A bill for an act

relating to health; modifying certain provider, hospital, and outpatient surgical center reporting requirements; modifying requirements for health board directories of licensees; providing for a price disclosure reminder; amending Minnesota Statutes 2004, sections 144.698, by adding a subdivision; 144.99, subdivision 1; Minnesota Statutes 2005 Supplement, section 214.071; proposing coding for new law in Minnesota Statutes, chapters 62J; 214.

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

Section 1. **[62J.18] PROVIDER REPORTING IN EXCESS OF $5,000,000.**

Subdivision 1. **Applicability; definitions.** (a) For purposes of this section, the terms used have the meanings given in section 62J.17, subdivision 2, except that "major spending commitment" means an expenditure in excess of $5,000,000.

(b) This section applies to providers and to persons who would become providers after making the expenditures described in subdivision 2. This section does not apply to hospital construction projects subject to the hospital construction moratorium under section 144.551 or to the public interest review under section 144.552.

Subd. 2. **Reporting requirement.** (a) A provider that intends to make a major spending commitment in excess of $5,000,000 for an acquisition, by purchase or lease, of a unit of medical equipment or in excess of $5,000,000 for a single capital project for the purposes of providing health care services must file a report with the commissioner at least 60 days before committing to make the expenditure. The report must contain the information described in section 62J.17, subdivision 4a, paragraphs (b) and (c).

(b) The commissioner shall maintain a database to track expenditures reported under this subdivision.

(c) The commissioner shall maintain a list of all persons who have registered with the commissioner for the purpose of receiving notice by electronic mail of a report filed under this subdivision. The commissioner shall, within 15 days of receiving an expenditure report, provide notice of such report by electronic mail to all persons on its list, and by publication in the State Register. The notice must include either a copy of the report or an easily understandable description of the proposed expenditure in the report. The notice in the State Register must include a copy of the report, along with an easily understandable description of the proposed expenditure in the report. In addition, the commissioner shall make reasonable efforts to notify persons or classes of persons who may be significantly affected by the proposed expenditure in the report. The commissioner may recover the reasonable costs incurred in providing notice as required in this paragraph through costs paid by third parties involved in proceedings described in this section.

(d) No provider may commit to making the expenditure until the procedures described in this section are completed.

Subd. 3. **Exceptions.** (a) This section does not apply to an expenditure:

(1) to replace existing equipment with comparable equipment used for direct patient care. Upgrades of equipment beyond the current model or comparable model are subject to this section;

(2) made by a research and teaching institution for purposes of conducting medical education, medical research supported or sponsored by a medical school or by a federal or foundation grant, or clinical trials;

(3) to repair, remodel, or replace existing buildings or fixtures if, in the judgment of the commissioner, the project does not involve a substantial expansion of the service capacity or a substantial change in the nature of health care services provided;

(4) for building maintenance, including heating, water, electricity, and other maintenance-related expenditures;

(5) for activities not directly related to the delivery of patient care services, including food service, laundry, housekeeping, and other service-related activities; or

(6) for computer equipment or data systems not directly related to the delivery of patient care services, including computer equipment or data systems related to medical record automation.

(b) In addition to the exceptions listed in paragraph (a), this section does not apply to mergers, acquisitions, and other changes in ownership or control that, in the judgment of the commissioner, do not involve a substantial expansion of service capacity or a substantial change in the nature of health care services provided.

Subd. 4. **Public meeting.** (a) Within 30 days from the date the notice requirements of subdivision 2, paragraph (c), are satisfied, a third party may request a public meeting on expenditures that exceed $5,000,000. The public meeting shall serve as an informational forum for the provider to answer inquiries of interested third parties.

(b) The commissioner shall arrange for and coordinate the meeting on an expedited basis. The party requesting the meeting shall pay the commissioner for the commissioner's cost of the meeting, as determined by the commissioner. Money received by the commissioner for reimbursement under this section is appropriated to the commissioner for the purpose of administering this section.

Subd. 5. **Information required.** If a public meeting is requested, the provider shall provide the following information to be presented at the meeting:

(1) need and access, including, but not limited to:

(i) the need of the population served or to be served by the proposed health services for those services;

(ii) the project's contribution to meeting the needs of the medically underserved, including persons in rural areas, low-income persons, racial and ethnic minorities, persons with disabilities, and the elderly, as well as the extent to which medically underserved residents in the provider's service area are likely to have access to the proposed health service; and

(iii) the distance, convenience, cost of transportation, and accessibility to health services for those to be served by the proposed health services;

(2) quality of health care, including, but not limited to:

(i) the impact of the proposed service on the quality of health services available to those proposed to be served by the project; and

(ii) the impact of the proposed service on the quality of health services offered by other providers;

(3) cost of health care, including, but not limited to:

(i) the financial feasibility of the proposal;

(ii) probable impact of the proposal on the costs of and charges for providing health services by the person proposing the service;

(iii) probable impact of the proposal on the costs of and charges for health services provided by other providers;

(iv) probable impact of the proposal on reimbursement for the proposed services; and

(v) the relationship, including the organizational relationship, of the proposed health services to ancillary or support services;

(4) alternatives available to the provider, including, but not limited to:

(i) the availability of alternative, less costly, or more effective methods of providing the proposed health services;

(ii) the relationship of the proposed project to the long-range development plan, if any, of the person or entity providing or proposing the services; and

(iii) possible sharing or cooperative arrangements among existing facilities and providers; and

(5) other considerations requested by the commissioner, including, but not limited to:

(i) the best interests of the patients, including conflicts of interest that may be present in influencing the utilization of the services, facility, or equipment relating to the expenditures;

(ii) special needs and circumstances of those entities that provide a substantial portion of their services or resources, or both, to individuals not residing in the immediate geographic area in which the entities are located, which entities may include, but are not limited to, medical and other health professional schools, multidisciplinary clinics, and specialty centers;

(iii) the special needs and circumstances of biomedical and behavioral research projects designed to meet a national need and for which local conditions offer special advantages; and

(iv) the impact of the proposed project on fostering competition between providers.

Subd. 6. **Enforcement.** The commissioner may enforce this section by denying or refusing to reissue the permit, license, registration, or certificate of a provider that does not comply with this section, according to section 144.99, subdivision 8.

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

Sec. 2. Minnesota Statutes 2004, section 144.698, is amended by adding a subdivision to read:

Subd. 6. **Reporting on uncompensated care.** (a) A report on the services provided to benefit the community, as required under subdivision 1, clause (5), must report charity care in compliance with the following requirements:

(1) For a facility to report amounts as charity care adjustments, the facility must:

(i) generate and record a charge;

(ii) have a policy on the provision of charity care that contains specific eligibility criteria and is communicated or made available to patients;

(iii) have made a reasonable effort to identify a third-party payer, encourage the patient to enroll in public programs, and, to the extent possible, aid the patient in the enrollment process; and

(iv) ensure that the patient meets the charity care criteria of this subdivision.

(2) In determining whether to classify care as charity care, the facility must consider the following:

(i) charity care may include services that the provider is obligated to render independently of the ability to collect;

(ii) charity care may include care provided to patients who meet the facility's charity care guidelines and have partial coverage, but who are unable to pay the remainder of their medical bills, but this does not apply to that portion of the bill that has been determined to be the patient's responsibility after a partial charity care classification by the facility;

(iii) charity care may include care provided to low-income patients who may qualify for a public health insurance program and meet the facility's eligibility criteria for charity care, but who do not complete the application process for public insurance despite the facility's reasonable efforts;

(iv) charity care may include care to individuals whose eligibility for charity care was determined through third-party services for information gathering purposes only;

(v) charity care does not include contractual allowances, which is the difference between gross charges and payments received under contractual arrangements with insurance companies and payers;

(vi) charity care does not include bad debt;

(vii) charity care does not include what may be perceived as underpayments for operating public programs;

(viii) charity care does not include unreimbursed costs of basic or clinical research or professional education and training;

(ix) charity care does not include professional courtesy discounts;

(x) charity care does not include community service or outreach activities; and

(xi) charity care does not include services for patients against whom collection actions were taken that resulted in a financial obligation documented on a patient's credit report with credit bureaus.

(3) When reporting charity care adjustments, the facility must report total dollar amounts and the number of contacts between a patient and a health care provider during which a service is provided for the following categories:

(i) care to patients with family incomes at or below 275 percent of the federal poverty guideline;

(ii) care to patients with family incomes above 275 percent of the federal poverty guideline; and

(iii) care to patients when the facility, with reasonable effort, is unable to determine family incomes.

(b) For the report required under subdivision 1, clause (5), the facility must, in determining whether to classify care as a bad debt expense:

(1) presume that a patient is able and willing to pay until and unless the facility has reason to consider the care as a charity care case under its charity care policy and the facility classifies the care as a charity care case; and

(2) include as a bad debt expense any unpaid deductibles, coinsurance, co-payments, noncovered services, and other unpaid patient responsibilities.

EFFECTIVE DATE. This section is effective for facility fiscal years ending on or after December 31, 2006.

Sec. 3. Minnesota Statutes 2004, section 144.99, subdivision 1, is amended to read:

Subdivision 1. **Remedies available.** The provisions of chapters 103I and 157 and sections 62J.18; 115.71 to 115.77; 144.12, subdivision 1, paragraphs (1), (2), (5), (6), (10), (12), (13), (14), and (15); 144.1201 to 144.1204; 144.121; 144.1222; 144.35; 144.381 to 144.385; 144.411 to 144.417; 144.495; 144.71 to 144.74; 144.9501 to 144.9509; 144.992; 326.37 to 326.45; 326.57 to 326.785; 327.10 to 327.131; and 327.14 to 327.28 and all rules, orders, stipulation agreements, settlements, compliance agreements, licenses, registrations, certificates, and permits adopted or issued by the department or under any other law now in force or later enacted for the preservation of public health may, in addition to provisions in other statutes, be enforced under this section.

Sec. 4. Minnesota Statutes 2005 Supplement, section 214.071, is amended to read:

214.071 HEALTH BOARDS; DIRECTORY OF LICENSEES.

Each ~~health~~ health-related licensing board ~~under chapters 147, 148, 148B, and 150A,~~ as defined in section 214.01, subdivision 2, shall establish a directory of licensees that includes biographical data for each licensee.

Sec. 5. **[214.121] PRICE DISCLOSURE REMINDER.**

Each health-related licensing board shall at least annually inform and remind its licensees of the price disclosure requirements of section 62J.052 or 151.214, as applicable, through the board's regular means of communicating with its licensees.

Senate Counsel, Research, and Fiscal Analysis

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Senate
State of Minnesota

S.F. No. 1640 - Reporting and Review of Provider Expenditures (First Engrossment)

Author: Senator Sheila M. Kiscaden

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

Date: April 10, 2006

S.F. No. 1640 establishes a process for third parties to request a public meeting on certain expenditures over $5 million.

Section 1 (62J.18) establishes reporting requirements and public meeting procedures for expenditures over $5 million.

Subdivision 1 states that this section applies to providers and those who would be a provider upon making an expenditure in excess of $5 million and exempts hospital construction moratorium projects.

Subdivision 2, paragraph (a), requires a provider intending to make a major spending commitment of $5 million for the acquisition of a unit of medical equipment or in excess of $5 million for a single capital project for the purpose of providing health care services must file a report with the Commissioner of Health at least 60 days before making the expenditure.

Paragraph (b), the Commissioner must maintain a database to track reported expenditures.

Paragraph (c), the Commissioner must maintain a list of persons interested in receiving notice of a report filed under this section and provide notice to all persons on the list and by publication in the *State Register* within 15 days of receiving the report. The notice must include a copy of the report or a description of the proposed expenditure.

Paragraph (d) states that no provider may commit to making the expenditure until the procedures of this section are completed.

Subdivision 3 exempts from the public meeting and hearing any expenditure:

(1) to replace existing equipment with comparable equipment;

(2) made by a research and teaching institution for purposes of conducting medical education, medical research, or clinical trials;

(3) to repair, remodel, or replace existing buildings or fixtures if it does not involve substantial expansion of service capacity or the nature of health services provided;

(4) for building maintenance;

(5) for activities not directly related to the delivery of patient care services; and

(6) for computer equipment or data systems not directly related to the delivery of patient care.

The exemption also does not apply to mergers, acquisitions, and other changes in ownership or control that do not involve substantial expansion of service capacity or substantial change in the services provided.

Subdivision 4 permits a third party to request a public meeting on projects that exceed $5 million in capital cost within 30 days of the filing of the report. The meeting is to be an informational forum for the provider to answer inquiries and must be arranged and coordinated by the Commissioner on an expedited basis. The requesting party is responsible for all costs related to the meeting.

Subdivision 5 describes the information to be presented at the public meeting: need and access; quality of health; cost of health care; alternatives available to the provider; and other considerations.

Subdivision 6 authorizes the Commissioner to enforce this section according to Minnesota Statutes, section 144.99, subdivision 8.

Section 2 (144.698, subdivision 6) requires a hospital and outpatient surgical center to file with annual financial information, information on charity care.

Section 3 (144.99, subdivision 1) adds section 62J.18 to the Commissioner of Health's enforcement authority.

Section 4 (214.071) makes a technical change.

Section 5 (214.121) requires health-related licensing boards to annually inform licensees of the price disclosure requirements.

KC:ph

Fiscal Note – 2005-06 Session

Bill #: S1640-1A **Complete Date:** 04/10/06

Chief Author: KISCADEN, SHEILA

Title: HEALTHCARE PROVIDER EXP REPORTING

Agency Name: Health Dept

Fiscal Impact	Yes	No
State	X	
Local		X
Fee/Departmental Earnings		X
Tax Revenue		X

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
Misc Special Revenue Fund			3	3	3
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
Misc Special Revenue Fund			3	3	3
Revenues					
Misc Special Revenue Fund			3	3	3
Net Cost <Savings>					
Misc Special Revenue Fund			0	0	0
Total Cost <Savings> to the State					

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
-- No Impact --					
Total FTE					

Bill Description

Section 1
Defines "major spending commitments" as those in excess of $5 million. Requires providers who intend to make a major spending commitment to file a report with the Commissioner at least 60 days before committing to make the expenditure. Report to include information outlined in Minnesota statutes section 62J.17, subdivision 4a, paragraphs (b) and (c). Requires the Commissioner of Health to notify all persons who have registered to receive notice of major expenditure reports, via email communication and publication in the State Register. Permits third parties to request a public meeting on major expenditures within 30 days from the notice described above. Requires providers who are the subject of public meetings to provide information about the proposed project at the meeting, including information on need and access, impact of the proposed project on the quality of services provided by other providers, financial feasibility, costs, impact on charges for health services, and other factors. Costs of the meeting are to be paid by the requesting third party to the Commissioner. Directs the Commissioner to arrange for and coordinate the meetings.

Assumptions

Section 1
Under the current capital expenditure reporting act (Minnesota Statutes 62J.17), the Department of Health receives an average of 12 reports each year for projects with a cost that exceeds $5 million. We estimate that the Department will continue to receive 12 reports per year, with six requests for public meetings. Costs for posting notices of all major expenditures filings in the State Register, finding/reserving space for meetings, posting public announcements of upcoming public meetings or hearings in the State Register and through other media as necessary, and other necessary preparations are estimated at $100 per major expenditure report and $300 per public meeting for a total of $3,000 each fiscal year. These costs will be recovered through revenues from the requesting parties. It is assumed that payments from requesters will be directed to the miscellaneous special revenue fund.

Expenditure and/or Revenue Formula

Costs amounting to $3,000 each year will be recovered through revenues from the requesting parties.

Long-Term Fiscal Considerations

Local Government Costs

References/Sources

Agency Contact Name: Scott Leitz (651-282-6361)
FN Coord Signature: MARGARET KELLY
Date: 04/03/06 Phone: 201-5812

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: CRAIG WIEBER
Date: 04/10/06 Phone: 282-5065

To: Senator Cohen, Chair

Committee on Finance

Senator Berglin,

Chair of the Health and Human Services Budget Division, to which was referred

S.F. No. 1640: A bill for an act relating to health; modifying certain provider, hospital, and outpatient surgical center reporting requirements; modifying requirements for health board directories of licensees; providing for a price disclosure reminder; amending Minnesota Statutes 2004, sections 144.698, by adding a subdivision; 144.99, subdivision 1; Minnesota Statutes 2005 Supplement, section 214.071; proposing coding for new law in Minnesota Statutes, chapters 62J; 214.

Reports the same back with the recommendation that the bill do pass and be referred to the full committee.

Linda Berglin
(Division Chair)

April 10, 2006
(Date of Division recommendation)

A bill for an act

relating to health; establishing the Patient Safety and Drug Review Transparency Act; requiring disclosure of clinical trials of prescription drugs; assessing fees; proposing coding for new law in Minnesota Statutes, chapter 144.

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

Section 1. **CITATION.**

Minnesota Statutes, sections 144.6602 to 144.6605, may be cited as the Patient Safety and Drug Review Transparency Act.

Sec. 2. **[144.6602] DEFINITIONS.**

Subdivision 1. **Scope of definitions.** The terms used in sections 144.6602 to 144.6605 have the following meanings, unless the context indicates otherwise.

Subd. 2. **Clinical trial.** "Clinical trial" means any pharmacological, pharmacokinetic, or other study of the safety or efficacy of a pharmaceutical drug, biological product, or vaccine, whether or not completed in full, including, but not limited to:

(1) a clinical investigation that involves any trial to test the safety or efficacy of a pharmaceutical drug or biological product with one or more human subjects and that is intended to be submitted to, or held for inspection by, the federal Food and Drug Administration as part of any application for a research or marketing permit or for any other type of application, permit, procedure, or requirement of the Food and Drug Administration, including, but not limited to, an abbreviated new drug application, an investigational new drug application, a new drug application, nonconfidential additions to

the drug master file, postmarketing adverse events recording, and compliance with the electronic or paper common technical document; and

(2) any pharmacological study subsequent to initial approval for sale by the Food and Drug Administration, including studies assessing potential off-label applications, new therapies, new ways of using known treatments, and comparative drug trials assessing the efficacy or safety of a drug compared to other therapies.

Subd. 3. **Manufacturer.** "Manufacturer" means a manufacturer of prescription drugs or biological products or an affiliate of the manufacturer.

Sec. 3. **[144.6603] DISCLOSURE OF CLINICAL TRIALS OF PRESCRIPTION DRUGS.**

Subdivision 1. **Information to be disclosed.** A manufacturer of prescription drugs shall make publicly available in accordance with subdivision 3 the following information regarding clinical trials conducted or sponsored by the manufacturer, or any entity on its behalf, for each prescription drug the manufacturer sold, delivered, dispensed, offered for sale, or gave away in this state:

(1) the names of all participating organizations and funding sources of the clinical trial, including the name and contact information, including institutional affiliation, of all sponsors, cosponsors, and administrators, including the name of the principal investigators and study centers, of the clinical trial;

(2) a summary of the purpose of the clinical trial, including the name of the drug being tested and its active ingredients; overall design of the study, including statistical method to be employed; status or phase type of the trial; inclusion and exclusion criteria; treatment methods to be used; all hypotheses tested by the trial; the medical condition or conditions being studied; and outcomes that were evaluated;

(3) the dates during which the trial took place; and

(4) information concerning the results and outcomes of the clinical trial, which shall include, but not be limited to, potential or actual adverse effects of the drug, including the frequency, severity, and nature of adverse events for any trial participant and the numbers of participants who discontinued participation in the trial and the reasons for their discontinuance.

Subd. 2. **Application.** The disclosure requirement in subdivision 1 shall apply to all clinical trials completed or terminated on or after January 1, 1990, including any clinical trials completed after a prescription drug has been approved for sale by the federal Food and Drug Administration.

Subd. 3. **Information to be posted.** The information required to be disclosed under subdivision 1 shall be posted on the publicly accessible Internet Web site of the federal National Institutes of Health or another publicly accessible Web site. In order to satisfy the requirements of this subdivision, the publicly accessible Web site and manner of posting must be acceptable to the commissioner and shall be a free, nonsubscription Web site that clearly indicates the location and instructions for downloading the files or information submitted under subdivision 1.

Subd. 4. **Disclosure of terminated trials.** Disclosure of clinical trials under subdivision 1 shall include clinical trials that the manufacturer, or an entity on its behalf, initiated but terminated prior to completion. For these trials, the manufacturer shall include an explanation for the termination of the trial, including, but not limited to, potential or actual adverse effects of the drug, including the frequency, severity, and nature of adverse events for any trial participant and numbers of participants who discontinued participation in the trial and the reasons for their discontinuance.

Sec. 4. **[144.6604] FEES.**

Beginning January 1, 2007, each manufacturer of prescription drugs that are provided to state residents through the medical assistance program shall pay a fee of $1,000 per calendar year to the commissioner. Fees collected under this section are appropriated to the commissioner to cover the cost of overseeing implementation of sections 144.6602 to 144.6605, including, but not limited to, maintaining links to publicly accessible Web sites to which manufacturers are posting clinical trial information under section 144.6603, and other relevant sites.

Sec. 5. **[144.6605] COMPLIANCE DATES.**

A manufacturer shall post the information required by section 144.6603 as follows:

(1) for a drug that has been approved for sale by the Food and Drug Administration, within 90 days after the completion or termination of the clinical trial, or within 90 days after the effective date of sections 144.6602 to 144.6605, whichever is later; or

(2) in the case of a clinical trial performed prior to approval for sale by the Food and Drug Administration, within 60 days after the date of approval for sale by the Food and Drug Administration, or within 90 days after the effective date of sections 144.6602 to 144.6605, whichever is later.

Fiscal Note – 2005-06 Session

Bill #: S3342-1A **Complete Date:** 04/10/06

Chief Author: HOTTINGER, JOHN

Title: PATIENT SAFETY & DRUG REVIEW TRANSP

Fiscal Impact	Yes	No
State		X
Local		X
Fee/Departmental Earnings		X
Tax Revenue		X

Agency Name: Health Dept

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
-- No Impact --					
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
-- No Impact --					
Revenues					
-- No Impact --					
Net Cost <Savings>					
-- No Impact --					
Total Cost <Savings> to the State					

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
-- No Impact --					
Total FTE					

Bill Description

Disclosure of clinical trails by prescription manufacturers shall be linked on the MDH website.

Assumptions

Clinical manufacturers will need to provide MDH with the information required in this bill to enable web links to be posted and maintained.

Expenditure and/or Revenue Formula

There is no fiscal impact to the department.

Long-Term Fiscal Considerations

None

References/Sources

David Giese, Division Director
Compliance Monitoring Division
651-201-3700

Agency Contact Name: David Giese (651-201-3700)
FN Coord Signature: MARGARET KELLY
Date: 03/31/06 Phone: 201-5812

EBO Comments

To the extent the federal government posts clinical trial information on their website, the Department will provide links on their own website for this information. Revenue for the $1000 per manufacturer fee isn't noted because of uncertainty in the number of manufacturers and trials that happen during any given year.

EBO Signature: CRAIG WIEBER
Date: 04/10/06 Phone: 282-5065

To: Senator Cohen, Chair

Committee on Finance

Senator Berglin,

Chair of the Health and Human Services Budget Division, to which was referred

S.F. No. 3342: A bill for an act relating to health; establishing the Patient Safety and Drug Review Transparency Act; requiring disclosure of clinical trials of prescription drugs; assessing fees; proposing coding for new law in Minnesota Statutes, chapter 144.

Reports the same back with the recommendation that the bill do pass and be referred to the full committee.

Linda Berglin
(Division Chair)

April 10, 2006
(Date of Division recommendation)

Trkg. Line	Page Number	Bill Reference	Fund	BACT	DESCRIPTION	GOVERNOR'S RECOMMENDATION FY 2006	FY 2007	FY 06-07	FY 2008	FY 2009	FY 08-09	SENATE FY 2006	FY 2007	FY 06-07	FY 2008	FY 2009	FY 08-09
NET FISCAL IMPACT: DIRECT APPROPRIATIONS +/- NON-DEDICATED REVENUE																	
		Note:	Increases in non-dedicated revenues are shown as negatives in this tracking														
1																	
2			**TOTAL - ALL AGENCIES**			**38,073**	**86,317**	**124,390**	**102,331**	**87,970**	**190,301**	**30,379**	**108,089**	**138,468**	**167,459**	**179,147**	**346,606**
3			GF		General Fund	37,059	49,644	86,703	59,899	50,623	110,522	29,865	50,009	79,874	104,348	104,057	208,405
4			SGSR		State Government Special Revenue Fund	514	122	636	117	117	234	514	122	636	117	117	234
5			HCAF		Health Care Access Fund	500	26,484	26,984	32,248	27,163	59,411	0	37,933	37,933	56,937	69,216	126,153
6			TANF		Federal TANF	0	10,067	10,067	10,067	10,067	20,134	0	19,125	19,125	6,057	5,757	11,814
7			LOTT		Lottery Prize Fund	0	0	0	0	0	0	0	0	0	0	0	0
8			OTH		Other Funds	0	0	0	0	0	0	0	0	0	0	0	0
9			DED		Statutory Funds	0	0	0	0	0	0	0	900	900	0	0	0
10																	
11																	
11			OTHER BILLS														
12			**MEDICARE PART D: PAYER OF LAST RESORT**			**570**	**0**	**570**	**0**	**0**	**0**	**570**	**0**	**570**	**0**	**0**	**0**
19																	
20			**HCAF FUND BALANCE**														
21					February 2005 Forecast	116,270	121,931		133,025	175,804		116,270	121,931		133,025	175,804	
22					Investment income change (cumulative, per DOF)	(6)	(708)		(3,110)	(7,251)		0	(2,553)		(5,693)	(11,716)	
23					Non DHS Proposals (cumulative)	(60)	(53,320)		(74,320)	(95,320)		0	(9,414)		(9,707)	(10,000)	
24					DHS Proposals (cumulative)	(500)	(4,984)		(25,732)	(41,395)		0	(28,519)		(85,163)	(154,086)	
25					Ending Balance	115,704	62,919		29,863	31,838		116,270	81,445		32,462	2	
26																	
27			**FEDERAL TANF BALANCE**														
28					February 2005 Forecast	72,649	27,595		29,912	30,939		72,649	27,595		29,912	30,939	
29					Proposals (cumulative)	0	(10,067)		(20,134)	(30,201)		0	(19,125)		(25,182)	(30,939)	
30					Ending Balance	72,649	17,528		9,778	738		72,649	8,470		4,730	0	
31																	
32																	
33																	
34			**DEPARTMENT OF HUMAN SERVICES**			**34,729**	**59,599**	**94,328**	**82,173**	**67,812**	**149,985**	**27,035**	**91,447**	**118,482**	**154,961**	**166,649**	**321,610**
35			GF		General Fund	34,229	45,048	79,277	51,358	42,082	93,440	27,035	42,903	69,938	92,260	91,969	184,229
36			SGSR		State Government Special Revenue Fund	0	0	0	0	0	0	0	0	0	0	0	0
37			HCAF		Health Care Access Fund	500	4,484	4,984	20,748	15,663	36,411	0	28,519	28,519	56,644	68,923	125,567
38			TANF		Federal TANF	0	10,067	10,067	10,067	10,067	20,134	0	19,125	19,125	6,057	5,757	11,814
39			LOTT		Lottery Prize Fund	0	0	0	0	0	0	0	0	0	0	0	0
40			OTH		Other Funds	0	0	0	0	0	0	0	0	0	0	0	0
41			DED		Other Funds	0	0	0	0	0	0	0	900	900	0	0	0
42																	
43			**DEPARTMENT OF HEALTH**			**0**	**26,596**	**29,426**	**20,041**	**20,041**	**40,082**	**2,830**	**16,520**	**19,350**	**12,381**	**12,381**	**24,762**
44			GF		General Fund	0	0	0	0	0	0	0	2,510	2,510	3,547	3,547	7,094
45			SGSR		State Government Special Revenue Fund	0	0	0	0	0	0	0	0	0	0	0	0
46			HCAF		Health Care Access Fund	0	22,000	22,000	11,500	11,500	23,000	0	9,414	9,414	293	293	586
47			TANF		Federal TANF	0	0	0	0	0	0	0	0	0	0	0	0
48			OTH		Other Funds	0	0	0	0	0	0	0	0	0	0	0	0
49																	
50			**VETERANS NURSING HOMES BOARD**			**2,830**	**4,596**	**7,426**	**8,541**	**8,541**	**17,082**	**2,830**	**4,596**	**7,426**	**8,541**	**8,541**	**17,082**
51			GF		General Fund	2,830	4,596	7,426	8,541	8,541	17,082	2,830	4,596	7,426	8,541	8,541	17,082
52			OTH		Other Funds	0	0	0	0	0	0	0	0	0	0	0	0
53																	
54			**HEALTH RELATED BOARDS**			**514**	**72**	**586**	**67**	**67**	**134**	**514**	**72**	**586**	**67**	**67**	**134**
55			GF		General Fund	0	0	0	0	0	0	0	0	0	0	0	0
56			SGSR		State Government Special Revenue Fund	514	72	586	67	67	134	514	72	586	67	67	134
57			HCAF		Health Care Access Fund	0	0	0	0	0	0	0	0	0	0	0	0
58			OTH		Other Funds	0	0	0	0	0	0	0	0	0	0	0	0
59																	
60			**EMERGENCY MEDICAL SERVICES BOARD**			**0**	**50**	**50**	**50**	**50**	**100**	**0**	**50**	**50**	**50**	**50**	**100**
61			GF		General Fund	0	0	0	0	0	0	0	0	0	0	0	0
62			SGSR		State Government Special Revenue Fund	0	50	50	50	50	100	0	50	50	50	50	100
63			OTH		Other Funds	0	0	0	0	0	0	0	0	0	0	0	0
64																	
65			**COUNCIL ON DISABILITY**			**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
66			GF		General Fund	0	0	0	0	0	0	0	0	0	0	0	0
67			OTH		Other Funds	0	0	0	0	0	0	0	0	0	0	0	0
68																	
69			**OMBUDSMAN FOR MENTAL HEALTH AND MENTAL RETARDATION**			**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
70			GF		General Fund	0	0	0	0	0	0	0	0	0	0	0	0
71			OTH		Other Funds	0	0	0	0	0	0	0	0	0	0	0	0
72																	
73			**OMBUDSMAN FOR FAMILIES**			**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
74			GF		General Fund	0	0	0	0	0	0		0	0	0	0	0

