a copy of the court's order, an application, and the fee to use the public authority's collection services; or

(3) the public authority commences withholding according to section 518.5513, subdivision ~~6~~ 5, paragraph (a), clause (5).

(c) For cases in which the public authority is not

providing child support services to the parties, income withholding under this subdivision shall take effect when an obligee requests it by making a written motion to the court and the court finds that previous support has not been paid on a timely consistent basis or that the obligor has threatened expressly or otherwise to stop or reduce payments.

(d) Within two days after the public authority commences withholding under this subdivision, the public authority shall send to the obligor at the obligor's last known address, notice that withholding has commenced. The notice shall include the information provided to the payor of funds in the notice of withholding.

Sec. 23. Laws 1997, chapter 245, article 2, section 11, as amended by Laws 2003, First Special Session chapter 14, article 10, section 7, and Laws 2004, chapter 288, article 4, section 60, is amended to read:

Sec. 11. [FEDERAL FUNDS FOR VISITATION AND ACCESS.]

The commissioner of human services shall apply for and accept on behalf of the state any federal funding received under Public Law Number 104-193 for access and visitation programs. The commissioner ~~shall transfer these funds in three equal amounts to the FATHER Project of Goodwill/Easter Seals Minnesota, the Hennepin County African American Men Project, and the Minnesota Fathers & Families Network for use of the activities allowed under federal law. These programs~~ must administer the funds for the activities allowed under federal law. The commissioner may distribute the funds on a competitive basis and must monitor, evaluate, and report on the access and visitation programs in accordance with any applicable regulations.

Sec. 24. [REVISOR'S INSTRUCTION.]

(a) The revisor of statutes shall change the term "education" to "human services" in Minnesota Statutes, sections 119A.11, subdivision 6; 119A.17; 119B.011, subdivision 8; 119B.189, subdivisions 2, clause (3), and 4; 119B.19; and 119B.24.

(b) The revisor of statutes shall change the term "Department of Human Services" to "Department of Education" and "Department of Education" to "Department of Human Services" in Minnesota Statutes, section 119A.04, subdivision 1.

(c) The revisor of statutes shall codify Laws 1997, chapter 162, article 3, section 7, and change "children, families, and learning" to "human services" wherever it appears in section 7.

(d) The revisor of statutes shall renumber each section of Minnesota Statutes specified in column A with the number specified in column B. The revisor shall make necessary cross-reference changes consistent with the renumbering.

Column A	Column B
13.319, subd. 5	13.461, subd. 30
13.321, subd. 7, para. (b)	13.461, subd. 31
119A.10	256E.20
119A.11	256E.21
119A.12	256E.22
119A.14	256E.24
119A.15	256E.25
119A.16	256E.26
119A.17	256E.27
119A.374	256E.30
119A.375	256E.31
119A.376	256E.32
119A.43	256E.33
119A.44	256E.34
119A.445	256E.35

(e) The revisor of statutes shall recodify any changes to Minnesota Statutes, chapter 119A, that occur during the 2005 legislative session to comply with the changes specified in this section. If a new section or subdivision is added to chapter 119A that is a program administered by the commissioner of human services, the revisor shall recodify that section or subdivision in the appropriate section specified under paragraph (d), column B.

Sec. 25. [REPEALER.]

Minnesota Statutes 2004, section 256K.35, is repealed.

ARTICLE 2

HEALTH CARE AND CONTINUING CARE

Section 1. Minnesota Statutes 2004, section 256B.04, subdivision 14, is amended to read:

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

(1) eyeglasses;

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

(3) hearing aids and supplies; and

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

~~(a)~~ (i) hospital beds;

~~(b)~~ (ii) commodes;

~~(c)~~ (iii) glide-about chairs;

~~(d)~~ (iv) patient lift apparatus;

~~(e)~~ (v) wheelchairs and accessories;

~~(f)~~ (vi) oxygen administration equipment;

~~(g)~~ (vii) respiratory therapy equipment;

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

(5) special transportation services; and

(6) drugs.

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

Sec. 2. Minnesota Statutes 2004, section 256B.056, subdivision 1c, is amended to read:

Subd. 1c. [FAMILIES WITH CHILDREN INCOME METHODOLOGY.] (a)(1) (Expired, 1Sp2003 c 14 art 12 s 17)

(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 July 1, 2003, 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.

(3) For children ages one through 18 whose eligibility is determined under section 256B.057, subdivision 2, the following deductions shall be applied to income counted toward the child's eligibility as allowed under the state's AFDC plan in effect as of July 16, 1996: $90 work expense, dependent care, and child support paid under court order. This clause is effective October 1, 2003.

(b) For families with children whose eligibility is determined using the standard specified in section 256B.056, subdivision 4, paragraph (c), 17 percent of countable earned income shall be disregarded for up to four months and the following deductions shall be applied to each individual's income counted toward eligibility as allowed under the state's AFDC plan in effect as of July 16, 1996: dependent care and child support paid under court order.

(c) If the four-month disregard in paragraph (b) has been applied to the wage earner's income for four months, the disregard shall not be applied again until the wage earner's income has not been considered in determining medical assistance eligibility for 12 consecutive months.

(d) The commissioner shall adjust the income standards under this section each July 1 by the annual update of the federal poverty guidelines following publication by the United States Department of Health and Human Services.

Sec. 3. Minnesota Statutes 2004, section 256B.0625, subdivision 5, is amended to read:

Subd. 5. [COMMUNITY MENTAL HEALTH CENTER SERVICES.] Medical assistance covers community mental health center services provided by a community mental health center that meets the requirements in paragraphs (a) to (j).

(a) The provider is licensed under Minnesota Rules, parts 9520.0750 to 9520.0870.

(b) The provider provides mental health services under the clinical supervision of a mental health professional who is licensed for independent practice at the doctoral level or by a board-certified psychiatrist or a psychiatrist who is eligible for board certification. Clinical supervision has the meaning given in Minnesota Rules, part 9505.0323, subpart 1, item F.

(c) The provider must be a private nonprofit corporation or a governmental agency and have a community board of directors as specified by section 245.66.

(d) The provider must have a sliding fee scale that meets the requirements in ~~Minnesota Rules, part 9550.0060~~ section 245.481, and agree to serve within the limits of its capacity all individuals residing in its service delivery area.

(e) At a minimum, the provider must provide the following outpatient mental health services: diagnostic assessment; explanation of findings; family, group, and individual psychotherapy, including crisis intervention psychotherapy services, multiple family group psychotherapy, psychological testing, and medication management. In addition, the provider must provide or be capable of providing upon request of the local mental health authority day treatment services and professional home-based mental health services. The provider must have the capacity to provide such services to specialized populations such as the elderly, families with children, persons who are seriously and persistently mentally ill, and children who are seriously emotionally disturbed.

(f) The provider must be capable of providing the services specified in paragraph (e) to individuals who are diagnosed with both mental illness or emotional disturbance, and chemical dependency, and to individuals dually diagnosed with a mental

illness or emotional disturbance and mental retardation or a related condition.

(g) The provider must provide 24-hour emergency care services or demonstrate the capacity to assist recipients in need of such services to access such services on a 24-hour basis.

(h) The provider must have a contract with the local mental health authority to provide one or more of the services specified in paragraph (e).

(i) The provider must agree, upon request of the local mental health authority, to enter into a contract with the county to provide mental health services not reimbursable under the medical assistance program.

(j) The provider may not be enrolled with the medical assistance program as both a hospital and a community mental health center. The community mental health center's administrative, organizational, and financial structure must be separate and distinct from that of the hospital.

Sec. 4. Minnesota Statutes 2004, section 256B.0625, subdivision 27, is amended to read:

Subd. 27. [ORGAN AND TISSUE TRANSPLANTS.] ~~Medical assistance coverage for organ and tissue transplant procedures is limited to those procedures covered by the Medicare program or approved by the Advisory Committee on Organ and Tissue Transplants.~~ All organ transplants must be performed at transplant centers meeting united network for organ sharing criteria or at Medicare-approved organ transplant centers. Stem cell or bone marrow transplant centers must meet the standards established by the Foundation for the Accreditation of Hematopoietic Cell Therapy ~~or be approved by the Advisory Committee on Organ and Tissue Transplants. Transplant procedures must comply with all applicable laws, rules, and regulations governing (1) coverage by the Medicare program, (2) federal financial participation by the Medicaid program, and (3) coverage by the Minnesota medical assistance program. Transplants performed out of Minnesota or the local trade area must be prior authorized.~~

Sec. 5. Minnesota Statutes 2004, section 256B.0911, subdivision 6, is amended to read:

Subd. 6. [PAYMENT FOR LONG-TERM CARE CONSULTATION SERVICES.] (a) The total payment for each county must be paid monthly by certified nursing facilities in the county. The monthly amount to be paid by each nursing facility for each fiscal year must be determined by dividing the county's annual allocation for long-term care consultation services by 12 to determine the monthly payment and allocating the monthly payment to each nursing facility based on the number of licensed beds in the nursing facility. Payments to counties in which there is no certified nursing facility must be made by increasing the payment rate of the two facilities located nearest to the county seat.

(b) The commissioner shall include the total annual payment determined under paragraph (a) for each nursing facility reimbursed under section 256B.431 or 256B.434 according to section 256B.431, subdivision 2b, paragraph (g), or 256B.435.

(c) In the event of the layaway, delicensure and decertification, or removal from layaway of 25 percent or more of the beds in a facility, the commissioner may adjust the per diem payment amount in paragraph (b) and may adjust the monthly payment amount in paragraph (a). The effective date of an adjustment made under this paragraph shall be on or after the first day of the month following the effective date of the layaway, delicensure and decertification, or removal from layaway.

(d) Payments for long-term care consultation services are available to the county or counties to cover staff salaries and expenses to provide the services described in subdivision 1a. The county shall employ, or contract with other agencies to employ, within the limits of available funding, sufficient personnel to provide long-term care consultation services while meeting the state's long-term care outcomes and objectives as defined in section 256B.0917, subdivision 1. The county shall be accountable for meeting local objectives as approved by the

commissioner in the ~~CSSA~~ biennial home and community based services quality assurance plan on a form provided by the commissioner.