Trkg. Line	Page Number	Bill Reference	Fund	BACT	DESCRIPTION	GOVERNOR'S RECOMMENDATION FY 2006	FY 2007	FY 06-07	FY 2008	FY 2009	FY 08-09	SENATE FY 2006	FY 2007	FY 06-07	FY 2008	FY 2009	FY 08-09
75			OTH		Other Funds	0	0	0	0	0	0	0	0	0	0	0	0
76																	
77		***DEPARTMENT OF HUMAN SERVICES***															
78																	
79																	
80	1	SF 3290			**MENTAL HEALTH SYSTEM TRANSFORMATION**	**0**	**3,366**	**3,366**	**24,032**	**22,196**	**46,228**	**0**	**2,866**	**2,866**	**24,032**	**22,196**	**46,228**
81					**GF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1,373**	**1,373**	**17,688**	**13,794**	**31,482**
82					**HCAF TOTAL**	**0**	**3,366**	**3,366**	**24,032**	**22,196**	**46,228**	**0**	**1,493**	**1,493**	**6,344**	**8,402**	**14,746**
83			GF	43	GAMC MH model benefit set	0	2,728	2,728	5,516	6,806	12,322	0	2,728	2,728	5,516	6,806	12,322
84			GF	74	Adult Mental Health Grants - Offset Model Benefit	0	(3,588)	(3,588)	(8,738)	(10,452)	(19,190)	0	(3,588)	(3,588)	(8,738)	(10,452)	(19,190)
85			GF	27	CCSG Model Benefit Set & Move FFS to PPHP	0	0	0	0	(2,849)	(2,849)	0	0	0	0	(2,849)	(2,849)
86			GF	41	MA F&C MH Model Benefit Set & Move FFS to PPHP	0	0	0	4,459	8,024	12,483	0	0	0	4,459	8,024	12,483
87			GF	42	MA E&D MH Model Benefit Set & move FFS to PPHP	0	0	0	4,969	6,597	11,566	0	0	0	4,969	6,597	11,566
88			GF	42	Eliminate Transfer MA Basic Health Care E&D -TCM	0	0	0	(4,240)	(13,356)	(17,596)	0	0	0	(4,240)	(13,356)	(17,596)
89			GF	43	GAMC grants Model Benefit Set & Move FFS to PPHP	0	0	0	1,135	2,181	3,316	0	0	0	1,135	2,181	3,316
90			GF	74	Adult Mental Health Model Benefit Set & Move FFS to PPHP	0	0	0	(2,236)	(5,672)	(7,908)	0	0	0	(2,236)	(5,672)	(7,908)
91			GF	50	HC Administration Model Benefit Set & Move FFS to PPHP	0	50	50	339	309	648	0	50	50	339	309	648
92			GF	51	HC Operations for HC purchasing Model Benefit Set & Move FFS to PPHP	0	10	10	0	0	0	0	10	10	0	0	0
93			GF	85	CC Admin for HC purchasing Model Benefit Set & Move FFS to PPHP	0	122	122	136	86	222	0	122	122	136	86	222
94			GF	REV1	Administrative FFP	0	(73)	(73)	(190)	(158)	(348)	0	(73)	(73)	(190)	(158)	(348)
95			GF	85	Mental Health Service outcomes	0	198	198	238	102	340	0	198	198	238	102	340
96			GF	REV1	Administrative FFP	0	(79)	(79)	(95)	(41)	(136)	0	(79)	(79)	(95)	(41)	(136)
97			GF	26	Children's Services Grants - MH Crisis services infrastructure	0	375	375	1,500	2,750	4,250	0	243	243	1,237	2,487	3,724
98			GF	74	Adult Mental Health - MH Crisis services infrastructure	0	875	875	3,500	4,500	8,000	0	743	743	3,236	4,236	7,472
99			GF	85	Continuing Care Admin MH Service tracking	0	250	250	86	86	172	0	250	250	86	86	172
100			GF	REV1	Administrative FFP MH Service tracking	0	(100)	(100)	(34)	(34)	(68)	0	(100)	(100)	(34)	(34)	(68)
101			GF	26	Children's Services Grants - MH school based infrastructure	0	1,740	1,740	6,960	8,700	15,660	0	1,740	1,740	6,960	8,700	15,660
102			GF	26	Children's Services Grants - Support evidence based practices	0	250	250	1,000	1,400	2,400	0	125	125	1,000	1,400	2,400
103			GF	74	Adult MH - Support evidence based practices	0	250	250	1,250	1,500	2,750	0	125	125	1,250	1,500	2,750
104			GF	41	MA Basic Health Care F&C - Address workforce shortages	0	0	0	873	1,048	1,921	0	0	0	873	1,048	1,921
105			GF	42	MA Basic Health Care E&D - Address workforce shortages	0	0	0	1,814	2,177	3,991	0	0	0	1,814	2,177	3,991
106			GF	43	GAMC Grants - Address workforce shortages	0	0	0	307	368	675	0	0	0	307	368	675
107			GF	26	Children's Service Grants - Cultural specific & specialty treatment-effective 4/01/07	0	250	250	1,000	1,250	2,250	0	125	125	1,000	1,250	2,250
108			GF	74	Adult MH - Cultural specific & specialty treatment - effective 4/01/07	0	250	250	1,000	1,250	2,250	0	125	125	1,000	1,250	2,250
109			GF	REV2	County Share- State Operated community based hospitals	0	(1,635)	(1,635)	(3,269)	(3,269)	(6,538)	0	(1,371)	(1,371)	(2,742)	(2,742)	(5,484)
110			GF	REV2	HCAF transfer from GF	0	(1,873)	(1,873)	(17,280)	(13,303)	(30,583)	0	0	0	0	0	0
111			HCAF	40	MNCARE MH model benefit set	0	1,493	1,493	4,764	5,491	10,255	0	1,493	1,493	4,764	5,491	10,255
112			HCAF	40	MNCARE Grants Model Benefit Set & Move FFS to PPHP	0	0	0	1,580	2,911	4,491	0	0	0	1,580	2,911	4,491
113			HCAF	40	Minnesota Care Grants - Address workforce shortages	0	0	0	408	491	899	0	0	0	0	0	0
114			GF	40	Minnesota Care Grants - Address workforce shortages	0	0	0	0	0	0	0	0	0	408	491	899
115			HCAF	REV2	HCAF transfer to GF	0	1,873	1,873	17,280	13,303	30,583	0	0	0	0	0	0
116																	
117																	
118	11	GOV			**SOS MINNESOTA SECURITY HOSPITAL (MSH) OPERATING SHORTFALL**	**12,874**	**18,129**	**31,003**	**20,521**	**20,544**	**41,065**	**12,874**	**18,129**	**31,003**	**20,521**	**20,544**	**41,065**
119					**RELATED TO GROWTH IN COMMITMENTS OF MENTALLY ILL AND DANGEROUS**												
120					**GF TOTAL**	**12,874**	**18,129**	**31,003**	**20,521**	**20,544**	**41,065**	**12,874**	**18,129**	**31,003**	**20,521**	**20,544**	**41,065**
121			GF	90	SOS appropriated services - crisis services and new beds	13,869	19,707	33,576	22,365	22,390	44,755	13,869	19,707	33,576	22,365	22,390	44,755
122			GF	REV2	SOS Collections - CSS Service Fees	(995)	(1,578)	(2,573)	(1,844)	(1,846)	(3,690)	(995)	(1,578)	(2,573)	(1,844)	(1,846)	(3,690)
123																	
124																	
125																	
126	15	GOV			**SOS MINNESOTA SEX OFFENDER PROGRAM (MSOP) OPERATING SHORTFALL**	**13,855**	**19,819**	**33,674**	**25,463**	**16,252**	**41,715**	**13,855**	**19,819**	**33,674**	**25,463**	**16,252**	**41,715**
127					**RELATED TO GROWTH IN COMMITMENTS**												
128					**GF TOTAL**	**13,855**	**19,819**	**33,674**	**25,463**	**16,252**	**41,715**	**13,855**	**19,819**	**33,674**	**25,463**	**16,252**	**41,715**
129			GF	90	SOS Approp services - MSOP	10,932	15,494	26,426	19,456	22,559	42,015	10,932	15,494	26,426	19,456	22,559	42,015
130			GF	90	SOS Approp services - cost of DOC Inmate Lease Space	1,706	5,874	7,580	7,953	2,680	10,633	1,706	5,874	7,580	7,953	2,680	10,633
131			GF	90	SOS Approp services - MSOP K building savings	0	0	0	0	(7,479)	(7,479)	0	0	0	0	(7,479)	(7,479)
132			GF	90	SOS Approp services - Moose Lake DOC Site	2,310	0	2,310	0	0	0	2,310	0	2,310	0	0	0
133			GF	REV2	SOS Collections - 10 % county share	(1,093)	(1,549)	(2,642)	(1,946)	(1,508)	(3,454)	(1,093)	(1,549)	(2,642)	(1,946)	(1,508)	(3,454)
134																	
135																	
136																	
137	19	GOV			**SOS MANAGEMENT OF GROWTH IN MINNESOTA EXTENDED -**	**667**	**1,350**	**2,017**	**1,137**	**1,137**	**2,274**	**667**	**871**	**1,538**	**521**	**521**	**1,042**
138					**TREATMENT OPTIONS (METO)**												
139					**GF TOTAL**	**667**	**1,350**	**2,017**	**1,137**	**1,137**	**2,274**	**667**	**871**	**1,538**	**521**	**521**	**1,042**
140			GF	90	SOS appropriated services - crisis services and new beds	1,753	3,553	5,306	3,553	3,553	7,106	1,753	3,553	5,306	3,553	3,553	7,106
141			GF	REV2	SOS Collections - CSS Service Fees	(1,086)	(2,203)	(3,289)	(2,416)	(2,416)	(4,832)	(1,086)	(2,682)	(3,768)	(3,032)	(3,032)	(6,064)
142																	
143																	
144																	
145	21	GOV			**SOS SALARY DEFICIT**	**6,833**	**10,274**	**17,107**	**10,274**	**10,274**	**20,548**	**0**	**0**	**0**	**0**	**0**	**0**
146					**GF TOTAL**	**6,833**	**10,274**	**17,107**	**10,274**	**10,274**	**20,548**	**0**	**0**	**0**	**0**	**0**	**0**
147			GF	90	SOS salary supplement - GF	6,833	11,985	18,818	11,985	11,985	23,970	0	0	0	0	0	0
148			GF	REV2	SOS Collections	0	(1,711)	(1,711)	(1,711)	(1,711)	(3,422)	0	0	0	0	0	0
149																	
150																	

Trkg. Line	Page Number	Bill Reference	Fund	BACT	DESCRIPTION	GOVERNOR'S RECOMMENDATION FY 2006	FY 2007	FY 06-07	FY 2008	FY 2009	FY 08-09	SENATE FY 2006	FY 2007	FY 06-07	FY 2008	FY 2009	FY 08-09
151																	
152	22	GOV			**STUDY ON EPIDEMIOLOGY OF CHILDREN & JUVENILES**	**0**	**200**	**200**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
153					**AT RISK OF BECOMING PREDATORY SEX OFFENDERS**												
154					**GF TOTAL**	**0**	**200**	**200**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
155			GF	90	SOS appropriated services	0	200	200	0	0	0	0	0	0	0	0	0
156																	
157																	
158																	
159	24	GOV			**FEDERAL DEFICIT REDUCTION ACT REQUIREMENTS FOR HEALTH CARE**	**0**	**(170)**	**(170)**	**(3,135)**	**(3,832)**	**(6,967)**	**0**	**(661)**	**(661)**	**(3,258)**	**(3,955)**	**(7,213)**
160					**INCLUDES LTC PARTNERSHIP (SF 2898)**												
161					**GF TOTAL**	**0**	**(1,202)**	**(1,202)**	**(3,516)**	**(4,213)**	**(7,729)**	**0**	**(1,202)**	**(1,202)**	**(3,516)**	**(4,213)**	**(7,729)**
162					**HCAF TOTAL**	**0**	**1,032**	**1,032**	**381**	**381**	**762**	**0**	**541**	**541**	**258**	**258**	**516**
163			GF	36	Children and Economic Assistance Operations	0	8	8	0	0	0	0	8	8	0	0	0
164			GF	42	MA E&D Home equity limit	0	(325)	(325)	(325)	(325)	(650)	0	(325)	(325)	(325)	(325)	(650)
165			GF	50	Health Care Administration	0	1,203	1,203	1,184	637	1,821	0	1,203	1,203	1,184	637	1,821
166			GF	51	HC Operations	0	28	28	24	94	118	0	28	28	24	94	118
167			GF	72	MA LTC Facilities	0	(1,276)	(1,276)	(2,937)	(3,201)	(6,138)	0	(1,276)	(1,276)	(2,937)	(3,201)	(6,138)
168			GF	73	MA LTC Waivers	0	(415)	(415)	(1,038)	(1,213)	(2,251)	0	(415)	(415)	(1,038)	(1,213)	(2,251)
169			GF	85	Cont Care Management	0	93	93	83	83	166	0	93	93	83	83	166
170			GF	REV1	Administrative FFP	0	(518)	(518)	(507)	(288)	(795)	0	(518)	(518)	(507)	(288)	(795)
171			HCAF	51	Health Care Operations - Excludes GAMC or MNCare Adults without Children	0	1,720	1,720	635	635	1,270	0	574	574	258	258	516
172			HCAF	REV1	Administrative FFP	0	(688)	(688)	(254)	(254)	(508)	0	(33)	(33)	0	0	0
173																	
174																	
175																	
176	31	GOV			**MANDATORY ASSET VERIFICATION FOR GAMC AND MINNESOTA CARE**	**0**	**9**	**9**	**(2,526)**	**(5,211)**	**(7,737)**	**0**	**0**	**0**	**0**	**0**	**0**
177					**GF TOTAL**	**0**	**0**	**0**	**(493)**	**(1,052)**	**(1,545)**	**0**	**0**	**0**	**0**	**0**	**0**
178					**HCAF TOTAL**	**0**	**9**	**9**	**(2,033)**	**(4,159)**	**(6,192)**	**0**	**0**	**0**	**0**	**0**	**0**
179			GF	43	GAMC Asset verification	0	0	0	(493)	(1,052)	(1,545)	0	0	0	0	0	0
180			HCAF	40	MinnesotaCare asset verification	0	0	0	(2,033)	(4,159)	(6,192)	0	0	0	0	0	0
181			HCAF	51	MMIS - health match	0	9	9	0	0	0	0	0	0	0	0	0
182																	
183																	
184																	
185	33	GOV			**EXEMPT CERTAIN GAMC GROUPS FROM SHIFT TO MINNESOTA CARE**	**0**	**309**	**309**	**695**	**787**	**1,482**	**0**	**309**	**309**	**695**	**787**	**1,482**
186					**GF TOTAL**	**0**	**2,119**	**2,119**	**5,740**	**6,371**	**12,111**	**0**	**2,119**	**2,119**	**5,740**	**6,371**	**12,111**
187					**HCAF TOTAL**	**0**	**(1,810)**	**(1,810)**	**(5,045)**	**(5,584)**	**(10,629)**	**0**	**(1,810)**	**(1,810)**	**(5,045)**	**(5,584)**	**(10,629)**
188			GF	43	GAMC Grants	0	2,108	2,108	5,740	6,371	12,111	0	2,108	2,108	5,740	6,371	12,111
189			GF	36	Children & Economic Assistance Operations	0	11	11	0	0	0	0	11	11	0	0	0
190			HCAF	40	Minnesota Care Grants	0	(1,810)	(1,810)	(5,045)	(5,584)	(10,629)	0	(1,810)	(1,810)	(5,045)	(5,584)	(10,629)
191																	
192																	
193		SF 2725			**ELIMINATE ADD-BACK OF DEPRECIATION FOR FARM SELF-EMPLOYED INCOME**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1,056**	**1,084**	**2,140**
194					**GF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
195					**HCAF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1,056**	**1,084**	**2,140**
196			HCAF	40	Minnesota Care Grants - effective 7/01/07	0	0	0	0	0	0	0	0	0	1,056	1,084	2,140
197																	
198																	
199		SF 2725			**ELIMINATE MINNESOTACARE LIMITED BENEFIT SET**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**7,152**	**7,883**	**15,035**
200					**GF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
201					**HCAF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**7,152**	**7,883**	**15,035**
202			HCAF	40	Minnesota Care Grants - effective 7/01/07	0	0	0	0	0	0	0	0	0	7,428	8,060	15,488
203			HCAF	40	Interaction with Mental Health benefit set expansion	0	0	0	0	0	0	0	0	0	(162)	(160)	(322)
204			HCAF	40	Savings in day treatment and partial hospitalization MNCare payments	0	0	0	0	0	0	0	0	0	(114)	(17)	(131)
205																	
206																	
207		SF 2725			**MINNESOTACARE OPTION FOR SMALL EMPLOYERS**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**577**	**577**	**154**	**3,621**	**3,775**
208					**GF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
209					**HCAF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**577**	**577**	**154**	**3,621**	**3,775**
210			HCAF	40	Minnesota Care Grants - effective 7/01/08	0	0	0	0	0	0	0	0	0	0	3,300	3,300
211			HCAF	50	MinnesotaCare Grants - Administration and Actuary Costs	0	0	0	0	0	0	0	116	116	256	535	791
212			HCAF	REV1	Administrative ffp	0	0	0	0	0	0	0	(46)	(46)	(102)	(214)	(316)
213			HCAF	51	MMIS	0	0	0	0	0	0	0	507	507	0	0	0
214																	
215																	
216		SF 2725			**MMIS SYSTEMS USER SUPPORT FOR PDDP/SMALL EMPLOYER PROGRAM**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**52**	**52**	**97**	**143**	**240**
217					**GF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
218					**HCAF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**52**	**52**	**97**	**143**	**240**
219			HCAF	51	MMIS	0	0	0	0	0	0	0	86	86	162	238	400
220			HCAF	REV1	Administrative ffp	0	0	0	0	0	0	0	(34)	(34)	(65)	(95)	(160)
221																	
222																	
223		SF 2725			**ELIMINATE 8% PREMIUM INCREASE FOR MINNESOTACARE**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1,198**	**1,198**	**2,141**	**2,145**	**4,286**

Trkg. Line	Page Number	Bill Reference	Fund	BACT	DESCRIPTION	GOVERNOR'S RECOMMENDATION FY 2006	FY 2007	FY 06-07	FY 2008	FY 2009	FY 08-09	SENATE FY 2006	FY 2007	FY 06-07	FY 2008	FY 2009	FY 08-09
224					**GF TOTAL**	0	0	0	0	0	0	0	0	0	0	0	0
225					**HCAF TOTAL**	0	0	0	0	0	0	0	1,198	1,198	2,141	2,145	4,286
226			HCAF	40	Minnesota Care Grants - effective 7/01/07	0	0	0	0	0	0	0	1,198	1,198	2,141	2,145	4,286
227																	
228																	
229		SF 2477			**WAIVE MINNESOTACARE PREMIUMS FOR MILITARY MEMBERS AND FAMILIES**	0	0	0	0	0	0	0	0	0	1,298	1,417	2,715
230					**GF TOTAL**	0	0	0	0	0	0	0	0	0	0	0	0
231					**HCAF TOTAL**	0	0	0	0	0	0	0	0	0	1,298	1,417	2,715
232			HCAF	40	Minnesota Care Grants - effective 7/01/07	0	0	0	0	0	0	0	0	0	1,274	1,396	2,670
233			HCAF	50	MinnesotaCare Grants - Administration	0	0	0	0	0	0	0	0	0	40	35	75
234			HCAF	REV1	Administrative FFP	0	0	0	0	0	0	0	0	0	(16)	(14)	(30)
235																	
236																	
237		SF 2725			**EXPAND MINNESOTACARE ELIGIBILITY FOR ADULTS W/OUT KIDS TO 200% FPG**	0	0	0	0	0	0	0	73	73	3,599	11,915	15,514
238					**GF TOTAL**	0	0	0	0	0	0	0	0	0	0	0	0
239					**HCAF TOTAL**	0	0	0	0	0	0	0	73	73	3,599	11,915	15,514
240			HCAF	40	Minnesota Care Grants - effective 7/01/07	0	0	0	0	0	0	0	0	0	3,551	11,772	15,323
241			HCAF	40	MinnesotaCare Grants - Interaction with expansion of MH benefit set	0	0	0	0	0	0	0	0	0	48	143	191
242			HCAF	51	MMIS - 200% eligibility expansion and increase inpatient hospital cap	0	0	0	0	0	0	0	73	73	0	0	0
243																	
244																	
245		SF 2725			**INCREASE MINNESOTACARE INPATIENT HOSP. CAP FROM $10,000 TO $20,000**	0	0	0	0	0	0	0	0	0	3,711	3,844	7,555
246					**GF TOTAL**	0	0	0	0	0	0	0	0	0	0	0	0
247					**HCAF TOTAL**	0	0	0	0	0	0	0	0	0	3,711	3,844	7,555
248			HCAF	40	Minnesota Care Grants - effective 7/01/07	0	0	0	0	0	0	0	0	0	3,711	3,844	7,555
249																	
250																	
251		SF 2725			**ELIMINATE DENTAL COPAYS FOR ADULTS W/OUT KIDS AND PARENTS <175%**	0	0	0	0	0	0	0	0	0	3,874	4,044	7,918
252					**GF TOTAL**	0	0	0	0	0	0	0	0	0	0	0	0
253					**HCAF TOTAL**	0	0	0	0	0	0	0	0	0	3,874	4,044	7,918
254			HCAF	40	Minnesota Care Grants - Adults w/out children, effective 7/01/07	0	0	0	0	0	0	0	0	0	2,957	3,238	6,195
255			HCAF	40	Minnesota Care Grants - Parents <175% fpg, effective 7/01/07	0	0	0	0	0	0	0	0	0	917	806	1,723
256																	
257																	
258		SF 2725			**TWO MONTH HEALTHMATCH DELAY FOR CERTAIN SF 2725 PROVISIONS**	0	0	0	0	0	0	0	929	929	(62)	(31)	(93)
259					**GF TOTAL**	0	0	0	0	0	0	0	0	0	(7,702)	(4,214)	(11,916)
260					**HCAF TOTAL**	0	0	0	0	0	0	0	929	929	7,640	4,183	11,823
261			HCAF	40	Minnesota Care Grants - MinnesotaCare Shift to MA	0	0	0	0	0	0	0	0	0	7,640	4,183	11,823
262			GF	41	MA Basic Health Care: F&C - MinnesotaCare Shift to MA	0	0	0	0	0	0	0	0	0	(7,702)	(4,214)	(11,916)
263			HCAF	51	Health Care Operations - HealthMatch Admin/systems cost	0	0		0	0		0	929	929	0	0	0
264																	
265																	
266		SF 2725			**ELIMINATE MINNESOTA INSURANCE BARRIERS FOR CHILDREN ABOVE 150% FP**	0	0	0	0	0	0	0	0	0	6	961	967
267					**GF TOTAL**	0	0	0	0	0	0	0	0	0	0	0	0
268					**HCAF TOTAL**	0	0	0	0	0	0	0	0	0	6	961	967
269			HCAF	40	Minnesota Care Grants - effective 1/01/09	0	0	0	0	0	0	0	0	0	0	919	919
270			HCAF	50	Health Care Administration	0	0	0	0	0	0	0	0	0	0	70	70
271			HCAF	REV1	Administrative ffp	0	0	0	0	0	0	0	0	0	0	(28)	(28)
272			HCAF	51	Health Care Operations - systems costs	0	0	0	0	0	0	0	0	0	6	0	6
273																	
274																	
275		SF 3016			**PERMIT MINNESOTACARE ELIGIBILITY FOR UNDOCUMENTED CHILDREN**	0	0	0	0	0	0	0	0	0	17	1,438	1,455
276					**GF TOTAL**	0	0	0	0	0	0	0	0	0	0	0	0
277					**HCAF TOTAL**	0	0	0	0	0	0	0	0	0	17	1,438	1,455
278			HCAF	40	Minnesota Care Grants - effective 1/01/09	0	0	0	0	0	0	0	0	0	0	1,438	1,438
279			HCAF	51	MMIS	0	0	0	0	0	0	0	0	0	6	0	6
280			HCAF	51	HealthMatch Cost	0	0	0	0	0	0	0	0	0	11	0	11
281																	
282																	
283		SF 2725			**COVER MEDICARE COPAYMENTS FOR DUAL ELIGIBLES**	0	0	0	0	0	0	0	11,467	11,467	11,931	12,287	24,218
284					**GF TOTAL**	0	0	0	0	0	0	0	0	0	0	0	0
285					**HCAF TOTAL**	0	0	0	0	0	0	0	11,467	11,467	11,931	12,287	24,218
286			HCAF	45	Other Health Care Grants	0	0	0	0	0	0	0	11,420	11,420	11,909	12,265	24,174
287			HCAF	51	MMIS	0	0	0	0	0	0	0	22	22	0	0	0
288			HCAF	50	Administration	0	0	0	0	0	0	0	41	41	36	36	72
289			HCAF	REV1	Administrative ffp	0	0	0	0	0	0	0	(16)	(16)	(14)	(14)	(28)
290																	
291																	
292		SF 2725			**REINSTATE MINNESOTACARE OUTREACH GRANTS**	0	0	0	0	0	0	0	846	846	846	846	1,692
293					**GF TOTAL**	0	0	0	0	0	0	0	0	0	0	0	0
294					**HCAF TOTAL**	0	0	0	0	0	0	0	846	846	846	846	1,692
295			HCAF	45	Other Health Care Grants - Outreach Grants	0	0	0	0	0	0	0	750	750	750	750	1,500
296			HCAF	50	Administration	0	0	0	0	0	0	0	160	160	160	160	320
297			HCAF	REV1	Administrative FFP	0	0	0	0	0	0	0	(64)	(64)	(64)	(64)	(128)

Trkg. Line	Page Number	Bill Reference	Fund	BACT	DESCRIPTION	GOVERNOR'S RECOMMENDATION FY 2006	FY 2007	FY 06-07	FY 2008	FY 2009	FY 08-09	SENATE FY 2006	FY 2007	FY 06-07	FY 2008	FY 2009	FY 08-09
298																	
299																	
300		SF 2725			**RESTORE CRITICAL ACCESS DENTAL PAYMENTS**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**3,610**	**3,610**	**6,687**	**7,878**	**14,565**
301					**GF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**6,687**	**7,878**	**14,565**
302					**HCAF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**3,610**	**3,610**	**0**	**0**	**0**
303			HCAF	45	Appropriation for Critical Access Dental Payments	0	0	0	0	0	0	0	3,532	3,532	0	0	0
304			GF	45	Appropriation for Critical Access Dental Payments	0	0	0	0	0	0	0	0	0	6,687	7,878	14,565
305			HCAF	51	MMIS systems costs	0	0	0	0	0	0	0	53	53	0	0	0
306			HCAF	50	Actuarial costs for Critical Dental Payments	0	0	0	0	0	0	0	25	25	0	0	0
307																	
308																	
309		SF 2725			**CRITICAL ACCESS DENTAL GRANTS FOR FQHC/SAFETY NET CLINICS**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**300**	**300**	**300**	**300**	**600**
310					**GF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
311					**HCAF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**300**	**300**	**300**	**300**	**600**
312			HCAF	45	Appropriation for Critical Access Dental Grants to Safety Net Clinics	0	0	0	0	0	0	0	300	300	300	300	600
313																	
314																	
315		SF 2725			**HEALTHCARE GRANTS TO FQHC/SAFETY NET CLINICS**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1,500**	**1,500**	**1,500**	**1,500**	**3,000**
316					**GF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
317					**HCAF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1,500**	**1,500**	**1,500**	**1,500**	**3,000**
318			HCAF	45	Appropriation for Disease Management, Information Tech and Disparities Grants	0	0	0	0	0	0	0	1,200	1,200	1,200	1,200	2,400
319			HCAF	45	Appropriation for Coordinated Safety Net Care Network Pilot Project	0	0	0	0	0	0	0	300	300	300	300	600
320																	
321																	
322		SF 2725			**PROVIDER RATE INCREASE THROUGH MINNESOTACARE - 2.049% EFF. FY 07**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**7,320**	**7,320**	**7,320**	**7,320**	**14,640**
323					**GF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
324					**HCAF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**7,320**	**7,320**	**7,320**	**7,320**	**14,640**
325			HCAF	40	MinnesotaCare Grants	0	0	0	0	0	0	0	7,320	7,320	7,320	7,320	14,640
326																	
327																	
328	35	GOV			**PAY-FOR-PERFORMANCE FOR HEALTH CARE PROVIDERS**	**0**	**280**	**280**	**274**	**286**	**560**	**0**	**280**	**280**	**274**	**0**	**274**
329					**GF TOTAL**	**0**	**75**	**75**	**75**	**85**	**160**	**0**	**75**	**75**	**75**	**0**	**75**
330					**HCAF TOTAL**	**0**	**205**	**205**	**199**	**201**	**400**	**0**	**205**	**205**	**199**	**0**	**199**
331			GF	41	MA Basic Health Care: F&C	0	75	75	75	85	160	0	75	75	75	0	75
332			HCAF	40	Minnesota Care Grants	0	18	18	18	20	38	0	18	18	18	0	18
333			HCAF	50	Health Care Administration	0	311	311	301	301	602	0	311	311	301	0	301
334			HCAF	REV1	Administrative FFP	0	(124)	(124)	(120)	(120)	(240)	0	(124)	(124)	(120)	0	(120)
335																	
336																	
337																	
338	37	GOV			**MINNESOTA PHARMACY ACCESS PROGRAM**	**0**	**200**	**200**	**1,858**	**1,272**	**3,130**	**0**	**0**	**0**	**0**	**0**	**0**
339					**HCAF TOTAL**	**0**	**200**	**200**	**1,858**	**1,272**	**3,130**	**0**	**0**	**0**	**0**	**0**	**0**
340			HCAF	50	Health Care Administration	0	190	190	470	470	940	0	0	0	0	0	0
341			HCAF	51	Health Care Operations	0	86	86	0	0	0	0	0	0	0	0	0
342			HCAF	REV1	Administrative FFP	0	(76)	(76)	(188)	(188)	(376)	0	0	0	0	0	0
343			HCAF	REV2	Transfer to dedicated special revenue fund-MPAP - rebate cash flow	0	0	0	1,576	990	2,566	0	0	0	0	0	0
344																	
345																	
346		SF 2725			**PRESCRIPTION DRUG DISCOUNT PROGRAM**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**218**	**218**	**2,246**	**916**	**3,162**
347					**HCAF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**218**	**218**	**2,246**	**916**	**3,162**
348			HCAF	50	Health Care Administration	0	0	0	0	0	0	0	190	190	470	0	470
349			HCAF	51	Health Care Operations	0	0	0	0	0	0	0	104	104	39	0	39
350			HCAF	REV1	Administrative FFP	0	0	0	0	0	0	0	(76)	(76)	(188)	0	(188)
351			HCAF	REV2	Transfer to dedicated special revenue fund-MPAP - rebate cash flow	0	0	0	0	0	0	0	0	0	1,925	916	2,841
352																	
353																	
354		SF 3240			**PHARMACY PAYMENT REFORM ADVISORY GROUP**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**45**	**45**	**0**	**0**	**0**
355					**GF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**45**	**45**	**0**	**0**	**0**
356			GF	50	Health Care Administration - admin for work group and cost of study	0	0	0	0	0	0	0	75	75	0	0	0
357			GF	REV1	Administrative ffp	0	0	0	0	0	0	0	(30)	(30)	0	0	0
358																	
359																	
360	40	GOV			**MEDICARE PART D IMPLEMENTATION: ENROLLMENT AND ACCESS**	**500**	**1,482**	**1,982**	**1,356**	**1,356**	**2,712**	**0**	**0**	**0**	**0**	**0**	**0**
361					**HCAF TOTAL**	**500**	**1,482**	**1,982**	**1,356**	**1,356**	**2,712**	**0**	**0**	**0**	**0**	**0**	**0**
362			HCAF	50	Health Care Administration	0	279	279	246	246	492	0	0	0	0	0	0
363			HCAF	70	Grants to AAA's for I and A	500	1,250	1,750	1,150	1,150	2,300	0	0	0	0	0	0
364			HCAF	85	Continuing Care Management	0	108	108	98	98	196	0	0	0	0	0	0
365			HCAF	REV1	Administrative FFP	0	(155)	(155)	(138)	(138)	(276)	0	0	0	0	0	0
366																	
367																	
368																	
369	44	GOV			**PERFORMANCE - INCENTIVE PAYMENTS FOR NURSING FACILITIES**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Trkg. Line	Page Number	Bill Reference	Fund	BACT	DESCRIPTION	GOVERNOR'S RECOMMENDATION FY 2006	FY 2007	FY 06-07	FY 2008	FY 2009	FY 08-09	SENATE FY 2006	FY 2007	FY 06-07	FY 2008	FY 2009	FY 08-09
370					**GF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
371			GF	72	MA LTC Facilities Grants	0	0	0	1,196	6,714	7,910	0	0	0	1,196	6,714	7,910
372			GF	72	MA LTC Facilities Grants	0	0	0	(1,196)	(6,714)	(7,910)	0	0	0	(1,196)	(6,714)	(7,910)
373																	
374																	
375																	
376	46	GOV			**RATE INCREASE FOR NURSING FACILITIES IN BENTON**	**0**	**1,788**	**1,788**	**1,954**	**1,957**	**3,911**	**0**	**0**	**0**	**0**	**0**	**0**
377					**SHERBURNE AND STEARNS COUNTIES**												
378					**GF TOTAL**	**0**	**1,788**	**1,788**	**1,954**	**1,957**	**3,911**	**0**	**0**	**0**	**0**	**0**	**0**
379			GF	72	Increase rates for NF's in three counties	0	1,788	1,788	1,954	1,957	3,911	0	0	0	0	0	0
380																	
381																	
382																	
383	47	GOV			**AH-GWAH-CHING CONVEYANCE PROPERTY PAYMENT RATE**	**0**	**0**	**0**	**125**	**140**	**265**	**0**	**0**	**0**	**49**	**55**	**104**
384					**GF TOTAL**	**0**	**0**	**0**	**125**	**140**	**265**	**0**	**0**	**0**	**49**	**55**	**104**
385			GF	72	MA LTC Facilities - Property rate of $25 a day	0	0	0	125	140	265	0	0	0	49	55	104
386																	
387																	
388																	
389	48	GOV			**ALTERNATIVE CARE PROGRAM FUNDING SHORTFALL**	**0**	**2,563**	**2,563**	**145**	**654**	**799**	**0**	**2,563**	**2,563**	**145**	**654**	**799**
390					**GF TOTAL**	**0**	**2,563**	**2,563**	**145**	**654**	**799**	**0**	**2,563**	**2,563**	**145**	**654**	**799**
391			GF	72	MA LTC Facilities	0	(627)	(627)	(1,169)	(144)	(1,313)	0	(627)	(627)	(1,169)	(144)	(1,313)
392			GF	42	MA Elderly and disabled	0	(147)	(147)	(286)	(35)	(321)	0	(147)	(147)	(286)	(35)	(321)
393			GF	71	Alternative care	0	3,337	3,337	1,600	833	2,433	0	3,337	3,337	1,600	833	2,433
394																	
395																	
396		SF 3322			**REVERSE MORTGAGE INCENTIVE PROGRAM**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**129**	**129**	**71**	**71**	**142**
397					**GF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**129**	**129**	**71**	**71**	**142**
398			GF	85	AC program costs to manage interagency agreement - .5 fte	0	0	0	0	0	0	0	0	0	0	0	0
399			GF	85	RMI and AC program material costs	0	0	0	0	0	0	0	100	100	50	50	100
400			GF	70	SLI -client tracking system update	0	0	0	0	0	0	0	25	25	0	0	0
401			GF	85	Mortgage insurance	0	0	0	0	0	0	0	38	38	38	38	76
402			GF	51	MMIS	0	0	0	0	0	0	0	18	18	18	18	36
403			GF	REV1	Administrative ffp	0	0	0	0	0	0	0	(52)	(52)	(35)	(35)	(70)
404																	
405																	
406		SF 2675			**MEEKER COUNTY DT & H PROVIDER RATE INCREASE (ONE TIME)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**29**	**29**	**0**	**0**	**0**
407					**GF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**29**	**29**	**0**	**0**	**0**
408			GF	71	MA long term care waivers	0	0	0	0	0	0	0	29	29	0	0	0
409																	
410																	
411		SF 3399			**MEDICARE-APPROVED SPECIAL PLAN NEEDS CONTRACTING**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**84**	**84**	**60**	**60**	**120**
412					**GF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**84**	**84**	**60**	**60**	**120**
413			GF	50	Health Care Administration - 1 fte for stakeholder group, planning for special needs purchasing	0	0	0	0	0	0	0	100	100	100	100	200
414			GF	51	MMIS Costs	0	0	0	0	0	0	0	24	24	0	0	0
415			GF	REV1	Administrative ffp	0	0	0	0	0	0	0	(40)	(40)	(40)	(40)	(80)
416																	
417																	
418		SF 3085			**GROUP RESIDENTIAL PILOT PROJECTED ESTABLISHED**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**168**	**168**	**168**	**168**	**336**
419					**GF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**168**	**168**	**168**	**168**	**336**
420			GF	30	GRH supplementary service rate of $700 a month	0	0	0	0	0	0	0	168	168	168	168	336
421																	
422																	
423		SF XXXX			**ELIMINATE CHILD CARE PROVIDER RATE FREEZE - MFIP/TY PORTION**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**13,934**	**13,934**	**23,381**	**28,769**	**52,150**
424					**GF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**23,381**	**28,769**	**52,150**
425					**TANF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**13,934**	**13,934**	**0**	**0**	**0**
426			GF	22	MFIP Child Care Assistance Grants	0	0	0	0	0	0	0	0	0	23,094	28,769	51,863
427			TANF	22	MFIP Child Care Assistance Grants	0	0	0	0	0	0	0	13,677	13,677	0	0	0
428			TANF	35	Administrative allowance and direct service cost due to transition	0	0	0	0	0	0	0	257	257	0	0	0
429			GF	35	Administrative allowance and direct service cost due to transition	0	0	0	0	0	0	0	0	0	287	0	287
430																	
431																	
432		SF XXXX			**CHILD CARE ACCREDITATION DIFFERENTIAL 15% - MFIP/TY PORTION**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**609**	**609**	**859**	**899**	**1,758**
433					**GF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**859**	**899**	**1,758**
434					**TANF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**609**	**609**	**0**	**0**	**0**
435			GF	22	MFIP Child Care Assistance Grants	0	0	0	0	0	0	0	0	0	818	856	1,674
436			TANF	22	MFIP Child Care Assistance Grants	0	0	0	0	0	0	0	580	580	0	0	0
437			TANF	35	County administrative allowance	0	0	0	0	0	0	0	29	29	0	0	0
438			GF	35	County administrative allowance	0	0	0	0	0	0	0	0	0	41	43	84
439																	
440																	
441		SF XXXX			**REDUCE CHILD CARE COPAYMENTS - MFIP/TY PORTION**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**510**	**510**	**688**	**690**	**1,378**
442					**GF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**688**	**690**	**1,378**
443					**TANF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**510**	**510**	**0**	**0**	**0**

Trkg. Line	Page Number	Bill Reference	Fund	BACT	DESCRIPTION	GOVERNOR'S RECOMMENDATION FY 2006	FY 2007	FY 06-07	FY 2008	FY 2009	FY 08-09	SENATE FY 2006	FY 2007	FY 06-07	FY 2008	FY 2009	FY 08-09
444			GF	22	MFIP Child Care Assistance Grants	0	0	0	0	0	0	0	0	0	656	657	1,313
445			TANF	22	MFIP Child Care Assistance Grants	0	0	0	0	0	0	0	486	486	0	0	0
446			TANF	35	County administrative allowance	0	0	0	0	0	0	0	24	24	0	0	0
447			GF	35	County administrative allowance	0	0	0	0	0	0	0	0	0	32	33	65
448																	
449																	
450		SF XXXX			**ALLOW PAYMENT FOR CHILD CARE HALF-DAY RATES - MFIP/TY PORTION**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**298**	**298**	**517**	**546**	**1,063**
451					**GF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**517**	**546**	**1,063**
452					**TANF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**298**	**298**	**0**	**0**	**0**
453			GF	22	MFIP Child Care Assistance Grants	0	0	0	0	0	0	0	0	0	493	520	1,013
454			TANF	22	MFIP Child Care Assistance Grants	0	0	0	0	0	0	0	284	284	0	0	0
455			TANF	35	County administrative allowance	0	0	0	0	0	0	0	14	14	0	0	0
456			GF	35	County administrative allowance	0	0	0	0	0	0	0	0	0	24	26	50
457																	
458																	
459		SF XXXX			**CHILD CARE ABSENT-DAY LIMITS REPEALED - MFIP/TY PORTION**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**661**	**661**	**816**	**851**	**1,667**
460					**GF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**816**	**851**	**1,667**
461					**TANF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**661**	**661**	**0**	**0**	**0**
462			GF	22	MFIP Child Care Assistance Grants	0	0	0	0	0	0	0	0	0	777	811	1,588
463			TANF	22	MFIP Child Care Assistance Grants	0	0	0	0	0	0	0	630	630		0	0
464			TANF	35	County administrative allowance	0	0	0	0	0	0	0	31	31	0	0	0
465			GF	35	County administrative allowance	0	0	0	0	0	0	0	0	0	39	40	79
466																	
467																	
468		SF 3307			**CHEMICAL USE ASSESSMENTS DHS STUDY AND DUTIES**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**48**	**48**	**30**	**30**	**60**
469					**GF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**48**	**48**	**30**	**30**	**60**
470			GF	85	Licensing information system	0	0	0	0	0	0	0	35	35	35	35	70
471			GF	85	Substance abuse program directory	0	0	0	0	0	0	0	45	45	15	15	30
472			GF	REV1	Administrative ffp	0	0	0	0	0	0	0	(32)	(32)	(20)	(20)	(40)
473																	
474																	
475		SF 3208			**POST-ADOPTION SEARCH SERVICES TRAINING**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**5**	**5**	**5**	**5**	**10**
476					**GF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**5**	**5**	**5**	**5**	**10**
477			GF	35	Children and Economic Assistance Management - curriculum development and six hour course	0	0	0	0	0	0	0	7	7	7	7	14
478			GF	REV1	Administrative ffp	0	0	0	0	0	0	0	(2)	(2)	(2)	(2)	(4)
479																	
480																	
481		SF 3346			**ADJUST APPROPRIATION FOR MINNESOTA FOOD ASSISTANCE PROGRAM**	**0**	**0**	**0**	**0**	**0**	**0**	**(361)**	**(452)**	**(813)**	**(452)**	**(452)**	**(904)**
482					**GF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**(361)**	**(452)**	**(813)**	**(452)**	**(452)**	**(904)**
483			GF	32	Decrease MFAP appropriation to be consistent with demand (assumes Food Stamp assest limit $7000)	0	0	0	0	0	0	(370)	(452)	(822)	(452)	(452)	(904)
484			GF	36	Food Support Eligibilty systems change (assumes Food Stamp assest limit $7000)	0	0	0	0	0	0	9	0	9	0	0	0
485																	
486																	
487		SF 3346			**DOMESTIC VIOLENCE INFORMATION BROCHURE**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**51**	**51**	**51**	**51**	**102**
488					**GF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
489					**TANF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**51**	**51**	**51**	**51**	**102**
490			TANF	35	Children and Economic Assistance Administration - cost of producting brochure	0	0	0	0	0	0	0	51	51	51	51	102
491																	
492																	
493		SF 3346			**NEW CHANCE PROGRAM APPROPRIATION**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**140**	**140**	**140**	**140**	**280**
494					**GF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
495					**TANF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**140**	**140**	**140**	**140**	**280**
496			TANF	32	Other Children & Economic Assistance Grants	0	0	0	0	0	0	0	140	140	140	140	280
497																	
498																	
499																	
500		SF 3103			**MFIP WORK PARTICIPATION RATE ENHANCEMENT PROGRAM**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**463**	**463**	**4,284**	**5,566**	**9,850**
501					**GF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
502					**TANF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**463**	**463**	**4,284**	**5,566**	**9,850**
503			TANF	20	Sanction policy for Work Prep program	0	0	0	0	0	0	0	56	56	74	74	148
504			TANF	20	Work requirements for Work Prep educational plans	0	0	0	0	0	0	0	166	166	363	363	726
505			TANF	36	Systems costs	0	0	0	0	0	0	0	241	241	0	0	0
506			TANF	20	MFIP Work Participation Bonus	0	0	0	0	0	0	0	0	0	2,891	3,854	6,745
507			TANF	20	DWP Work Participation Bonus	0	0	0	0	0	0	0	0	0	956	1,275	2,231
508																	
509																	
510		SF 3016			**REPEAL $50 MFIP SUBSIDIZED HOUSING PENALTY**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**2,459**	**2,459**	**2,028**	**2,690**	**4,718**
511					**GF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**446**	**2,690**	**3,136**
512					**TANF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**2,459**	**2,459**	**1,582**	**0**	**1,582**
513			TANF	20	MFIP/DWP grants	0	0	0	0	0	0	0	2,459	2,459	1,582	0	1,582
514			GF	20	MFIP/DWP grants	0	0	0	0	0	0	0	0	0	446	2,690	3,136
515																	
516																	

Trkg. Line	Page Number	Bill Reference	Fund	BACT	DESCRIPTION	GOVERNOR'S RECOMMENDATION FY 2006	FY 2007	FY 06-07	FY 2008	FY 2009	FY 08-09	SENATE FY 2006	FY 2007	FY 06-07	FY 2008	FY 2009	FY 08-09
517		SF XXXX	**SPECIAL REVENUE ACCOUNT TRANSFER**			**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
518					**GF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(900)**	**(900)**	**0**	**0**	**0**
519					**SPECIAL REVENUE TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**900**	**900**	**0**	**0**	
520			GF	REV2	Account transfer	0	0	0	0	0	0	0	(900)	(900)	0	0	0
521			DED	REV3	Account transfer	0	0	0	0	0	0	0	900	900	0	0	0
522																	
523																	
524	50	GOV	**FEDERAL DEFICIT REDUCTION ACT REQUIREMENT FOR**			**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
525			**$25 FEDERAL CHILD SUPPORT ENFORCEMENT COLLECTION FEE**														
526					**GF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
527					Special Revenue Fund Impact	0	0	0	0	0	0	0	0	0	0	0	0
528																	
529																	
530																	
531	52	GOV	**TANF RELATED EXPENDITURES DESIGNATED AS MAINTENANCE OF EFFORT**			**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
532						**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
533																	
534																	
535																	
536	54	GOV	**COUNTY FLEXIBILITY TO ADDRESS ONE-TIME ACCELERATION OF TIMING**			**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
537			**OF CHILD CARE PAYMENTS**														
538					**GF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
539					Rider Only	0	0	0	0	0	0	0	0	0	0	0	0
540																	
541																	
542																	
543	56	GOV	**FEDERAL HURRICANE RELIEF FUNDS: COUNTY ALLOCATIONS**			**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
544					**GF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
545					Rider only												
546																	
547																	
548	57	GOV	**TANF/CCDF REFINANCING**			**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
549					**GF TOTAL**	**0**	**(10,067)**	**(10,067)**	**(10,067)**	**(10,067)**	**(20,134)**	**0**	**0**	**0**	**0**	**0**	**0**
550					**TANF TOTAL**	**0**	**10,067**	**10,067**	**10,067**	**10,067**	**20,134**	**0**	**0**	**0**	**0**	**0**	**0**
551			GF	22	MFIP Child Care Assistance Grants - Refinance with TANF	0	(10,067)	(10,067)	(10,067)	(10,067)	(20,134)	0	0	0	0	0	0
552			TANF	22	MFIP Child Care Assistance Grants	0	10,067	10,067	10,067	10,067	20,134	0	0	0	0	0	0
553																	
554																	
555																	
556																	
557																	
558																	
559		***DEPARTMENT OF HEALTH***															
560																	
561																	
562		GOV	**MINNESOT E-HEALTH INITIATIVE**			**0**	**11,000**	**11,000**	**500**	**500**	**1,000**	**0**	**9,414**	**9,414**	**293**	**293**	**586**
563					**HCAF TOTAL**	**0**	**11,000**	**11,000**	**500**	**500**	**1,000**	**0**	**9,414**	**9,414**	**293**	**293**	**586**
564																	
565			HCAF	2	Grants to support community collabratives	0	10,500	10,500	0	0	0	0	9,121	9,121	0	0	0
566			HCAF	2	Minnesota E-Health coordination - 2ftes	0	500	500	500	500	1,000	0	293	293	293	293	586
567																	
568		GOV	**PANDEMIC INFLUENZA PREPAREDNESS**			**0**	**10,500**	**10,500**	**10,500**	**10,500**	**21,000**	**0**	**2,510**	**2,510**	**1,660**	**1,660**	**3,320**
569					**GF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**2,510**	**2,510**	**1,660**	**1,660**	**3,320**
570					**HCAF TOTAL**	**0**	**10,500**	**10,500**	**10,500**	**10,500**	**21,000**	**0**	**0**	**0**	**0**	**0**	**0**
571			HCAF	3	Preparing Communities to Respond	0	4,930	4,930	5,940	5,940	11,880	0	0	0	0	0	0
572			HCAF	3	Infection Control	0	100	100	100	100	200	0	0	0	0	0	0
573			HCAF	3	*Disease Surveillance & Lab Capacity*	0	300	300	300	300	600	0	0	0	0	0	0
574			HCAF	3	Use and Distribution of Vaccine	0	100	100	100	100	200	0	0	0	0	0	0
575			HCAF	3	Use and Distribution of Antiviral Drugs	0	2,510	2,510	1,660	1,660	3,320	0	0	0	0	0	0
576			HCAF	3	Communication and Public Education	0	550	550	550	550	1,100	0	0	0	0	0	0
577			HCAF	3	State agency preparation & coordination	0	950	950	950	950	1,900	0	0	0	0	0	0
578			HCAF	3	Infrastructure & Business Continuity	0	100	100	100	100	200	0	0	0	0	0	0
579			HCAF	3	Testing the System	0	960	960	800	800	1,600	0	0	0	0	0	0
580			GF	3	Use and Distribution of Vaccine	0	0	0	0	0	0	0	100	100	100	100	200
581			GF	3	Use and Distribution of Antiviral Drugs	0	0	0	0	0	0	0	2,410	2,410	1,560	1,560	3,120
582																	
583																	
584		GOV	**IMMIGRANT HEALTH INITIATIVE**			**0**	**500**	**500**	**500**	**500**	**1,000**	**0**	**0**	**0**	**0**	**0**	**0**
585					**HCAF TOTAL**	**0**	**500**	**500**	**500**	**500**	**1,000**	**0**	**0**	**0**	**0**	**0**	**0**

Trkg. Line	Page Number	Bill Reference	Fund	BACT	DESCRIPTION	GOVERNOR'S RECOMMENDATION FY 2006	FY 2007	FY 06-07	FY 2008	FY 2009	FY 08-09	SENATE FY 2006	FY 2007	FY 06-07	FY 2008	FY 2009	FY 08-09
586			HCAF	3	Perinatal Hepatitis B	0	210	210	210	210	420	0	0	0	0	0	0
587			HCAF	3	Tuberculosis	0	290	290	290	290	580	0	0	0	0	0	0
588																	
589		SF XXXX	**RESTORE FAMILY PLANNING GRANTS**			**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1,887**	**1,887**	**3,774**
590					**GF TOTAL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1,887**	**1,887**	**3,774**
591			GF	2	Family planning grants	0	0	0	0	0	0	0	0	0	1,887	1,887	3,774
592																	
593		SF 2888	**ASSISTED LIVING REQUIREMENTS; LICENSING AND REGULATION**			**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
594					**SGSR**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
595			SGSR	3	Enforcement activities for Housing with Services providers	0	0	0	0	0	0	0	140	140	280	280	560
596			SGSR	REV	Registration fee $20 for Housing with Services, Assisted Living and Home Care providers	0	0	0	0	0	0	0	(140)	(140)	(280)	(280)	(560)
739																	
740																	
741		***VETERANS NURSING HOMES BOARD***															
742																	
743																	
744		GOV	**CONSULTANT STUDY RECOMMENDATIONS**			**382**	**1,163**	**1,545**	**1,163**	**1,163**	**2,326**	**382**	**1,163**	**1,545**	**1,163**	**1,163**	**2,326**
745					**GF TOTAL**	**382**	**1,163**	**1,545**	**1,163**	**1,163**	**2,326**	**382**	**1,163**	**1,545**	**1,163**	**1,163**	**2,326**
746			GF	1	General Fund appropriation	382	1,163	1,545	1,163	1,163	2,326	382	1,163	1,545	1,163	1,163	2,326
747																	
748		GOV	**OPERATIONAL SHORTFALL**			**0**	**759**	**759**	**4,704**	**4,704**	**9,408**	**0**	**759**	**759**	**4,704**	**4,704**	**9,408**
749					**GF TOTAL**	**0**	**759**	**759**	**4,704**	**4,704**	**9,408**	**0**	**759**	**759**	**4,704**	**4,704**	**9,408**
750			GF	1	General Fund appropriation	0	759	759	4,704	4,704	9,408	0	759	759	4,704	4,704	9,408
751																	
752		GOV	**QUALITY ASSURANCE**			**2,448**	**2,674**	**5,122**	**2,674**	**2,674**	**5,348**	**2,448**	**2,674**	**5,122**	**2,674**	**2,674**	**5,348**
753					**GF TOTAL**	**2,448**	**2,674**	**5,122**	**2,674**	**2,674**	**5,348**	**2,448**	**2,674**	**5,122**	**2,674**	**2,674**	**5,348**
754			GF	1	General Fund appropriation	2,448	2,674	5,122	2,674	2,674	5,348	2,448	2,674	5,122	2,674	2,674	5,348
755																	
761																	
762		***HEALTH-RELATED BOARDS***															
763																	
764																	
765		GOV	**HEALTH RELATED BOARDS ADJUSTMENTS**			**514**	**72**	**586**	**67**	**67**	**134**	**514**	**72**	**586**	**67**	**67**	**134**
766					**SGSR TOTAL**	**514**	**72**	**586**	**67**	**67**	**134**	**514**	**72**	**586**	**67**	**67**	**134**
767			SGSR	5	Medical Practice Board - Contested case expenditures	500	0	500	0	0	0	500	0	500	0	0	0
768			SGSR	10	Physical Therapy Board - Payment system conversion	9	0	9	0	0	0	9	0	9	0	0	0
769			SGSR	1	Chiropractics Board - Payment system conversion	5	5	10	0	0	0	5	5	10	0	0	0
770			SGSR	2	Denistry Board - Retain legal anaylst	0	67	67	67	67	134	0	67	67	67	67	134
771																	
772																	
773																	
774		***EMERGENCY MEDICAL SERVICES BOARD***															
775																	
776																	
777		GOV	**HEALTH PROFESSIONAL SERVICE PROGRAM OPERATING INCREASE**			**0**	**50**	**50**	**50**	**50**	**100**	**0**	**50**	**50**	**50**	**50**	**100**
778					**SGSR TOTAL**	**0**	**50**	**50**	**50**	**50**	**100**	**0**	**50**	**50**	**50**	**50**	**100**
779			SGSR	1	SGSR appropriation	0	50	50	50	50	100	0	50	50	50	50	100
780																	
781																	

Federal TANF Reserve F.Y. 2004 - F.Y. 2009 February 2005

($ in thousands)

	F.Y. 2005	F.Y. 2006	F.Y. 2007	F.Y. 2008	F.Y. 2009
Actual & Estimated Resources					
Balance Forward From Prior Year	40,885	81,188	72,649	8,470	4,730
Prior year adjustment	416	251	-	-	-
Rounding adj	1	0	1	0	1
Adjusted Balance Forward	41,302	81,439	72,650	8,470	4,731
Block Grant* ***	266,230	263,434	263,434	263,434	263,434
Performance Award**	13,399	13,399	-	-	-
TANF Contingency		50			
Total Resources Available	320,931	358,322	336,084	271,904	268,165
Actual & Estimated Uses					
Expenditures:					
Education Finance					
Children, Families & Learning, Dept of	-	-	-	-	-
Health, Human Services & Corrections					
Interagency Agreement of LIHEAP	-	13,399	-	-	-
10 Financial Management	67	122	122	122	122
11 Legal and Regulatory Affairs	108	100	100	100	100
15 Admin. Reimbursement & Pass Through Less Transfers	3,282	6,324	6,310	6,310	6,310
20 MFIP/DWP Grant	85,849	101,871	114,404	94,552	96,393
21 Support Services Grants	95,207	102,844	102,632	102,632	102,632
25 Child Support Enforcement Grants	-	-	-	-	-
32 Other Children and Economic Assistance Grants	-	1,327	1,327	-	-
MFIP Work Participation Rate Enhancement Program -SF 3103	-	-	463	4,284	5,566
Eliminate $50 MFIP Subsidized Housing Penalty	-	-	2,459	1,582	
New Chance Appropriation	-	-	140	140	140
Domestic Violence Brochure - SF3346	-	-	51	51	51
MFIP/TY Eliminate Child Care Provider Rate Freeze	-	-	13,934	-	-
MFIP/TY Accreditation Incentive 15%	-	-	609	-	-
MFIP/TY Half Day Rates	-	-	298		
MFIP/TY Reduce Copayments	-	-	510	-	-
MFIP/TY Absent Day Policy Repeal	-	-	661	-	-
	-	-	-	-	-
35 Children and Economic Assistance Admin.	377	1,222	1,222	1,152	1,152
Human Services, Dept of	184,890	227,209	245,242	210,925	212,466
Health Department	6,270	6,000	6,000	6,000	6,000
Subtotal-Health, Human Services & Corrections	191,160	233,209	251,242	216,925	218,466
Economic Development					
Employment and Economic Development	211	153	-	-	-
Housing Finance Agency	-	-	-	-	-
Subtotal-Ecomonic Development	211	153	-	-	-
Total TANF Expenditures	**191,371**	**233,362**	**251,242**	**216,925**	**218,466**
Transfers to Other Funds					
Federal Title XX (300)	7,927	4,790	4,790	4,790	4,790
Federal Child Care and Development Fund (300)	22,619	29,794	54,505	27,170	27,170
Working Family Tax Credit (General Fund)	17,826	17,727	18,077	18,289	18,739
Undesignated Refinancing (General Fund)	-	-	-	-	-
	48,372	52,311	77,372	50,249	50,699
Total Uses	**239,743**	**285,673**	**328,614**	**267,174**	**269,165**
Cancelation****	0		(1,000)		(1,000)
TANF Reserve	**$81,188**	**$72,649**	**$8,470**	**$4,730**	**$0**

* The first actual TANF award received by the state started October 1, 1997. F.Y. 2004-07 assumes a continuation of TANF funding amount as it exists in current law. The Authorization for TANF expired on Funding has been extended through several continuing resolutions. The most recent resolution expires March 31, 2005.

**High Performance Bonuses awarded by bonus year (FFY1999: $9,424,075: FFY 2000: $2,592,312: FFY 2001: $2,993,030; FFY 2003: $13,399,244; FFY2004: 13,399,244) spread over state fiscal years.

*** Less Mille Lacs Band Tribal TANF award: annualized level of $823,539 - Oct 1, 1998 to March 31,2005; annualized level of $4,550,817 starting 4/1/2005

Health Care Access Fund - 2006 Senate Health and Human Services Omnibus Budget Bill

FY 2004-2009
(in 000s)

	Sources/Expenditures	Closing FY04	Closing FY05	Budgeted FY06	Projected 2007	Projected 2008	Projected 2009
1							
2	**ESTIMATED RESOURCES**						
3	Balance forward from prior year	177,224	136,774	53,938	116,270	81,445	32,462
4	Prior year adjustments	273	147	-			
5	Adjusted balance forward	177,497	136,921	53,938	116,270	81,445	32,462
6	**Revenues**						
7	**Provider Tax**	255,861	359,858	393,047	424,050	454,515	484,256
8	**Gross Premium Tax**	23,795	60,659	67,955	72,575	78,018	83,739
9	**State share of MnCare enrollee premiums**	25,226	22,867	19,066	22,442	24,005	23,795
10	**State Share of Prescription Rebates**	-	-	-	-	-	-
11	**Investment Income***	1,666	2,753	3,408	3,035	1,887	-
12							
13	**Federal match on administrative costs**	3,695	3,756	6,387	6,117	4,760	4,644
14	**Revenue refunds**	(12,852)	(10,503)	(12,000)	(12,000)	(12,000)	(12,000)
15	**All Other**	54	28	70	70	70	70
16	**Total Revenues**	297,445	439,418	477,933	516,289	551,255	584,504
17							
18	**Transfer From GF**	4,600					
19	**Total Resources Available**	479,542	576,339	531,871	632,559	632,700	616,966
20							
21	**ESTIMATED USES**						
22							
23	**Grant Expenditures**						
24	**MnCare Direct Appropriation - net of administrative ffp**	270,157	227,726	255,212	334,765	433,025	439,437
25	Eliminate self-employed farm income depreciation add-back	-	-	-	-	1,056	1,084
26	Eliminate MinnesotaCare limited benefit set	-	-	-	-	7,428	8,060
27	Interaction with of Elimination of MLB with Mental Health Benefit Expansion	-	-	-	-	(162)	(160)
28	Decrease costs for Day Treatment and Partial Hosp with Repeal of MLB	-	-	-	-	(114)	(17)
29	Increase inpatient hospital cap	-	-	-	-	3,711	3,844
30	Eliminate dental copays for parents under 175%	-	-	-	-	917	806
31	Elliminate Dental Cap for Adults	-	-	-	-	2,957	3,238
32	Adults w/out children eligible to 200% fpg	-	-	-	-	3,551	11,772
33	Interaction with of Elimination of 200% Eligibility with Mental Health Benefit Expansion	-	-	-	-	48	143
34	MMIS Costs of 200% Eligibility Expansion	-	-	-	73	-	-
35	Two Month HealthMatch Delay Program Costs	-	-	-	-	7,640	4,183
36	Two Month HealthMatch Delay Administrative Costs	-	-	-	929	-	-
37	Eliminate insurance barriers	-	-	-	-	6	961
38	Cover Medicare Copayments for Dual Eligibles	-	-	-	11,467	11,931	12,287
39	Prescription Drug Discount Program	-	-	-	218	2,246	916
40	Eliminate 8% MinnesotaCare premium increase	-	-	-	1,198	2,141	2,145
41	MinnesotaCare option for small employers	-	-	-	577	154	3,621
42	MMIS System User Support - PDDP/Small Employer	-	-	-	52	97	143
43	Critical Access Dental	-	-	-	3,610	-	-
44	Critical Access Dental Clinic Grants	-	-	-	300	300	300
45	FQHC Grants	-	-	-	1,500	1,500	1,500
46	MinnesotaCare Millitary Premium Eliminated	-	-	-	-	1,298	1,417
47	MinnesotaCare Outreach Grants	-	-	-	846	846	846
48	Permit MinnesotaCare Eligibility for Undocumented Children	-	-	-	-	17	1,438
49	MH System Transformation-Expand MinnesotaCare Benefit	-	-	-	1,493	4,764	5,491
50	MH System Transformation-MNCare PMAP Implementation	-	-	-	-	1,580	2,911
51	Exempt Certain GAMC Groups From Shift to MNCare	-	-	-	(1,810)	(5,045)	(5,584)
52	HCAF appropriation for GAMC Groups Not Shifted from MNCare	-	-	-	-	-	-
53	Pay-for-Performance for Health Care Providers	-	-	-	205	199	-
54	Citizenship Verification for MNCare Enrollees Eligible for FFP	-	-	-	541	258	258
55	Minnesota E-Health Initiative - MDH	-	-	-	9,414	293	293
56	Provider Reimbursement Rate Increase - 2.049% eff. FY 07	-	-	-	7,320	7,320	7,320
57	Subtotal of Proposals						
58							
59	**Subtotal MnCare Direct**	270,157	227,726	255,212	372,698	489,962	508,653
60							
61	**State share of MnCare enrollee premiums**	25,226	22,881	19,066	22,442	24,005	23,795
62	**State Share of Prescription Rebates**	-	-	-	-	-	-
63							
64	Federal MA and S-CHIP offset (non-add)	177,740	142,861	150,957	153,214	148,499	122,279
65							
66							
67	**Administrative Expenditures**						
68	**University of Minnesota**	2,157	2,157	2,157	2,157	2,157	2,157
69	**Dept. of Human Services**	16,754	16,565	28,305	27,456	27,503	25,698

Health Care Access Fund - 2006 Senate Health and Human Services Omnibus Budget Bill

FY 2004-2009
(in 000s)

	Sources/Expenditures	Closing FY04	Closing FY05	Budgeted FY06	Projected 2007	Projected 2008	Projected 2009
70	**Dept. of Health**	5,624	6,350	6,273	6,279	6,279	6,279
71	**Board of Dentistry**	43	66	-	-	-	-
72	**Legislature**	128	128	128	128	128	128
73	**Dept. of Revenue**	1,470	1,837	1,654	1,654	1,654	1,654
74	**DOR payment of claims issue**	39	-	-	-	-	-
75	**Interest on tax refunds**	208	191	450	500	550	600
76	**Subtotal Administrative expenditures**	26,423	27,294	38,967	38,174	38,271	36,516
77							
78	**Total Expenditures**	321,806	277,901	313,245	433,314	552,238	568,964
79							
80	**Transfers Out**						
81	Special Revenue Fund - MAXIS/MMIS	4,375	5,736	-	-	-	-
82	Transfer From GF						
83	GF - Provider Tax/Gross Premium Tax (MA/GAMC)	16,587	46,322	49,413	58,695	48,000	48,000
84	**Subtotal Transfers Out**	**20,962**	**52,058**	**49,413**	**58,695**	**48,000**	**48,000**
85							
86	**Total Uses**	342,768	329,959	362,658	492,009	600,238	616,964
87							
89	**Balance Before Reserve**	136,774	246,380	169,213	140,550	32,462	2
90	**Transfer to General Fund**	-	192,442	52,943	59,105	-	-
91	**Balance After Transfer**		53,938	116,270	81,445	32,462	2
92							
93							
94							
95							
96							
97	**Assumes interest rate of 2.8%*						

ARTICLE 12

HEALTH DEPARTMENT AND LICENSING BOARDS

Section 1. **[144.90] STATE-LEVEL METHAMPHETAMINE COORDINATOR.**

Subdivision 1. **Establishment; purpose; appointment.** A state-level, statewide methamphetamine coordinator is created in the Department of Health. The methamphetamine coordinator shall coordinate Minnesota's efforts to reduce the incidence of methamphetamine addiction and the related consequences, by working with various state agencies, local units of government, law enforcement, the courts, the chemical dependency treatment community, the federal government, other states, and other interested individuals and parties in order to coordinate the state's resources to provide and oversee education, research, and training related to methamphetamine. To the extent possible, the coordinator must coordinate efforts with tribal governments. The coordinator shall be appointed by the governor.

Subd. 2. **Duties.** The duties of the methamphetamine coordinator include, but are not limited to:

(1) providing health-based information and safety training materials to law enforcement, first responders, and others exposed to methamphetamine use and manufacturing;

(2) promoting and tracking first responder training provided by the Minnesota Bureau of Criminal Apprehension, the United States Drug Enforcement Agency, and others;

(3) providing train-the-trainer materials for state and local agencies and community groups working to respond to methamphetamine problems in their communities;

(4) serving as a clearinghouse for information and materials on all aspects of methamphetamine response, including treatment and treatment providers, law enforcement, corrections and drug courts, education, prevention, children's issues, staff training and safety, and K-12 curricula;

(5) tracking of grant and other funding opportunities available to Minnesota agencies, organizations, and communities;

(6) coordinating media-based prevention opportunities, including methamphetamine and other antidrug materials available for use by local communities;

(7) establishing a speaker's bureau of experts on methamphetamine and other addictions;

(8) fielding methamphetamine-related calls;

(9) maintaining current knowledge and understanding of methamphetamine-related research in the areas of remediation, children's health, health of users, best prevention and treatment practices, and other issues;

(10) tracking trends in use, manufacturing, incidence of methamphetamine labs and seizures, costs, incarcerations, and child involvement nationwide and for Minnesota specifically;

(11) making recommendations to the legislature for methamphetamine policy changes and funding;

(12) serving as coordinator or point-of-contact for a Minnesota drug endangered children's alliance; and

(13) coordinating prevention information efforts related to methamphetamine with the Minnesota Prevention Resource Center.

Subd. 3. **Toll-free telephone number.** The coordinator shall establish a toll-free telephone number during business hours for providing information and counseling on methamphetamine use and addiction.

Subd. 4. **Annual report.** The methamphetamine coordinator shall submit to the legislature an annual report by January 15 of each year beginning January 15, 2008, summarizing goals that have been established and met, and plans for the upcoming year.

Subd. 5. **Office space.** The commissioner of health shall provide the coordinator with adequate office space and administrative services.

Sec. 2. **[144.995] HEALTHY MINNESOTANS BIOMONITORING PROGRAM.**

Subdivision 1. **Citation.** Sections 144.995 to 144.999 may be cited as the healthy Minnesotans biomonitoring program.

Subd. 2. **Definitions.** (a) For purposes of sections 144.995 to 144.999, the following definitions apply.

(b) "Biomonitoring" means the process by which the presence and concentration of toxic chemicals and their metabolites are identified within a biospecimen as a means to assess the accumulation of pollutants in a human body.

(c) "Biospecimen" means a sample of human blood, hair, urine, breast milk, body fat, or other body tissue or any other biophysical substance that is reasonably available as a medium to measure the presence and concentration of toxic chemicals.

(d) "Commissioner" means the commissioner of health.

(e) "Panel" means the Healthy Minnesotans Biomonitoring Program Advisory Panel established under section 144.996.

(f) "Toxic chemical" means a chemical:

(1) for which data provided by scientific, peer-reviewed animal, cell, or human studies have demonstrated the chemical is known or strongly suspected to negatively impact human health by contributing to an increase in serious illness or mortality; and

(2) that has been identified according to section 144.997.

Subd. 3. **Establishment; duties.** (a) The commissioner shall establish the healthy Minnesotans biomonitoring program. The program shall provide community-based biomonitoring on a strictly voluntary and confidential basis by utilizing biospecimens, as appropriate, to identify toxic chemicals that may be present in the environment.

(b) Initially, to the extent that funds are available, the program shall examine breast milk in three economically, racially, and geographically diverse communities and identify any toxic chemical that is present in the breast milk. The commissioner shall expand the program, to the extent that funds are available, by examining other biospecimens in additional communities.

(c) When a toxic chemical is detected in a program participant, the commissioner, in consultation with the commissioners of agriculture, natural resources, and the Pollution Control Agency, and other public or private entities, as appropriate, shall examine the possible presence of the toxic chemical in the surrounding environment and possible routes of exposure and disease outcomes and shall develop recommendations to reduce or minimize possible contamination or exposure to the toxic chemical.

Subd. 4. **Participation.** (a) Participation in the biomonitoring program is voluntary. All participants shall be evaluated for the presence of toxic chemicals as a component of the biomonitoring process. Participants shall receive consultation, health care referrals, and follow-up counseling and shall be offered educational materials, including, but not limited to, information regarding possible routes of exposure, ways to reduce exposure, and the availability of state and local resources.

(b) Data collected under the biomonitoring program are health data for purposes of section 13.3805 and shall not be made public without the written and informed consent of the individual to whom it pertains.

Subd. 5. **Program guidelines.** (a) The commissioner, in consultation with the panel, shall develop:

(1) model protocols or program guidelines that address the science and practice of biomonitoring to be utilized and procedures for changing those protocols to incorporate new and more accurate or efficient technologies as they become available. The model protocols shall be developed utilizing a peer review process in a manner that is participatory and community-based in design, implementation, and evaluation;

(2) guidelines for ensuring confidentiality; informed consent; follow-up counseling and support; and communicating findings to participants, communities, and the general public;

(3) educational and outreach materials that are culturally appropriate for dissemination to program participants and communities. Priority shall be given to the development of materials specifically designed to ensure that parents are informed about all of the benefits of breastfeeding so that the program does not result in an unjustified fear of toxins in breast milk, which might inadvertently lead parents to avoid breastfeeding. The materials shall communicate relevant scientific findings; data on the accumulation of pollutants; possible routes of exposure; population-based health effects and toxicity; the benefits of linking the accumulation of pollutants to community health; and the required responses by local, state, and other governmental entities in regulating toxicant exposures;

(4) a training program that is culturally sensitive specifically for health care providers, health educators, and other program administrators; and

(5) a designation process for state and private laboratories that are qualified to analyze biospecimens and report the findings.

(b) The commissioner may enter into contractual agreements with health clinics, community-based organizations, or experts in a particular field to perform any of the activities described under this subdivision.

EFFECTIVE DATE. This section is effective July 1, 2006, or upon receiving sufficient nonstate funds to implement the healthy Minnesotan's biomonitoring program, whichever is later. In the event that nonstate funds are not secured by the commissioner of health to adequately fund the implementation of the program, the commissioner is not required to implement these sections without subsequent appropriation from the legislature.

Sec. 3. **[144.996] HEALTHY MINNESOTANS BIOMONITORING PROGRAM ADVISORY PANEL.**

Subdivision 1. **Creation.** (a) The commissioner shall establish the Healthy Minnesotans Biomonitoring Program Advisory Panel. The panel shall be composed of two committees, the scientific committee and the community representative committee, with a membership of eight voting members on each committee. The community representative committee shall also include nonvoting members appointed according to subdivision 2, paragraph (d).

(b) The commissioner shall appoint, from the panel's membership, the chair of each of the committees, who shall also serve as cochairs of the panel.

(c) The panel shall meet as often as it deems necessary but at a minimum on a quarterly basis.

(d) Members of the panel and the committees shall serve without compensation but shall be reimbursed for travel and other necessary expenses incurred through performance of their duties under sections 144.995 to 144.997.

Subd. 2. **Membership.** (a) Eight of the voting members shall be appointed by the commissioner, four of the voting members shall be appointed under the rules of the senate, and four of the voting members shall be appointed under the rules of the house of representatives. Nonvoting members shall be appointed by the commissioner according to paragraph (d). All members shall be appointed to the panel by July 1, 2006. Each voting member shall be appointed for a three-year term. All appointments made by the commissioner shall be approved by the governor.

(b) The scientific committee shall be composed of eight members with background or training in interpreting biomonitoring studies or in related fields or science, including, but not limited to, the fields of health tracking, social science, laboratory science, occupational health, industrial hygiene, toxicology, epidemiology, environmental health, environmental hazards, and public health.

(c) The community representative committee shall be composed of eight members from the following nongovernmental organizations:

(1) one member from a breast cancer awareness organization;

(2) one member from an organization with a focus on environmental health;

(3) one member from an organization with a focus on environmental justice;

(4) one member from an organization with a focus on child environmental health;

(5) one member from an organization promoting breastfeeding;

(6) one member from a labor organization;

(7) one member from private industry with a verifiable and consistent commitment to sustainable core business practices that reduce environmental toxins; and

(8) one member from a public health organization.