(e) Notwithstanding section 256B.0641, overpayments attributable to payment of the screening costs under the medical assistance program may not be recovered from a facility.

(f) The commissioner of human services shall amend the Minnesota medical assistance plan to include reimbursement for the local consultation teams.

(g) The county may bill, as case management services, assessments, support planning, and follow-along provided to persons determined to be eligible for case management under Minnesota health care programs. No individual or family member shall be charged for an initial assessment or initial support plan development provided under subdivision 3a or 3b.

Sec. 6. Minnesota Statutes 2004, section 256B.0913, subdivision 13, is amended to read:

Subd. 13. [COUNTY BIENNIAL PLAN.] The county biennial plan for long-term care consultation services under section 256B.0911, the alternative care program under this section, and waivers for the elderly under section 256B.0915, shall be ~~incorporated into the biennial Community Social Services Act plan and shall meet the regulations and timelines of~~ that submitted by the lead agency as the home and community based services quality assurance plan on a form provided by the commissioner.

Sec. 7. Minnesota Statutes 2004, section 256B.092, subdivision 1f, is amended to read:

Subd. 1f. [COUNTY WAITING LIST.] The county agency shall maintain a waiting list of persons with developmental disabilities specifying the services needed but not provided. This waiting list shall be used by county agencies to assist them in developing needed services or amending their children and community ~~social services plan~~ service agreements.

Sec. 8. Minnesota Statutes 2004, section 256B.094, subdivision 8, is amended to read:

Subd. 8. [PAYMENT LIMITATION.] Services that are not eligible for payment as a child welfare targeted case management service include, but are not limited to:

(1) assessments prior to opening a case;

(2) therapy and treatment services;

(3) legal services, including legal advocacy, for the client;

(4) information and referral services ~~that are part of a county's community social services plan,~~ that are not provided to an eligible recipient;

(5) outreach services including outreach services provided through the community support services program;

(6) services that are not documented as required under subdivision 7 and Minnesota Rules, parts 9505.2165 and 9505.2175;

(7) services that are otherwise eligible for payment on a separate schedule under rules of the Department of Human Services;

(8) services to a client that duplicate the same case management service from another case manager;

(9) case management services provided to patients or residents in a medical assistance facility except as described under subdivision 2, clause (9); and

(10) for children in foster care, group homes, or residential care, payment for case management services is limited to case management services that focus on permanency planning or return to the family home and that do not duplicate the facility's discharge planning services.

Sec. 9. Minnesota Statutes 2004, section 256B.0943, subdivision 6, is amended to read:

Subd. 6. [PROVIDER ENTITY CLINICAL INFRASTRUCTURE REQUIREMENTS.] (a) To be an eligible provider entity under this section, a provider entity must have a clinical infrastructure that utilizes diagnostic assessment, an individualized treatment plan, service delivery, and individual treatment plan review that are culturally competent, child-centered, and family-driven

to achieve maximum benefit for the client. The provider entity must review and update the clinical policies and procedures every three years and must distribute the policies and procedures to staff initially and upon each subsequent update.

(b) The clinical infrastructure written policies and procedures must include policies and procedures for:

(1) providing or obtaining a client's diagnostic assessment that identifies acute and chronic clinical disorders, co-occurring medical conditions, sources of psychological and environmental problems, and a functional assessment. The functional assessment must clearly summarize the client's individual strengths and needs;

(2) developing an individual treatment plan that is:

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

(ii) developed no later than the end of the first psychotherapy session after the completion of the client's diagnostic assessment by the mental health professional who provides the client's psychotherapy;

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

(iv) reviewed at least once every 90 days and revised, if necessary; and

(v) 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;

(3) developing an individual behavior plan that documents services to be provided by the mental health behavioral aide. The individual behavior plan must include:

(i) detailed instructions on the service to be provided;

(ii) time allocated to each service;

(iii) methods of documenting the child's behavior;

(iv) methods of monitoring the child's progress in reaching objectives; and

(v) goals to increase or decrease targeted behavior as identified in the individual treatment plan;

(4) clinical supervision of the mental health practitioner and mental health behavioral aide. A mental health professional must document the clinical supervision the professional provides by cosigning individual treatment plans and making entries in the client's record on supervisory activities. Clinical supervision does not include the authority to make or terminate court-ordered placements of the child. A clinical supervisor must be available for urgent consultation as required by the individual client's needs or the situation. Clinical supervision may occur individually or in a small group to discuss treatment and review progress toward goals. The focus of clinical supervision must be the client's treatment needs and progress and the mental health practitioner's or behavioral aide's ability to provide services;

(4a) CTSS certified provider entities providing day treatment programs must meet the conditions in items (i) to (iii):

(i) the provider must be present and available on the premises more than 50 percent of the time in a five-working-day period during which the supervisee is providing a mental health service;

(ii) the diagnosis and the client's individual treatment plan or a change in the diagnosis or individual treatment plan must be made by or reviewed, approved, and signed by the provider; and

(iii) every 30 days, the supervisor must review and sign the record of the client's care for all activities in the preceding 30-day period;

(4b) for all other services provided under CTSS, clinical supervision standards provided in items (i) to (iii) must be used:

(i) medical assistance shall reimburse a mental health

practitioner who maintains a consulting relationship with a mental health professional who accepts full professional responsibility and is present on-site for at least one observation during the first 12 hours in which the mental health practitioner provides the individual, family, or group skills training to the child or the child's family;

(ii) thereafter, the mental health professional is required to be present on-site for observation as clinically appropriate when the mental health practitioner is providing individual, family, or group skills training to the child or the child's family; and

(iii) the observation must be a minimum of one clinical unit. The on-site presence of the mental health professional must be documented in the child's record and signed by the mental health professional who accepts full professional responsibility;

(5) providing direction to a mental health behavioral aide. For entities that employ mental health behavioral aides, the clinical supervisor must be employed by the provider entity to ensure necessary and appropriate oversight for the client's treatment and continuity of care. The mental health professional or mental health practitioner giving direction must begin with the goals on the individualized treatment plan, and instruct the mental health behavioral aide on how to construct therapeutic activities and interventions that will lead to goal attainment. The professional or practitioner giving direction must also instruct the mental health behavioral aide about the client's diagnosis, functional status, and other characteristics that are likely to affect service delivery. Direction must also include determining that the mental health behavioral aide has the skills to interact with the client and the client's family in ways that convey personal and cultural respect and that the aide actively solicits information relevant to treatment from the family. The aide must be able to clearly explain the activities the aide is doing with the client and the activities' relationship to treatment goals. Direction is more didactic

than is supervision and requires the professional or practitioner providing it to continuously evaluate the mental health behavioral aide's ability to carry out the activities of the individualized treatment plan and the individualized behavior plan. When providing direction, the professional or practitioner must:

(i) review progress notes prepared by the mental health behavioral aide for accuracy and consistency with diagnostic assessment, treatment plan, and behavior goals and the professional or practitioner must approve and sign the progress notes;

(ii) identify changes in treatment strategies, revise the individual behavior plan, and communicate treatment instructions and methodologies as appropriate to ensure that treatment is implemented correctly;

(iii) demonstrate family-friendly behaviors that support healthy collaboration among the child, the child's family, and providers as treatment is planned and implemented;

(iv) ensure that the mental health behavioral aide is able to effectively communicate with the child, the child's family, and the provider; and

(v) record the results of any evaluation and corrective actions taken to modify the work of the mental health behavioral aide;

(6) providing service delivery that implements the individual treatment plan and meets the requirements under subdivision 9; and

(7) individual treatment plan review. The review must determine the extent to which the services have met the goals and objectives in the previous treatment plan. The review must assess the client's progress and ensure that services and treatment goals continue to be necessary and appropriate to the client and the client's family or foster family. Revision of the individual treatment plan does not require a new diagnostic assessment unless the client's mental health status has changed markedly. The updated treatment plan must be signed by the

client, if appropriate, and by the client's parent or other person authorized by statute to give consent to the mental health services for the child.

Sec. 10. Minnesota Statutes 2004, section 256B.0943, subdivision 12, is amended to read:

Subd. 12. [EXCLUDED SERVICES.] The following services are not eligible for medical assistance payment as children's therapeutic services and supports:

(1) service components of children's therapeutic services and supports simultaneously provided by more than one provider entity unless prior authorization is obtained;

(2) children's therapeutic services and supports provided in violation of medical assistance policy in Minnesota Rules, part 9505.0220;

(3) mental health behavioral aide services provided by a personal care assistant who is not qualified as a mental health behavioral aide and employed by a certified children's therapeutic services and supports provider entity;

(4) ~~services~~ service components of CTSS that are the responsibility of a residential or program license holder, including foster care providers under the terms of a service agreement or administrative rules governing licensure; and

(5) adjunctive activities that may be offered by a provider entity but are not otherwise covered by medical assistance, including:

(i) a service that is primarily recreation oriented or that is provided in a setting that is not medically supervised. This includes sports activities, exercise groups, activities such as craft hours, leisure time, social hours, meal or snack time, trips to community activities, and tours;

(ii) a social or educational service that does not have or cannot reasonably be expected to have a therapeutic outcome related to the client's emotional disturbance;

(iii) consultation with other providers or service agency staff about the care or progress of a client;

(iv) prevention or education programs provided to the

community; and

(v) treatment for clients with primary diagnoses of alcohol or other drug abuse.

Sec. 11. Minnesota Statutes 2004, section 256B.0943, subdivision 13, is amended to read:

Subd. 13. [EXCEPTION TO EXCLUDED SERVICES.] Notwithstanding subdivision 12, up to 15 hours of children's therapeutic services and supports provided within a six-month period to a child with severe emotional disturbance who is residing in a hospital; a group home as defined in Minnesota Rules, ~~part 9560.0520, subpart 4~~ parts 2960.0130 to 2960.0220; a residential treatment facility licensed under Minnesota Rules, parts ~~9545.0900 to 9545.1090~~ 2960.0580 to 2960.0690; a regional treatment center; or other institutional group setting or who is participating in a program of partial hospitalization are eligible for medical assistance payment if part of the discharge plan.

Sec. 12. Minnesota Statutes 2004, section 256B.503, is amended to read:

256B.503 [RULES.]

To implement Laws 1983, chapter 312, article 9, sections 1 to 7, the commissioner shall promulgate rules. Rules adopted to implement Laws 1983, chapter 312, article 9, section 5, must (a) ~~be in accord with the provisions of Minnesota Statutes, chapter 256E, (b)~~ set standards for case management which include, encourage, and enable flexible administration, ~~(c)~~ (b) require the county boards to develop individualized procedures governing case management activities, ~~(d)~~ (c) consider criteria promulgated under section 256B.092, subdivision 3, and the federal waiver plan, ~~(e)~~ (d) identify cost implications to the state and to county boards, and ~~(f)~~ (e) require the screening teams to make recommendations to the county case manager for development of the individual service plan.

The commissioner shall adopt rules to implement this section by July 1, 1986.

Sec. 13. Minnesota Statutes 2004, section 256B.75, is

amended to read:

256B.75 [HOSPITAL OUTPATIENT REIMBURSEMENT.]

(a) For outpatient hospital facility fee payments for services rendered on or after October 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge, or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for which there is a federal maximum allowable payment. Effective for services rendered on or after January 1, 2000, payment rates for nonsurgical outpatient hospital facility fees and emergency room facility fees shall be increased by eight percent over the rates in effect on December 31, 1999, except for those services for which there is a federal maximum allowable payment. Services for which there is a federal maximum allowable payment shall be paid at the lower of (1) submitted charge, or (2) the federal maximum allowable payment. Total aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare upper limit. If it is determined that a provision of this section conflicts with existing or future requirements of the United States government with respect to federal financial participation in medical assistance, the federal requirements prevail. The commissioner may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial participation resulting from rates that are in excess of the Medicare upper limitations.

(b) Notwithstanding paragraph (a), payment for outpatient, emergency, and ambulatory surgery hospital facility fee services for critical access hospitals designated under section 144.1483, clause ~~(11)~~ (10), shall be paid on a cost-based payment system that is based on the cost-finding methods and allowable costs of the Medicare program.

(c) Effective for services provided on or after July 1, 2003, rates that are based on the Medicare outpatient prospective payment system shall be replaced by a budget neutral prospective payment system that is derived using medical assistance data. The commissioner shall provide a proposal to

the 2003 legislature to define and implement this provision.

(d) For fee-for-service services provided on or after July 1, 2002, the total payment, before third-party liability and spenddown, made to hospitals for outpatient hospital facility services is reduced by .5 percent from the current statutory rate.

(e) In addition to the reduction in paragraph (d), the total payment for fee-for-service services provided on or after July 1, 2003, made to hospitals for outpatient hospital facility services before third-party liability and spenddown, is reduced five percent from the current statutory rates. Facilities defined under section 256.969, subdivision 16, are excluded from this paragraph.

Sec. 14. Minnesota Statutes 2004, section 256D.03, subdivision 3, is amended to read:

Subd. 3. [GENERAL ASSISTANCE MEDICAL CARE; ELIGIBILITY.] (a) General assistance medical care may be paid for any person who is not eligible for medical assistance under chapter 256B, including eligibility for medical assistance based on a spenddown of excess income according to section 256B.056, subdivision 5, or MinnesotaCare as defined in paragraph (b), except as provided in paragraph (c), and:

(1) who is receiving assistance under section 256D.05, except for families with children who are eligible under Minnesota family investment program (MFIP), or who is having a payment made on the person's behalf under sections 256I.01 to 256I.06; or

(2) who is a resident of Minnesota; and

(i) who has gross countable income not in excess of 75 percent of the federal poverty guidelines for the family size, using a six-month budget period and whose equity in assets is not in excess of $1,000 per assistance unit. Exempt assets, the reduction of excess assets, and the waiver of excess assets must conform to the medical assistance program in section 256B.056, subdivision 3, with the following exception: the maximum amount of undistributed funds in a trust that could be distributed to

or on behalf of the beneficiary by the trustee, assuming the full exercise of the trustee's discretion under the terms of the trust, must be applied toward the asset maximum; ~~or~~

(ii) who has gross countable income above 75 percent of the federal poverty guidelines but not in excess of 175 percent of the federal poverty guidelines for the family size, using a six-month budget period, whose equity in assets is not in excess of the limits in section 256B.056, subdivision 3c, and who applies during an inpatient hospitalization; or

(iii) the commissioner shall adjust the income standards under this section each July 1 by the annual update of the federal poverty guidelines following publication by the United States Department of Health and Human Services.

(b) General assistance medical care may not be paid for applicants or recipients who meet all eligibility requirements of MinnesotaCare as defined in sections 256L.01 to 256L.16, and are adults with dependent children under 21 whose gross family income is equal to or less than 275 percent of the federal poverty guidelines.

(c) For applications received on or after October 1, 2003, eligibility may begin no earlier than the date of application. For individuals eligible under paragraph (a), clause (2), item (i), a redetermination of eligibility must occur every 12 months. Individuals are eligible under paragraph (a), clause (2), item (ii), only during inpatient hospitalization but may reapply if there is a subsequent period of inpatient hospitalization. Beginning January 1, 2000, Minnesota health care program applications completed by recipients and applicants who are persons described in paragraph (b), may be returned to the county agency to be forwarded to the Department of Human Services or sent directly to the Department of Human Services for enrollment in MinnesotaCare. If all other eligibility requirements of this subdivision are met, eligibility for general assistance medical care shall be available in any month during which a MinnesotaCare eligibility determination and enrollment are pending. Upon notification of eligibility for

MinnesotaCare, notice of termination for eligibility for general assistance medical care shall be sent to an applicant or recipient. If all other eligibility requirements of this subdivision are met, eligibility for general assistance medical care shall be available until enrollment in MinnesotaCare subject to the provisions of paragraph (e).

(d) The date of an initial Minnesota health care program application necessary to begin a determination of eligibility shall be the date the applicant has provided a name, address, and Social Security number, signed and dated, to the county agency or the Department of Human Services. If the applicant is unable to provide a name, address, Social Security number, and signature when health care is delivered due to a medical condition or disability, a health care provider may act on an applicant's behalf to establish the date of an initial Minnesota health care program application by providing the county agency or Department of Human Services with provider identification and a temporary unique identifier for the applicant. The applicant must complete the remainder of the application and provide necessary verification before eligibility can be determined. The county agency must assist the applicant in obtaining verification if necessary.

(e) County agencies are authorized to use all automated databases containing information regarding recipients' or applicants' income in order to determine eligibility for general assistance medical care or MinnesotaCare. Such use shall be considered sufficient in order to determine eligibility and premium payments by the county agency.

(f) General assistance medical care is not available for a person in a correctional facility unless the person is detained by law for less than one year in a county correctional or detention facility as a person accused or convicted of a crime, or admitted as an inpatient to a hospital on a criminal hold order, and the person is a recipient of general assistance medical care at the time the person is detained by law or admitted on a criminal hold order and as long as the person

continues to meet other eligibility requirements of this subdivision.

(g) General assistance medical care is not available for applicants or recipients who do not cooperate with the county agency to meet the requirements of medical assistance.

(h) In determining the amount of assets of an individual eligible under paragraph (a), clause (2), item (i), there shall be included any asset or interest in an asset, including an asset excluded under paragraph (a), that was given away, sold, or disposed of for less than fair market value within the 60 months preceding application for general assistance medical care or during the period of eligibility. Any transfer described in this paragraph shall be presumed to have been for the purpose of establishing eligibility for general assistance medical care, unless the individual furnishes convincing evidence to establish that the transaction was exclusively for another purpose. For purposes of this paragraph, the value of the asset or interest shall be the fair market value at the time it was given away, sold, or disposed of, less the amount of compensation received. For any uncompensated transfer, the number of months of ineligibility, including partial months, shall be calculated by dividing the uncompensated transfer amount by the average monthly per person payment made by the medical assistance program to skilled nursing facilities for the previous calendar year. The individual shall remain ineligible until this fixed period has expired. The period of ineligibility may exceed 30 months, and a reapplication for benefits after 30 months from the date of the transfer shall not result in eligibility unless and until the period of ineligibility has expired. The period of ineligibility begins in the month the transfer was reported to the county agency, or if the transfer was not reported, the month in which the county agency discovered the transfer, whichever comes first. For applicants, the period of ineligibility begins on the date of the first approved application.

(i) When determining eligibility for any state benefits

under this subdivision, the income and resources of all noncitizens shall be deemed to include their sponsor's income and resources as defined in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, title IV, Public Law 104-193, sections 421 and 422, and subsequently set out in federal rules.

(j) Undocumented noncitizens and nonimmigrants are ineligible for general assistance medical care. For purposes of this subdivision, a nonimmigrant is an individual in one or more of the classes listed in United States Code, title 8, section 1101(a)(15), and an undocumented noncitizen is an individual who resides in the United States without the approval or acquiescence of the Immigration and Naturalization Service.

(k) Notwithstanding any other provision of law, a noncitizen who is ineligible for medical assistance due to the deeming of a sponsor's income and resources, is ineligible for general assistance medical care.

(l) Effective July 1, 2003, general assistance medical care emergency services end.

Sec. 15. Minnesota Statutes 2004, section 256L.01, subdivision 3a, is amended to read:

Subd. 3a. [FAMILY WITH CHILDREN.] (a) "Family with children" means:

(1) parents~~,~~ and their children~~,-and-dependent-siblings~~ residing in the same household; or

(2) grandparents, foster parents, relative caretakers as defined in the medical assistance program, or legal guardians; and their wards who are children~~,-and-dependent siblings~~ residing in the same household.

(b) The term includes children ~~and-dependent-siblings~~ who are temporarily absent from the household in settings such as schools, camps, or parenting time with noncustodial parents.