(d) The commissioner shall appoint the following additional nonvoting members to the community representative committee:

(1) one representative from the Maternal and Child Health Division of the Department of Health; and

(2) one member from each participating community.

Members appointed under this paragraph may be reappointed at any time and are not subject to the three-year term.

Subd. 3. **Committee duties.** (a) The scientific committee shall make recommendations to the panel on:

(1) chemicals that should be added to or deleted from the list of chemicals identified under section 144.997;

(2) priorities for biomonitoring in Minnesota;

(3) the adequacy and appropriate interpretation of biomonitoring investigations carried out under the program; and

(4) collecting and analyzing data, including the tracking of diseases for which there is scientific evidence of an environmental etiology.

(b) The community representative committee shall make recommendations to the panel on:

(1) study sites or communities for the program;

(2) identifying possible community partners;

(3) training programs and educational and outreach materials; and

(4) dissemination of findings to biomonitoring program participants and to the general public.

EFFECTIVE DATE. This section is effective July 1, 2006, or upon receiving sufficient nonstate funds to implement the healthy Minnesotan's biomonitoring program, whichever is later. In the event that nonstate funds are not secured by the commissioner of health to adequately fund the implementation of the program, the commissioner is not required to implement these sections without subsequent appropriation from the legislature.

Sec. 4. **[144.997] TOXIC CHEMICALS.**

Subdivision 1. **Identification.** The commissioner shall identify and list toxic chemicals that shall be included within the scope of the healthy Minnesotans biomonitoring program. To be included on the list, all of the following criteria must be met:

(1) the chemical is recommended for inclusion by the scientific committee under section 144.996;

(2) the scientific, peer-reviewed data from animal, cell, or human studies have demonstrated the chemical is known or strongly suspected to negatively impact human health by contributing to an increase in serious illness or mortality;

(3) Minnesotans are exposed to the chemical; and

(4) the chemical is listed as a toxic chemical on either a state or federal list.

Subd. 2. **Implementation.** (a) The commissioner shall prioritize the toxic chemicals under subdivision 1 according to the threat the chemicals pose to public health.

(b) The commissioner shall initially implement the biomonitoring activities of the program with regard to the 20 toxic chemicals that present the greatest public health risk.

(c) The commissioner shall add additional chemicals in order of priority to the extent funds are available.

EFFECTIVE DATE. This section is effective July 1, 2006, or upon receiving sufficient nonstate funds to implement the healthy Minnesotan's biomonitoring program, whichever is later. In the event that nonstate funds are not secured by the commissioner of health to adequately fund the implementation of the program, the commissioner is not required to implement these sections without subsequent appropriation from the legislature.

Sec. 5. **[144.998] BIOMONITORING FISCAL PROVISIONS.**

Subdivision 1. **Creation of account.** A healthy Minnesotans biomonitoring program account is established in the state government special revenue fund. The account consists of money appropriated by the legislature and any other funds identified for use by the healthy Minnesotans biomonitoring program. All interest earned on money deposited into the account shall be retained in the account. Money in the account is appropriated to the commissioner for the purpose of implementing the healthy Minnesotan biomonitoring program.

Subd. 2. **Other funding.** The commissioner shall seek funding from federal and private sources.

EFFECTIVE DATE. This section is effective July 1, 2006, or upon receiving sufficient nonstate funds to implement the healthy Minnesotan's biomonitoring program, whichever is later. In the event that nonstate funds are not secured by the commissioner of health to adequately fund the implementation of the program, the commissioner is not required to implement these sections without subsequent appropriation from the legislature.

Sec. 6. **[144.999] BIOMONITORING REPORTS.**

(a) By January 15, 2008, the commissioner shall submit a report to the legislature summarizing the initial activities of the healthy Minnesotans biomonitoring program, including a program description, the methodology used, and the initial outcomes.

(b) Thereafter, the commissioner shall prepare a biennial report describing the effectiveness of the program, including analysis of the health and environmental exposure data collected to adequately monitor the activities under section 144.995. The report shall

be made available to local public health departments and the general public in a summary format that protects the confidentiality of program participants. The commissioner shall disseminate the report via the Department of Health's Web site.

EFFECTIVE DATE. This section is effective July 1, 2006, or upon receiving sufficient nonstate funds to implement the healthy Minnesotan's biomonitoring program, whichever is later. In the event that nonstate funds are not secured by the commissioner of health to adequately fund the implementation of the program, the commissioner is not required to implement these sections without subsequent appropriation from the legislature.

Sec. 7. **[152.126] ALL SCHEDULES PRESCRIPTION ELECTRONIC REPORTING PROGRAM.**

Subdivision 1. **Definitions.** For purposes of this section, the terms defined in this subdivision have the meanings given.

(a) "Board" means the Minnesota State Board of Pharmacy established under chapter 151.

(b) "Controlled substances" means those substances listed in section 152.02, subdivisions 3 to 6, and those substances defined by the board pursuant to section 152.02, subdivisions 7, 8, and 12.

(c) "Dispense" or "dispensing" has the meaning given in section 151.01, subdivision 30.

(d) "Dispenser" means a person authorized by law to dispense, pursuant to a valid prescription, a controlled substance. A dispenser does not include a licensed hospital pharmacy that distributes controlled substances for inpatient hospital care.

(e) "Prescriber" means a licensed health care professional who is authorized to prescribe a controlled substance under section 152.12, subdivision 1.

(f) "Prescription" has the meaning given in section 151.01, subdivision 16.

Subd. 2. **Establishment of a prescription electronic reporting program.** (a) The board shall establish by January 1, 2008, an electronic system for reporting the information required under subdivision 4 for all controlled substances dispensed within the state.

(b) The board may contract with a vendor for the purpose of obtaining technical assistance in the design, implementation, and maintenance of the electronic reporting system. The vendor's role shall be limited to providing technical support to the board concerning the software, databases, and computer systems required to interface with the existing systems currently used by pharmacies to dispense prescriptions and transmit prescription data to other third parties.

Subd. 3. **Prescription Electronic Reporting Advisory Committee.** (a) The board may convene an advisory committee. If the board convenes a committee, the committee must include at least one representative of:

(1) the Department of Health;

(2) the Department of Human Services;

(3) each health-related licensing board that licenses prescribers;

(4) a professional medical association, which may include an association of pain management and chemical dependency specialists;

(5) a professional pharmacy association;

(6) a consumer privacy or security advocate; and

(7) a consumer or patient rights organization.

(b) The advisory committee shall advise the board on the development and operation of the electronic reporting system, including, but not limited to:

(1) technical standards for electronic prescription drug reporting;

(2) proper analysis and interpretation of prescription monitoring data; and

(3) an evaluation process for the program.

Subd. 4. **Reporting requirements.** (a) Each dispenser must submit the following data to the board or its designated vendor:

(1) name of the prescriber;

(2) national provider identifier of the prescriber;

(3) name of the dispenser;

(4) national provider identifier of the dispenser;

(5) name of the patient for whom the prescription was written;

(6) date of birth of the patient for whom the prescription was written;

(7) date the prescription was written;

(8) date the prescription was filled;

(9) name and strength of the controlled substance;

(10) quantity of controlled substance prescribed; and

(11) quantity of controlled substance dispensed.

(b) The dispenser must submit the required information by a procedure and in a format established by the board.

(c) A dispenser is not required to submit this data for those controlled substance prescriptions dispensed for individuals residing in licensed skilled nursing or intermediate care facilities.

Subd. 5. **Use of data by board.** The board shall develop and maintain a database of the data reported under subdivision 4 and shall use the database for the identification of:

(1) individuals receiving prescriptions for controlled substances from prescribers who subsequently obtain controlled substances from dispensers in quantities or with a frequency inconsistent with generally recognized standards of dosage for those controlled substances; and

(2) individuals presenting forged or otherwise false or altered prescriptions for controlled substances to dispensers.

Subd. 6. **Access to prescription electronic reporting program data.** (a) Except as indicated in this subdivision, the data submitted to the board under subdivision 4 is private data on individuals as defined in section 13.02, subdivision 12.

(b) The board may provide data submitted under subdivision 4 for public research, policy or education purposes, to the extent that any information that is likely to reveal the identity of the patient or other person who is the subject of the data has been removed.

(c) The following persons shall be considered permissible users and may access the data submitted under subdivision 4 in the same or similar manner, and for the same or similar purposes, as those persons who are authorized to access similar private data on individuals under federal and state law:

(1) a prescriber, to the extent the information relates specifically to a current patient of the prescriber, to whom the practitioner is prescribing or considering prescribing any controlled substance;

(2) a dispenser to the extent the information relates specifically to a current patient to whom that dispenser is dispensing or considering dispensing any controlled substance;

(3) an individual who is the recipient of a controlled substance prescription for which data was submitted under subdivision 4;

(4) personnel of the board specifically assigned to conduct investigations related to controlled substances laws under the jurisdiction of the board;

(5) personnel of the board engaged in the collection of controlled substance prescription information as part of the assigned duties and responsibilities of their employment;

(6) authorized personnel of a vendor under contract with the board who are engaged in the design, implementation, and maintenance of the electronic reporting system as part of the assigned duties and responsibilities of their employment, provided that access to data is limited to the minimum amount necessary to test and maintain the system databases;

(7) a designated representative of a health-related licensing board responsible for the licensure, regulation, or discipline of prescribers or dispensers provided that the requested data relates to a bona fide investigation of a specific licensee;

(8) federal, state, and local law enforcement authorities engaged in a bona fide investigation of a specific person; and

(9) personnel of the medical assistance program assigned to use the data collected under this section to identify recipients whose usage of controlled substances may warrant restriction to a single primary care physician, a single outpatient pharmacy, or a single hospital.

(d) Any permissible user identified in paragraph (c) that directly accesses the data electronically shall implement and maintain a comprehensive information security program that contains administrative, technical, and physical safeguards that are appropriate to the user's size and complexity, and the sensitivity of the personal information obtained. The permissible user shall identify reasonably foreseeable internal and external risks to the security, confidentiality, and integrity of personal information that could result in the unauthorized disclosure, misuse, or other compromise of the information and assess the sufficiency of any safeguards in place to control the risks.

(e) The board shall not release data submitted under this section unless it is provided with evidence, satisfactory to the board, that the person requesting the information is entitled to receive the data. Access to the data by law enforcement authorities must be accompanied by a valid search warrant.

(f) The board shall maintain a log of all persons who access the data and shall ensure that any permissible user complies with paragraph (d) prior to attaining direct access to the data.

Subd. 7. **Disciplinary action.** (a) A dispenser who knowingly fails to submit data to the board as required under this section is subject to disciplinary action by the appropriate health-related licensing board.

(b) A prescriber or dispenser authorized to access the data who knowingly discloses the data in violation of state or federal laws relating to the privacy of healthcare data shall be subject to disciplinary action by the appropriate health-related licensing board.

Subd. 8. **Evaluation and reporting.** (a) The board shall evaluate the prescription electronic reporting program to determine if the program is cost-effective. The board may contract with a vendor to design and conduct the evaluation.

(b) The board shall submit the evaluation of the program to the legislature by January 15, 2009.

EFFECTIVE DATE. This section is effective July 1, 2006, or upon receiving sufficient nonstate funds to implement the prescription electronic reporting program, whichever is later. In the event that nonstate funds are not secured by the Board of Pharmacy to adequately fund the implementation of the prescription electronic reporting

program, the board is not required to implement section 1, without a subsequent appropriation from the legislature.

Sec. 8. Laws 2005, First Special Session chapter 4, article 9, section 3, subdivision 2, is amended to read:

Subd. 2. **Community and Family Health Improvement**

Summary by Fund		
General	40,413,000	40,382,000
State Government Special Revenue	141,000	128,000
Health Care Access	3,510,000	3,516,000
Federal TANF	6,000,000	6,000,000

~~[FAMILY PLANNING BASE REDUCTION.] Base level funding for the family planning special projects grant program is reduced by $1,877,000 each year of the biennium beginning July 1, 2007, provided that this reduction shall only take place upon full implementation of the family planning project section of the 1115 waiver. Notwithstanding Minnesota Statutes, section 145.925, the commissioner shall give priority to community health care clinics providing family planning services that either serve a high number of women who do not qualify for medical assistance or are unable to participate in the medical assistance program as a medical assistance provider when allocating the remaining appropriations. Notwithstanding section 15, this paragraph shall not expire.~~

[SHAKEN BABY VIDEO.] Of the state government special revenue fund

appropriation, $13,000 in 2006 is appropriated to the commissioner of health to provide a video to hospitals on shaken baby syndrome. The commissioner of health shall assess a fee to hospitals to cover the cost of the approved shaken baby video and the revenue received is to be deposited in the state government special revenue fund.

Sec. 9. **FEDERAL GRANTS.**

The Board of Pharmacy shall apply for any applicable federal grants or other nonstate funds to establish and fully implement the prescription electronic reporting program.

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

ARTICLE 13
HEALTH CARE

Section 1. Minnesota Statutes 2004, section 47.58, subdivision 8, is amended to read:

Subd. 8. **Counseling; requirement; penalty.** A lender, mortgage banking company, or other mortgage lender not related to the mortgagor must keep a certificate on file documenting that the borrower, prior to entering into the reverse mortgage loan, received counseling as defined in this subdivision from an organization that meets the requirements of section 462A.209 and is a housing counseling agency approved by the Department of Housing and Urban Development. The certificate must be signed by the mortgagor and the counselor and include the date of the counseling, the name, address, and telephone number of both the mortgagor and the organization providing counseling. A failure by the lender to comply with this subdivision results in a $1,000 civil penalty payable to the mortgagor. For the purposes of this subdivision, "counseling" means the following services are provided to the borrower:

(1) a review of the advantages and disadvantages of reverse mortgage programs;

(2) an explanation of how the reverse mortgage affects the borrower's estate and public benefits;

(3) an explanation of the lending process;

(4) a discussion of the borrower's supplemental income needs; ~~and~~

(5) an explanation of the provisions of sections 256B.0913, subdivision 17, and 462A.05, subdivision 42; and

(6) an opportunity to ask questions of the counselor.

Sec. 2. Minnesota Statutes 2004, section 144A.071, subdivision 4c, is amended to read:

Subd. 4c. **Exceptions for replacement beds after June 30, 2003.** (a) The commissioner of health, in coordination with the commissioner of human services, may approve the renovation, replacement, upgrading, or relocation of a nursing home or boarding care home, under the following conditions:

(1) to license and certify an 80-bed city-owned facility in Nicollet County to be constructed on the site of a new city-owned hospital to replace an existing 85-bed facility attached to a hospital that is also being replaced. The threshold allowed for this project under section 144A.073 shall be the maximum amount available to pay the additional medical assistance costs of the new facility;

(2) to license and certify 29 beds to be added to an existing 69-bed facility in St. Louis County, provided that the 29 beds must be transferred from active or layaway status at an existing facility in St. Louis County that had 235 beds on April 1, 2003. The licensed capacity at the 235-bed facility must be reduced to 206 beds, but the payment rate at that facility shall not be adjusted as a result of this transfer. The operating payment rate of the facility adding beds after completion of this project shall be the same as it was on the day prior to the day the beds are licensed and certified. This project shall not proceed unless it is approved and financed under the provisions of section 144A.073; ~~and~~

(3) to license and certify a new 60-bed facility in Austin, provided that: (i) 45 of the new beds are transferred from a 45-bed facility in Austin under common ownership that is closed and 15 of the new beds are transferred from a 182-bed facility in Albert Lea under common ownership; (ii) the commissioner of human services is authorized by the 2004 legislature to negotiate budget-neutral planned nursing facility closures; and (iii) money is available from planned closures of facilities under common ownership to make implementation of this clause budget-neutral to the state. The bed capacity of the Albert Lea facility shall be reduced to 167 beds following the transfer. Of the 60 beds at the new facility, 20 beds shall be used for a special care unit for persons with Alzheimer's disease or related dementias~~.~~; and

(4) to license and certify up to 80 beds transferred from an existing state-owned nursing facility in Cass County to a new facility in the same county. The operating cost payment rates for the new facility shall be determined based on the interim and settle-up payment provisions of Minnesota Rules, part 9549.0057, and the reimbursement provisions of section 256B.431. The property payment rate for the first three years of operation shall be $25 per day.

(b) Projects approved under this subdivision shall be treated in a manner equivalent to projects approved under subdivision 4a.

Sec. 3. **[144A.441] ASSISTED LIVING BILL OF RIGHTS ADDENDUM.**

Assisted living clients, as defined in section 144G.01, subdivision 3, shall be provided with the home care bill of rights required by section 144A.44, except that the home care bill of rights provided to these clients must include the following provision in place of the provision in section 144A.44, subdivision 1, clause (16):

"(16) the right to reasonable, advance notice of changes in services or charges, including at least 30 days' advance notice of the termination of a service by a provider, except in cases where:

(i) the recipient of services engages in conduct that alters the conditions of employment as specified in the employment contract between the home care provider and the individual providing home care services, or creates an abusive or unsafe work environment for the individual providing home care services;

(ii) an emergency for the informal caregiver or a significant change in the recipient's condition has resulted in service needs that exceed the current service provider agreement and that cannot be safely met by the home care provider; or

(iii) the provider has not received payment for services, for which at least ten days' advance notice of the termination of a service shall be provided."

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

Sec. 4. **[144A.442] TERMINATION OF HOME CARE SERVICES FOR ASSISTED LIVING CLIENTS.**

If an arranged home care provider, as defined in section 144D.01, subdivision 2a, who is not also Medicare certified terminates a service agreement or service plan with an assisted living client, as defined in section 144G.01, subdivision 3, the home care provider shall provide the assisted living client and the legal or designated representatives of the client, if any, with a written notice of termination which includes the following information:

(1) the effective date of termination;

(2) the reason for termination;

(3) without extending the termination notice period, an affirmative offer to meet with the assisted living client or client representatives within no more than five business days of the date of the termination notice to discuss the termination;

(4) contact information for a reasonable number of other home care providers in the geographic area of the assisted living client, as required by Minnesota Rules, part 4668.0050;

(5) a statement that the provider will participate in a coordinated transfer of the care of the client to another provider or caregiver, as required by section 144A.44, subdivision 1, clause (17);

(6) the name and contact information of a representative of the home care provider with whom the client may discuss the notice of termination;

(7) a copy of the home care bill of rights; and

(8) a statement that the notice of termination of home care services by the home care provider does not constitute notice of termination of the housing with services contract with a housing with services establishment.

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

Sec. 5. Minnesota Statutes 2004, section 144A.4605, is amended to read:

144A.4605 ~~ASSISTED LIVING HOME CARE~~ CLASS F PROVIDER.

Subdivision 1. **Definitions.** For purposes of this section, the term "~~assisted living~~ class F home care provider" means a home care provider who provides nursing services, delegated nursing services, other services performed by unlicensed personnel, or central storage of medications solely for residents of one or more housing with services establishments registered under chapter 144D.

Subd. 2. **~~Assisted living~~ Class F home care license established.** A home care provider license category entitled ~~assisted living~~ class F home care provider is hereby established. A home care provider may obtain ~~an assisted living~~ a class F license if the program meets the following requirements:

(a) nursing services, delegated nursing services, other services performed by unlicensed personnel, or central storage of medications under the ~~assisted living~~ class F license are provided solely for residents of one or more housing with services establishments registered under chapter 144D;

(b) unlicensed personnel perform home health aide and home care aide tasks identified in Minnesota Rules, parts 4668.0100, subparts 1 and 2, and 4668.0110, subpart 1. Qualifications to perform these tasks shall be established in accordance with subdivision 3;

(c) periodic supervision of unlicensed personnel is provided as required by rule;

(d) notwithstanding Minnesota Rules, part 4668.0160, subpart 6, item D, client records shall include:

(1) daily records or a weekly summary of home care services provided;

(2) documentation each time medications are administered to a client; and

(3) documentation on the day of occurrence of any significant change in the client's status or any significant incident, such as a fall or refusal to take medications.

All entries must be signed by the staff providing the services and entered into the record no later than two weeks after the end of the service day, except as specified in clauses (2) and (3);

(e) medication and treatment orders, if any, are included in the client record and are renewed at least every 12 months, or more frequently when indicated by a clinical assessment;

(f) the central storage of medications in a housing with services establishment registered under chapter 144D is managed under a system that is established by a registered nurse and addresses the control of medications, handling of medications, medication containers, medication records, and disposition of medications; and

(g) in other respects meets the requirements established by rules adopted under sections 144A.45 to 144A.47.

Subd. 3. **Training or competency evaluations required.** (a) Unlicensed personnel must:

(1) satisfy the training or competency requirements established by rule under sections 144A.45 to 144A.47; or

(2) be trained or determined competent by a registered nurse in each task identified under Minnesota Rules, part 4668.0100, subparts 1 and 2, when offered to clients in a housing with services establishment as described in paragraphs (b) to (e).

(b) Training for tasks identified under Minnesota Rules, part 4668.0100, subparts 1 and 2, shall use a curriculum which meets the requirements in Minnesota Rules, part 4668.0130.

(c) Competency evaluations for tasks identified under Minnesota Rules, part 4668.0100, subparts 1 and 2, must be completed and documented by a registered nurse.

(d) Unlicensed personnel performing tasks identified under Minnesota Rules, part 4668.0100, subparts 1 and 2, shall be trained or demonstrate competency in the following topics:

(1) an overview of sections 144A.43 to 144A.47 and rules adopted thereunder;

(2) recognition and handling of emergencies and use of emergency services;

(3) reporting the maltreatment of vulnerable minors or adults under sections 626.556 and 626.557;

(4) home care bill of rights;

(5) handling of clients' complaints and reporting of complaints to the Office of Health Facility Complaints;

(6) services of the ombudsman for older Minnesotans;

(7) observation, reporting, and documentation of client status and of the care or services provided;

(8) basic infection control;

(9) maintenance of a clean, safe, and healthy environment;

(10) communication skills;

(11) basic elements of body functioning and changes in body function that must be reported to an appropriate health care professional; and

(12) physical, emotional, and developmental needs of clients, and ways to work with clients who have problems in these areas, including respect for the client, the client's property, and the client's family.

(e) Unlicensed personnel who administer medications must comply with rules relating to the administration of medications in Minnesota Rules, part 4668.0100, subpart 2, except that unlicensed personnel need not comply with the requirements of Minnesota Rules, part 4668.0100, subpart 5.

Subd. 4. **License required.** (a) A housing with services establishment registered under chapter 144D that is required to obtain a home care license must obtain ~~an assisted living~~ a class F home care license according to this section or a class A or class ~~E~~ B license according to rule. A housing with services establishment that obtains a class ~~E~~ B license under this subdivision remains subject to the payment limitations in sections 256B.0913, subdivision 5f, paragraph (b), and 256B.0915, subdivision 3d.

(b) A board and lodging establishment registered for special services as of December 31, 1996, and also registered as a housing with services establishment under chapter 144D, must deliver home care services according to sections 144A.43 to 144A.47, and may apply for a waiver from requirements under Minnesota Rules, parts 4668.0002 to 4668.0240, to operate a licensed agency under the standards of section 157.17. Such waivers as may be granted by the department will expire upon promulgation of home care rules implementing section 144A.4605.

~~(c) An adult foster care provider licensed by the Department of Human Services and registered under chapter 144D may continue to provide health-related services under its foster care license until the promulgation of home care rules implementing this section.~~

~~(d) An assisted living~~ (c) A class F home care provider licensed under this section must comply with the disclosure provisions of section 325F.72 to the extent they are applicable.

Subd. 5. **License fees.** The license fees for ~~assisted living~~ class F home care providers shall be as follows:

(1) $125 annually for those providers serving a monthly average of 15 or fewer clients, and for ~~assisted living~~ class F providers of all sizes during the first year of operation;

(2) $200 annually for those providers serving a monthly average of 16 to 30 clients;

(3) $375 annually for those providers serving a monthly average of 31 to 50 clients; and

(4) $625 annually for those providers serving a monthly average of 51 or more clients.

Subd. 6. **Waiver.** Upon request of the home care provider, the commissioner may waive the provisions of this section relating to registered nurse duties.

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

Sec. 6. Minnesota Statutes 2004, section 144D.01, is amended by adding a subdivision to read:

Subd. 2a. **Arranged home care provider.** "Arranged home care provider" means a home care provider licensed under Minnesota Rules, chapter 4668, that provides services to some or all of the residents of a housing with services establishment and that is either the establishment itself or another entity with which the establishment has an arrangement.

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

Sec. 7. Minnesota Statutes 2004, section 144D.015, is amended to read:

144D.015 ASSISTED LIVING FACILITY OR ASSISTED LIVING RESIDENCE DEFINITION FOR PURPOSES OF LONG-TERM CARE INSURANCE.

For purposes of consistency with terminology commonly used in long-term care insurance policies and notwithstanding chapter 144G, a housing with services establishment that is registered under section 144D.03 and that holds, or ~~contracts~~ makes arrangements with an individual or entity that holds~~, a~~ any type of home care license and all other licenses, permits, registrations, or other governmental approvals legally required for delivery of the services the establishment offers or provides to its residents, constitutes an "assisted living facility" or "assisted living residence."

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

Sec. 8. Minnesota Statutes 2004, section 144D.02, is amended to read:

144D.02 REGISTRATION REQUIRED.

No entity may establish, operate, conduct, or maintain ~~an elderly~~ a housing with services establishment in this state without registering and operating as required in sections 144D.01 to 144D.06.

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

Sec. 9. Minnesota Statutes 2004, section 144D.03, subdivision 2, is amended to read:

Subd. 2. **Registration information.** The establishment shall provide the following information to the commissioner in order to be registered:

(1) the business name, street address, and mailing address of the establishment;

(2) the name and mailing address of the owner or owners of the establishment and, if the owner or owners are not natural persons, identification of the type of business entity of the owner or owners, and the names and addresses of the officers and members of the governing body, or comparable persons for partnerships, limited liability corporations, or other types of business organizations of the owner or owners;

(3) the name and mailing address of the managing agent, whether through management agreement or lease agreement, of the establishment, if different from the owner or owners, and the name of the on-site manager, if any;

(4) verification that the establishment has entered into ~~an elderly~~ a housing with services contract, as required in section 144D.04, with each resident or resident's representative;

(5) verification that the establishment is complying with the requirements of section 325F.72, if applicable;

(6) the name and address of at least one natural person who shall be responsible for dealing with the commissioner on all matters provided for in sections 144D.01 to 144D.06, and on whom personal service of all notices and orders shall be made, and who shall be authorized to accept service on behalf of the owner or owners and the managing agent, if any; and

(7) the signature of the authorized representative of the owner or owners or, if the owner or owners are not natural persons, signatures of at least two authorized representatives of each owner, one of which shall be an officer of the owner.

Personal service on the person identified under clause (6) by the owner or owners in the registration shall be considered service on the owner or owners, and it shall not be a defense to any action that personal service was not made on each individual or entity. The

designation of one or more individuals under this subdivision shall not affect the legal responsibility of the owner or owners under sections 144D.01 to 144D.06.

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

Sec. 10. Minnesota Statutes 2004, section 144D.04, is amended to read:

144D.04 ~~ELDERLY~~ HOUSING WITH SERVICES CONTRACTS.

Subdivision 1. **Contract required.** No ~~elderly~~ housing with services establishment may operate in this state unless a written ~~elderly~~ housing with services contract, as defined in subdivision 2, is executed between the establishment and each resident or resident's representative and unless the establishment operates in accordance with the terms of the contract. The resident or the resident's representative shall be given a complete copy of the contract and all supporting documents and attachments and any changes whenever changes are made.

Subd. 2. **Contents of contract.** ~~An elderly~~ A housing with services contract, which need not be entitled as such to comply with this section, shall include at least the following elements in itself or through supporting documents or attachments:

(1) the name, street address, and mailing address of the establishment;

(2) the name and mailing address of the owner or owners of the establishment and, if the owner or owners is not a natural person, identification of the type of business entity of the owner or owners;

(3) the name and mailing address of the managing agent, through management agreement or lease agreement, of the establishment, if different from the owner or owners;

(4) the name and address of at least one natural person who is authorized to accept service of process on behalf of the owner or owners and managing agent;

(5) a statement describing the registration and licensure status of the establishment and any provider providing health-related or supportive services under an arrangement with the establishment;

(6) the term of the contract;

(7) a description of the services to be provided to the resident in the base rate to be paid by resident;

(8) a description of any additional services, including home care services, available for an additional fee from the establishment directly or through arrangements with the establishment, and a schedule of fees charged for these services;

~~(9) fee schedules outlining the cost of any additional services;~~

~~(10)~~ (9) a description of the process through which the contract may be modified, amended, or terminated;

~~(11)~~ (10) a description of the establishment's complaint resolution process available to residents including the toll-free complaint line for the Office of Ombudsman for Older Minnesotans;

~~(12)~~ (11) the resident's designated representative, if any;

~~(13)~~ (12) the establishment's referral procedures if the contract is terminated;

~~(14) criteria~~ (13) requirements of residency used by the establishment to determine who may reside or continue to reside in the ~~elderly~~ housing with services establishment;

~~(15)~~ (14) billing and payment procedures and requirements;

~~(16)~~ (15) a statement regarding the ability of residents to receive services from service providers with whom the establishment does not have an arrangement; ~~and~~

~~(17)~~ (16) a statement regarding the availability of public funds for payment for residence or services in the establishment; and

(17) a statement regarding the availability of and contact information for long-term care consultation services under section 256B.0911 in the county in which the establishment is located.

Subd. 3. **Contracts in permanent files.** ~~Elderly~~ Housing with services contracts and related documents executed by each resident or resident's representative shall be maintained by the establishment in files from the date of execution until three years after the contract is terminated. The contracts and the written disclosures required under section 325F.72, if applicable, shall be made available for on-site inspection by the commissioner upon request at any time.

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

Sec. 11. **[144D.045] INFORMATION CONCERNING ARRANGED HOME CARE PROVIDERS.**

If a housing with services establishment has one or more arranged home care providers, the establishment shall arrange to have that arranged home care provider deliver the following information in writing to a prospective resident, prior to the date on which the prospective resident executes a contract with the establishment or the prospective resident's move-in date, whichever is earlier:

(1) the name, mailing address, and telephone number of the arranged home care provider;

(2) the name and mailing address of at least one natural person who is authorized to accept service of process on behalf of the entity described in clause (1) ;

(3) a description of the process through which a home care service agreement or service plan between a resident and the arranged home care provider, if any, may be modified, amended, or terminated;

(4) the arranged home care provider's billing and payment procedures and requirements; and

(5) any limits to the services available from the arranged provider.

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

Sec. 12. Minnesota Statutes 2004, section 144D.05, is amended to read:

144D.05 AUTHORITY OF COMMISSIONER.

The commissioner shall, upon receipt of information which may indicate the failure of the ~~elderly~~ housing with services establishment, a resident, a resident's representative, or a service provider to comply with a legal requirement to which one or more of them may be subject, make appropriate referrals to other governmental agencies and entities having jurisdiction over the subject matter. The commissioner may also make referrals to any public or private agency the commissioner considers available for appropriate assistance to those involved.

The commissioner shall have standing to bring an action for injunctive relief in the district court in the district in which an establishment is located to compel the ~~elderly~~ housing with services establishment to meet the requirements of this chapter or other requirements of the state or of any county or local governmental unit to which the establishment is otherwise subject. Proceedings for securing an injunction may be brought by the commissioner through the attorney general or through the appropriate county attorney. The sanctions in this section do not restrict the availability of other sanctions.

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

Sec. 13. Minnesota Statutes 2004, section 144D.065, is amended to read:

144D.065 ESTABLISHMENTS THAT SERVE PERSONS WITH ALZHEIMER'S DISEASE OR RELATED DISORDERS.

(a) If a housing with services establishment registered under this chapter markets or otherwise promotes services for persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the ~~facility's~~ establishment's direct care staff and their supervisors must be trained in dementia care.

(b) Areas of required training include:

(1) an explanation of Alzheimer's disease and related disorders;

(2) assistance with activities of daily living;

(3) problem solving with challenging behaviors; and

(4) communication skills.

(c) The establishment shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. This information satisfies the disclosure requirements of section 325F.72, subdivision 2, clause (4).

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

Sec. 14. **[144G.01] DEFINITIONS.**

Subdivision 1. **Scope; other definitions.** For purposes of sections 144G.01 to 144G.05, the following definitions apply. In addition, the definitions provided in section 144D.01 also apply to sections 144G.01 to 144G.05.

Subd. 2. **Assisted living.** "Assisted living" means a service or package of services advertised, marketed, or otherwise described, offered, or promoted using the phrase "assisted living" either alone or in combination with other words, whether orally or in writing, and which is subject to the requirements of this chapter.

Subd. 3. **Assisted living client.** "Assisted living client" or "client" means a housing with services resident who receives assisted living that is subject to the requirements of this chapter.

Subd. 4. **Commissioner.** "Commissioner" means the commissioner of health.

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

Sec. 15. **[144G.02] ASSISTED LIVING; PROTECTED TITLE; RESTRICTION ON USE; REGULATORY FUNCTIONS.**

Subdivision 1. **Protected title; restriction on use.** No person or entity may use the phrase "assisted living," whether alone or in combination with other words and whether orally or in writing, to advertise, market, or otherwise describe, offer, or promote itself, or any housing, service, service package, or program that it provides within this state, unless the person or entity is a housing with services establishment that meets the requirements of this chapter, or is a person or entity that provides some or all components of assisted living that meet the requirements of this chapter. A person or entity entitled to use the phrase "assisted living" shall use the phrase only in the context of its participation in assisted living that meets the requirements of this chapter. A housing with services establishment offering or providing assisted living that is not made available to residents in all of its

housing units shall identify the number or location of the units in which assisted living is available, and may not use the term "assisted living" in the name of the establishment registered with the commissioner under chapter 144D, or in the name the establishment uses to identify itself to residents or the public.

Subd. 2. **Authority of commissioner.** (a) The commissioner, upon receipt of information that may indicate the failure of a housing with services establishment, the arranged home care provider, an assisted living client, or an assisted living client's representative to comply with a legal requirement to which one or more of the entities may be subject, shall make appropriate referrals to other governmental agencies and entities having jurisdiction over the subject matter. The commissioner may also make referrals to any public or private agency the commissioner considers available for appropriate assistance to those involved.

(b) In addition to the authority with respect to licensed home care providers under sections 144A.45 and 144A.46 and with respect to housing with services establishments under chapter 144D, the commissioner shall have standing to bring an action for injunctive relief in the district court in the district in which a housing with services establishment is located to compel the housing with services establishment or the arranged home care provider to meet the requirements of this chapter or other requirements of the state or of any county or local governmental unit to which the establishment or arranged home care provider is otherwise subject. Proceedings for securing an injunction may be brought by the commissioner through the attorney general or through the appropriate county attorney. The sanctions in this section do not restrict the availability of other sanctions.

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

Sec. 16. **[144G.03] ASSISTED LIVING REQUIREMENTS.**

Subdivision 1. **Verification in annual registration.** A registered housing with services establishment using the phrase "assisted living," pursuant to section 144G.02, subdivision 1, shall verify to the commissioner in its annual registration pursuant to chapter 144D that the establishment is complying with sections 144G.01 to 144G.05, as applicable.

Subd. 2. **Minimum requirements for assisted living.** (a) Assisted living shall be provided or made available only to individuals residing in a registered housing with services establishment. Except as expressly stated in this chapter, a person or entity offering assisted living may define the available services and may offer assisted living to all or some of the residents of a housing with services establishment. The services that comprise assisted living may be provided or made available directly by a housing with

services establishment or by persons or entities with which the housing with services establishment has made arrangements.

(b) A person or entity entitled to use the phrase "assisted living," according to section 144G.02, subdivision 1, shall do so only with respect to a housing with services establishment, or a service, service package, or program available within a housing with services establishment that, at a minimum:

(1) provides or makes available health related services under a class A or class F home care license. At a minimum, health related services must include:

(i) assistance with self-administration of medication as defined in Minnesota Rules, part 4668.0003, subpart 2a, or medication administration as defined in Minnesota Rules, part 4668.0003, subpart 21a; and

(ii) assistance with at least three of the following seven activities of daily living: bathing, dressing, grooming, eating, transferring, continence care, and toileting.

All health related services shall be provided in a manner that complies with applicable home care licensure requirements in chapter 144A and Minnesota Rules, chapter 4668, and with sections 148.171 to 148.285;

(2) provides necessary assessments of the physical and cognitive needs of assisted living clients by a registered nurse, as required by applicable home care licensure requirements in chapter 144A and Minnesota Rules, chapter 4668, and by sections 148.171 to 148.285;

(3) has and maintains a system for delegation of health care activities to unlicensed assistive health care personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by applicable home care licensure requirements in chapter 144A and Minnesota Rules, chapter 4668, and by sections 148.171 to 148.285;

(4) provides staff access to an on-call registered nurse 24 hours per day, seven days per week;

(5) has and maintains a system to check on each assisted living client at least daily;

(6) provides a means for assisted living clients to request assistance for health and safety needs 24 hours per day, seven days per week, from the establishment or a person or entity with which the establishment has made arrangements;

(7) has a person or persons available 24 hours per day, seven days per week, who is responsible for responding to the requests of assisted living clients for assistance with health or safety needs, who shall be:

(i) awake;

(ii) located in the same building, in an attached building, or on a contiguous campus with the housing with services establishment in order to respond within a reasonable amount of time;

(iii) capable of communicating with assisted living clients;

(iv) capable of recognizing the need for assistance;

(v) capable of providing either the assistance required or summoning the appropriate assistance; and

(vi) capable of following directions;

(8) offers to provide or make available at least the following supportive services to assisted living clients:

(i) two meals per day;

(ii) weekly housekeeping;

(iii) weekly laundry service;

(iv) upon the request of the client, reasonable assistance with arranging for transportation to medical and social services appointments, and the name of or other identifying information about the person or persons responsible for providing this assistance;

(v) upon the request of the client, reasonable assistance with accessing community resources and social services available in the community, and the name of or other identifying information about the person or persons responsible for providing this assistance; and

(vi) periodic opportunities for socialization; and

(9) makes available to all prospective and current assisted living clients information consistent with the uniform format and the required components adopted by the commissioner under section 144G.06. This information must be made available beginning no later than six months after the commissioner makes the uniform format and required components available to providers according to section 144G.06.

Subd. 3. **Exemption from awake-staff requirement.** (a) A housing with services establishment that offers or provides assisted living is exempt from the requirement in subdivision 2, paragraph (b), clause (7), item (i), that the person or persons available and responsible for responding to requests for assistance must be awake, if the establishment meets the following requirements:

(1) the establishment has a maximum capacity to serve 12 or fewer assisted living clients;

(2) the person or persons available and responsible for responding to requests for assistance are physically present within the housing with services establishment in which the assisted living clients reside;

(3) the establishment has a system in place that is compatible with the health, safety, and welfare of the establishment's assisted living clients;

(4) the establishment's housing with services contract, as required by section 144D.04, includes a statement disclosing the establishment's qualification for, and intention to rely upon, this exemption;

(5) the establishment files with the commissioner, for purposes of public information but not review or approval by the commissioner, a statement describing how the establishment meets the conditions in clauses (1) to (5), and makes a copy of this statement available to actual and prospective assisted living clients; and

(6) the establishment indicates on its housing with services registration, under section 144D.02 or 144D.03, as applicable, that is qualifies for and intends to rely upon the exemption under this subdivision.

Subd. 4. **Nursing assessment.** (a) A housing with services establishment offering or providing assisted living shall:

(1) offer to have the arranged home care provider conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a service agreement or service plan prior to the date on which a prospective resident executes a contract with a housing with services establishment or the date on which a prospective resident moves in, whichever is earlier; and

(2) inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a housing with services establishment or the date on which a prospective resident moves in, whichever is earlier.

(b) An arranged home care provider is not obligated to conduct a nursing assessment by a registered nurse when requested by a prospective resident if either the geographic distance between the prospective resident and the provider, or urgent or unexpected circumstances, do not permit the assessment to be conducted prior to the date on which the prospective resident executes a contract or moves in, whichever is earlier. When such circumstances occur, the arranged home care provider shall offer to conduct a telephone conference whenever reasonably possible.

(c) The arranged home care provider shall comply with applicable home care licensure requirements in chapter 144A and Minnesota Rules, chapter 4668, and with sections 148.171 to 148.285 with respect to the provision of a nursing assessment prior

to the delivery of nursing services and the execution of a home care service plan or service agreement.

Subd. 5. **Assistance with arranged home care provider.** The housing with services establishment shall provide each assisted living client with identifying information about a person or persons reasonably available to assist the client with concerns the client may have with respect to the services provided by the arranged home care provider. The establishment shall keep each assisted living client reasonably informed of any changes in the personnel referenced in this subdivision. Upon request of the assisted living client, such personnel or designee shall provide reasonable assistance to the assisted living client in addressing concerns regarding services provided by the arranged home care provider.

Subd. 6. **Termination of housing with services contract.** If a housing with services establishment terminates a housing with services contract with an assisted living client, the establishment shall provide the assisted living client, and the legal or designated representative of the assisted living client, if any, with a written notice of termination which includes the following information:

(1) the effective date of termination;

(2) the section of the contract that authorizes the termination;

(3) without extending the termination notice period, an affirmative offer to meet with the assisted living client and, if applicable, client representatives, within no more than five business days of the date of the termination notice to discuss the termination;

(4) an explanation that:

(i) the assisted living client must vacate the apartment, along with all personal possessions, on or before the effective date of termination;

(ii) failure to vacate the apartment by the date of termination may result in the filing of an eviction action in court by the establishment, and that the assisted living client may present a defense, if any, to the court at that time; and

(iii) the assisted living client may seek legal counsel in connection with the notice of termination;

(5) a statement that, with respect to the notice of termination, reasonable accommodation is available for the disability of the assisted living client, if any; and

(6) the name and contact information of the representative of the establishment with whom the assisted living client or client representatives may discuss the notice of termination.

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

Sec. 17. **[144G.04] RESERVATION OF RIGHTS.**

Subdivision 1. **Use of services.** Nothing in this chapter requires an assisted living client to utilize any service provided or made available in assisted living.

Subd. 2. **Housing with services contracts.** Nothing in this chapter requires a housing with services establishment to execute or refrain from terminating a housing with services contract with a prospective or current resident who is unable or unwilling to meet the requirements of residency, with or without assistance.

Subd. 3. **Provision of services.** Nothing in this chapter requires the arranged home care provider to offer or continue to provide services under a service agreement or service plan to a prospective or current resident of the establishment whose needs cannot be met by the arranged home care provider.

Subd. 4. **Altering operations; service packages.** Nothing in this chapter requires a housing with services establishment or arranged home care provider offering assisted living to fundamentally alter the nature of the operations of the establishment or the provider in order to accommodate the request or need for facilities or services by any assisted living client, or to refrain from requiring, as a condition of residency, that an assisted living client pay for a package of assisted living services even if the client does not choose to utilize all or some of the services in the package.

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

Sec. 18. **[144G.05] REIMBURSEMENT UNDER ASSISTED LIVING SERVICE PACKAGES.**

Notwithstanding the provisions of this chapter, the requirements for the Elderly Waiver program's assisted living payment rates under section 256B.0915, subdivision 3e, shall continue to be effective and providers who do not meet the requirements of this chapter may continue to receive payment under section 256B.0915, subdivision 3e, as long as they continue to meet the definitions and standards for assisted living and assisted living plus set forth in the federally approved Elderly Home and Community Based Services Waiver Program (Control Number 0025.91).

Providers of assisted living for the Community Alternatives for Disabled Individuals (CADI) and Traumatic Brain Injury (TBI) waivers shall continue to receive payment as long as they continue to meet the definitions and standards for assisted living and assisted living plus set forth in the federally approved CADI and TBI waiver plans.

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

Sec. 19. **[144G.06] UNIFORM CONSUMER INFORMATION GUIDE.**

(a) The commissioner of health shall establish an advisory committee consisting of representatives of consumers, providers, county and state officials, and other groups the commissioner considers appropriate. The advisory committee shall present recommendations to the commissioner on:

(1) a format for a guide to be used by individual providers of assisted living, as defined in Minnesota Statutes, section 144G.01, that includes information about services offered by that provider, service costs, and other relevant provider-specific information, as well as a statement of philosophy and values associated with assisted living, presented in uniform categories that facilitate comparison with guides issued by other providers; and

(2) requirements for informing assisted living clients, as defined in Minnesota Statutes, section 144G.01, of their applicable legal rights.

(b) The commissioner, after reviewing the recommendations of the advisory committee, shall adopt a uniform format for the guide to be used by individual providers, and the required components of materials to be used by providers to inform assisted living clients of their legal rights, and shall make the uniform format and the required components available to assisted living providers.

Sec. 20. Minnesota Statutes 2004, section 256.01, is amended by adding a subdivision to read:

Subd. 2b. **Performance payments.** The commissioner shall develop and implement a pay-for-performance system to provide performance payments to medical groups that demonstrate optimum care in serving individuals with chronic diseases that are enrolled in health care programs administered by the commissioner under chapters 256B, 256D, and 256L. This subdivision shall expire June 30, 2008.

Sec. 21. Minnesota Statutes 2004, section 256.01, is amended by adding a subdivision to read:

Subd. 23. **Reverse mortgage information and referral.** The commissioner, in cooperation with the commissioner of the Minnesota Housing Finance Agency, shall:

(1) establish an information and referral system to inform eligible persons regarding the availability of reverse mortgages and state incentives available to persons who take out certain reverse mortgages. The information and referral system shall be established involving the Senior LinkAge Line, county and tribal agencies, community housing agencies and organizations, reverse mortgage counselors and lenders, senior and elder community organizations, and other relevant entities; and

(2) coordinate necessary training for Senior LinkAge Line employees, mortgage counselors, and lenders regarding the provisions of sections 256B.0913, subdivision 17, and 462A.05, subdivision 42.

Sec. 22. **[256.9545] PRESCRIPTION DRUG DISCOUNT PROGRAM.**

Subdivision 1. **Establishment; administration.** The commissioner shall establish and administer the prescription drug discount program.

Subd. 2. **Commissioner's authority.** The commissioner shall administer a drug rebate program for drugs purchased according to the prescription drug discount program. The commissioner shall execute a rebate agreement from all manufacturers that choose to participate in the program for those drugs covered under the medical assistance program. For each drug, the amount of the rebate shall be equal to the rebate as defined for purposes of the federal rebate program in United States Code, title 42, section 1396r-8. The rebate program shall utilize the terms and conditions used for the federal rebate program established according to section 1927 of title XIX of the federal Social Security Act.

Subd. 3. **Definitions.** For purposes of this section, the following terms have the meanings given them.

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

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

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

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

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

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

Subd. 4. **Eligibility.** (a) To be eligible for the program, an applicant must:

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

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

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

(4) not be enrolled in and have currently available prescription drug coverage under a Medicare supplement policy, as defined in sections 62A.31 to 62A.44; and

(5) have individual or family gross income equal to or less than 300 percent of the federal poverty guidelines. The commissioner shall adjust the income limit 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) Notwithstanding paragraph (a), clause (3), an individual who is enrolled in a Medicare Part D prescription drug plan or Medicare Advantage plan is eligible for the program but only for drugs that are not covered under the Medicare Part D plan or for drugs that are covered under the plan, but according to the conditions of the plan, the individual is responsible for 100 percent of the cost of the prescription drug.

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

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

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

Subd. 6. **Participating pharmacy.** (a) Upon implementation of the prescription drug discount program, and until January 1, 2008, a participating pharmacy, with a valid prescription, must sell a covered prescription drug to an enrolled individual at the medical assistance rate.

(b) After January 1, 2008, a participating pharmacy, with a valid prescription, must sell a covered prescription drug to an enrolled individual at the medical assistance rate, minus an amount that is equal to the rebate amount described in subdivision 8.

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

Subd. 7. **Notification of rebate amount.** The commissioner shall notify each participating manufacturer, each calendar quarter or according to a schedule established by the commissioner, of the amount of the rebate owed on the prescription drugs sold by participating pharmacies to enrolled individuals.

Subd. 8. **Provision of rebate.** To the extent that a participating manufacturer's prescription drugs are prescribed to a resident of this state, the manufacturer must provide a rebate equal to the rebate provided under the medical assistance program for any prescription drug distributed by the manufacturer that is purchased at a participating pharmacy by an enrolled individual. The participating manufacturer must provide full payment within 38 days of receipt of the state invoice for the rebate, or according to a schedule to be established by the commissioner. The commissioner shall deposit all rebates received into the Minnesota prescription drug dedicated fund established under subdivision 11. The manufacturer must provide the commissioner with any information necessary to verify the rebate determined per drug.

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

Subd. 10. **Enrollment fee.** Beginning July 1, 2008, the commissioner shall establish an annual enrollment fee that covers the commissioner's expenses for enrollment, processing claims, and distributing rebates under this program.

Subd. 11. **Dedicated fund; creation; use of fund.** (a) The Minnesota prescription drug dedicated fund is established as an account in the state treasury. The commissioner of finance shall credit to the dedicated fund all rebates paid under subdivision 8, any federal funds received for the program, all enrollment fees paid by the enrollees, and any appropriations or allocations designated for the fund. The commissioner of finance

shall ensure that fund money is invested under section 11A.25. All money earned by the fund must be credited to the fund. The fund shall earn a proportionate share of the total state annual investment income.

(b) Money in the fund is appropriated to the commissioner to reimburse participating pharmacies for prescription drugs provided to enrolled individuals under subdivision 6, paragraph (b); to reimburse the commissioner for costs related to enrollment, processing claims, and distributing rebates and for other reasonable administrative costs related to administration of the prescription drug discount program; and to repay the appropriation provided by law for this section. The commissioner must administer the program so that the costs total no more than funds appropriated plus the drug rebate proceeds.

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

Sec. 23. Minnesota Statutes 2004, section 256.975, subdivision 7, is amended to read:

Subd. 7. **Consumer information and assistance; Senior LinkAge.** (a) The Minnesota Board on Aging shall operate a statewide information and assistance service to aid older Minnesotans and their families in making informed choices about long-term care options and health care benefits. Language services to persons with limited English language skills may be made available. The service, known as Senior LinkAge Line, must be available during business hours through a statewide toll-free number and must also be available through the Internet.

(b) The service must assist older adults, caregivers, and providers in accessing information about choices in long-term care services that are purchased through private providers or available through public options. The service must:

(1) develop a comprehensive database that includes detailed listings in both consumer- and provider-oriented formats;

(2) make the database accessible on the Internet and through other telecommunication and media-related tools;

(3) link callers to interactive long-term care screening tools and make these tools available through the Internet by integrating the tools with the database;

(4) develop community education materials with a focus on planning for long-term care and evaluating independent living, housing, and service options;

(5) conduct an outreach campaign to assist older adults and their caregivers in finding information on the Internet and through other means of communication;

(6) implement a messaging system for overflow callers and respond to these callers by the next business day;

(7) link callers with county human services and other providers to receive more in-depth assistance and consultation related to long-term care options; ~~and~~

(8) provide information and assistance to inform older adults about reverse mortgages, including the provisions of sections 47.58; 256B.0913, subdivision 17; and 462A.05, subdivision 42; and

(9) link callers with quality profiles for nursing facilities and other providers developed by the commissioner of health.

(c) The Minnesota Board on Aging shall conduct an evaluation of the effectiveness of the statewide information and assistance, and submit this evaluation to the legislature by December 1, 2002. The evaluation must include an analysis of funding adequacy, gaps in service delivery, continuity in information between the service and identified linkages, and potential use of private funding to enhance the service.

Sec. 24. Minnesota Statutes 2004, section 256B.0625, is amended by adding a subdivision to read:

Subd. 13i. **Medicare Part D co-payments.** For recipients who are enrolled in a Medicare Part D prescription drug plan or Medicare Advantage plan, medical assistance covers the co-payments in which the recipient is responsible for under the Medicare Part D prescription drug plan or Medicare Advantage plan.

Sec. 25. Minnesota Statutes 2005 Supplement, section 256B.075, subdivision 2, is amended to read:

Subd. 2. **Fee-for-service.** (a) The commissioner shall develop and implement a disease management program for medical assistance and general assistance medical care recipients who are not enrolled in the prepaid medical assistance or prepaid general assistance medical care programs and who are receiving services on a fee-for-service basis. The commissioner may contract with an outside organization to provide ~~these~~ services under this subdivision.

(b) The commissioner shall seek any federal approval necessary to implement this section and to obtain federal matching funds.

(c) The commissioner shall develop and implement a pilot intensive care management program for medical assistance children with complex and chronic medical issues who are not able to participate in the metro-based U Special Kids program due to geographic distance.

(d) The commissioner shall develop and implement an intensive care management pilot program for children, adults, and families who have complex and chronic medical

issues, or who are high risk of developing them, and who receive their primary care through a federally qualified health center or community clinic. For purposes of this paragraph, "federally qualified health center" means an entity that is receiving a grant under United States Code, title 42, section 254b, or, based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the secretary to meet the requirements for receiving such a grant; and "community clinic" means a clinic that is not a federally qualified health center, but is certified by the Minnesota Department of Health as being eligible to receive a grant under section 145.9268.

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

Sec. 26. Minnesota Statutes 2005 Supplement, section 256B.0911, subdivision 1a, is amended to read:

Subd. 1a. **Definitions.** For purposes of this section, the following definitions apply:

(a) "Long-term care consultation services" means:

(1) providing information and education to the general public regarding availability of the services authorized under this section;

(2) an intake process that provides access to the services described in this section;

(3) assessment of the health, psychological, and social needs of referred individuals;

(4) assistance in identifying services needed to maintain an individual in the least restrictive environment;

(5) providing recommendations on cost-effective community services that are available to the individual;

(6) development of an individual's community support plan, which may include the use of reverse mortgage payments to pay for services needed to maintain the individual in the person's home;

(7) providing information regarding eligibility for Minnesota health care programs;

(8) preadmission screening to determine the need for a nursing facility level of care;

(9) preliminary determination of Minnesota health care programs eligibility for individuals who need a nursing facility level of care, with appropriate referrals for final determination;

(10) providing recommendations for nursing facility placement when there are no cost-effective community services available; and

(11) assistance to transition people back to community settings after facility admission.

(b) "Minnesota health care programs" means the medical assistance program under chapter 256B and the alternative care program under section 256B.0913.

Sec. 27. Minnesota Statutes 2004, section 256B.0911, subdivision 3a, is amended to read:

Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment, services planning, or other assistance intended to support community-based living must be visited by a long-term care consultation team within ten working days after the date on which an assessment was requested or recommended. Assessments must be conducted according to paragraphs (b) to (g).

(b) The county may utilize a team of either the social worker or public health nurse, or both, to conduct the assessment in a face-to-face interview. The consultation team members must confer regarding the most appropriate care for each individual screened or assessed.

(c) The long-term care consultation team must assess the health and social needs of the person, using an assessment form provided by the commissioner.

(d) The team must conduct the assessment in a face-to-face interview with the person being assessed and the person's legal representative, if applicable.

(e) The team must provide the person, or the person's legal representative, with written recommendations for facility- or community-based services. The team must document that the most cost-effective alternatives available were offered to the individual. For purposes of this requirement, "cost-effective alternatives" means community services and living arrangements that cost the same as or less than nursing facility care.

(f) If the person chooses to use community-based services, the team must provide the person or the person's legal representative with a written community support plan, regardless of whether the individual is eligible for Minnesota health care programs. The person may request assistance in developing a community support plan without participating in a complete assessment. <u>If the person chooses to obtain a reverse mortgage under section 47.58 as part of the community support plan, the plan must include a spending plan for the reverse mortgage payments.</u>

(g) The team must give the person receiving assessment or support planning, or the person's legal representative, materials supplied by the commissioner containing the following information:

(1) the purpose of preadmission screening and assessment;

(2) information about Minnesota health care programs and about reverse mortgages, including the provisions of sections 47.58; 256B.0913, subdivision 17; and 462A.05, subdivision 42;

(3) the person's freedom to accept or reject the recommendations of the team;

(4) the person's right to confidentiality under the Minnesota Government Data Practices Act, chapter 13; and

(5) the person's right to appeal the decision regarding the need for nursing facility level of care or the county's final decisions regarding public programs eligibility according to section 256.045, subdivision 3.

Sec. 28. Minnesota Statutes 2004, section 256B.0913, is amended by adding a subdivision to read:

Subd. 17. **Services for persons using reverse mortgages.** (a) Alternative care services are available to a person who satisfies the following criteria:

(1) the person qualifies for the reverse mortgage incentive program under section 462A.05, subdivision 42, and has received the final payment on a qualifying reverse mortgage, or the person satisfies the criteria in section 462A.05, subdivision 42, paragraph (b), clauses (1) to (5), and has otherwise obtained a reverse mortgage and payments from the reverse mortgage for a period of at least 24 months or in an amount of at least $15,000 are used for services and supports, including basic shelter needs, home maintenance, and modifications or adaptations, necessary to allow the person to remain in the home as an alternative to a nursing facility placement; and

(2) the person satisfies the eligibility criteria under this section, other than age, income, and assets, and verifies that reverse mortgage expenditures were made according to the spending plan established under section 256B.0911, if one has been established.

(b) In addition to the other services provided under this section, a person who qualifies under this subdivision shall not be assessed a monthly participation fee under subdivision 12 nor be subject to an estate claim under section 256B.15 for services received under this section.

(c) The commissioner shall require a certification of loan satisfaction or other documentation that the person qualifies under this subdivision.

Sec. 29. Minnesota Statutes 2005 Supplement, section 256B.0918, subdivision 1, is amended to read:

Subdivision 1. **Program criteria.** Beginning on or after October 1, 2005, within the limits of appropriations specifically available for this purpose, the commissioner shall

provide funding to qualified provider applicants for employee scholarships for education in nursing and other health care fields. Employee scholarships must be for a course of study that is expected to lead to career advancement with the provider or in the field of long-term care, including home care or care of persons with disabilities, or nursing. Providers that secure this funding must use it to award scholarships to employees who work an average of at least 20 hours per week for the provider. Executive management staff without direct care duties, registered nurses, and therapists are not eligible to receive scholarships under this section.

Sec. 30. Minnesota Statutes 2005 Supplement, section 256B.0918, subdivision 3, is amended to read:

Subd. 3. **Provider selection criteria.** To be considered for scholarship funding, the provider shall submit a completed application within the time frame specified by the commissioner. In awarding funding, the commissioner shall consider the following:

(1) the size of the provider as measured in annual billing to the medical assistance program. To be eligible, a provider must receive at least ~~$500,000~~ $300,000 annually in medical assistance payments;

(2) the percentage of employees meeting the scholarship program recipient requirements;

(3) staff retention rates for paraprofessionals; and

(4) other criteria determined by the commissioner.

Sec. 31. Minnesota Statutes 2005 Supplement, section 256B.0918, subdivision 4, is amended to read:

Subd. 4. **Funding specifics.** Within the limits of appropriations specifically available for this purpose, for the rate period beginning on or after October 1, 2005, to September 30, 2007, the commissioner shall provide to each provider listed in subdivision 2 and awarded funds under subdivision 3 a medical assistance rate increase to fund scholarships up to ~~two-tenths~~ three-tenths percent of the medical assistance reimbursement rate. The commissioner shall require providers to repay any portion of funds awarded under subdivision 3 that is not used to fund scholarships. If applications exceed available funding, funding shall be targeted to providers that employ a higher percentage of paraprofessional staff or have lower rates of turnover of paraprofessional staff. During the subsequent years of the program, the rate adjustment may be recalculated, at the discretion of the commissioner. In making a recalculation the commissioner may consider

the provider's success at granting scholarships based on the amount spent during the previous year and the availability of appropriations to continue the program.

Sec. 32. Minnesota Statutes 2004, section 256B.15, is amended by adding a subdivision to read:

Subd. 9. **Recovery of alternative care and certain reverse mortgages.** The state and a county agency shall not recover alternative care paid for a person under section 256B.0913, subdivision 17, under this section.

Sec. 33. Minnesota Statutes 2005 Supplement, section 256B.434, subdivision 4, is amended to read:

Subd. 4. **Alternate rates for nursing facilities.** (a) For nursing facilities which have their payment rates determined under this section rather than section 256B.431, the commissioner shall establish a rate under this subdivision. The nursing facility must enter into a written contract with the commissioner.

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

(c) A nursing facility's case mix payment rates for the second and subsequent years of a facility's contract under this section are the previous rate year's contract payment rates plus an inflation adjustment and, for facilities reimbursed under this section or section 256B.431, an adjustment to include the cost of any increase in Health Department licensing fees for the facility taking effect on or after July 1, 2001. The index for the inflation adjustment must be based on the change in the Consumer Price Index-All Items (United States City average) (CPI-U) forecasted by the commissioner of finance's national economic consultant, as forecasted in the fourth quarter of the calendar year preceding the rate year. The inflation adjustment must be based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined. For the rate years beginning on July 1, 1999, July 1, 2000, July 1, 2001, July 1, 2002, July 1, 2003, July 1, 2004, July 1, 2005, July 1, 2006, July 1, 2007, and July 1, 2008, this paragraph shall apply only to the property-related payment rate, except that adjustments to include the cost of any increase in Health Department licensing fees taking effect on or after July 1, 2001, shall be provided. Beginning in 2005, adjustment to the property payment rate under this section and section 256B.431 shall be effective on October 1. In determining the amount of the property-related payment rate adjustment under this paragraph, the commissioner shall determine the proportion of the facility's

rates that are property-related based on the facility's most recent cost report. Beginning October 1, 2006, facilities reimbursed under this section shall be allowed to receive a property rate adjustment for building projects under section 144A.071, subdivision 2.

(d) The commissioner shall develop additional incentive-based payments of up to five percent above a facility's operating payment rate for achieving outcomes specified in a contract. The commissioner may solicit contract amendments and implement those which, on a competitive basis, best meet the state's policy objectives. The commissioner shall limit the amount of any incentive payment and the number of contract amendments under this paragraph to operate the incentive payments within funds appropriated for this purpose. The contract amendments may specify various levels of payment for various levels of performance. Incentive payments to facilities under this paragraph may be in the form of time-limited rate adjustments or supplemental payments. In establishing the specified outcomes and related criteria, the commissioner shall consider the following state policy objectives:

(1) successful diversion or discharge of residents to the residents' prior home or other community-based alternatives;

(2) adoption of new technology to improve quality or efficiency;

(3) improved quality as measured in the Nursing Home Report Card;

(4) reduced acute care costs; and

(5) any additional outcomes proposed by a nursing facility that the commissioner finds desirable.

Sec. 34. Minnesota Statutes 2004, section 256B.69, subdivision 9, is amended to read:

Subd. 9. **Reporting.** (a) Each demonstration provider shall submit information as required by the commissioner, including data required for assessing client satisfaction, quality of care, cost, and utilization of services for purposes of project evaluation. The commissioner shall also develop methods of data reporting and collection ~~from county advocacy activities~~ in order to provide aggregate enrollee information on encounters and outcomes to determine access and quality assurance. Required information shall be specified before the commissioner contracts with a demonstration provider.

(b) Nonpersonally identifiable health plan encounter data, aggregate spending data for major categories of service as reported to the commissioners of health and commerce under section 62D.08, subdivision 3, and criteria for service authorization and service use are public data that the commissioner shall make available and use in public reports. The commissioner shall require each health plan and county-based purchasing plan to provide:

(1) encounter data for each service provided, using standard codes and unit of service definitions set by the commissioner, in a form that the commissioner can report by age, eligibility groups, and health plan; and

(2) criteria, written policies, and procedures required to be disclosed under section 62M.10, subdivision 7, and Code of Federal Regulations, title 42, part 438.210(b)(1), used for each type of service for which authorization is required.

Sec. 35. Minnesota Statutes 2005 Supplement, section 256B.69, subdivision 23, is amended to read:

Subd. 23. **Alternative services; elderly and disabled persons.** (a) The commissioner may implement demonstration projects to create alternative integrated delivery systems for acute and long-term care services to elderly persons and persons with disabilities as defined in section 256B.77, subdivision 7a, that provide increased coordination, improve access to quality services, and mitigate future cost increases. The commissioner may seek federal authority to combine Medicare and Medicaid capitation payments for the purpose of such demonstrations and may contract with Medicare-approved special needs plans to provide Medicaid services. Medicare funds and services shall be administered according to the terms and conditions of the federal waiver and demonstration provisions. For the purpose of administering medical assistance funds, demonstrations under this subdivision are subject to subdivisions 1 to 22. The provisions of Minnesota Rules, parts 9500.1450 to 9500.1464, apply to these demonstrations, with the exceptions of parts 9500.1452, subpart 2, item B; and 9500.1457, subpart 1, items B and C, which do not apply to persons enrolling in demonstrations under this section. An initial open enrollment period may be provided. Persons who disenroll from demonstrations under this subdivision remain subject to Minnesota Rules, parts 9500.1450 to 9500.1464. When a person is enrolled in a health plan under these demonstrations and the health plan's participation is subsequently terminated for any reason, the person shall be provided an opportunity to select a new health plan and shall have the right to change health plans within the first 60 days of enrollment in the second health plan. Persons required to participate in health plans under this section who fail to make a choice of health plan shall not be randomly assigned to health plans under these demonstrations. Notwithstanding section 256L.12, subdivision 5, and Minnesota Rules, part 9505.5220, subpart 1, item A, if adopted, for the purpose of demonstrations under this subdivision, the commissioner may contract with managed care organizations, including counties, to serve only elderly persons eligible for medical assistance, elderly and disabled persons, or disabled persons only. For persons with primary diagnoses of mental retardation or a related condition,

serious and persistent mental illness, or serious emotional disturbance, the commissioner must ensure that the county authority has approved the demonstration and contracting design. Enrollment in these projects for persons with disabilities shall be voluntary. The commissioner shall not implement any demonstration project under this subdivision for persons with primary diagnoses of mental retardation or a related condition, serious and persistent mental illness, or serious emotional disturbance, without approval of the county board of the county in which the demonstration is being implemented.

(b) Notwithstanding chapter 245B, sections 252.40 to 252.46, 256B.092, 256B.501 to 256B.5015, and Minnesota Rules, parts 9525.0004 to 9525.0036, 9525.1200 to 9525.1330, 9525.1580, and 9525.1800 to 9525.1930, the commissioner may implement under this section projects for persons with developmental disabilities. The commissioner may capitate payments for ICF/MR services, waivered services for mental retardation or related conditions, including case management services, day training and habilitation and alternative active treatment services, and other services as approved by the state and by the federal government. Case management and active treatment must be individualized and developed in accordance with a person-centered plan. Costs under these projects may not exceed costs that would have been incurred under fee-for-service. Beginning July 1, 2003, and until two years after the pilot project implementation date, subcontractor participation in the long-term care developmental disability pilot is limited to a nonprofit long-term care system providing ICF/MR services, home and community-based waiver services, and in-home services to no more than 120 consumers with developmental disabilities in Carver, Hennepin, and Scott Counties. The commissioner shall report to the legislature prior to expansion of the developmental disability pilot project. This paragraph expires two years after the implementation date of the pilot project.

(c) Before implementation of a demonstration project for disabled persons, the commissioner must provide information to appropriate committees of the house of representatives and senate and must involve representatives of affected disability groups in the design of the demonstration projects.

(d) A nursing facility reimbursed under the alternative reimbursement methodology in section 256B.434 may, in collaboration with a hospital, clinic, or other health care entity provide services under paragraph (a). The commissioner shall amend the state plan and seek any federal waivers necessary to implement this paragraph.

(e) The commissioner, in consultation with the commissioners of commerce and health, may approve and implement programs for all-inclusive care for the elderly (PACE) according to federal laws and regulations governing that program and state laws or rules applicable to participating providers. The process for approval of these programs shall

begin only after the commissioner receives grant money in an amount sufficient to cover the state share of the administrative and actuarial costs to implement the programs during state fiscal years 2006 and 2007. Grant amounts for this purpose shall be deposited in an account in the special revenue fund and are appropriated to the commissioner to be used solely for the purpose of PACE administrative and actuarial costs. A PACE provider is not required to be licensed or certified as a health plan company as defined in section 62Q.01, subdivision 4. Persons age 55 and older who have been screened by the county and found to be eligible for services under the elderly waiver or community alternatives for disabled individuals or who are already eligible for Medicaid but meet level of care criteria for receipt of waiver services may choose to enroll in the PACE program. Medicare and Medicaid services will be provided according to this subdivision and federal Medicare and Medicaid requirements governing PACE providers and programs. PACE enrollees will receive Medicaid home and community-based services through the PACE provider as an alternative to services for which they would otherwise be eligible through home and community-based waiver programs and Medicaid State Plan Services. The commissioner shall establish Medicaid rates for PACE providers that do not exceed costs that would have been incurred under fee-for-service or other relevant managed care programs operated by the state.

(f) The commissioner shall seek federal approval to expand the Minnesota disability health options (MnDHO) program established under this subdivision in stages, first to regional population centers outside the seven-county metro area and then to all areas of the state. Until January 1, 2008, expansion for MnDHO projects that include home and community-based services is limited to the two projects and service areas in effect on March 1, 2006. Enrollment in integrated MnDHO programs that include home and community-based services shall remain voluntary. Costs for home and community-based services included under MnDHO must not exceed costs that would have been incurred under the fee-for-service program. In developing program specifications for expansion of integrated programs, the commissioner shall involve and consult the state-level stakeholder group established in subdivision 28, paragraph (d), including consultation on whether and how to include home and community-based waiver programs. Plans for further expansion of MnDHO projects shall be presented to the chairs of the house and senate committees with jurisdiction over health and human services policy and finance by February 1, 2007.

(g) Notwithstanding section 256B.0261, health plans providing services under this section are responsible for home care targeted case management and relocation targeted case management. Services must be provided according to the terms of the waivers and contracts approved by the federal government.