~~(c)-For-purposes-of-this-subdivision,-a-dependent-sibling means-an-unmarried-child-who-is-a-full-time-student-under-the age-of-25-years-who-is-financially-dependent-upon-a-parent, grandparent,-foster-parent,-relative-caretaker,-or-legal~~

~~guardian.--Proof-of-school-enrollment-is-required.~~

Sec. 16. Minnesota Statutes 2004, section 256L.04, is amended by adding a subdivision to read:

Subd. 7b. [ANNUAL INCOME LIMITS ADJUSTMENT.] The commissioner shall adjust the income limits under this section each July 1 by the annual update of the federal poverty guidelines following publication by the United States Department of Health and Human Services.

Sec. 17. Minnesota Statutes 2004, section 626.557, subdivision 12b, is amended to read:

Subd. 12b. [DATA MANAGEMENT.] (a) [COUNTY DATA.] In performing any of the duties of this section as a lead agency, the county social service agency shall maintain appropriate records. Data collected by the county social service agency under this section are welfare data under section 13.46. Notwithstanding section 13.46, subdivision 1, paragraph (a), data under this paragraph that are inactive investigative data on an individual who is a vendor of services are private data on individuals, as defined in section 13.02. The identity of the reporter may only be disclosed as provided in paragraph (c).

Data maintained by the common entry point are confidential data on individuals or protected nonpublic data as defined in section 13.02. Notwithstanding section 138.163, the common entry point shall destroy data three calendar years after date of receipt.

(b) [LEAD AGENCY DATA.] The commissioners of health and human services shall prepare an investigation memorandum for each report alleging maltreatment investigated under this section. County social service agencies must maintain private data on individuals but are not required to prepare an investigation memorandum. During an investigation by the commissioner of health or the commissioner of human services, data collected under this section are confidential data on individuals or protected nonpublic data as defined in section 13.02. Upon completion of the investigation, the data are classified as provided in clauses (1) to (3) and paragraph (c).

(1) The investigation memorandum must contain the following data, which are public:

(i) the name of the facility investigated;

(ii) a statement of the nature of the alleged maltreatment;

(iii) pertinent information obtained from medical or other records reviewed;

(iv) the identity of the investigator;

(v) a summary of the investigation's findings;

(vi) statement of whether the report was found to be substantiated, inconclusive, false, or that no determination will be made;

(vii) a statement of any action taken by the facility;

(viii) a statement of any action taken by the lead agency; and

(ix) when a lead agency's determination has substantiated maltreatment, a statement of whether an individual, individuals, or a facility were responsible for the substantiated maltreatment, if known.

The investigation memorandum must be written in a manner which protects the identity of the reporter and of the vulnerable adult and may not contain the names or, to the extent possible, data on individuals or private data listed in clause (2).

(2) Data on individuals collected and maintained in the investigation memorandum are private data, including:

(i) the name of the vulnerable adult;

(ii) the identity of the individual alleged to be the perpetrator;

(iii) the identity of the individual substantiated as the perpetrator; and

(iv) the identity of all individuals interviewed as part of the investigation.

(3) Other data on individuals maintained as part of an investigation under this section are private data on individuals upon completion of the investigation.

(c) [IDENTITY OF REPORTER.] The subject of the report may

compel disclosure of the name of the reporter only with the consent of the reporter or upon a written finding by a court that the report was false and there is evidence that the report was made in bad faith. This subdivision does not alter disclosure responsibilities or obligations under the Rules of Criminal Procedure, except that where the identity of the reporter is relevant to a criminal prosecution, the district court shall do an in-camera review prior to determining whether to order disclosure of the identity of the reporter.

(d) [DESTRUCTION OF DATA.] Notwithstanding section 138.163, data maintained under this section by the commissioners of health and human services must be destroyed under the following schedule:

(1) data from reports determined to be false, two years after the finding was made;

(2) data from reports determined to be inconclusive, four years after the finding was made;

(3) data from reports determined to be substantiated, seven years after the finding was made; and

(4) data from reports which were not investigated by a lead agency and for which there is no final disposition, two years from the date of the report.

(e) [SUMMARY OF REPORTS.] The commissioners of health and human services shall each annually report to the legislature and the governor on the number and type of reports of alleged maltreatment involving licensed facilities reported under this section, the number of those requiring investigation under this section, and the resolution of those investigations. The report shall identify:

(1) whether and where backlogs of cases result in a failure to conform with statutory time frames;

(2) where adequate coverage requires additional appropriations and staffing; and

(3) any other trends that affect the safety of vulnerable adults.

(f) [RECORD RETENTION POLICY.] Each lead agency must have

a record retention policy.

(g) [EXCHANGE OF INFORMATION.] Lead agencies, prosecuting authorities, and law enforcement agencies may exchange not public data, as defined in section 13.02, if the agency or authority requesting the data determines that the data are pertinent and necessary to the requesting agency in initiating, furthering, or completing an investigation under this section. Data collected under this section must be made available to prosecuting authorities and law enforcement officials, local county agencies, and licensing agencies investigating the alleged maltreatment under this section. The lead agency shall exchange not public data with the vulnerable adult maltreatment review panel established in section 256.021 if the data are pertinent and necessary for a review requested under that section. Upon completion of the review, not public data received by the review panel must be returned to the lead agency.

(h) [COMPLETION TIME.] Each lead agency shall keep records of the length of time it takes to complete its investigations.

(i) [NOTIFICATION OF OTHER AFFECTED PARTIES.] A lead agency may notify other affected parties and their authorized representative if the agency has reason to believe maltreatment has occurred and determines the information will safeguard the well-being of the affected parties or dispel widespread rumor or unrest in the affected facility.

(j) [FEDERAL REQUIREMENTS.] Under any notification provision of this section, where federal law specifically prohibits the disclosure of patient identifying information, a lead agency may not provide any notice unless the vulnerable adult has consented to disclosure in a manner which conforms to federal requirements.

Sec. 18. [REPEALER.]

(a) Minnesota Statutes 2004, sections 119A.01, subdivision 3; 119A.20; 119A.21; 119A.22; 119A.35; 119B.21, subdivision 11; 256.014, subdivision 3; 256.045, subdivision 3c; 256B.0629, subdivisions 1, 2, and 4; 256J.95, subdivision 20; and 256K.35, are repealed.

(b) Laws 1998, chapter 407, article 4, section 63, is repealed.

ARTICLE 3

MISCELLANEOUS

Section 1. Minnesota Statutes 2004, section 245.463, subdivision 2, is amended to read:

Subd. 2. [TECHNICAL ASSISTANCE.] The commissioner shall provide ongoing technical assistance to county boards to ~~develop the adult mental health component of the community social services plan to~~ improve system capacity and quality. The commissioner and county boards shall exchange information as needed about the numbers of adults with mental illness residing in the county and extent of existing treatment components locally available to serve the needs of those persons. County boards shall cooperate with the commissioner in obtaining necessary planning information upon request.

Sec. 2. Minnesota Statutes 2004, section 245.464, subdivision 1, is amended to read:

Subdivision 1. [COORDINATION.] The commissioner shall supervise the development and coordination of locally available adult mental health services by the county boards in a manner consistent with sections 245.461 to 245.486. The commissioner shall coordinate locally available services with those services available from the regional treatment center serving the area including state-operated services offered at sites outside of the regional treatment centers. The commissioner shall ~~review the adult mental health component of the community social services plan developed by county boards as specified in section 245.463 and~~ provide technical assistance to county boards in developing and maintaining locally available mental health services. The commissioner shall monitor the county board's progress in developing its full system capacity and quality through ongoing review of the county board's adult mental health component of the community social services plan and other information as required by sections 245.461 to 245.486.

Sec. 3. Minnesota Statutes 2004, section 245.465,

subdivision 1, is amended to read:

Subdivision 1. [SPEND ACCORDING TO PLAN; OTHER LISTED DUTIES.] The county board in each county shall use its share of mental health ~~and Community Social Services Act~~ funds allocated by the commissioner according to the ~~biennial~~ mental health ~~component of the county's community social services~~ plan ~~as~~ approved by the commissioner. The county board must:

(1) develop and coordinate a system of affordable and locally available adult mental health services in accordance with sections 245.461 to 245.486;

(2) with the involvement of the local adult mental health advisory council or the adult mental health subcommittee of an existing advisory council, develop a biennial adult mental health ~~component of the community social services~~ plan which considers the assessment of unmet needs in the county as reported by the local adult mental health advisory council under section 245.466, subdivision 5, clause (3). The county shall provide, upon request of the local adult mental health advisory council, readily available data to assist in the determination of unmet needs;

(3) provide for case management services to adults with serious and persistent mental illness in accordance with sections 245.462, subdivisions 3 and 4; 245.4711; and 245.486;

(4) provide for screening of adults specified in section 245.476 upon admission to a residential treatment facility or acute care hospital inpatient, or informal admission to a regional treatment center;

(5) prudently administer grants and purchase-of-service contracts that the county board determines are necessary to fulfill its responsibilities under sections 245.461 to 245.486; and

(6) assure that mental health professionals, mental health practitioners, and case managers employed by or under contract with the county to provide mental health services have experience and training in working with adults with mental illness.

Sec. 4. Minnesota Statutes 2004, section 245.466, subdivision 1, is amended to read:

Subdivision 1. [DEVELOPMENT OF SERVICES.] The county board in each county is responsible for using all available resources to develop and coordinate a system of locally available and affordable adult mental health services. The county board may provide some or all of the mental health services and activities specified in subdivision 2 directly through a county agency or under contracts with other individuals or agencies. A county or counties may enter into an agreement with a regional treatment center under section 246.57 or with any state facility or program as defined in section 246.50, subdivision 3, to enable the county or counties to provide the treatment services in subdivision 2. Services provided through an agreement between a county and a regional treatment center must meet the same requirements as services from other service providers. County boards shall demonstrate their continuous progress toward full implementation of sections 245.461 to 245.486 during the period July 1, 1987, to January 1, 1990. County boards must develop fully each of the treatment services and management activities prescribed by sections 245.461 to 245.486 by January 1, 1990, according to the priorities established in section 245.464 and the adult mental health ~~component of the community social services~~ plan approved by the commissioner.

Sec. 5. Minnesota Statutes 2004, section 245.466, subdivision 5, is amended to read:

Subd. 5. [LOCAL ADVISORY COUNCIL.] The county board, individually or in conjunction with other county boards, shall establish a local adult mental health advisory council or mental health subcommittee of an existing advisory council. The council's members must reflect a broad range of community interests. They must include at least one consumer, one family member of an adult with mental illness, one mental health professional, and one community support services program representative. The local adult mental health advisory council or mental health subcommittee of an existing advisory council

shall meet at least quarterly to review, evaluate, and make recommendations regarding the local mental health system. Annually, the local adult mental health advisory council or mental health subcommittee of an existing advisory council shall:

(1) arrange for input from the regional treatment center's mental illness program unit regarding coordination of care between the regional treatment center and community-based services;

(2) identify for the county board the individuals, providers, agencies, and associations as specified in section 245.462, subdivision 10;

(3) provide to the county board a report of unmet mental health needs of adults residing in the county to be included in the county's ~~biennial~~ mental health ~~component of the community social services~~ plan, and participate in developing the mental health ~~component of the~~ plan; and

(4) coordinate its review, evaluation, and recommendations regarding the local mental health system with the state advisory council on mental health.

The county board shall consider the advice of its local mental health advisory council or mental health subcommittee of an existing advisory council in carrying out its authorities and responsibilities.

Sec. 6. Minnesota Statutes 2004, section 245.4661, subdivision 7, is amended to read:

Subd. 7. [DUTIES OF COUNTY BOARD.] The county board, or other entity which is approved to administer a pilot project, shall:

(1) administer the project in a manner which is consistent with the objectives described in subdivision 2 and the planning process described in subdivision 5;

(2) assure that no one is denied services for which they would otherwise be eligible; and

(3) provide the commissioner of human services with timely and pertinent information through the following methods:

(i) submission of ~~community social services act~~ mental

health plans and plan amendments which are based on a format and timetable determined by the commissioner;

(ii) submission of social services expenditure and grant reconciliation reports, based on a coding format to be determined by mutual agreement between the project's managing entity and the commissioner; and

(iii) submission of data and participation in an evaluation of the pilot projects, to be designed cooperatively by the commissioner and the projects.

Sec. 7. Minnesota Statutes 2004, section 245.483, subdivision 1, is amended to read:

Subdivision 1. [FUNDS NOT PROPERLY USED.] If the commissioner determines that a county is not meeting the requirements of sections 245.461 to 245.486 and 245.487 to 245.4887, or that funds are not being used according to the approved ~~biennial~~ mental health ~~component-of-the-community social-services~~ plan, all or part of the mental health ~~and Community-Social-Services-Act~~ funds may be terminated upon 30 days' notice to the county board. The commissioner may require repayment of any funds not used according to the approved ~~biennial~~ mental health ~~component-of-the-community-social services~~ plan. If the commissioner receives a written appeal from the county board within the 30-day period, opportunity for a hearing under the Minnesota Administrative Procedure Act, chapter 14, must be provided before the allocation is terminated or is required to be repaid. The 30-day period begins when the county board receives the commissioner's notice by certified mail.

Sec. 8. Minnesota Statutes 2004, section 245.483, subdivision 3, is amended to read:

Subd. 3. [DELAYED PAYMENTS.] If the commissioner finds that a county board or its contractors are not in compliance with the approved ~~biennial~~ mental health ~~component-of-the community-social-services~~ plan or sections 245.461 to 245.486 and 245.487 to 245.4887, the commissioner may delay payment of all or part of the quarterly mental health ~~and-Community-Social~~

~~Service Act~~ funds until the county board and its contractors meet the requirements. The commissioner shall not delay a payment longer than three months without first issuing a notice under subdivision 2 that all or part of the allocation will be terminated or required to be repaid. After this notice is issued, the commissioner may continue to delay the payment until completion of the hearing in subdivision 2.

Sec. 9. Minnesota Statutes 2004, section 245.4872, subdivision 2, is amended to read:

Subd. 2. [TECHNICAL ASSISTANCE.] The commissioner shall provide ongoing technical assistance to county boards ~~to develop the children's mental health component of the community social services plan~~ to improve system capacity and quality. The commissioner and county boards shall exchange information as needed about the numbers of children with emotional disturbances residing in the county and the extent of existing treatment components locally available to serve the needs of those persons. County boards shall cooperate with the commissioner in obtaining necessary planning information upon request.

Sec. 10. Minnesota Statutes 2004, section 245.4873, subdivision 5, is amended to read:

Subd. 5. [DUTIES OF THE COMMISSIONER.] The commissioner shall supervise the development and coordination of locally available children's mental health services by the county boards in a manner consistent with sections 245.487 to 245.4887. The commissioner shall ~~review the children's mental health component of the community social services plan developed by county boards as specified in section 245.4872 and~~ provide technical assistance to county boards in developing and maintaining locally available and coordinated children's mental health services. The commissioner shall monitor the county board's progress in developing its full system capacity and quality through ongoing review of the county board's children's mental health proposals and other information as required by sections 245.487 to 245.4887.

Sec. 11. Minnesota Statutes 2004, section 245.4874, is

amended to read:

245.4874 [DUTIES OF COUNTY BOARD.]

~~The county board in each county shall use its share of mental health and Community Social Services Act funds allocated by the commissioner according to a biennial children's mental health component of the community social services plan that is approved by the commissioner.~~ The county board must:

(1) develop a system of affordable and locally available children's mental health services according to sections 245.487 to 245.4887;

(2) establish a mechanism providing for interagency coordination as specified in section 245.4875, subdivision 6;

(3) ~~develop a biennial children's mental health component of the community social services plan which considers~~ consider the assessment of unmet needs in the county as reported by the local children's mental health advisory council under section 245.4875, subdivision 5, paragraph (b), clause (3). The county shall provide, upon request of the local children's mental health advisory council, readily available data to assist in the determination of unmet needs;

(4) assure that parents and providers in the county receive information about how to gain access to services provided according to sections 245.487 to 245.4887;

(5) coordinate the delivery of children's mental health services with services provided by social services, education, corrections, health, and vocational agencies to improve the availability of mental health services to children and the cost-effectiveness of their delivery;

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

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

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

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

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

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

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

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

(14) consistent with section 245.486, arrange for or provide a children's mental health screening to a child receiving child protective services or a child in out-of-home placement, a child for whom parental rights have been terminated, a child found to be delinquent, and a child found to have committed a juvenile petty offense for the third or subsequent time, unless a screening has been performed within the previous 180 days, or the child is currently under the care of a mental health professional. The court or county agency must notify a parent or guardian whose parental rights have not been terminated of the potential mental health screening and the option to prevent the screening by notifying the court or county

agency in writing. The screening shall be conducted with a screening instrument approved by the commissioner of human services according to criteria that are updated and issued annually to ensure that approved screening instruments are valid and useful for child welfare and juvenile justice populations, and shall be conducted by a mental health practitioner as defined in section 245.4871, subdivision 26, or a probation officer or local social services agency staff person who is trained in the use of the screening instrument. Training in the use of the instrument shall include training in the administration of the instrument, the interpretation of its validity given the child's current circumstances, the state and federal data practices laws and confidentiality standards, the parental consent requirement, and providing respect for families and cultural values. If the screen indicates a need for assessment, the child's family, or if the family lacks mental health insurance, the local social services agency, in consultation with the child's family, shall have conducted a diagnostic assessment, including a functional assessment, as defined in section 245.4871. The administration of the screening shall safeguard the privacy of children receiving the screening and their families and shall comply with the Minnesota Government Data Practices Act, chapter 13, and the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191. Screening results shall be considered private data and the commissioner shall not collect individual screening results.

Sec. 12. Minnesota Statutes 2004, section 245.4875, subdivision 1, is amended to read:

Subdivision 1. [DEVELOPMENT OF CHILDREN'S SERVICES.] The county board in each county is responsible for using all available resources to develop and coordinate a system of locally available and affordable children's mental health services. The county board may provide some or all of the children's mental health services and activities specified in subdivision 2 directly through a county agency or under

contracts with other individuals or agencies. A county or counties may enter into an agreement with a regional treatment center under section 246.57 to enable the county or counties to provide the treatment services in subdivision 2. Services provided through an agreement between a county and a regional treatment center must meet the same requirements as services from other service providers. County boards shall demonstrate their continuous progress toward fully implementing sections 245.487 to 245.4887 during the period July 1, 1989, to January 1, 1992. County boards must develop fully each of the treatment services prescribed by sections 245.487 to 245.4887 by January 1, 1992, according to the priorities established in section 245.4873 and the children's mental health ~~component of the community social services~~ plan approved by the commissioner under section 245.4887.

Sec. 13. Minnesota Statutes 2004, section 245.4875, subdivision 5, is amended to read:

Subd. 5. [LOCAL CHILDREN'S ADVISORY COUNCIL.] (a) By October 1, 1989, the county board, individually or in conjunction with other county boards, shall establish a local children's mental health advisory council or children's mental health subcommittee of the existing local mental health advisory council or shall include persons on its existing mental health advisory council who are representatives of children's mental health interests. The following individuals must serve on the local children's mental health advisory council, the children's mental health subcommittee of an existing local mental health advisory council, or be included on an existing mental health advisory council: (1) at least one person who was in a mental health program as a child or adolescent; (2) at least one parent of a child or adolescent with severe emotional disturbance; (3) one children's mental health professional; (4) representatives of minority populations of significant size residing in the county; (5) a representative of the children's mental health local coordinating council; and (6) one family community support services program representative.