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

Sec. 36. Minnesota Statutes 2004, section 256B.69, is amended by adding a subdivision to read:

Subd. 28. **Medicare special needs plans and medical assistance basic health care for persons with disabilities.** (a) The commissioner may contract with qualified Medicare-approved special needs plans to provide medical assistance basic health care services to persons with disabilities, including those with developmental disabilities. Basic health care services include:

(1) those services covered by the medical assistance state plan except for ICF/MR services, home and community-based waiver services, case management for persons with developmental disabilities under section 256B.0625, subdivision 20a, and personal care and certain home care services defined by the commissioner in consultation with the stakeholder group established under paragraph (d);

(2) basic health care services may also include risk for up to 100 days of nursing facility services for persons who reside in a noninstitutional setting and home health services related to rehabilitation as defined by the commissioner after consultation with the stakeholder group; and

(3) the commissioner may exclude other medical assistance services from the basic health care benefit set. Enrollees in these plans can access any excluded services on the same basis as other medical assistance recipients who have not enrolled.

Unless a person is otherwise required to enroll in managed care, enrollment in these plans for Medicaid services must be voluntary. For purposes of this subdivision, automatic enrollment with an option to opt out is not voluntary enrollment.

(b) Beginning January 1, 2007, the commissioner may contract with qualified Medicare special needs plans to provide basic health care services under medical assistance to persons who are dually eligible for both Medicare and Medicaid and those Social Security beneficiaries eligible for Medicaid but in the waiting period for Medicare. The commissioner shall consult with the stakeholder group under paragraph (d) in developing program specifications for these services. The commissioner shall report to the chairs of the house and senate committees with jurisdiction over health and human services policy and finance by February 1, 2007, on implementation of these programs and the need for increased funding for the ombudsman for managed care and other consumer assistance and protections needed due to enrollment in managed care of persons with disabilities. Payment for Medicaid services provided under this subdivision for the months of May and June will be made no earlier than July 1 of the same calendar year.

(c) Beginning January 1, 2008, the commissioner may expand contracting under this subdivision to all persons with disabilities not otherwise required to enroll in managed care.

(d) The commissioner shall establish a state-level stakeholder group to provide advice on managed care programs for persons with disabilities, including both MnDHO and contracts with special needs plans that provide basic health care services as described in paragraphs (a) and (b). The stakeholder group shall provide advice on program expansions under this subdivision and subdivision 23, including:

(1) implementation efforts;

(2) consumer protections; and

(3) program specifications such as quality assurance measures, data collection and reporting, and evaluation of costs, quality, and results.

(e) Each plan under contract to provide medical assistance basic health care services shall establish a local or regional stakeholder group, including representatives of the counties covered by the plan, members, consumer advocates, and providers, for advice on issues that arise in the local or regional area.

Sec. 37. Minnesota Statutes 2004, section 256B.76, is amended to read:

256B.76 PHYSICIAN AND DENTAL REIMBURSEMENT.

(a) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for physician services as follows:

(1) payment for level one Centers for Medicare and Medicaid Services' common procedural coding system codes titled "office and other outpatient services," "preventive medicine new and established patient," "delivery, antepartum, and postpartum care," "critical care," cesarean delivery and pharmacologic management provided to psychiatric patients, and level three codes for enhanced services for prenatal high risk, shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992. If the rate on any procedure code within these categories is different than the rate that would have been paid under the methodology in section 256B.74, subdivision 2, then the larger rate shall be paid;

(2) payments for all other services shall be paid at the lower of (i) submitted charges, or (ii) 15.4 percent above the rate in effect on June 30, 1992;

(3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases except that payment rates for home health agency services shall be the rates in effect on September 30, 1992;

(4) effective for services rendered on or after January 1, 2000, payment rates for physician and professional services shall be increased by three percent over the rates in effect on December 31, 1999, except for home health agency and family planning agency services; and

(5) the increases in clause (4) shall be implemented January 1, 2000, for managed care.

(b) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for dental services as follows:

(1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992;

(2) dental rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases;

(3) effective for services rendered on or after January 1, 2000, payment rates for dental services shall be increased by three percent over the rates in effect on December 31, 1999;

(4) the commissioner shall award grants to community clinics or other nonprofit community organizations, political subdivisions, professional associations, or other organizations that demonstrate the ability to provide dental services effectively to public program recipients. Grants may be used to fund the costs related to coordinating access for recipients, developing and implementing patient care criteria, upgrading or establishing new facilities, acquiring furnishings or equipment, recruiting new providers, or other development costs that will improve access to dental care in a region. In awarding grants, the commissioner shall give priority to applicants that plan to serve areas of the state in which the number of dental providers is not currently sufficient to meet the needs of recipients of public programs or uninsured individuals. The commissioner shall consider the following in awarding the grants:

(i) potential to successfully increase access to an underserved population;

(ii) the ability to raise matching funds;

(iii) the long-term viability of the project to improve access beyond the period of initial funding;

(iv) the efficiency in the use of the funding; and

(v) the experience of the proposers in providing services to the target population.

The commissioner shall monitor the grants and may terminate a grant if the grantee does not increase dental access for public program recipients. The commissioner shall consider grants for the following:

(i) implementation of new programs or continued expansion of current access programs that have demonstrated success in providing dental services in underserved areas;

(ii) a pilot program for utilizing hygienists outside of a traditional dental office to provide dental hygiene services; and

(iii) a program that organizes a network of volunteer dentists, establishes a system to refer eligible individuals to volunteer dentists, and through that network provides donated dental care services to public program recipients or uninsured individuals;

(5) beginning October 1, 1999, the payment for tooth sealants and fluoride treatments shall be the lower of (i) submitted charge, or (ii) 80 percent of median 1997 charges;

(6) the increases listed in clauses (3) and (5) shall be implemented January 1, 2000, for managed care; and

(7) effective for services provided on or after January 1, 2002, payment for diagnostic examinations and dental x-rays provided to children under age 21 shall be the lower of (i) the submitted charge, or (ii) 85 percent of median 1999 charges.

(c) Effective for dental services rendered on or after ~~January 1, 2002~~ October 1, 2006, the commissioner ~~may, within the limits of available appropriation,~~ shall increase reimbursements to dentists and dental clinics deemed by the commissioner to be critical access dental providers~~. Reimbursement to a critical access dental provider may be increased~~ by ~~not more than 50~~ 38 percent above the reimbursement rate that would otherwise be paid to the provider. Payments to health plan companies made on or after January 1, 2007, shall be adjusted to reflect increased reimbursements to critical access dental providers as approved by the commissioner. In determining which dentists and dental clinics shall be deemed critical access dental providers, the commissioner shall review:

(1) the utilization rate in the service area in which the dentist or dental clinic operates for dental services to patients covered by medical assistance, general assistance medical care, or MinnesotaCare as their primary source of coverage;

(2) the level of services provided by the dentist or dental clinic to patients covered by medical assistance, general assistance medical care, or MinnesotaCare as their primary source of coverage; and

(3) whether the level of services provided by the dentist or dental clinic is critical to maintaining adequate levels of patient access within the service area.

(d) The commissioner shall award special hardship grants to nonprofit dental providers with a high proportion of uninsured patients that equals or exceeds 15 percent of the total number of patients served by that provider and the provider does not receive

a financial benefit comparable to other critical access dental providers under the critical access dental provider formula described in paragraph (c). The commissioner shall award a grant to these providers allocated in proportion to each critical access dental provider's ratio of uninsured patients to the total number of patients served by all providers who qualify for a grant under this paragraph.

In the absence of a critical access dental provider in a service area, the commissioner may designate a dentist or dental clinic as a critical access dental provider if the dentist or dental clinic is willing to provide care to patients covered by medical assistance, general assistance medical care, or MinnesotaCare at a level which significantly increases access to dental care in the service area.

~~(d)~~ (e) An entity that operates both a Medicare certified comprehensive outpatient rehabilitation facility and a facility which was certified prior to January 1, 1993, that is licensed under Minnesota Rules, parts 9570.2000 to 9570.3600, and for whom at least 33 percent of the clients receiving rehabilitation services in the most recent calendar year are medical assistance recipients, shall be reimbursed by the commissioner for rehabilitation services at rates that are 38 percent greater than the maximum reimbursement rate allowed under paragraph (a), clause (2), when those services are (1) provided within the comprehensive outpatient rehabilitation facility and (2) provided to residents of nursing facilities owned by the entity.

~~(e)~~ (f) Effective for services rendered on or after January 1, 2007, the commissioner shall make payments for physician and professional services based on the Medicare relative value units (RVUs). This change shall be budget neutral and the cost of implementing RVUs will be incorporated in the established conversion factor.

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

Sec. 38. Minnesota Statutes 2005 Supplement, 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;

(ii) who has gross countable income above 75 percent of the federal poverty guidelines but not in excess of 175 percent of the federal poverty guidelines for the family size, using a six-month budget period, whose equity in assets is not in excess of the limits in section 256B.056, subdivision 3c, and who applies during an inpatient hospitalization; or

(iii) the commissioner shall adjust the income standards under this section each July 1 by the annual update of the federal poverty guidelines following publication by the United States Department of Health and Human Services.

(b) Effective for applications and renewals processed on or after September 1, 2006, general assistance medical care may not be paid for applicants or recipients who are adults with dependent children under 21 whose gross family income is equal to or less than 275 percent of the federal poverty guidelines who are not described in paragraph (e).

(c) Effective for applications and renewals processed on or after September 1, 2006, general assistance medical care may be paid for applicants and recipients who meet all eligibility requirements of paragraph (a), clause (2), item (i), for a temporary period beginning the date of application. Immediately following approval of general assistance medical care, enrollees shall be enrolled in MinnesotaCare under section 256L.04, subdivision 7, with covered services as provided in section 256L.03 for the rest of the six-month eligibility period, until their six-month renewal.

(d) To be eligible for general assistance medical care following enrollment in MinnesotaCare as required by paragraph (c), an individual must complete a new application.

(e) Applicants and recipients eligible under paragraph (a), clause (1)~~; or~~; who have applied for and are awaiting a determination of blindness or disability by the state medical review team or a determination of eligibility for Supplemental Security Income or Social Security Disability Insurance by the Social Security Administration~~; or~~; who fail to meet the requirements of section 256L.09, subdivision 2~~;~~; who are classified as end-stage renal

disease beneficiaries in the Medicare program; who are enrolled in private health care coverage as defined in section 256B.02, subdivision 9; who are eligible under paragraph (j); or who receive treatment funded pursuant to section 254B.02 are exempt from the MinnesotaCare enrollment requirements of this subdivision.

(f) For applications received on or after October 1, 2003, eligibility may begin no earlier than the date of application. For individuals eligible under paragraph (a), clause (2), item (i), a redetermination of eligibility must occur every 12 months. Individuals are eligible under paragraph (a), clause (2), item (ii), only during inpatient hospitalization but may reapply if there is a subsequent period of inpatient hospitalization.

(g) Beginning September 1, 2006, Minnesota health care program applications and renewals completed by recipients and applicants who are persons described in paragraph (c) and submitted to the county agency shall be determined for MinnesotaCare eligibility by the county agency. If all other eligibility requirements of this subdivision are met, eligibility for general assistance medical care shall be available in any month during which MinnesotaCare enrollment is pending. Upon notification of eligibility for MinnesotaCare, notice of termination for eligibility for general assistance medical care shall be sent to an applicant or recipient. If all other eligibility requirements of this subdivision are met, eligibility for general assistance medical care shall be available until enrollment in MinnesotaCare subject to the provisions of paragraphs (c), (e), and (f).

(h) The date of an initial Minnesota health care program application necessary to begin a determination of eligibility shall be the date the applicant has provided a name, address, and Social Security number, signed and dated, to the county agency or the Department of Human Services. If the applicant is unable to provide a name, address, Social Security number, and signature when health care is delivered due to a medical condition or disability, a health care provider may act on an applicant's behalf to establish the date of an initial Minnesota health care program application by providing the county agency or Department of Human Services with provider identification and a temporary unique identifier for the applicant. The applicant must complete the remainder of the application and provide necessary verification before eligibility can be determined. The county agency must assist the applicant in obtaining verification if necessary.

(i) County agencies are authorized to use all automated databases containing information regarding recipients' or applicants' income in order to determine eligibility for general assistance medical care or MinnesotaCare. Such use shall be considered sufficient in order to determine eligibility and premium payments by the county agency.

(j) General assistance medical care is not available for a person in a correctional facility unless the person is detained by law for less than one year in a county correctional

or detention facility as a person accused or convicted of a crime, or admitted as an inpatient to a hospital on a criminal hold order, and the person is a recipient of general assistance medical care at the time the person is detained by law or admitted on a criminal hold order and as long as the person continues to meet other eligibility requirements of this subdivision.

(k) General assistance medical care is not available for applicants or recipients who do not cooperate with the county agency to meet the requirements of medical assistance.

(l) In determining the amount of assets of an individual eligible under paragraph (a), clause (2), item (i), there shall be included any asset or interest in an asset, including an asset excluded under paragraph (a), that was given away, sold, or disposed of for less than fair market value within the 60 months preceding application for general assistance medical care or during the period of eligibility. Any transfer described in this paragraph shall be presumed to have been for the purpose of establishing eligibility for general assistance medical care, unless the individual furnishes convincing evidence to establish that the transaction was exclusively for another purpose. For purposes of this paragraph, the value of the asset or interest shall be the fair market value at the time it was given away, sold, or disposed of, less the amount of compensation received. For any uncompensated transfer, the number of months of ineligibility, including partial months, shall be calculated by dividing the uncompensated transfer amount by the average monthly per person payment made by the medical assistance program to skilled nursing facilities for the previous calendar year. The individual shall remain ineligible until this fixed period has expired. The period of ineligibility may exceed 30 months, and a reapplication for benefits after 30 months from the date of the transfer shall not result in eligibility unless and until the period of ineligibility has expired. The period of ineligibility begins in the month the transfer was reported to the county agency, or if the transfer was not reported, the month in which the county agency discovered the transfer, whichever comes first. For applicants, the period of ineligibility begins on the date of the first approved application.

(m) When determining eligibility for any state benefits under this subdivision, the income and resources of all noncitizens shall be deemed to include their sponsor's income and resources as defined in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, title IV, Public Law 104-193, sections 421 and 422, and subsequently set out in federal rules.

(n) Undocumented noncitizens and nonimmigrants are ineligible for general assistance medical care. For purposes of this subdivision, a nonimmigrant is an individual in one or more of the classes listed in United States Code, title 8, section 1101(a)(15), and

an undocumented noncitizen is an individual who resides in the United States without the approval or acquiescence of the Immigration and Naturalization Service.

(o) Notwithstanding any other provision of law, a noncitizen who is ineligible for medical assistance due to the deeming of a sponsor's income and resources, is ineligible for general assistance medical care.

(p) Effective July 1, 2003, general assistance medical care emergency services end.

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

Sec. 39. Minnesota Statutes 2005 Supplement, section 256L.01, subdivision 4, is amended to read:

Subd. 4. **Gross individual or gross family income.** (a) "Gross individual or gross family income" for nonfarm self-employed means income calculated for the six-month period of eligibility using the net profit or loss reported on the applicant's federal income tax form for the previous year and using the medical assistance families with children methodology for determining allowable and nonallowable self-employment expenses and countable income.

(b) "Gross individual or gross family income" for farm self-employed means income calculated for the six-month period of eligibility using as the baseline the adjusted gross income reported on the applicant's federal income tax form for the previous year ~~and adding back in reported depreciation amounts that apply to the business in which the family is currently engaged~~.

(c) "Gross individual or gross family income" means the total income for all family members, calculated for the six-month period of eligibility.

EFFECTIVE DATE. This section is effective July 1, 2006, or upon federal approval, whichever is later.

Sec. 40. Minnesota Statutes 2005 Supplement, section 256L.03, subdivision 1, is amended to read:

Subdivision 1. **Covered health services.** ~~For individuals under section 256L.04, subdivision 7, with income no greater than 75 percent of the federal poverty guidelines or for families with children under section 256L.04, subdivision 1, all subdivisions of this section apply.~~ "Covered health services" means the health services reimbursed under chapter 256B, with the exception of inpatient hospital services, special education services, private duty nursing services, adult dental care services other than services covered under section 256B.0625, subdivision 9, orthodontic services, nonemergency

medical transportation services, personal care assistant and case management services, nursing home or intermediate care facilities services, inpatient mental health services, and chemical dependency services. Outpatient mental health services covered under the MinnesotaCare program are limited to diagnostic assessments, psychological testing, explanation of findings, mental health telemedicine, psychiatric consultation, medication management by a physician, day treatment, partial hospitalization, and individual, family, and group psychotherapy.

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

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

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

Sec. 41. Minnesota Statutes 2004, section 256L.03, subdivision 3, is amended to read:

Subd. 3. **Inpatient hospital services.** (a) Covered health services shall include inpatient hospital services, including inpatient hospital mental health services and inpatient hospital and residential chemical dependency treatment, subject to those limitations necessary to coordinate the provision of these services with eligibility under the medical assistance spenddown. ~~Prior to July 1, 1997, the inpatient hospital benefit for adult enrollees is subject to an annual benefit limit of $10,000.~~ The inpatient hospital benefit for adult enrollees who qualify under section 256L.04, subdivision 7, or who qualify under section 256L.04, subdivisions 1 and 2, with family gross income that exceeds 175 percent of the federal poverty guidelines and who are not pregnant, is subject to an annual limit of ~~$10,000~~ $20,000.

(b) Admissions for inpatient hospital services paid for under section 256L.11, subdivision 3, must be certified as medically necessary in accordance with Minnesota Rules, parts 9505.0500 to 9505.0540, except as provided in clauses (1) and (2):

(1) all admissions must be certified, except those authorized under rules established under section 254A.03, subdivision 3, or approved under Medicare; and

(2) payment under section 256L.11, subdivision 3, shall be reduced by five percent for admissions for which certification is requested more than 30 days after the day of admission. The hospital may not seek payment from the enrollee for the amount of the payment reduction under this clause.

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

Sec. 42. Minnesota Statutes 2005 Supplement, section 256L.03, subdivision 5, is amended to read:

Subd. 5. **Co-payments and coinsurance.** (a) Except as provided in paragraphs (b) and (c), the MinnesotaCare benefit plan shall include the following co-payments and coinsurance requirements for all enrollees:

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

(2) $3 per prescription for adult enrollees;

(3) $25 for eyeglasses for adult enrollees;

(4) $3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;

(5) $6 for nonemergency visits to a hospital-based emergency room; and

(6) 50 percent of the fee-for-service rate for adult dental care services other than preventive care services for persons eligible under section 256L.04, ~~subdivisions 1 to~~ subdivision 7, with income equal to or ~~less~~ greater than 175 percent of the federal poverty guidelines.

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

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

(d) Adult enrollees with family gross income that exceeds 175 percent of the federal poverty guidelines and who are not pregnant shall be financially responsible for the coinsurance amount, if applicable, and amounts which exceed the ~~$10,000~~ $20,000 inpatient hospital benefit limit.

(e) When a MinnesotaCare enrollee becomes a member of a prepaid health plan, or changes from one prepaid health plan to another during a calendar year, any charges submitted towards the ~~$10,000~~ $20,000 annual inpatient benefit limit, and any

out-of-pocket expenses incurred by the enrollee for inpatient services, that were submitted or incurred prior to enrollment, or prior to the change in health plans, shall be disregarded.

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

Sec. 43. Minnesota Statutes 2005 Supplement, section 256L.04, subdivision 1a, is amended to read:

Subd. 1a. **Social Security number required.** (a) Individuals and families applying for MinnesotaCare coverage must provide a Social Security number. This requirement does not apply to an undocumented noncitizen or nonimmigrant who is eligible for MinnesotaCare.

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

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

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

Sec. 44. Minnesota Statutes 2004, section 256L.04, subdivision 7, is amended to read:

Subd. 7. **Single adults and households with no children.** The definition of eligible persons includes all individuals and households with no children who have gross family incomes that are equal to or less than ~~175~~ 200 percent of the federal poverty guidelines.

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

Sec. 45. Minnesota Statutes 2004, section 256L.04, subdivision 10, is amended to read:

Subd. 10. **Citizenship requirements.** (a) Eligibility for MinnesotaCare is limited to citizens or nationals of the United States, qualified noncitizens, and other persons residing lawfully in the United States as described in section 256B.06, subdivision 4, paragraphs (a) to (e) and (j). Undocumented noncitizens and nonimmigrants are ineligible for MinnesotaCare. ~~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~~ This paragraph does not apply to children.

(b) Citizens or nationals of the United States must provide satisfactory documentary evidence of citizenship or nationality as required by the federal Deficit Reduction Act of 2005, Public Law 109-171.

(c) 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.

Sec. 46. Minnesota Statutes 2004, section 256L.04, is amended by adding a subdivision to read:

Subd. 14. **MinnesotaCare outreach.** (a) The commissioner shall award grants to public or private organizations to provide information on the importance of maintaining insurance coverage and on how to obtain coverage through the MinnesotaCare program in areas of the state with high uninsured populations.

(b) In awarding the grants, the commissioner shall consider the following:

(1) geographic areas and populations with high uninsured rates;

(2) the ability to raise matching funds; and

(3) the ability to contact or serve eligible populations.

The commissioner shall monitor the grants and may terminate a grant if the outreach effort does not increase enrollment in medical assistance, general assistance medical care, or the MinnesotaCare program.

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

Sec. 47. Minnesota Statutes 2005 Supplement, section 256L.07, subdivision 1, is amended to read:

Subdivision 1. **General requirements.** (a) ~~Children enrolled in the original children's health plan as of September 30, 1992, children who enrolled in the MinnesotaCare program after September 30, 1992, pursuant to Laws 1992, chapter 549, article 4, section 17, and children who have family gross incomes that are equal to or less than 150 percent of the federal poverty guidelines are eligible without meeting the requirements of subdivision 2 and the four-month requirement in subdivision 3, as long as they maintain continuous coverage in the MinnesotaCare program or medical assistance. Children who apply for MinnesotaCare on or after the implementation date of the employer-subsidized health coverage program as described in Laws 1998, chapter~~

~~407, article 5, section 45, who have family gross incomes that are equal to or less than 150 percent of the federal poverty guidelines, must meet the requirements of subdivision 2 to be eligible for MinnesotaCare.~~

~~(b)~~ Families enrolled in MinnesotaCare under section 256L.04, subdivision 1, whose income increases above 275 percent of the federal poverty guidelines, are no longer eligible for the program and shall be disenrolled by the commissioner. Individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose income increases above ~~175~~ 200 percent of the federal poverty guidelines are no longer eligible for the program and shall be disenrolled by the commissioner. For persons disenrolled under this subdivision, MinnesotaCare coverage terminates the last day of the calendar month following the month in which the commissioner determines that the income of a family or individual exceeds program income limits.

~~(c)~~ (b) Notwithstanding paragraph ~~(b)~~ (a), children may remain enrolled in MinnesotaCare if ten percent of their gross individual or gross family income as defined in section 256L.01, subdivision 4, is less than the premium for a six-month policy with a $500 deductible available through the Minnesota Comprehensive Health Association. Children who are no longer eligible for MinnesotaCare under this clause shall be given a 12-month notice period from the date that ineligibility is determined before disenrollment. The premium for children remaining eligible under this clause shall be the maximum premium determined under section 256L.15, subdivision 2, paragraph (b).

~~(d)~~ (c) Notwithstanding paragraphs ~~(b)~~ (a) and ~~(c)~~ (b), parents are not eligible for MinnesotaCare if gross household income exceeds $25,000 for the six-month period of eligibility.

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

Sec. 48. Minnesota Statutes 2004, section 256L.07, subdivision 2, is amended to read:

Subd. 2. **Must not have access to employer-subsidized coverage.** (a) To be eligible, a family or individual must not have access to subsidized health coverage through an employer and must not have had access to employer-subsidized coverage through a current employer for 18 months prior to application or reapplication. A family or individual whose employer-subsidized coverage is lost due to an employer terminating health care coverage as an employee benefit during the previous 18 months is not eligible.

(b) This subdivision does not apply to a family or individual who was enrolled in MinnesotaCare within six months or less of reapplication and who no longer has employer-subsidized coverage due to the employer terminating health care coverage as an employee benefit.

(c) For purposes of this requirement, subsidized health coverage means health coverage for which the employer pays at least 50 percent of the cost of coverage for the employee or dependent, or a higher percentage as specified by the commissioner. ~~Children are eligible for employer-subsidized coverage through either parent, including the noncustodial parent.~~ The commissioner must treat employer contributions to Internal Revenue Code Section 125 plans and any other employer benefits intended to pay health care costs as qualified employer subsidies toward the cost of health coverage for employees for purposes of this subdivision.

(d) This subdivision does not apply to children.

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

Sec. 49. Minnesota Statutes 2005 Supplement, section 256L.07, subdivision 3, is amended to read:

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

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

~~(i) basic hospital insurance;~~

~~(ii) medical-surgical insurance;~~

~~(iii) prescription drug coverage;~~

~~(iv) dental coverage; or~~

~~(v) vision coverage;~~

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

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

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

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

(c) For purposes of this subdivision, an applicant or enrollee who is entitled to Medicare Part A or enrolled in Medicare Part B coverage under title XVIII of the Social Security Act, United States Code, title 42, sections 1395c to 1395w-152, is considered to have health coverage. An applicant or enrollee who is entitled to premium-free Medicare Part A may not refuse to apply for or enroll in Medicare coverage to establish eligibility for MinnesotaCare.

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

(e) Cost-effective health insurance that was paid for by medical assistance is not considered health coverage for purposes of the four-month requirement under this section, except if the insurance continued after medical assistance no longer considered it cost-effective or after medical assistance closed.

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

Sec. 50. Minnesota Statutes 2004, section 256L.11, subdivision 1, is amended to read:

Subdivision 1. **Medical assistance rate to be used.** Payment to providers under sections 256L.01 to 256L.11 shall be at the same rates and conditions established for medical assistance, except as provided in subdivisions 2 to ~~6~~ 8.

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

Sec. 51. Minnesota Statutes 2004, section 256L.11, is amended by adding a subdivision to read:

Subd. 7. **Critical access dental providers.** Effective for dental services provided to MinnesotaCare enrollees on or after January 1, 2007, the commissioner shall increase payment rates to dentists and dental clinics deemed by the commissioner to be critical access providers under section 256B.76, paragraph (c), by 50 percent above the payment rate that would otherwise be paid to the provider. The commissioner shall adjust the rates paid on or after January 1, 2007, to prepaid health plans under contract with the commissioner to reflect this rate increase. The prepaid health plan must pass this rate increase to providers who have been identified by the commissioner as critical access dental providers under section 256B.76, paragraph (c).

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

Sec. 52. Minnesota Statutes 2004, section 256L.11, is amended by adding a subdivision to read:

Subd. 8. **Provider rate increase.** (a) Effective for services provided on or after July 1, 2006, the commissioner shall increase the provider rates by 2.049 percent. The commissioner shall adjust rates paid on or after January 1, 2007, to prepaid health plans under contract with the commissioner to reflect this rate increase. The prepaid health plan must pass this rate increase to providers.

(b) On September 1 of each year, beginning September 1, 2008, the commissioner of finance shall determine the projected balance of the health care access fund as of June 30 of the following year based on the most recent February forecast adjusted for any legislative session changes. If the commissioner of finance determines that the projected balance in the health care access fund as of that June 30 will exceed five percent of the projected expenditures from the fund for the fiscal year ending the following June 30, the rate increase described in paragraph (a) shall be paid at a percentage adjusted so that the projected balance in the fund is reduced to an amount equal to five percent of the projected expenditures from the fund. If the commissioner of finance determines that the projected balance in the health care access fund as of June 30 will not exceed five percent of the projected expenditures from the fund for the fiscal year ending the following June 30, the rate increase described in paragraph (a) shall not be paid for the following fiscal year.

Sec. 53. Minnesota Statutes 2004, section 256L.15, subdivision 1, is amended to read:

Subdivision 1. **Premium determination.** (a) Families with children and individuals shall pay a premium determined according to subdivision 2.

(b) Pregnant women and children under age two are exempt from the provisions of section 256L.06, subdivision 3, paragraph (b), clause (3), requiring disenrollment for failure to pay premiums. For pregnant women, this exemption continues until the first day of the month following the 60th day postpartum. Women who remain enrolled during pregnancy or the postpartum period, despite nonpayment of premiums, shall be disenrolled on the first of the month following the 60th day postpartum for the penalty period that otherwise applies under section 256L.06, unless they begin paying premiums.

(c) Members of the military and their families who meet the eligibility criteria for MinnesotaCare upon eligibility approval made within 24 months following the end of the member's tour of active duty shall have their premiums paid by the commissioner. The effective date of coverage for an individual or family who meets the criteria of this paragraph shall be the first day of the month following the month in which eligibility is

approved. This exemption shall apply for 12 months if the individual or family remains eligible upon six-month renewal.

EFFECTIVE DATE. This section is effective July 1, 2006, or upon federal approval, whichever is later.

Sec. 54. Minnesota Statutes 2005 Supplement, section 256L.15, subdivision 2, is amended to read:

Subd. 2. **Sliding fee scale to determine percentage of monthly gross individual or family income.** (a) The commissioner shall establish a sliding fee scale to determine the percentage of monthly gross individual or family income that households at different income levels must pay to obtain coverage through the MinnesotaCare program. The sliding fee scale must be based on the enrollee's monthly gross individual or family income. The sliding fee scale must contain separate tables based on enrollment of one, two, or three or more persons. The sliding fee scale begins with a premium of 1.5 percent of monthly gross individual or family income for individuals or families with incomes below the limits for the medical assistance program for families and children in effect on January 1, 1999, and proceeds through the following evenly spaced steps: 1.8, 2.3, 3.1, 3.8, 4.8, 5.9, 7.4, and 8.8 percent. These percentages are matched to evenly spaced income steps ranging from the medical assistance income limit for families and children in effect on January 1, 1999, to 275 percent of the federal poverty guidelines for the applicable family size, up to a family size of five. The sliding fee scale for a family of five must be used for families of more than five. Effective October 1, 2003, the commissioner shall increase each percentage by 0.5 percentage points for enrollees with income greater than 100 percent but not exceeding 200 percent of the federal poverty guidelines and shall increase each percentage by 1.0 percentage points for families and children with incomes greater than 200 percent of the federal poverty guidelines. The sliding fee scale and percentages are not subject to the provisions of chapter 14. If a family or individual reports increased income after enrollment, premiums shall be adjusted at the time the change in income is reported.

(b) Children in families whose gross income is above 275 percent of the federal poverty guidelines shall pay the maximum premium. The maximum premium is defined as a base charge for one, two, or three or more enrollees so that if all MinnesotaCare cases paid the maximum premium, the total revenue would equal the total cost of MinnesotaCare medical coverage and administration. In this calculation, administrative costs shall be assumed to equal ten percent of the total. The costs of medical coverage for pregnant women and children under age two and the enrollees in these groups shall

be excluded from the total. The maximum premium for two enrollees shall be twice the maximum premium for one, and the maximum premium for three or more enrollees shall be three times the maximum premium for one.

~~(c) After calculating the percentage of premium each enrollee shall pay under paragraph (a), eight percent shall be added to the premium.~~

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

Sec. 55. **[256L.20] MINNESOTACARE OPTION FOR SMALL EMPLOYERS.**

Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms used have the meanings given them.

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

(c) "Eligible employee" means an employee who works at least 20 hours per week for an eligible employer. Eligible employee does not include an employee who works on a temporary or substitute basis or who does not work more than 26 weeks annually. Coverage of an eligible employee includes the employee's spouse.

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

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

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

(g) "Program" means the MinnesotaCare program.

Subd. 2. **Option.** Eligible employees and their dependents may enroll in MinnesotaCare if the eligible employer meets the requirements of subdivision 3. The effective date of coverage is as defined in section 256L.05, subdivision 3.

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

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

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

(3) offer coverage to all eligible employees, spouses, and dependents of eligible employees; and

(4) have not provided employer-subsidized health coverage as an employee benefit during the previous 12 months, as defined in section 256L.07, subdivision 2, paragraph (c).

Subd. 4. **Premiums.** (a) The premium for coverage provided under this section is equal to the maximum premium regardless of the income of the eligible employee, as defined in section 256L.15, subdivision 2, paragraph (b).

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

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

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

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

Subd. 6. **Enrollment.** Upon payment of the premium, according to this section and section 256L.06, eligible employees, spouses, and dependents shall be enrolled in MinnesotaCare. For purposes of enrollment under this section, income eligibility limits established under sections 256L.04 and 256L.07, subdivision 1, and asset limits established under section 256L.17 do not apply. The barriers established under section 256L.07, subdivision 2 or 3, do not apply to enrollees eligible under this section. The commissioner may require eligible employees to provide income verification to determine premiums.

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

Sec. 56. Minnesota Statutes 2004, section 462A.05, is amended by adding a subdivision to read:

Subd. 42. **Reverse mortgage incentive program.** (a) The agency shall, within the limits of appropriations made available for this purpose, establish, in cooperation with the commissioner of human services, a program to encourage eligible persons to obtain reverse mortgages to pay for eligible costs of maintaining the person in the home as an alternative to a nursing facility placement.

(b) The incentive program shall be made available to a person who has been determined by the commissioner of human services or the commissioner's designated agent to meet all of the following criteria:

(1) is age 62 or older;

(2) would be eligible for medical assistance within 365 days of admission to a nursing home;

(3) is not a medical assistance recipient, is not eligible for medical assistance without a spenddown or waiver obligation, is not ineligible for the medical assistance program due to an asset transfer penalty, and does not have income greater than the maintenance needs allowance under section 256B.0915, subdivision 1d, but equal to or less than 120 percent of the federal poverty guidelines effective July 1 in the year for which program eligibility is established, who would be eligible for the elderly waiver with a waiver obligation;

(4) needs services that are not funded through other state or federal funding for which the person qualifies;

(5) obtains a reverse mortgage loan under section 47.58 on a home with an estimated market value not to exceed $150,000. This limit shall be adjusted annually on April 1 by the percentage change for the previous calendar year in the housing component of the United States Consumer Price Index - All Urban Consumers; and

(6) agrees to make expenditures of reverse mortgage payments in accordance with a spending plan established under section 256B.0911, subdivision 3a, in which payments, services, and supports meet the following standards:

(i) payments received under the loan for a period of at least 24 months or in an amount of at least $15,000 are used for services and supports, including basic shelter needs, home maintenance, and modifications or adaptations, necessary to allow the person to remain in the home as an alternative to a nursing facility placement;

(ii) reimbursements for services, supplies, and equipment shall not exceed the market rate; and

(iii) if the person's spouse qualifies under section 256B.0913, subdivisions 1 to 14, the reverse mortgage payments may be used to pay client fees under that section.

(c) The incentives available under this program shall include:

(1) payment of the initial mortgage insurance premium for a reverse mortgage. The maximum payment under this clause shall be limited to $1,500. This limit shall be adjusted annually on April 1 by the percentage change for the previous calendar year in the housing component of the United States Consumer Price Index - All Urban Consumers;

(2) with federal approval, payments to reduce service fee set-asides, through an advance payment to the lender, an agreement to guarantee fee payments after 60 months if the set-aside is limited to 60 months, or through other mechanisms approved by the commissioner; and

(3) other incentives approved by the commissioner.

(d) After calculating the adjusted maximum payment limits under paragraphs (b) and (c), the commissioner shall annually notify the Office of the Revisor of Statutes in writing, on or before May 1, of the adjusted limits. The revisor shall annually publish in the Minnesota Statutes the adjusted maximum payment limits under paragraph (b).

Sec. 57. Laws 2005, First Special Session chapter 4, article 9, section 5, subdivision 8, is amended to read:

Subd. 8. **Board of Nursing**	3,078,000	3,631,000

BASE ADJUSTMENT. The base for the board of nursing is increased by $141,000 in fiscal year 2008 and by $216,000 in fiscal year 2009.

BOARD OF NURSING APPROPRIATIONS INCREASE. Of this appropriation, $120,000 the first year and $126,000 the second year are for the increased cost of board operations, excluding salary increases and $85,000 each year is to hire an advanced practice registered nurse.

TRANSFERS FROM SPECIAL REVENUE FUND. Of this appropriation, the following transfers shall be made as directed from the state government special revenue fund:

(a) $392,000 in fiscal year 2006, $864,000 in fiscal year 2007, $930,000 in fiscal year 2008, and $930,000 in fiscal year 2009 shall be transferred to the general fund and is appropriated to the Department of Human Services to offset the state share of the medical assistance program costs of the long-term care and home and community-based care employee scholarship program and associated administrative costs. At the end of each biennium, any funds not expended for the scholarship program and associated administrative costs shall be ~~transferred to the state government special revenue fund~~ carried over to the next biennium for the same purpose. Notwithstanding section 15, this paragraph expires June 30, ~~2009~~ 2011.

(b) $125,000 the first year and $200,000 the second year shall be transferred to the health professional education loan forgiveness program account for loan forgiveness for nurses under Minnesota Statutes, section 144.1501. This appropriation shall become part of base level funding for the commissioner for the biennium beginning July 1, 2007, but shall not be part of base level funding for the biennium beginning July 1, 2009. Notwithstanding section 15, this paragraph expires on June 30, 2009.

Sec. 58. **FEDERAL GOVERNMENT CHANGES.**

The commissioner of human services shall seek reimbursement from the federal government for funds expended by the state to provide drug coverage to medical assistance recipients who are enrolled or in the process of enrolling in Medicare Part D. The commissioner shall also continue to pursue federal changes to Medicare Part D to address

lapses in drug coverage for medical assistance recipients who are enrolled in Medicare Part D but who are taking prescription drugs that are not included in the formularies used by the Medicare Part D drug plans that meet the low-income premium benchmark set for Minnesota or who are in the process of enrolling in a Medicare Part D prescription drug plan, or who are eligible for Medicare Part D, and in the process of enrolling.

Sec. 59. **PHARMACY PAYMENT REFORM ADVISORY COMMITTEE.**

Subdivision 1. **Definitions.** For purposes of this section, the following words, terms, and phrases have the following meanings:

(a) "Department" means the Department of Human Services.

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

(c) "Cost of dispensing" includes, but is not limited to, operational and overhead costs; professional counseling as required under the Omnibus Budget Reconciliation Act of 1990, excluding medication management services under Minnesota Statutes, section 256B.0625, subdivision 13h; salaries; and other associated administrative costs, as well as a reasonable return on investment. In addition, cost of dispensing includes expenses transferred by wholesale drug distributors to pharmacies as a result of the wholesale drug distributor tax under Minnesota Statutes, sections 295.52 to 295.582.

(d) "Additional costs" include, but are not limited to, costs relating to coordination of benefits, bad debt, uncollected co-pays, payment lag times, and high rate of rejected claims.

(e) "Advisory committee" means the Pharmacy Payment Reform Advisory Committee established by this section.

Subd. 2. **Advisory committee.** The Pharmacy Payment Reform Advisory Committee is established under the direction of the commissioner of human services. The commissioner, after receiving recommendations from the Minnesota Pharmacists Association, the Minnesota Retailers Association, the Minnesota Hospital Association, and the Minnesota Wholesale Druggists Association, shall convene a pharmacy payment reform advisory committee to advise the commissioner and make recommendations to the legislature on implementation of pharmacy reforms contained in title VI, chapter IV, of the Deficit Reduction Act of 2005. The committee shall be comprised of three licensed pharmacists representing both independent and chain pharmacy entities, one of whom must have expertise in pharmacoeconomics, two individuals representing hospitals with outpatient pharmacies, and two individuals with expertise in wholesale drug distribution. The committee shall be staffed by an employee of the department who shall serve as an ex officio nonvoting member of the committee. The department's pharmacy program manager shall also serve as an ex officio, nonvoting member of the committee. The

committee is governed by Minnesota Statutes, section 15.059, except that committee members do not receive compensation or reimbursement for expenses. The advisory committee expires on January 31, 2008.

Subd. 3. **Cost of dispensing study.** The commissioner shall conduct a prescription drug cost of dispensing study to determine the average cost of dispensing Medicaid prescriptions in Minnesota. The commissioner shall contract with an independent third party in the state that has experience conducting business cost allocation studies, such as an academic institution, to conduct a prescription drug cost of dispensing study. If no independent third-party entity exists in the state, the commissioner may contract with an out-of-state entity. The cost of dispensing study shall be completed by an independent third party no later than October 1, 2006, and reported to the commissioner and the advisory committee upon completion.

Subd. 4. **Content of study.** The study shall determine the cost of dispensing the average prescription and any additional costs that might be incurred for dispensing Medicaid prescriptions. The study shall include the current level of dispensing fees paid to providers and an estimate of revenues required to adequately adjust reimbursement to cover the cost to pharmacies.

Subd. 5. **Methodology of study and publishing requirement.** The independent third-party entity performing the cost of dispensing research shall submit to the advisory committee the entity's proposed research methodology and shall publish the collected data to allow other independent researchers to validate the study results. The data shall be published in a manner that does not identify the source of the data.

Subd. 6. **Recommendations.** The advisory committee shall use the information from the cost of dispensing study and make recommendations to the commissioner on implementation of pharmacy reforms contained in title VI, chapter IV, of the Deficit Reduction Act of 2005. The commissioner shall report the findings of the study and the recommendations of the advisory committee to the legislature by January 15, 2007. The commissioner, in consultation with the advisory committee, shall make recommendations to the legislature on how to adequately adjust reimbursement rates to pharmacies to cover the costs of dispensing and additional costs to pharmacies. Reports shall include the current level of dispensing fees paid to providers and an estimate of revenues required to adequately adjust reimbursement to ensure that:

(1) reimbursement is sufficient to enlist an adequate number of participating pharmacy providers so that pharmacy services are as available for Medicaid recipients under the program as for the state's general population;

(2) Medicaid dispensing fees are adequate to reimburse pharmacy providers for the costs of dispensing prescriptions under the Medicaid program;

(3) Medicaid pharmacy reimbursement for multiple-source drugs included on the federal upper reimbursement limit is set at the level established by the federal government under United States Code, title 42, section 1396r-8(e)(5);

(4) the combined Medicaid program reimbursement for prescription drug product and the dispensing fee provides a return adequate to provide a reasonable profit for the participating pharmacy; and

(5) the new payment system does not create disincentives for pharmacists to dispense generic drugs.

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

Sec. 60. **STAKEHOLDER PARTICIPATION.**

The commissioner of human services shall confer with one or more stakeholder groups of interested persons, including representatives of recipients, advocacy groups, counties, providers, and health plans to provide information and advice on the development of any substantial proposals for changes in the medical assistance program authorized by the federal Deficit Reduction Act of 2005, Public Law 109-171. In addition, for any substantial Deficit Reduction Act-related medical assistance change that affects recipients and that is proposed outside of the legislative or rulemaking process, the commissioner shall convene a stakeholder meeting and provide a 30-day comment period before the change becomes effective. If the time frame required to comply with a federal mandate precludes the 30-day advance notice, notice shall be given to the stakeholder group as soon as possible.

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

Sec. 61. **REVISOR'S INSTRUCTION.**

(a) The revisor of statutes shall strike all references to the "Class E assisted living home care programs license, "Class E license," and similar terms in Minnesota Rules, chapters 4668 and 4669. In sections affected by this instruction, the revisor may make changes necessary to correct the punctuation, grammar, or structure of the remaining text and preserve its meaning.

(b) The revisor of statutes shall change the term "assisted living home care provider," "assisted living license," and similar terms to "Class F home care provider," "Class F license," and similar terms to "Class F home care provider," "Class F license," and similar

terms, in Minnesota Rules, chapter 4668. In sections affected by this instruction, the revisor may make changes necessary to correct the punctuation, grammar, or structure of the remaining text and preserve its meaning.

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

Sec. 62. **REPEALER.**

(a) Minnesota Statutes 2005 Supplement, section 256L.035, is repealed.

(b) Minnesota Rules, part 4668.0215, is repealed, effective January 1, 2007.

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

ARTICLE 14
HEALTH CARE FEDERAL COMPLIANCE

Section 1. Minnesota Statutes 2004, section 62A.045, is amended to read:

62A.045 PAYMENTS ON BEHALF OF ENROLLEES IN GOVERNMENT HEALTH PROGRAMS.

(a) As a condition of doing business in Minnesota, each health insurer shall comply with the requirements of the federal Deficit Reduction Act of 2005, Public Law 109-171, including any federal regulations adopted under that act, to the extent that it imposes a requirement that applies in this state and that is not also required by the laws of this state. This section does not require compliance with any provision of the federal act prior to the effective date provided for that provision in the federal act. The commissioner shall enforce this section.

"Health insurer" for the purpose of this section includes self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are by contract legally responsible to pay a claim for a healthcare item or service for an individual receiving benefits under paragraph (b).

(b) No health plan issued or renewed to provide coverage to a Minnesota resident shall contain any provision denying or reducing benefits because services are rendered to a person who is eligible for or receiving medical benefits pursuant to title XIX of the Social Security Act (Medicaid) in this or any other state; chapter 256; 256B; or 256D or services pursuant to section 252.27; 256L.01 to 256L.10; 260B.331, subdivision 2; 260C.331, subdivision 2; or 393.07, subdivision 1 or 2. No health carrier providing benefits under

plans covered by this section shall use eligibility for medical programs named in this section as an underwriting guideline or reason for nonacceptance of the risk.

~~(b)~~ (c) If payment for covered expenses has been made under state medical programs for health care items or services provided to an individual, and a third party has a legal liability to make payments, the rights of payment and appeal of an adverse coverage decision for the individual, or in the case of a child their responsible relative or caretaker, will be subrogated to the state agency. The state agency may assert its rights under this section within three years of the date the service was rendered. For purposes of this section, "state agency" includes prepaid health plans under contract with the commissioner according to sections 256B.69, 256D.03, subdivision 4, paragraph (c), and 256L.12; children's mental health collaboratives under section 245.493; demonstration projects for persons with disabilities under section 256B.77; nursing homes under the alternative payment demonstration project under section 256B.434; and county-based purchasing entities under section 256B.692.

~~(c)~~ (d) Notwithstanding any law to the contrary, when a person covered by a health plan receives medical benefits according to any statute listed in this section, payment for covered services or notice of denial for services billed by the provider must be issued directly to the provider. If a person was receiving medical benefits through the Department of Human Services at the time a service was provided, the provider must indicate this benefit coverage on any claim forms submitted by the provider to the health carrier for those services. If the commissioner of human services notifies the health carrier that the commissioner has made payments to the provider, payment for benefits or notices of denials issued by the health carrier must be issued directly to the commissioner. Submission by the department to the health carrier of the claim on a Department of Human Services claim form is proper notice and shall be considered proof of payment of the claim to the provider and supersedes any contract requirements of the health carrier relating to the form of submission. Liability to the insured for coverage is satisfied to the extent that payments for those benefits are made by the health carrier to the provider or the commissioner as required by this section.

~~(d)~~ (e) When a state agency has acquired the rights of an individual eligible for medical programs named in this section and has health benefits coverage through a health carrier, the health carrier shall not impose requirements that are different from requirements applicable to an agent or assignee of any other individual covered.

~~(e)~~ (f) For the purpose of this section, health plan includes coverage offered by community integrated service networks, any plan governed under the federal Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, sections

1001 to 1461, and coverage offered under the exclusions listed in section 62A.011, subdivision 3, clauses (2), (6), (9), (10), and (12).

Sec. 2. Minnesota Statutes 2004, section 144.6501, subdivision 6, is amended to read:

Subd. 6. **Medical assistance payment.** (a) An admission contract for a facility that is certified for participation in the medical assistance program must state that neither the prospective resident, nor anyone on the resident's behalf, is required to pay privately any amount for which the resident's care at the facility has been approved for payment by medical assistance or to make any kind of donation, voluntary or otherwise. Except as permitted under federal law, an admission contract must state that the facility does not require as a condition of admission, either in its admission contract or by oral promise before signing the admission contract, that residents remain in private pay status for any period of time.

(b) The admission contract must state that upon presentation of proof of eligibility, the facility will submit a medical assistance claim for reimbursement and will return any and all payments made by the resident, or by any person on the resident's behalf, for services covered by medical assistance, upon receipt of medical assistance payment.

(c) A facility that participates in the medical assistance program shall not charge for the day of the resident's discharge from the facility or subsequent days.

(d) If a facility's charges incurred by the resident are delinquent for 30 days, and no person has agreed to apply for medical assistance for the resident, the facility may petition the court under chapter 525 to appoint a representative for the resident in order to apply for medical assistance for the resident.

(e) The remedy provided in this subdivision does not preclude a facility from seeking any other remedy available under other laws of this state.

Sec. 3. Minnesota Statutes 2004, section 256B.02, subdivision 9, is amended to read:

Subd. 9. **Private health care coverage.** "Private health care coverage" means any plan regulated by chapter 62A, 62C or 64B. Private health care coverage also includes any ~~self-insurance~~ self-insured plan providing health care benefits, pharmacy benefit manager, service benefit plan, managed care organization, and other parties that are by contract legally responsible for payment of a claim for a health care item or service for an individual receiving medical benefits under chapter 256B, 256D, or 256L.

Sec. 4. Minnesota Statutes 2004, section 256B.056, subdivision 2, is amended to read:

Subd. 2. **Homestead; exclusion and homestead equity limit for institutionalized persons.** (a) The homestead shall be excluded for the first six calendar months of a person's stay in a long-term care facility and shall continue to be excluded for as long as the recipient can be reasonably expected to return to the homestead. For purposes of this subdivision, "reasonably expected to return to the homestead" means the recipient's attending physician has certified that the expectation is reasonable, and the recipient can show that the cost of care upon returning home will be met through medical assistance or other sources. The homestead shall continue to be excluded for persons residing in a long-term care facility if it is used as a primary residence by one of the following individuals:

~~(a)~~ (1) the spouse;

~~(b)~~ (2) a child under age 21;

~~(c)~~ (3) a child of any age who is blind or permanently and totally disabled as defined in the supplemental security income program;

~~(d)~~ (4) a sibling who has equity interest in the home and who resided in the home for at least one year immediately before the date of the person's admission to the facility; or

~~(e)~~ (5) a child of any age, or, subject to federal approval, a grandchild of any age, who resided in the home for at least two years immediately before the date of the person's admission to the facility, and who provided care to the person that permitted the person to reside at home rather than in an institution.

(b) The equity interest in the homestead of an individual whose eligibility for long-term care services is determined on or after January 1, 2006, shall not exceed $500,000, unless it is the lawful residence of the individual's spouse or child who is under age 21, blind, or disabled. The amount specified in this paragraph shall be increased beginning in year 2011, from year-to-year based on the percentage increase in the Consumer Price Index for all urban consumers (all items; United States city average), rounded to the nearest $1,000. This provision may be waived in the case of demonstrated hardship by a process to be determined by the secretary of health and human services pursuant to section 6014 of the Deficit Reduction Act of 2005, Public Law 109-171.

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

Subd. 3e. **Treatment of continuing care retirement and life care community entrance fees.** An entrance fee paid by an individual to a continuing care retirement or life care community shall be treated as an available asset to the extent that:

(1) the individual has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, to pay for care should other resources or income of the individual be insufficient to pay for care;

(2) the individual is eligible for a refund of any remaining entrance fees when the individual dies or terminates the continuing care retirement or life care community contract and leaves the community; and

(3) the entrance fee does not confer an ownership interest in the continuing care retirement or life care community.

Sec. 6. Minnesota Statutes 2004, section 256B.056, is amended by adding a subdivision to read:

Subd. 11. **Treatment of annuities.** (a) Any individual applying for or seeking recertification of eligibility for medical assistance payment of long-term care services shall provide a complete description of any interest either the individual or the individual's spouse has in annuities. The individual and the individual's spouse shall furnish the agency responsible for determining eligibility with complete current copies of their annuities and related documents for review as part of the application process on disclosure forms provided by the department as part of their application.

(b) The disclosure form shall include a statement that the department becomes the remainder beneficiary under the annuity or similar financial instrument by virtue of the receipt of medical assistance. The disclosure form shall include a notice to the issuer of the department's right under this section as a preferred remainder beneficiary under the annuity or similar financial instrument for medical assistance furnished to the individual or the individual's spouse, and require the issuer to provide confirmation that a remainder beneficiary designation has been made and to notify the county agency when there is a change in the amount of the income or principal being withdrawn from the annuity or other similar financial instrument at the time of the most recent disclosure required under this section. The individual and the individual's spouse shall execute separate disclosure forms for each annuity or similar financial instrument that they are required to disclose under this section and in which they have an interest.

(c) An issuer of an annuity or similar financial instrument who receives notice on a disclosure form as described in paragraph (b) shall provide confirmation to the requesting agency that a remainder beneficiary designating the state has been made and shall notify the county agency when there is a change in the amount of income or principal being withdrawn from the annuity or other similar financial instrument.

Sec. 7. Minnesota Statutes 2005 Supplement, section 256B.0571, is amended to read:

256B.0571 LONG-TERM CARE PARTNERSHIP PROGRAM.

Subdivision 1. **Definitions.** For purposes of this section, the following terms have the meanings given them.

~~Subd. 2. **Home care service.** "Home care service" means care described in section 144A.43.~~

Subd. 3. **Long-term care insurance.** "Long-term care insurance" means a policy described in section 62S.01.

Subd. 4. **Medical assistance.** "Medical assistance" means the program of medical assistance established under section 256B.01.

~~Subd. 5. **Nursing home.** "Nursing home" means a nursing home as described in section 144A.01.~~

Subd. 6. **Partnership policy.** "Partnership policy" means a long-term care insurance policy that meets the requirements under subdivision 10 ~~or 11, regardless of when the policy~~ and was ~~first~~ issued on or after the effective date of the state plan amendment implementing the partnership program in Minnesota.

Subd. 7. **Partnership program.** "Partnership program" means the Minnesota partnership for long-term care program established under this section.

Subd. 7a. **Protected assets.** "Protected assets" means assets or proceeds of assets that are protected from recovery under subdivisions 13 and 15.

Subd. 8. **Program established.** (a) The commissioner, in cooperation with the commissioner of commerce, shall establish the Minnesota partnership for long-term care program to provide for the financing of long-term care through a combination of private insurance and medical assistance.

(b) An individual who meets the requirements in this paragraph is eligible to participate in the partnership program. The individual must:

(1) be a Minnesota resident at the time coverage first became effective under the partnership policy;

(2) ~~purchase a partnership policy that is delivered, issued for delivery, or renewed on or after the effective date of Laws 2005, First Special Session chapter 4, article 7, section 5, and maintain the partnership policy in effect throughout the period of participation in the partnership program~~ be a beneficiary of a partnership policy that (i) is issued on or after the effective date of the state plan amendment implementing the partnership program in Minnesota, or (ii) qualifies as a partnership policy under the provisions of subdivision 8a; and

(3) ~~exhaust the minimum~~ have exhausted all of the benefits under the partnership policy as described in this section. Benefits received under a long-term care insurance policy before ~~the effective date of Laws 2005, First Special Session chapter 4, article 7, section 5~~ July 1, 2006, do not count toward the exhaustion of benefits required in this subdivision.

Subd. 8a. **Exchange for long-term care partnership policy; addition of policy rider.** (a) If federal law is amended or federal approval is granted with respect to the partnership program established in this section, a long-term care insurance policy that was issued before the effective date of the state plan amendment implementing the partnership program in Minnesota that was exchanged after the effective date of the state plan amendment for a long-term care partnership policy that meets the requirements of Public Law 109-171, section 6021, qualifies as a long-term care partnership policy under this section.

(b) If federal law is amended or federal approval is granted with respect to the partnership program established in this section, a long-term care insurance policy that was issued before the effective date of the state plan amendment implementing the partnership program in Minnesota that has a rider added after the effective date of the state plan amendment that meets the requirements of Public Law 109-171, section 6021, qualifies as a long-term care partnership policy under this section.

Subd. 9. **Medical assistance eligibility.** (a) Upon application ~~of~~ for medical assistance program payment of long-term care services by an individual who meets the requirements described in subdivision 8, the commissioner shall determine the individual's eligibility for medical assistance according to paragraphs (b) ~~and (c)~~ to (i).

(b) After ~~disregarding financial~~ determining assets ~~exempted under medical assistance eligibility requirements~~ subject to the asset limit under section 256B.056, subdivision 3 or 3c, or section 256B.057, subdivision 9 or 10, the commissioner shall ~~disregard an additional amount of financial assets equal~~ allow the individual to designate assets to be protected from recovery under subdivisions 13 and 15 of this section up to the dollar amount of ~~coverage~~ the benefits utilized under the partnership policy. Designated assets shall be disregarded for purposes of determining eligibility for payment of long-term care services.

(c) ~~The commissioner shall consider the individual's income according to medical assistance eligibility requirements.~~ The individual shall identify the designated assets and the full fair market value of those assets and designate them as assets to be protected at the time of initial application for medical assistance. The full fair market value of real property or interests in real property shall be based on the most recent full assessed value

for property tax purposes for the real property, unless the individual provides a complete professional appraisal by a licensed appraiser to establish the full fair market value. The extent of a life estate in real property shall be determined using the life estate table in the health care program's manual. Ownership of any asset in joint tenancy shall be treated as ownership as tenants in common for purposes of its designation as a disregarded asset. The unprotected value of any protected asset is subject to estate recovery according to subdivisions 13 and 15.

(d) The right to designate assets to be protected is personal to the individual and ends when the individual dies, except as otherwise provided in subdivisions 13 and 15. It does not include the increase in the value of the protected asset and the income, dividends, or profits from the asset. It may be exercised by the individual or by anyone with the legal authority to do so on the individual's behalf. It shall not be sold, assigned, transferred, or given away.

(e) If the dollar amount of the benefits utilized under a partnership policy is greater than the full fair market value of all assets protected at the time of the application for medical assistance long-term care services, the individual may designate additional assets that become available during the individual's lifetime for protection under this section. The individual must make the designation in writing to the county agency no later than the last date on which the individual must report a change in circumstances to the county agency, as provided for under the medical assistance program. Any excess used for this purpose shall not be available to the individual's estate to protect assets in the estate from recovery under section 256B.15, section 524.3-1202, or otherwise.

(f) This section applies only to estate recovery under United States Code, title 42, section 1396p, subsections (a) and (b), and does not apply to recovery authorized by other provisions of federal law, including, but not limited to, recovery from trusts under United States Code, title 42, section 1396p, subsection (d)(4)(A) and (C), or to recovery from annuities, or similar legal instruments, subject to section 6012, subsections (a) and (b), of the Deficit Reduction Act of 2005, Public Law 109-171.

(g) An individual's protected assets owned by the individual's spouse who applies for payment of medical assistance long-term care services shall not be protected assets or disregarded for purposes of eligibility of the individual's spouse solely because they were protected assets of the individual.

(h) Assets designated under this subdivision shall not be subject to penalty under section 256B.0595.

(i) The commissioner shall otherwise determine the individual's eligibility for payment of long-term care services according to medical assistance eligibility requirements.

Subd. 10. **~~Dollar-for-dollar asset protection policies~~ Long-term care partnership policy inflation protection.** ~~(a) A dollar-for-dollar asset protection policy must meet all of the requirements in paragraphs (b) to (e).~~

~~(b) The policy must satisfy the requirements of chapter 62S.~~

~~(c) The policy must offer an elimination period of not more than 180 days for an adjusted premium.~~

~~(d) The policy must satisfy the requirements established by the commissioner of human services under subdivision 14.~~

~~(e) Minimum daily benefits shall be $130 for nursing home care or $65 for home care, with inflation protection provided in the policy as described in section 62S.23, subdivision 1, clause (1). These minimum daily benefit amounts shall be adjusted by the commissioner on October 1 of each year by a percentage equal to the inflation protection feature described in section 62S.23, subdivision 1, clause (1), for purposes of setting minimum requirements that a policy must meet in future years in order to initially qualify as an approved policy under this subdivision. Adjusted minimum daily benefit amounts shall be rounded to the nearest whole dollar.~~ A long-term care partnership policy must provide the inflation protection described in this subdivision. If the policy is sold to an individual who:

(1) has not attained age 61 as of the date of purchase, the policy must provide compound annual inflation protection;

(2) has attained age 61, but has not attained age 76 as of such date, the policy must provide some level of inflation protection; and

(3) has attained age 76 as of such date, the policy may, but is not required to, provide some level of inflation protection.

~~Subd. 11. **Total asset protection policies.** (a) A total asset protection policy must meet all of the requirements in subdivision 10, paragraphs (b) to (d), and this subdivision.~~

~~(b) Minimum coverage shall be for a period of not less than three years and for a dollar amount equal to 36 months of nursing home care at the minimum daily benefit rate determined and adjusted under paragraph (c).~~

~~(c) Minimum daily benefits shall be $150 for nursing home care or $75 for home care, with inflation protection provided in the policy as described in section 62S.23, subdivision 1, clause (1). These minimum daily benefit amounts shall also be adjusted by the commissioner on October 1 of each year by a percentage equal to the inflation~~

~~protection feature described in section 62S.23, subdivision 1, clause (1), for purposes of setting minimum requirements that a policy must meet in future years in order to initially qualify as an approved policy under this subdivision. Adjusted minimum daily benefit amounts shall be rounded to the nearest whole dollar.~~

~~(d) The policy must cover all of the following services:~~

~~(1) nursing home stay;~~

~~(2) home care service; and~~

~~(3) care management.~~

Subd. 12. **Compliance with federal law.** An issuer of a partnership policy must comply with ~~any federal law authorizing partnership policies in Minnesota~~ Public Law 109-171, section 6021, including any federal regulations, as amended, adopted under that law. ~~This subdivision does not require compliance with any provision of this federal law until the date upon which the law requires compliance with the provision. The commissioner has authority to enforce this subdivision.~~

Subd. 13. **Limitations on estate recovery.** (a) ~~For an individual who exhausts the minimum benefits of a dollar-for-dollar asset protection policy under subdivision 10, and is determined eligible for medical assistance under subdivision 9, the state shall limit recovery under the provisions of section 256B.15 against the estate of the individual or individual's spouse for medical assistance benefits received by that individual to an amount that exceeds the dollar amount of coverage utilized under the partnership policy.~~ Protected assets of the individual shall not be subject to recovery under section 256B.15 or section 524.3-1201 for medical assistance or alternative care paid on behalf of the individual. Protected assets of the individual in the estate of the individual's surviving spouse shall not be liable to pay a claim for recovery of medical assistance paid for the predeceased individual that is filed in the estate of the surviving spouse under section 256B.15. Protected assets of the individual shall not be protected assets in the surviving spouse's estate by reason of the preceding sentence and shall be subject to recovery under section 256B.15 or section 524.3-1201 for medical assistance paid on behalf of the surviving spouse.

(b) ~~For an individual who exhausts the minimum benefits of a total asset protection policy under subdivision 11, and is determined eligible for medical assistance under subdivision 9, the state shall not seek recovery under the provisions of section 256B.15 against the estate of the individual or individual's spouse for medical assistance benefits received by that individual.~~ The personal representative may protect the full fair market value of an individual's unprotected assets in the individual's estate in an amount equal to the unused amount of asset protection the individual had on the date of death. The

personal representative shall apply the asset protection so that the full fair market value of any unprotected asset in the estate is protected. When or if the asset protection available to the personal representative is or becomes less than the full fair market value of any remaining unprotected asset, it shall be applied to partially protect one unprotected asset.

(c) The asset protection described in paragraph (a) terminates with respect to an asset includable in the individual's estate under chapter 524 or section 256B.15:

(1) when the estate distributes the asset; or

(2) if the estate of the individual has not been probated within one year from the date of death.

(d) If an individual owns a protected asset on the date of death and the estate is opened for probate more than one year after death, the state or a county agency may file and collect claims in the estate under section 256B.15, and no statute of limitations in chapter 524 that would otherwise limit or bar the claim shall apply.

(e) Except as otherwise provided, nothing in this section shall limit or prevent recovery of medical assistance.

Subd. 14. **Implementation.** ~~(a) If federal law is amended or a federal waiver is granted to permit implementation of this section, the commissioner, in consultation with the commissioner of commerce, may alter the requirements of subdivisions 10 and 11, and may establish additional requirements for approved policies in order to conform with federal law or waiver authority. In establishing these requirements, the commissioner shall seek to maximize purchase of qualifying policies by Minnesota residents while controlling medical assistance costs.~~

~~(b) The commissioner is authorized to suspend implementation of this section until the next session of the legislature if the commissioner, in consultation with the commissioner of commerce, determines that the federal legislation or federal waiver authorizing a partnership program in Minnesota is likely to impose substantial unforeseen costs on the state budget.~~

~~(c) The commissioner must take action under paragraph (a) or (b) within 45 days of final federal action authorizing a partnership policy in Minnesota.~~

~~(d) The commissioner must notify the appropriate legislative committees of action taken under this subdivision within 50 days of final federal action authorizing a partnership policy in Minnesota.~~

~~(e) The commissioner must publish a notice in the State Register of implementation decisions made under this subdivision as soon as practicable.~~ The commissioner shall submit a state plan amendment to the federal government to implement the long-term care partnership program in accordance with this section.

Subd. 15. **Limitation on liens.** (a) An individual's interest in real property shall not be subject to a medical assistance lien or a notice of potential claim while it is protected under subdivision 9 to the extent it is protected.

(b) Medical assistance liens or liens arising under notices of potential claims against an individual's interests in real property in the individual's estate that are designated as protected under subdivision 13, paragraph (b), shall be released to the extent of the dollar value of the protection applied to the interest.

(c) If an interest in real property is protected from a lien for recovery of medical assistance paid on behalf of the individual under paragraph (a) or (b), no lien for recovery of medical assistance paid on behalf of that individual shall be filed against the protected interest in real property after it is distributed to the individual's heirs or devisees.

Subd. 16. **Burden of proof.** Any individual or the personal representative of the individual's estate who asserts that an asset is a disregarded or protected asset under this section in connection with any determination of eligibility for benefits under the medical assistance program or any appeal, case, controversy, or other proceedings, shall have the initial burden of:

(1) documenting and proving by convincing evidence that the asset or source of funds for the asset in question was designated as disregarded or protected;

(2) tracing the asset and the proceeds of the asset from that time forward; and

(3) documenting that the asset or proceeds of the asset remained disregarded or protected at all relevant times.

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

Sec. 8. **[256B.0594] PAYMENT OF BENEFITS FROM AN ANNUITY.**

When payment becomes due under an annuity that names the department a remainder beneficiary as described in section 256B.056, subdivision 11, the issuer shall pay the department an amount equal to the lesser of the amount due the department under the annuity or the total amount of medical assistance paid on behalf of the individual or the individual's spouse. The issuer shall request and the department shall provide a written statement of the total amount of medical assistance paid. Any amounts remaining after the issuer's payment to the department shall be payable according to the terms of the annuity or similar financial instrument.

Sec. 9. Minnesota Statutes 2004, section 256B.0595, subdivision 1, is amended to read:

Subdivision 1. **Prohibited transfers.** (a) For transfers of assets made on or before August 10, 1993, if a person or the person's spouse has given away, sold, or disposed of,

for less than fair market value, any asset or interest therein, except assets other than the homestead that are excluded under the supplemental security program, within 30 months before or any time after the date of institutionalization if the person has been determined eligible for medical assistance, or within 30 months before or any time after the date of the first approved application for medical assistance if the person has not yet been determined eligible for medical assistance, the person is ineligible for long-term care services for the period of time determined under subdivision 2.

(b) Effective for transfers made after August 10, 1993, a person, a person's spouse, or any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of the person or person's spouse, may not give away, sell, or dispose of, for less than fair market value, any asset or interest therein, except assets other than the homestead that are excluded under the supplemental security income program, for the purpose of establishing or maintaining medical assistance eligibility. This applies to all transfers, including those made by a community spouse after the month in which the institutionalized spouse is determined eligible for medical assistance. For purposes of determining eligibility for long-term care services, any transfer of such assets within 36 months before or any time after an institutionalized person applies for medical assistance, or 36 months before or any time after a medical assistance recipient becomes institutionalized, for less than fair market value may be considered. Any such transfer is presumed to have been made for the purpose of establishing or maintaining medical assistance eligibility and the person is ineligible for long-term care services for the period of time determined under subdivision 2, unless the person furnishes convincing evidence to establish that the transaction was exclusively for another purpose, or unless the transfer is permitted under subdivision 3 or 4. ~~Notwithstanding the provisions of this paragraph,~~ In the case of payments from a trust or portions of a trust that are considered transfers of assets under federal law, or in the case of any other disposal of assets made on or after February 8, 2006, any transfers made within 60 months before or any time after an institutionalized person applies for medical assistance and within 60 months before or any time after a medical assistance recipient becomes institutionalized, may be considered.

(c) This section applies to transfers, for less than fair market value, of income or assets, including assets that are considered income in the month received, such as inheritances, court settlements, and retroactive benefit payments or income to which the person or the person's spouse is entitled but does not receive due to action by the person, the person's spouse, or any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of the person or the person's spouse.

(d) This section applies to payments for care or personal services provided by a relative, unless the compensation was stipulated in a notarized, written agreement which was in existence when the service was performed, the care or services directly benefited the person, and the payments made represented reasonable compensation for the care or services provided. A notarized written agreement is not required if payment for the services was made within 60 days after the service was provided.

(e) This section applies to the portion of any asset or interest that a person, a person's spouse, or any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of the person or the person's spouse, transfers to any annuity that exceeds the value of the benefit likely to be returned to the person or spouse while alive, based on estimated life expectancy using the life expectancy tables employed by the supplemental security income program to determine the value of an agreement for services for life. The commissioner may adopt rules reducing life expectancies based on the need for long-term care. This section applies to an annuity described in this paragraph purchased on or after March 1, 2002, that:

(1) is not purchased from an insurance company or financial institution that is subject to licensing or regulation by the Minnesota Department of Commerce or a similar regulatory agency of another state;

(2) does not pay out principal and interest in equal monthly installments; or

(3) does not begin payment at the earliest possible date after annuitization.