(b) The local children's mental health advisory council or children's mental health subcommittee of an existing advisory council shall seek input from parents, former consumers, providers, and others about the needs of children with emotional disturbance in the local area and services needed by families of these children, and shall meet monthly, unless otherwise determined by the council or subcommittee, but not less than quarterly, to review, evaluate, and make recommendations regarding the local children's mental health system. Annually, the local children's mental health advisory council or children's mental health subcommittee of the existing local mental health advisory council shall:

(1) arrange for input from the local system of care providers regarding coordination of care between the services;

(2) identify for the county board the individuals, providers, agencies, and associations as specified in section 245.4877, clause (2); and

(3) provide to the county board a report of unmet mental health needs of children residing in the county ~~to be included in the county's biennial children's mental health component of the community social services plan and participate in developing the mental health component of the plan~~.

(c) The county board shall consider the advice of its local children's mental health advisory council or children's mental health subcommittee of the existing local mental health advisory council in carrying out its authorities and responsibilities.

Sec. 14. Minnesota Statutes 2004, section 245A.16, subdivision 6, is amended to read:

Subd. 6. [CERTIFICATION BY THE COMMISSIONER.] The commissioner shall ensure that rules are uniformly enforced throughout the state by reviewing each county and private agency for compliance with this section and other applicable laws and rules at least every four years. County agencies that comply with this section shall be certified by the commissioner. If a county agency fails to be certified by the commissioner, the commissioner shall certify a reduction of ~~up to 20 percent of~~

~~the county's Community Social Services Act funding or an equivalent amount from~~ state administrative aids in an amount up to 20 percent of the county's state portion of Children and Community Services Act funding.

Sec. 15. Minnesota Statutes 2004, section 252.24, subdivision 5, is amended to read:

Subd. 5. [DEVELOPMENTAL ACHIEVEMENT CENTERS: SALARY ADJUSTMENT PER DIEM.] The commissioner shall approve a two percent increase in the payment rates for day training and habilitation services vendors effective July 1, 1991. All revenue generated shall be used by vendors to increase salaries, fringe benefits, and payroll taxes by at least three percent for personnel below top management. County boards shall amend contracts with vendors to require that all revenue generated by this provision is expended on salary increases to staff below top management. County boards shall verify in writing to the commissioner that each vendor has complied with this requirement. If a county board determines that a vendor has not complied with this requirement for a specific contract period, the county board shall reduce the vendor's payment rates for the next contract period to reflect the amount of money not spent appropriately. The commissioner shall modify reporting requirements for vendors and counties as necessary to monitor compliance with this provision.

Each county agency shall report to the commissioner by July 30, 1991, its actual social service day training and habilitation expenditures for calendar year 1990. ~~The commissioner shall allocate the day habilitation service CSSA appropriation made available for this purpose to county agencies in proportion to these expenditures.~~

Sec. 16. Minnesota Statutes 2004, section 252.282, subdivision 2, is amended to read:

Subd. 2. [CONSUMER NEEDS AND PREFERENCES.] In conducting the local system needs planning process, the host county must use information from the individual service plans of persons for whom the county is financially responsible and of persons from

other counties for whom the county has agreed to be the host county. The determination of services and supports offered within the county shall be based on the preferences and needs of consumers. The host county shall also consider the community social services plan, waiting lists, and other sources that identify unmet needs for services. A review of ICF/MR facility licensing and certification surveys, substantiated maltreatment reports, and established service standards shall be employed to assess the performance of providers and shall be considered in the county's recommendations. Continuous quality improvement goals as well as consumer satisfaction surveys may also be considered in this process.

Sec. 17. Minnesota Statutes 2004, section 252.46, subdivision 10, is amended to read:

Subd. 10. [VENDOR'S REPORT; AUDIT.] The vendor shall report to the commissioner and the county board on forms prescribed by the commissioner at times specified by the commissioner. The reports shall include programmatic and fiscal information. ~~Fiscal information shall be provided in an annual audit that complies with the requirements of Minnesota Rules, parts 9550.0010 to 9550.0092.~~ The audit must be done according to generally accepted auditing standards to result in statements that include a balance sheet, income statement, changes in financial position, and the certified public accountant's opinion. The county's annual audit shall satisfy the audit required under this subdivision for any county-operated day training and habilitation program. Except for day training and habilitation programs operated by a county, the audit must provide supplemental statements for each day training and habilitation program with an approved unique set of rates.

Sec. 18. Minnesota Statutes 2004, section 256.045, subdivision 3, is amended to read:

Subd. 3. [STATE AGENCY HEARINGS.] (a) State agency hearings are available for the following: (1) any person applying for, receiving or having received public assistance, medical care, or a program of social services granted by the

state agency or a county agency or the federal Food Stamp Act whose application for assistance is denied, not acted upon with reasonable promptness, or whose assistance is suspended, reduced, terminated, or claimed to have been incorrectly paid; (2) any patient or relative aggrieved by an order of the commissioner under section 252.27; (3) a party aggrieved by a ruling of a prepaid health plan; (4) except as provided under chapter 245C, any individual or facility determined by a lead agency to have maltreated a vulnerable adult under section 626.557 after they have exercised their right to administrative reconsideration under section 626.557; (5) any person whose claim for foster care payment according to a placement of the child resulting from a child protection assessment under section 626.556 is denied or not acted upon with reasonable promptness, regardless of funding source; (6) any person to whom a right of appeal according to this section is given by other provision of law; (7) an applicant aggrieved by an adverse decision to an application for a hardship waiver under section 256B.15; (8) except as provided under chapter 245A, an individual or facility determined to have maltreated a minor under section 626.556, after the individual or facility has exercised the right to administrative reconsideration under section 626.556; or (9) except as provided under chapter 245C, an individual disqualified under sections 245C.14 and 245C.15, on the basis of serious or recurring maltreatment; a preponderance of the evidence that the individual has committed an act or acts that meet the definition of any of the crimes listed in section 245C.15, subdivisions 1 to 4; or for failing to make reports required under section 626.556, subdivision 3, or 626.557, subdivision 3. Hearings regarding a maltreatment determination under clause (4) or (8) and a disqualification under this clause in which the basis for a disqualification is serious or recurring maltreatment, which has not been set aside under sections 245C.22 and 245C.23, shall be consolidated into a single fair hearing. In such cases, the scope of review by the human services referee shall include both the maltreatment

determination and the disqualification. The failure to exercise the right to an administrative reconsideration shall not be a bar to a hearing under this section if federal law provides an individual the right to a hearing to dispute a finding of maltreatment. Individuals and organizations specified in this section may contest the specified action, decision, or final disposition before the state agency by submitting a written request for a hearing to the state agency within 30 days after receiving written notice of the action, decision, or final disposition, or within 90 days of such written notice if the applicant, recipient, patient, or relative shows good cause why the request was not submitted within the 30-day time limit.

The hearing for an individual or facility under clause (4), (8), or (9) is the only administrative appeal to the final agency determination specifically, including a challenge to the accuracy and completeness of data under section 13.04. Hearings requested under clause (4) apply only to incidents of maltreatment that occur on or after October 1, 1995. Hearings requested by nursing assistants in nursing homes alleged to have maltreated a resident prior to October 1, 1995, shall be held as a contested case proceeding under the provisions of chapter 14. Hearings requested under clause (8) apply only to incidents of maltreatment that occur on or after July 1, 1997. A hearing for an individual or facility under clause (8) is only available when there is no juvenile court or adult criminal action pending. If such action is filed in either court while an administrative review is pending, the administrative review must be suspended until the judicial actions are completed. If the juvenile court action or criminal charge is dismissed or the criminal action overturned, the matter may be considered in an administrative hearing.

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

The scope of hearings involving claims to foster care payments under clause (5) shall be limited to the issue of whether the county is legally responsible for a child's

placement under court order or voluntary placement agreement and, if so, the correct amount of foster care payment to be made on the child's behalf and shall not include review of the propriety of the county's child protection determination or child placement decision.

(b) A vendor of medical care as defined in section 256B.02, subdivision 7, or a vendor under contract with a county agency to provide social services is not a party and may not request a hearing under this section, except if assisting a recipient as provided in subdivision 4.

(c) An applicant or recipient is not entitled to receive social services beyond the services ~~included in the amended community social services plan~~ prescribed under chapter 256M or other social services the person is eligible for under state law.

(d) The commissioner may summarily affirm the county or state agency's proposed action without a hearing when the sole issue is an automatic change due to a change in state or federal law.

Sec. 19. Minnesota Statutes 2004, section 256G.01, subdivision 3, is amended to read:

Subd. 3. [PROGRAM COVERAGE.] This chapter applies to all social service programs administered by the commissioner in which residence is the determining factor in establishing financial responsibility. These include, but are not limited to: commitment proceedings, including voluntary admissions; emergency holds; poor relief funded wholly through local agencies; social services, including title XX, IV-E and ~~other components of the Community Social Services Act,~~ section 256E.12; social services programs funded wholly through the resources of county agencies; social services provided under the Minnesota Indian Family Preservation Act, sections 260.751 to 260.781; costs for delinquency confinement under section 393.07, subdivision 2; service responsibility for these programs; and group residential housing.

Sec. 20. Minnesota Statutes 2004, section 256M.30, subdivision 2, is amended to read:

Subd. 2. [CONTENTS.] The service plan shall be completed in a form prescribed by the commissioner. The plan must include:

(1) a statement of the needs of the children, adolescents, and adults who experience the conditions defined in section 256M.10, subdivision 2, paragraph (a), and strengths and resources available in the community to address those needs;

(2) strategies the county will pursue to achieve the performance targets. Strategies must include specification of how funds under this section and other community resources will be used to achieve desired performance targets;

(3) a description of the county's process to solicit public input and a summary of that input;

(4) beginning with the service plans submitted for the period from January 1, 2006, through December ~~21~~ 31, 2007, performance targets on statewide indicators for each county to measure outcomes of children's mental health, and child safety, permanency, and well-being. The commissioner shall consult with counties and other stakeholders to develop these indicators and collect baseline data to inform the establishment of individual county performance targets for the 2006-2007 biennium and subsequent plans; and

(5) a budget for services to be provided with funds under this section. The county must budget at least 40 percent of funds appropriated under sections 256M.01 to 256M.80 for services to ensure the mental health, safety, permanency, and well-being of children from low-income families. The commissioner may reduce the portion of child and community services funds that must be budgeted by a county for services to children in low-income families if:

(i) the incidence of children in low-income families within the county's population is significantly below the statewide median; or

(ii) the county has successfully achieved past performance targets for children's mental health, and child safety, permanency, and well-being and its proposed service plan is judged by the commissioner to provide an adequate level of

service to the population with less funding.

Sec. 21. Minnesota Statutes 2004, section 260C.212, subdivision 12, is amended to read:

Subd. 12. [FAIR HEARING REVIEW.] Any person whose claim for foster care payment pursuant to the placement of a child resulting from a child protection assessment under section 626.556 is denied or not acted upon with reasonable promptness may appeal the decision under section 256.045, subdivision 3. ~~The application and fair hearing procedures set forth in the administration of community social services rule, Minnesota Rules, parts 9550.0070 to 9550.0092, do not apply to foster care payment issues appealable under this subdivision.~~

Sec. 22. Minnesota Statutes 2004, section 275.62, subdivision 4, is amended to read:

Subd. 4. [PENALTY FOR LATE REPORTING.] If a local government unit fails to submit the report required in subdivision 1 by January 30 of the year after the year in which the tax was levied, aid payments to the local governmental unit in the year after the year in which the tax was levied shall be reduced as follows:

(1) for a county, the aid amount under ~~section 256E.06~~ chapter 256M shall be reduced by five percent; and

(2) for other local governmental units, the aid certified to be received under sections 477A.011 to 477A.014 shall be reduced by five percent.

Sec. 23. Minnesota Statutes 2004, section 626.5571, subdivision 2, is amended to read:

Subd. 2. [DUTIES OF TEAM.] A multidisciplinary adult protection team may provide public and professional education, develop resources for prevention, intervention, and treatment, and provide case consultation to the local welfare agency to better enable the agency to carry out its adult protection functions under section 626.557 ~~and the Community Social Services Act,~~ and to meet the community's needs for adult protection services. Case consultation may be performed by a committee of the team composed of the team members representing

social services, law enforcement, the county attorney, health care, and persons directly involved in an individual case as determined by the case consultation committee. Case consultation is a case review process that results in recommendations about services to be provided to the identified adult and family.

Sec. 24. [REVISOR INSTRUCTION.]

In the next publication of Minnesota Statutes, the revisor of statutes shall make the changes in paragraphs (a) to (e) to be consistent with the changes in Laws 2003, First Special Session chapter 14, article 11, section 12. The revisor of statutes shall:

(a) In Minnesota Statutes, section 62Q.075, subdivisions 2 and 4; delete the term "and 256E" and make changes necessary to correct the punctuation, grammar, or structure of the remaining text and preserve its meaning.

(b) In Minnesota Statutes, section 245.483, subdivision 4; delete "Community Social Services Act and".

(c) In Minnesota Statutes, section 254B.01, subdivision 6; delete "community social services block grants,".

(d) In Minnesota Statutes, section 256B.0917, subdivision 2; delete "Community Social Services Act,".

(e) In Minnesota Statutes, section 256B.0917, subdivision 4; delete "and the Community Social Services Act".

Sec. 25. [REPEALER.]

Minnesota Statutes 2004, sections 245.713, subdivisions 2 and 4; 245.716; and 626.5551, subdivision 4, are repealed.

APPENDIX
Repealed Minnesota Statutes for 05-0370

119A.01 ESTABLISHMENT; PURPOSE; AND GOALS.

Subd. 3. **Purpose.** The purpose in creating the department is to increase the capacity of Minnesota communities to measurably improve the well-being of children and families by:

(1) coordinating and integrating state funded and locally administered family and children programs;

(2) improving flexibility in the design, funding, and delivery of programs affecting children and families;

(3) providing greater focus on strategies designed to prevent problems affecting the well-being of children and families;

(4) enhancing local decision making, collaboration, and the development of new governance models;

(5) improving public accountability through the provision of research, information, and the development of measurable program outcomes;

(6) increasing the capacity of communities to respond to the whole child by improving the ability of families to gain access to services;

(7) encouraging all members of a community to nurture all the children in the community;

(8) supporting parents in their dual roles as breadwinners and parents; and

(9) reducing the condition of poverty for families and children through comprehensive, community-based strategies.

119A.20 ABUSED CHILD PROGRAM.

Subdivision 1. **Definitions.** For the purposes of sections 119A.20 to 119A.22, the following terms have the meanings given.

Subd. 2. **Abused child.** "Abused child" means a child, under the age of 18 years, who has suffered physical, emotional, or mental injury, harmful neglect, sexual abuse or exploitation, or negligent treatment.

Subd. 3. **Abused children services.** "Abused children services" means any service or program designed to provide advocacy, education, prevention, or direct service to or on behalf of abused children, children at risk, and their families.

Subd. 4. **Commissioner.** "Commissioner" means the commissioner of the Department of Education or a designee.

119A.21 GRANTS TO SERVICE PROVIDER PROGRAMS.

Subdivision 1. **Grants awarded.** The commissioner shall award grants to programs that provide services to abused or neglected children. Grants shall be awarded in a manner that ensures that they are equitably distributed to programs serving metropolitan and nonmetropolitan populations.

Subd. 2. **Applications.** Any public or private nonprofit agency may apply to the commissioner for a grant. The application shall be submitted on a form prescribed by the commissioner.

Subd. 3. **Duties.** Every public or private nonprofit agency which receives a grant under this section shall comply with all requirements of the commissioner related to the administration of the grants.

Subd. 4. **Classification of data collected by grantees.** Personal history information and other information collected, used, or maintained by a grantee from which the identity of any abused child or family members may be determined is private data on individuals as defined in section 13.02, subdivision 12, and the grantee shall maintain the data in accordance with

provisions of chapter 13.

119A.22 DUTIES OF COMMISSIONER.

The commissioner shall:

(1) review applications and award grants to programs pursuant to section 119A.21;

(2) design a uniform method of collecting data to be used to monitor and assure compliance of the programs funded under section 119A.21;

(3) provide technical assistance to applicants in the development of grant requests and to grantees in meeting the data collection requirements established by the commissioner; and

(4) adopt, under chapter 14, all rules necessary to implement the provisions of sections 119A.20 to 119A.22.

119A.35 ADVISORY COUNCIL.

Subdivision 1. **Generally.** The Advisory Council is established under section 15.059 to advise the commissioner on the implementation and continued operations of sections 119A.10 to 119A.16 and 119A.20 to 119A.22. The council shall expire June 30, 2005.

Subd. 2. **Council membership.** The council shall consist of a total of 22 members. The governor shall appoint 18 of these members. The commissioners of human services and health shall each appoint one member. The senate shall appoint one member from the senate committee with jurisdiction over family and early childhood education and the house of representatives shall appoint one member from the house committee with jurisdiction over family and early childhood education.

Council members shall have knowledge in the areas of child abuse and neglect prevention and intervention and knowledge of the risk factors that can lead to child abuse and neglect. Council members shall be representative of: local government, criminal justice, parents, consumers of services, health and human services professionals, faith community, professional and volunteer providers of child abuse and neglect prevention and intervention services, racial and ethnic minority communities, and the demographic and geographic composition of the state. Ten council members shall reside in the seven-county metropolitan area and eight shall reside in nonmetropolitan areas.

Subd. 3. **Responsibilities.** The council shall:

(1) advise the commissioner on planning, policy development, data collection, rulemaking, funding, and evaluation of the programs under the sections listed in subdivision 1;

(2) coordinate and exchange information on the establishment and ongoing operation of the programs listed in subdivision 1;

(3) develop and publish criteria and guidelines for receiving grants relating to child abuse and neglect prevention and safety and support of child victims, including, but not limited to, funds dedicated to the children's trust fund and abused children program;

(4) provide guidance in the development of statewide education and public information activities that increase public awareness in the prevention and intervention of child abuse and neglect and encourage the development of prevention and intervention programs, which includes the safety of child

victims;

(5) guide, analyze, and disseminate results in the development of appropriate evaluation procedures for all programs receiving funds under subdivision 1; and

(6) assist the commissioner in identifying service gaps or duplication in services including geographic dispersion of resources, programs reflecting the cycle of child abuse, and the availability of culturally appropriate intervention and prevention services.

119B.21 CHILD CARE SERVICES GRANTS.

Subd. 11. **Statewide advisory task force.** The commissioner may convene a statewide advisory task force to advise the commissioner on statewide grants or other child care issues. The following groups must be represented: family child care providers, child care center programs, school-age care providers, parents who use child care services, health services, social services, Head Start, public schools, school-based early childhood programs, special education programs, employers, and other citizens with demonstrated interest in child care issues. Additional members may be appointed by the commissioner. The commissioner may compensate members for their travel, child care, and child care provider substitute expenses for attending task force meetings. The commissioner may also pay a stipend to parent representatives for participating in task force meetings.

245.713 ALLOCATION FORMULA.

Subd. 2. **Total funds available; allocation.** Funds granted to the state by the federal government under United States Code, title 42, sections 300X to 300X-9 each federal fiscal year for mental health services must be allocated as follows:

(a) Any amount set aside by the commissioner of human services for American Indian organizations within the state, which funds shall not duplicate any direct federal funding of American Indian organizations and which funds shall be at least 25 percent of the total federal allocation to the state for mental health services; provided that sufficient applications for funding are received by the commissioner which meet the specifications contained in requests for proposals. Money from this source may be used for special committees to advise the commissioner on mental health programs and services for American Indians and other minorities or underserved groups. For purposes of this subdivision, "American Indian organization" means an American Indian tribe or band or an organization providing mental health services that is legally incorporated as a nonprofit organization registered with the secretary of state and governed by a board of directors having at least a majority of American Indian directors.

(b) An amount not to exceed five percent of the federal block grant allocation for mental health services to be retained by the commissioner for administration.

(c) Any amount permitted under federal law which the commissioner approves for demonstration or research projects for severely disturbed children and adolescents, the underserved, special populations or multiply disabled mentally ill persons. The groups to be served, the extent and nature of services to be provided, the amount and duration of any grant awards are to be based on criteria set forth in the Alcohol, Drug Abuse and Mental Health Block Grant Law, United States Code, title 42, sections 300X to 300X-9, and on state policies and procedures

determined necessary by the commissioner. Grant recipients must comply with applicable state and federal requirements and demonstrate fiscal and program management capabilities that will result in provision of quality, cost-effective services.

(d) The amount required under federal law, for federally mandated expenditures.

(e) An amount not to exceed 15 percent of the federal block grant allocation for mental health services to be retained by the commissioner for planning and evaluation.

Subd. 4. **Funds available due to transfer.** Any federal funds available to the commissioner for mental health services prescribed under United States Code, title 42, sections 300X to 300X-9 due to transfer of funds between block grants shall be allocated as prescribed in section 256E.07, subdivision 1, clauses (a) and (b).

245.716 REPORTS; DATA COLLECTION.

Subdivision 1. **Periodic reports.** The commissioner shall specify requirements for reports, including quarterly fiscal reports, according to section 256.01, subdivision 2, paragraph (17).

Subd. 2. **Social services report.** Beginning in calendar year 1983, each county shall include in the report required by section 256E.10 a part or subpart which addresses the items specified in section 256E.10, subdivision 1, clauses (a) and (b), as they pertain to the use of funds available from the federal government for services of qualified community mental health centers.

256.014 STATE AND COUNTY SYSTEMS.

Subd. 3. **Report.** The commissioner of human services shall report to the chair of the house Ways and Means Committee and the chair of the senate Finance Committee on January 1 of each year detailing project expenditures to date, methods used to maximize county participation, and the fiscal impact on programs, counties, and clients.

256.045 ADMINISTRATIVE AND JUDICIAL REVIEW OF HUMAN SERVICE MATTERS.

Subd. 3c. **Final order in hearing under section 119B.16.** The state human services referee shall recommend an order to the commissioner of education in an appeal under section 119B.16. The commissioner shall affirm, reverse, or modify the order. An order issued under this subdivision is conclusive on the parties unless an appeal is taken under subdivision 7.

256B.0629 ADVISORY COMMITTEE ON ORGAN AND TISSUE TRANSPLANTS.

Subdivision 1. **Creation and membership.** By July 1, 1990, the commissioner shall appoint and convene a 12-member advisory committee to provide advice and recommendations to the commissioner concerning the eligibility of organ and tissue transplant procedures for reimbursement by medical assistance and general assistance medical care. The committee must include representatives of the transplant provider community, hospitals, patient recipient groups or organizations, the Department of Human Services, the Department of Finance, and the Department of Health, at least one representative of a health plan regulated under chapter 62A, 62C, or 62D, and persons with expertise in ethics, law, and economics. The terms and removal of members shall be governed by section 15.059. Members shall not receive per diems but shall be compensated for expenses. The advisory committee does not expire as provided in section 15.059,

subdivision 6.

Subd. 2. **Function and objectives.** The committee's activities include, but are not limited to:

(1) collection of information on the efficacy and experience of various forms of transplantation not approved by Medicare;

(2) collection of information from Minnesota transplant providers on available services, success rates, and the current status of transplant activity in the state;

(3) development of guidelines for determining when and under what conditions organ and tissue transplants not approved by Medicare should be eligible for reimbursement by medical assistance and general assistance medical care;

(4) providing recommendations to the commissioner on: (i) organ and tissue transplant procedures, beyond those approved by Medicare, that should also be eligible for reimbursement under medical assistance and general assistance medical care; and (ii) which transplant centers should be eligible for reimbursement from medical assistance and general assistance medical care.

Subd. 4. **Responsibilities of the commissioner.** The commissioner shall periodically:

(1) Determine criteria governing the eligibility of organ and tissue transplant procedures for reimbursement from medical assistance and general assistance medical care. Procedures approved by Medicare are automatically eligible for medical assistance and general assistance medical care reimbursement. Additional procedures are eligible for reimbursement only if they are recommended by the task force, approved by the commissioner, and published in the State Register.

(2) Determine criteria for certifying transplant centers within and outside of Minnesota where Minnesotans receiving medical assistance and general assistance medical care may obtain transplants. Only centers recommended by the task force and approved by the commissioner may be certified by the commissioner.

256J.95 DIVERSIONARY WORK PROGRAM.

Subd. 20. **Implementation of DWP.** Counties may establish a diversionary work program according to this section any time on or after July 1, 2003. Prior to establishing a diversionary work program, the county must notify the commissioner. All counties must implement the provisions of this section no later than July 1, 2004.

256K.35 AT-RISK YOUTH OUT-OF-WEDLOCK PREGNANCY PREVENTION PROGRAM.

Subdivision 1. **Establishment and purpose.** The commissioner shall establish a statewide grant program to prevent or reduce the incidence of out-of-wedlock pregnancies among homeless, runaway, or thrown-away youth who are at risk of being prostituted or currently being used in prostitution. The goal of the out-of-wedlock pregnancy prevention program is to significantly increase the number of existing short-term shelter beds for these youth in the state. By providing street outreach and supportive services for emergency shelter, transitional housing, and services to reconnect the youth with their families where appropriate, the number of youth at risk of being sexually exploited or actually being sexually exploited, and thus at risk of experiencing an out-of-wedlock pregnancy, will be reduced.

Subd. 2. **Funds available.** The commissioner shall make funds for street outreach and supportive services for

emergency shelter and transitional housing for out-of-wedlock pregnancy prevention available to eligible nonprofit corporations or government agencies to provide supportive services for emergency and transitional housing for at-risk youth. The commissioner shall consider the need for emergency and transitional housing supportive services throughout the state, and must give priority to applicants who offer 24-hour emergency facilities.

Subd. 3. **Application; eligibility.** (a) A nonprofit corporation or government agency must submit an application to the commissioner in the form and manner the commissioner establishes. The application must describe how the applicant meets the eligibility criteria under paragraph (b). The commissioner may also require an applicant to provide additional information.

(b) To be eligible for funding under this section, an applicant must meet the following criteria:

(1) the applicant must have a commitment to helping the community, children, and preventing juvenile prostitution. If the applicant does not have any past experience with youth involved in or at risk of being used in prostitution, the applicant must demonstrate knowledge of best practices in this area and develop a plan to follow those practices;

(2) the applicant must present a plan to communicate with local law enforcement officials, social services, and the commissioner consistent with state and federal law; and

(3) the applicant must present a plan to encourage homeless, runaway, or thrown-away youth to either reconnect with family or to transition into long-term housing.

Subd. 4. **Uses of funds.** (a) Funds available under this section must be used to create and maintain supportive services for emergency shelter and transitional housing for homeless, runaway, and thrown-away youth. Federal TANF funds must be used to serve youth and their families with household income below 200 percent of the federal poverty guidelines. If other funds are available, services may be provided to youth outside of TANF-eligible families.

(b) Funds available under this section shall not be used to conduct general education or awareness programs unrelated to the operation of an emergency shelter or transitional housing.

626.5551 ALTERNATIVE RESPONSE PROGRAMS FOR CHILD PROTECTION ASSESSMENTS OR INVESTIGATIONS.

Subd. 4. **Plan.** The county community social service plan required under section 256E.09 must address the extent that the county will use the alternative response program authorized under this section, based on the availability of new federal funding that is earned and other available revenue sources to fund the additional cost to the county of using the program. To the extent the county uses the program, the county must include the program in the community social service plan and in the program evaluation under section 256E.10. The plan must address alternative responses and services that will be used for the program and protocols for determining the appropriate response to reports under section 626.556 and address how the protocols comply with the guidelines of the commissioner under subdivision 5.

Senator ..... moves to amend S.F. No. 1720 as follows:

Page 13, delete section 14

Page 17, lines 10 to 12, delete the new language

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

S.F. 1720 Lourey **H.F. 1875 Bradley**

TITLE: DHS Technical Bill

Article 1

Children and Family Services

Dept. of Education Program Transfers to DHS

Corrects language in 119A regarding programs transferred from the Department of Education to the Department of Human Services and moves 119A to the Human Services sections of statute; removes outdated language and makes other technical changes.

Community Social Services Act (CSSA) Corrections

Removes statutory references to the former Community Social Services Act (256E) where appropriate or reference to the new Children and Community Services Act and makes technical correction regarding service plan date (Dec. 21, 2007 changed to Dec. 31, 2007).

MFIP Universal Participation

- Corrects the reference to foster care payments in the income exclusions;
- Clarifies how the child under 12 weeks exception from universal participation applies to capped children and correct the cross reference in DWP; and
- Makes other technical clean-up including changes to 256J.68 (Injury Protection Program).

Child Support
Makes technical change to correct cross-references and clarifies law that passed in 2004 to corrects an error to reflect legislative intent so that recipients of access and visitation grant funds are chosen through an RFP process.

Articles 2 and 3

Health Care, Continuing Care and Miscellanous

Children's Theraputic Services and Supports (CTSS)
Makes technical changes and corrections.

Rate Increases/Volume Purchasing: clarifies that recent rate increases do not impact volume purchases/competitive bid contract payments unless specified.

Codify Authority of When to Adjust Income Standards for Minnesota Health Care Programs: codifies an annual rider adjusting Health Care program federal poverty guideline related income standards on July 1 each year.

Organ Tissue and Transplant Advisory Commission Eliminated: eliminates references to an inactive committee.

Critical Access Hospital Technical Correction: amends 256B.75 to correct a citation to critical access hospitals.

Dependent Sibling Language Removed: removes an obsolete reference to dependent sibling in MinnesotaCare..

Vulnerable Adult Reporting: clarifies local units are not required to prepare information memorandums.

Repeals a requirement for an annual report to the legislature on the Department of Human Services' major systems. The contents of the report can be incorporated into the human services biennial budget narratives.

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