(f) Effective for transactions, including the purchase of an annuity, occurring on or after February 8, 2006, the purchase of an annuity by or on behalf of an individual who has applied for long-term care services shall be treated as the disposal of an asset for less than fair market value unless:

(1) the department is named as the remainder beneficiary in first position for an amount equal to at least the total amount of medical assistance paid on behalf of the individual or the individual's spouse; or the department is named as the remainder beneficiary in second position for an amount equal to at least the total amount of medical assistance paid on behalf of the individual or the individual's spouse after the individual's community spouse or minor or disabled child and is named as the remainder beneficiary in the first position if the community spouse or a representative of the minor or disabled child disposes of the remainder for less than fair market value. Any subsequent change to the designation of the department as a remainder beneficiary shall result in the annuity being treated as a disposal of assets for less than fair market value. The amount of such transfer shall be the maximum amount the individual or the individual's spouse could receive from the annuity or similar financial instrument. Any change in the amount of the income or

principal being withdrawn from the annuity or other similar financial instrument at the time of the most recent disclosure shall be deemed to be a transfer of assets for less than fair market value unless the individual or the individual's spouse demonstrates that the transaction was for fair market value; or

(2) the annuity is:

(i) an annuity described in subsection (b) or (q) of section 408 of the Internal Revenue Code of 1986; or

(ii) purchased with proceeds from:

(A) an account or trust described in subsection (a), (c), or (p) of section 408 of the Internal Revenue Code;

(B) a simplified employee pension within the meaning of section 408(k) of the Internal Revenue Code; or

(C) a Roth IRA described in section 408A of the Internal Revenue Code; or

(iii) an annuity that is irrevocable and nonassignable; is actuarially sound as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration; and provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

~~(f)~~ (g) For purposes of this section, long-term care services include services in a nursing facility, services that are eligible for payment according to section 256B.0625, subdivision 2, because they are provided in a swing bed, intermediate care facility for persons with mental retardation, and home and community-based services provided pursuant to sections 256B.0915, 256B.092, and 256B.49. For purposes of this subdivision and subdivisions 2, 3, and 4, "institutionalized person" includes a person who is an inpatient in a nursing facility or in a swing bed, or intermediate care facility for persons with mental retardation or who is receiving home and community-based services under sections 256B.0915, 256B.092, and 256B.49.

(h) This section applies to funds used to purchase a promissory note, loan, or mortgage unless such note, loan, or mortgage:

(1) has a repayment term that is actuarially sound;

(2) provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and

(3) prohibits the cancellation of the balance upon the death of the lender.

(b) In the case of a promissory note, loan, or mortgage that does not meet an exception in paragraph (a), the value of such note, loan, or mortgage shall be the outstanding balance due as of the date of the individual's application for long-term care services.

(i) This section applies to the purchase of a life estate interest in another individual's home unless the purchaser resides in the home for a period of at least one year after the date of purchase.

Sec. 10. Minnesota Statutes 2005 Supplement, section 256B.0595, subdivision 2, is amended to read:

Subd. 2. **Period of ineligibility.** (a) For any uncompensated transfer occurring on or before August 10, 1993, the number of months of ineligibility for long-term care services shall be the lesser of 30 months, or the uncompensated transfer amount divided by the average medical assistance rate for nursing facility services in the state in effect on the date of application. The amount used to calculate the average medical assistance payment rate shall be adjusted each July 1 to reflect payment rates for the previous calendar year. The period of ineligibility begins with the month in which the assets were transferred. If the transfer was not reported to the local agency at the time of application, and the applicant received long-term care services during what would have been the period of ineligibility if the transfer had been reported, a cause of action exists against the transferee for the cost of long-term care services provided during the period of ineligibility, or for the uncompensated amount of the transfer, whichever is less. The action may be brought by the state or the local agency responsible for providing medical assistance under chapter 256G. The uncompensated transfer amount is the fair market value of the asset at the time it was given away, sold, or disposed of, less the amount of compensation received.

(b) For uncompensated transfers made after August 10, 1993, the number of months of ineligibility for long-term care services shall be the total uncompensated value of the resources transferred divided by the average medical assistance rate for nursing facility services in the state in effect on the date of application. The amount used to calculate the average medical assistance payment rate shall be adjusted each July 1 to reflect payment rates for the previous calendar year. The period of ineligibility begins with the first day of the month after the month in which the assets were transferred except that if one or more uncompensated transfers are made during a period of ineligibility, the total assets transferred during the ineligibility period shall be combined and a penalty period calculated to begin on the first day of the month after the month in which the first uncompensated transfer was made. If the transfer was reported to the local agency after the date that advance notice of a period of ineligibility that affects the next month could be provided to the recipient and the recipient received medical assistance services or the transfer was not reported to the local agency, and the applicant or recipient received medical assistance services during what would have been the period of ineligibility if the transfer had been

reported, a cause of action exists against the transferee for the cost of medical assistance services provided during the period of ineligibility, or for the uncompensated amount of the transfer, whichever is less. The action may be brought by the state or the local agency responsible for providing medical assistance under chapter 256G. The uncompensated transfer amount is the fair market value of the asset at the time it was given away, sold, or disposed of, less the amount of compensation received. Effective for transfers made on or after March 1, 1996, involving persons who apply for medical assistance on or after April 13, 1996, no cause of action exists for a transfer unless:

(1) the transferee knew or should have known that the transfer was being made by a person who was a resident of a long-term care facility or was receiving that level of care in the community at the time of the transfer;

(2) the transferee knew or should have known that the transfer was being made to assist the person to qualify for or retain medical assistance eligibility; or

(3) the transferee actively solicited the transfer with intent to assist the person to qualify for or retain eligibility for medical assistance.

(c) For uncompensated transfers made on or after February 8, 2006, the period of ineligibility begins on the first day of the month in which advance notice can be given following the month in which assets have been transferred for less than fair market value, or the date on which the individual is eligible for medical assistance under the Medicaid state plan and would otherwise be receiving long-term care services based on an approved application for such care but for the application of the penalty period, whichever is later, and which does not occur during any other period of ineligibility.

(d) If a calculation of a penalty period results in a partial month, payments for long-term care services shall be reduced in an amount equal to the fraction;. ~~except that in calculating the value of uncompensated transfers, if the total value of all uncompensated transfers made in a month not included in an existing penalty period does not exceed $200, then such transfers shall be disregarded for each month prior to the month of application for or during receipt of medical assistance.~~

(e) In the case of multiple fractional transfers of assets in more than one month for less than fair market value on or after February 8, 2006, the period of ineligibility is calculated by treating the total, cumulative uncompensated value of all assets transferred during all months on or after February 8, 2006, as one transfer.

Sec. 11. Minnesota Statutes 2004, section 256B.0595, subdivision 3, is amended to read:

Subd. 3. **Homestead exception to transfer prohibition.** (a) An institutionalized person is not ineligible for long-term care services due to a transfer of assets for less than fair market value if the asset transferred was a homestead and:

(1) title to the homestead was transferred to the individual's:

(i) spouse;

(ii) child who is under age 21;

(iii) blind or permanently and totally disabled child as defined in the supplemental security income program;

(iv) sibling who has equity interest in the home and who was residing in the home for a period of at least one year immediately before the date of the individual's admission to the facility; or

(v) son or daughter who was residing in the individual's home for a period of at least two years immediately before the date of the individual's admission to the facility, and who provided care to the individual that, as certified by the individual's attending physician, permitted the individual to reside at home rather than in an institution or facility;

(2) a satisfactory showing is made that the individual intended to dispose of the homestead at fair market value or for other valuable consideration; or

(3) the local agency grants a waiver of a penalty resulting from a transfer for less than fair market value because denial of eligibility would cause undue hardship for the individual, based on imminent threat to the individual's health and well-being. Whenever an applicant or recipient is denied eligibility because of a transfer for less than fair market value, the local agency shall notify the applicant or recipient that the applicant or recipient may request a waiver of the penalty if the denial of eligibility will cause undue hardship. With the written consent of the individual or the personal representative of the individual, a long-term care facility in which an individual is residing may file an undue hardship waiver request, on behalf of the individual who is denied eligibility for long-term care services on or after July 1, 2006, due to a period of ineligibility resulting from a transfer on or after February 8, 2006. In evaluating a waiver, the local agency shall take into account whether the individual was the victim of financial exploitation, whether the individual has made reasonable efforts to recover the transferred property or resource, whether the individual has taken any action to prevent the designation of the department as a remainder beneficiary on an annuity as described in section 256B.056, subdivision 11, and other factors relevant to a determination of hardship. If the local agency does not approve a hardship waiver, the local agency shall issue a written notice to the individual stating the reasons for the denial and the process for appealing the local agency's decision.

(b) When a waiver is granted under paragraph (a), clause (3), a cause of action exists against the person to whom the homestead was transferred for that portion of long-term care services granted within:

(1) 30 months of a transfer made on or before August 10, 1993;

(2) 60 months if the homestead was transferred after August 10, 1993, to a trust or portion of a trust that is considered a transfer of assets under federal law; ~~or~~

(3) 36 months if transferred in any other manner after August 10, 1993, but prior to February 8, 2006; or

(4) 60 months if the homestead was transferred on or after February 8, 2006,

or the amount of the uncompensated transfer, whichever is less, together with the costs incurred due to the action. The action shall be brought by the state unless the state delegates this responsibility to the local agency responsible for providing medical assistance under chapter 256G.

Sec. 12. Minnesota Statutes 2004, section 256B.0595, subdivision 4, is amended to read:

Subd. 4. **Other exceptions to transfer prohibition.** An institutionalized person who has made, or whose spouse has made a transfer prohibited by subdivision 1, is not ineligible for long-term care services if one of the following conditions applies:

(1) the assets were transferred to the individual's spouse or to another for the sole benefit of the spouse; or

(2) the institutionalized spouse, prior to being institutionalized, transferred assets to a spouse, provided that the spouse to whom the assets were transferred does not then transfer those assets to another person for less than fair market value. (At the time when one spouse is institutionalized, assets must be allocated between the spouses as provided under section 256B.059); or

(3) the assets were transferred to the individual's child who is blind or permanently and totally disabled as determined in the supplemental security income program; or

(4) a satisfactory showing is made that the individual intended to dispose of the assets either at fair market value or for other valuable consideration; or

(5) the local agency determines that denial of eligibility for long-term care services would work an undue hardship and grants a waiver of a penalty resulting from a transfer for less than fair market value based on an imminent threat to the individual's health and well-being. Whenever an applicant or recipient is denied eligibility because of a transfer for less than fair market value, the local agency shall notify the applicant or recipient that the applicant or recipient may request a waiver of the penalty if the denial of

eligibility will cause undue hardship. With the written consent of the individual or the personal representative of the individual, a long-term care facility in which an individual is residing may file an undue hardship waiver request, on behalf of the individual who is denied eligibility for long-term care services on or after July 1, 2006, due to a period of ineligibility resulting from a transfer on or after February 8, 2006. In evaluating a waiver, the local agency shall take into account whether the individual was the victim of financial exploitation, whether the individual has made reasonable efforts to recover the transferred property or resource, and other factors relevant to a determination of hardship. If the local agency does not approve a hardship waiver, the local agency shall issue a written notice to the individual stating the reasons for the denial and the process for appealing the local agency's decision. When a waiver is granted, a cause of action exists against the person to whom the assets were transferred for that portion of long-term care services granted within:

(i) 30 months of a transfer made on or before August 10, 1993;

(ii) 60 months of a transfer if the assets were transferred after August 30, 1993, to a trust or portion of a trust that is considered a transfer of assets under federal law; ~~or~~

(iii) 36 months of a transfer if transferred in any other manner after August 10, 1993, but prior to February 8, 2006; or

(iv) 60 months of any transfer made on or after February 8, 2006,

or the amount of the uncompensated transfer, whichever is less, together with the costs incurred due to the action. The action shall be brought by the state unless the state delegates this responsibility to the local agency responsible for providing medical assistance under this chapter; or

(6) for transfers occurring after August 10, 1993, the assets were transferred by the person or person's spouse: (i) into a trust established for the sole benefit of a son or daughter of any age who is blind or disabled as defined by the Supplemental Security Income program; or (ii) into a trust established for the sole benefit of an individual who is under 65 years of age who is disabled as defined by the Supplemental Security Income program.

"For the sole benefit of" has the meaning found in section 256B.059, subdivision 1.

Sec. 13. Minnesota Statutes 2005 Supplement, section 256B.06, subdivision 4, is amended to read:

Subd. 4. **Citizenship requirements.** (a) Eligibility for medical assistance is limited to citizens of the United States, qualified noncitizens as defined in this subdivision, and other persons residing lawfully in the United States. Citizens or nationals of the United

States must provide satisfactory documentary evidence of citizenship or nationality as required by the federal Deficit Reduction Act of 2005, Public Law 109-171.

(b) "Qualified noncitizen" means a person who meets one of the following immigration criteria:

(1) admitted for lawful permanent residence according to United States Code, title 8;

(2) admitted to the United States as a refugee according to United States Code, title 8, section 1157;

(3) granted asylum according to United States Code, title 8, section 1158;

(4) granted withholding of deportation according to United States Code, title 8, section 1253(h);

(5) paroled for a period of at least one year according to United States Code, title 8, section 1182(d)(5);

(6) granted conditional entrant status according to United States Code, title 8, section 1153(a)(7);

(7) determined to be a battered noncitizen by the United States Attorney General according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, title V of the Omnibus Consolidated Appropriations Bill, Public Law 104-200;

(8) is a child of a noncitizen determined to be a battered noncitizen by the United States Attorney General according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, title V, of the Omnibus Consolidated Appropriations Bill, Public Law 104-200; or

(9) determined to be a Cuban or Haitian entrant as defined in section 501(e) of Public Law 96-422, the Refugee Education Assistance Act of 1980.

(c) All qualified noncitizens who were residing in the United States before August 22, 1996, who otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance with federal financial participation.

(d) All qualified noncitizens who entered the United States on or after August 22, 1996, and who otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance with federal financial participation through November 30, 1996.

Beginning December 1, 1996, qualified noncitizens who entered the United States on or after August 22, 1996, and who otherwise meet the eligibility requirements of this chapter are eligible for medical assistance with federal participation for five years if they meet one of the following criteria:

(i) refugees admitted to the United States according to United States Code, title 8, section 1157;

(ii) persons granted asylum according to United States Code, title 8, section 1158;

(iii) persons granted withholding of deportation according to United States Code, title 8, section 1253(h);

(iv) veterans of the United States armed forces with an honorable discharge for a reason other than noncitizen status, their spouses and unmarried minor dependent children; or

(v) persons on active duty in the United States armed forces, other than for training, their spouses and unmarried minor dependent children.

Beginning December 1, 1996, qualified noncitizens who do not meet one of the criteria in items (i) to (v) are eligible for medical assistance without federal financial participation as described in paragraph (j).

(e) Noncitizens who are not qualified noncitizens as defined in paragraph (b), who are lawfully residing in the United States and who otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance under clauses (1) to (3). These individuals must cooperate with the Immigration and Naturalization Service to pursue any applicable immigration status, including citizenship, that would qualify them for medical assistance with federal financial participation.

(1) Persons who were medical assistance recipients on August 22, 1996, are eligible for medical assistance with federal financial participation through December 31, 1996.

(2) Beginning January 1, 1997, persons described in clause (1) are eligible for medical assistance without federal financial participation as described in paragraph (j).

(3) Beginning December 1, 1996, persons residing in the United States prior to August 22, 1996, who were not receiving medical assistance and persons who arrived on or after August 22, 1996, are eligible for medical assistance without federal financial participation as described in paragraph (j).

(f) Nonimmigrants who otherwise meet the eligibility requirements of this chapter are eligible for the benefits as provided in paragraphs (g) to (i). For purposes of this subdivision, a "nonimmigrant" is a person in one of the classes listed in United States Code, title 8, section 1101(a)(15).

(g) Payment shall also be made for care and services that are furnished to noncitizens, regardless of immigration status, who otherwise meet the eligibility requirements of this chapter, if such care and services are necessary for the treatment of an emergency medical condition, except for organ transplants and related care and services and routine prenatal care.

(h) For purposes of this subdivision, the term "emergency medical condition" means a medical condition that meets the requirements of United States Code, title 42, section 1396b(v).

(i) Pregnant noncitizens who are undocumented, nonimmigrants, or eligible for medical assistance as described in paragraph (j), and who are not covered by a group health plan or health insurance coverage according to Code of Federal Regulations, title 42, section 457.310, and who otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance through the period of pregnancy, including labor and delivery, to the extent federal funds are available under title XXI of the Social Security Act, and the state children's health insurance program, followed by 60 days postpartum without federal financial participation.

(j) Qualified noncitizens as described in paragraph (d), and all other noncitizens lawfully residing in the United States as described in paragraph (e), who are ineligible for medical assistance with federal financial participation and who otherwise meet the eligibility requirements of chapter 256B and of this paragraph, are eligible for medical assistance without federal financial participation. Qualified noncitizens as described in paragraph (d) are only eligible for medical assistance without federal financial participation for five years from their date of entry into the United States.

(k) Beginning October 1, 2003, persons who are receiving care and rehabilitation services from a nonprofit center established to serve victims of torture and are otherwise ineligible for medical assistance under this chapter are eligible for medical assistance without federal financial participation. These individuals are eligible only for the period during which they are receiving services from the center. Individuals eligible under this paragraph shall not be required to participate in prepaid medical assistance.

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

Sec. 14. Minnesota Statutes 2005 Supplement, section 256B.0625, subdivision 1a, is amended to read:

Subd. 1a. **Services provided in a hospital emergency room.** Medical assistance ~~does not cover visits to a hospital emergency room that are not for emergency and emergency poststabilization care or urgent care, and does not pay for any services provided in a hospital emergency room that are not for emergency and emergency poststabilization care or urgent care~~ payment of a nonemergency emergency room facility component will be reduced to the payment level of the appropriate outpatient clinic facility component.

ARTICLE 15

QUALIFIED LONG-TERM CARE INSURANCE REGULATORY CHANGES

Section 1. Minnesota Statutes 2004, section 62S.05, is amended by adding a subdivision to read:

Subd. 4. **Extension of limitation periods.** The commissioner may extend the limitation periods set forth in subdivisions 1 and 2 as to specific age group categories in specific policy forms upon finding that the extension is in the best interest of the public.

Sec. 2. Minnesota Statutes 2004, section 62S.08, subdivision 3, is amended to read:

Subd. 3. **Mandatory format.** The following standard format outline of coverage must be used, unless otherwise specifically indicated:

COMPANY NAME
ADDRESS - CITY AND STATE
TELEPHONE NUMBER
LONG-TERM CARE INSURANCE
OUTLINE OF COVERAGE

Policy Number or Group Master Policy and Certificate Number

(Except for policies or certificates which are guaranteed issue, the following caution statement, or language substantially similar, must appear as follows in the outline of coverage.)

CAUTION: The issuance of this long-term care insurance (policy) (certificate) is based upon your responses to the questions on your application. A copy of your (application) (enrollment form) (is enclosed) (was retained by you when you applied). If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises. If, for any reason, any of your answers are incorrect, contact the company at this address: (insert address).

(1) This policy is (an individual policy of insurance) (a group policy) which was issued in the (indicate jurisdiction in which group policy was issued).

(2) PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance

company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY (OR CERTIFICATE) CAREFULLY.

(3) THIS PLAN IS INTENDED TO BE A QUALIFIED LONG-TERM CARE INSURANCE CONTRACT AS DEFINED UNDER SECTION 7702(B)(b) OF THE INTERNAL REVENUE CODE OF 1986.

(4) TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED.

(a) (For long-term care health insurance policies or certificates describe one of the following permissible policy renewability provisions:

(1) Policies and certificates that are guaranteed renewable shall contain the following statement:) RENEWABILITY: THIS POLICY (CERTIFICATE) IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your policy, (certificate) to continue this policy as long as you pay your premiums on time. (company name) cannot change any of the terms of your policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

(2) (Policies and certificates that are noncancelable shall contain the following statement:) RENEWABILITY: THIS POLICY (CERTIFICATE) IS NONCANCELABLE. This means that you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. (company name) cannot change any of the terms of your policy on its own and cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits, (company name) may increase your premium at that time for those additional benefits.

(b) (For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy.)

(c) (Describe waiver of premium provisions or state that there are not such provisions.)

(5) TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS.

(In bold type larger than the maximum type required to be used for the other provisions of the outline of coverage, state whether or not the company has a right to change the premium and, if a right exists, describe clearly and concisely each circumstance under which the premium may change.)

(6) TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

(a) (Provide a brief description of the right to return – "free look" provision of the policy.)

(b) (Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.)

~~(5)~~ (7) THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.

(a) (For agents) neither (insert company name) nor its agents represent Medicare, the federal government, or any state government.

(b) (For direct response) (insert company name) is not representing Medicare, the federal government, or any state government.

~~(6)~~ (8) LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community, or in the home.

This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy (limitations), (waiting periods), and (coinsurance) requirements. (Modify this paragraph if the policy is not an indemnity policy.)

~~(7)~~ (9) BENEFITS PROVIDED BY THIS POLICY.

(a) (Covered services, related deductible(s), waiting periods, elimination periods, and benefit maximums.)

(b) (Institutional benefits, by skill level.)

(c) (Noninstitutional benefits, by skill level.)

(d) (Eligibility for payment of benefits.)

(Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and must be defined and described as part of the outline of coverage.)

(Any benefit screens must be explained in this section. If these screens differ for different benefits, explanation of the screen should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified. If activities of daily living (ADLs) are used to measure an insured's need for long-term care, then these qualifying criteria or screens must be explained.)

~~(8)~~ (10) LIMITATIONS AND EXCLUSIONS:

Describe:

(a) preexisting conditions;

(b) noneligible facilities/provider;

(c) noneligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);

(d) exclusions/exceptions; and

(e) limitations.

(This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in paragraph ~~(6)~~ (8).)

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

~~(9)~~ (11) RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. As applicable, indicate the following:

(a) that the benefit level will not increase over time;

(b) any automatic benefit adjustment provisions;

(c) whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;

(d) if there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations; and

(e) whether there will be any additional premium charge imposed and how that is to be calculated.

~~(10)~~ (12) ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS. (State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically, describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.)

~~(11)~~ (13) PREMIUM.

(a) State the total annual premium for the policy.

(b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.

~~(12)~~ (14) ADDITIONAL FEATURES.

(a) Indicate if medical underwriting is used.

(b) Describe other important features.

(15) CONTACT THE STATE DEPARTMENT OF COMMERCE OR SENIOR LINKAGE LINE IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE.

Sec. 3. Minnesota Statutes 2004, section 62S.081, subdivision 4, is amended to read:

Subd. 4. **Forms.** An insurer shall use the forms in Appendices B (Personal Worksheet) and F (Potential Rate Increase Disclosure Form) of the Long-term Care Insurance Model Regulation adopted by the National Association of Insurance Commissioners to comply with the requirements of subdivisions 1 and 2.

Sec. 4. Minnesota Statutes 2004, section 62S.10, subdivision 2, is amended to read:

Subd. 2. **Contents.** The summary must include the following information:

(1) an explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;

(2) an illustration of the amount of benefits, the length of benefits, and the guaranteed lifetime benefits, if any, for each covered person; ~~and~~

(3) any exclusions, reductions, and limitations on benefits of long-term care; and

(4) a statement that any long-term care inflation protection option required by section 62S.23 is not available under this policy.

Sec. 5. Minnesota Statutes 2004, section 62S.13, is amended by adding a subdivision to read:

Subd. 6. **Death of insured.** In the event of the death of the insured, this section shall not apply to the remaining death benefit of a life insurance policy that accelerates benefits for long-term care. In this situation, the remaining death benefits under these policies shall be governed by section 61A.03, subdivision 1, paragraph (c). In all other situations, this section shall apply to life insurance policies that accelerate benefits for long-term care.

Sec. 6. Minnesota Statutes 2004, section 62S.14, subdivision 2, is amended to read:

Subd. 2. **Terms.** The terms "guaranteed renewable" and "noncancelable" may not be used in an individual long-term care insurance policy without further explanatory language that complies with the disclosure requirements of section 62S.20. The term

"level premium" may only be used when the insurer does not have the right to change the premium.

Sec. 7. Minnesota Statutes 2004, section 62S.15, is amended to read:

62S.15 AUTHORIZED LIMITATIONS AND EXCLUSIONS.

No policy may be delivered or issued for delivery in this state as long-term care insurance if the policy limits or excludes coverage by type of illness, treatment, medical condition, or accident, except as follows:

(1) preexisting conditions or diseases;

(2) mental or nervous disorders; except that the exclusion or limitation of benefits on the basis of Alzheimer's disease is prohibited;

(3) alcoholism and drug addiction;

(4) illness, treatment, or medical condition arising out of war or act of war; participation in a felony, riot, or insurrection; service in the armed forces or auxiliary units; suicide, attempted suicide, or intentionally self-inflicted injury; or non-fare-paying aviation; ~~and~~

(5) treatment provided in a government facility unless otherwise required by law, services for which benefits are available under Medicare or other government program except Medicaid, state or federal workers' compensation, employer's liability or occupational disease law, motor vehicle no-fault law; services provided by a member of the covered person's immediate family; and services for which no charge is normally made in the absence of insurance; and

(6) expenses for services or items available or paid under another long-term care insurance or health insurance policy.

This subdivision does not prohibit exclusions and limitations by type of provider or territorial limitations.

Sec. 8. Minnesota Statutes 2004, section 62S.20, subdivision 1, is amended to read:

Subdivision 1. **Renewability.** (a) Individual long-term care insurance policies must contain a renewability provision that is appropriately captioned, appears on the first page of the policy, and clearly states ~~the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed~~ that the coverage is guaranteed renewable or noncancelable. This subdivision does not apply to policies which are part of or combined with life insurance policies which do not contain a renewability provision and under which the right to nonrenew is reserved solely to the policyholder.

(b) A long-term care insurance policy or certificate, other than one where the insurer does not have the right to change the premium, shall include a statement that premium rates may change.

Sec. 9. Minnesota Statutes 2004, section 62S.24, subdivision 1, is amended to read:

Subdivision 1. **Required questions.** An application form must include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent, except where the coverage is sold without an agent, containing the following questions may be used. If a replacement policy is issued to a group as defined under section 62S.01, subdivision 15, clause (1), the following questions may be modified only to the extent necessary to elicit information about long-term care insurance policies other than the group policy being replaced; provided, however, that the certificate holder has been notified of the replacement:

(1) do you have another long-term care insurance policy or certificate in force (including health care service contract or health maintenance organization contract)?;

(2) did you have another long-term care insurance policy or certificate in force during the last 12 months?;

(i) if so, with which company?; and

(ii) if that policy lapsed, when did it lapse?; ~~and~~

(3) are you covered by Medicaid?; and

(4) do you intend to replace any of your medical or health insurance coverage with this policy (certificate)?

Sec. 10. Minnesota Statutes 2004, section 62S.24, is amended by adding a subdivision to read:

Subd. 1a. **Other health insurance policies sold by agent.** Agents shall list all other health insurance policies they have sold to the applicant that are still in force or were sold in the past five years and are no longer in force.

Sec. 11. Minnesota Statutes 2004, section 62S.24, subdivision 3, is amended to read:

Subd. 3. **Solicitations other than direct response.** After determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods or its agent, shall furnish the applicant, before issuance or delivery of

the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of the notice must be retained by the applicant and an additional copy signed by the applicant must be retained by the insurer. The required notice must be provided in the following manner:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

(Insurance company's name and address)

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by (company name) insurance company. Your new policy provides 30 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT (BROKER OR OTHER REPRESENTATIVE):
(Use additional sheets, as necessary.)

I have reviewed your current medical health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

(a) Health conditions which you presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(b) State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

(c) If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of

your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(d) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

.....

(Signature of Agent, Broker, or Other Representative)

(Typed Name and Address of Agency or Broker)

The above "Notice to Applicant" was delivered to me on:

.....
(Date)

.....
(Applicant's Signature)

Sec. 12. Minnesota Statutes 2004, section 62S.24, subdivision 4, is amended to read:

Subd. 4. **Direct response solicitations.** Insurers using direct response solicitation methods shall deliver a notice regarding replacement of long-term care coverage to the applicant upon issuance of the policy. The required notice must be provided in the following manner:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF

ACCIDENT AND SICKNESS OR
LONG-TERM CARE INSURANCE

(Insurance company's name and address)

SAVE THIS NOTICE! IT MAY BE
IMPORTANT TO YOU IN THE FUTURE.

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with the long-term care insurance policy delivered herewith issued by (company name) insurance company.

Your new policy provides 30 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

(a) Health conditions which you presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(b) State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

(c) If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(d) (To be included only if the application is attached to the policy.)

If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to (company name and address) within 30 days if any information is not correct and complete, or if any past medical history has been left out of the application.

.....
(Company Name)

Sec. 13. Minnesota Statutes 2004, section 62S.24, is amended by adding a subdivision to read:

Subd. 7. **Life insurance policies.** Life insurance policies that accelerate benefits for long-term care shall comply with this section if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply with the replacement requirements of sections 61A.53 to 61A.60. If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer shall comply with both the long-term care and the life insurance replacement requirements.

Sec. 14. Minnesota Statutes 2004, section 62S.25, subdivision 6, is amended to read:

Subd. 6. **Claims denied.** Each insurer shall report annually by June 30 the number of claims denied for any reason during the reporting period for each class of business, expressed as a percentage of claims denied, other than claims denied for failure to meet the waiting period or because of any applicable preexisting condition. For purposes of this subdivision, "claim" means a request for payment of benefits under an in-force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met.

Sec. 15. Minnesota Statutes 2004, section 62S.25, is amended by adding a subdivision to read:

Subd. 7. **Reports.** Reports under this section shall be done on a statewide basis and filed with the commissioner. They shall include, at a minimum, the information in the format contained in Appendix E (Claim Denial Reporting Form) and in Appendix G (Replacement and Lapse Reporting Form) of the Long-Term Care Model Regulation adopted by the National Association of Insurance Commissioners.

Sec. 16. Minnesota Statutes 2004, section 62S.26, is amended to read:

62S.26 LOSS RATIO.

Subdivision 1. **Minimum loss ratio.** ~~(a)~~ The minimum loss ratio must be at least 60 percent, calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, the commissioner shall give consideration to all relevant factors, including:

(1) statistical credibility of incurred claims experience and earned premiums;

(2) the period for which rates are computed to provide coverage;

(3) experienced and projected trends;

(4) concentration of experience within early policy duration;

(5) expected claim fluctuation;

(6) experience refunds, adjustments, or dividends;

(7) renewability features;

(8) all appropriate expense factors;

(9) interest;

(10) experimental nature of the coverage;

(11) policy reserves;

(12) mix of business by risk classification; and

(13) product features such as long elimination periods, high deductibles, and high maximum limits.

Subd. 2. **Life insurance policies.** Subdivision 1 shall not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following provisions:

(1) the interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

(2) the portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of section 61A.24;

(3) the policy meets the disclosure requirements of sections 62S.09, 62S.10, and 62S.11; and

(4) an actuarial memorandum is filed with the commissioner that includes:

(i) a description of the basis on which the long-term care rates were determined;

(ii) a description of the basis for the reserves;

(iii) a summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

(iv) a description and a table of each actuarial assumption used. For expenses, an insurer must include percentage of premium dollars per policy and dollars per unit of benefits, if any;

(v) a description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(vi) the estimated average annual premium per policy and the average issue age;

(vii) a statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(viii) a description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values, and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status.

Subd. 3. **Nonapplication.** ~~(b)~~ This section does not apply to policies or certificates that are subject to sections 62S.021, 62S.081, and 62S.265, and that comply with those sections.

Sec. 17. Minnesota Statutes 2004, section 62S.266, subdivision 2, is amended to read:

Subd. 2. **Requirement.** (a) An insurer must offer each prospective policyholder a nonforfeiture benefit in compliance with the following requirements:

(1) a policy or certificate offered with nonforfeiture benefits must have coverage elements, eligibility, benefit triggers, and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer must be the benefit described in subdivision 5; and

(2) the offer must be in writing if the nonforfeiture benefit is not otherwise described in the outline of coverage or other materials given to the prospective policyholder.

(b) When a group long-term care insurance policy is issued, the offer required in paragraph (a) shall be made to the group policy holder. However, if the policy is issued as group long-term care insurance as defined in section 62S.01, subdivision 15, clause (4), other than to a continuing care retirement community or other similar entity, the offering shall be made to each proposed certificate holder.

Sec. 18. Minnesota Statutes 2004, section 62S.29, subdivision 1, is amended to read:

Subdivision 1. **Requirements.** An insurer or other entity marketing long-term care insurance coverage in this state, directly or through its producers, shall:

(1) establish marketing procedures and agent training requirements to assure that ~~a~~ any marketing activities, including any comparison of policies by its agents or other producers, are fair and accurate;

(2) establish marketing procedures to assure excessive insurance is not sold or issued;

(3) display prominently by type, stamp, or other appropriate means, on the first page of the outline of coverage and policy, the following:

"Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations.";

(4) provide copies of the disclosure forms required in section 62S.081, subdivision 4, to the applicant;

(5) inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has long-term care insurance and the types and amounts of the insurance;

~~(5)~~ (6) establish auditable procedures for verifying compliance with this subdivision; and

~~(6)~~ (7) if applicable, provide written notice to the prospective policyholder and certificate holder, at solicitation, that a senior insurance counseling program approved by the commissioner is available and the name, address, and telephone number of the program;

(8) use the terms "noncancelable" or "level premium" only when the policy or certificate conforms to section 62S.14; and

(9) provide an explanation of contingent benefit upon lapse provided for in section 62S.266.

Sec. 19. Minnesota Statutes 2004, section 62S.30, is amended to read:

62S.30 ~~APPROPRIATENESS OF RECOMMENDED PURCHASE~~ SUITABILITY.

~~In recommending the purchase or replacement of a long-term care insurance policy or certificate, an agent shall comply with section 60K.46, subdivision 4.~~

Subdivision 1. **Standards.** Every insurer or other entity marketing long-term care insurance shall:

(1) develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;

(2) train its agents in the use of its suitability standards; and

(3) maintain a copy of its suitability standards and make them available for inspection upon request by the commissioner.

Subd. 2. **Procedures.** (a) To determine whether the applicant meets the standards developed by the insurer or other entity marketing long-term care insurance, the agent and insurer or other entity marketing long-term care insurance shall develop procedures that take the following into consideration:

(1) the ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;

(2) the applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet those goals or needs; and

(3) the values, benefits, and costs of the applicant's existing insurance, if any, when compared to the values, benefits, and costs of the recommended purchase or replacement.

(b) The insurer or other entity marketing long-term care insurance, and where an agent is involved, the agent, shall make reasonable efforts to obtain the information set forth in paragraph (a). The efforts shall include presentation to the applicant, at or prior

to application, of the "Long-Term Care Insurance Personal Worksheet." The personal worksheet used by the insurer or other entity marketing long-term care insurance shall contain, at a minimum, the information in the format contained in Appendix B of the Long-Term Care Model Regulation adopted by the National Association of Insurance Commissioners, in not less than 12-point type. The insurer or other entity marketing long-term care insurance may request the applicant to provide additional information to comply with its suitability standards. The insurer or other entity marketing long-term care insurance shall file a copy of its personal worksheet with the commissioner.

(c) A completed personal worksheet shall be returned to the insurer or other entity marketing long-term care insurance prior to consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses. The sale or dissemination by the insurer or other entity marketing long-term care insurance, or the agent, of information obtained through the personal worksheet, is prohibited.

(d) The insurer or other entity marketing long-term care insurance shall use the suitability standards it has developed under this section in determining whether issuing long-term care insurance coverage to an applicant is appropriate. Agents shall use the suitability standards developed by the insurer or other entity marketing long-term care insurance in marketing long-term care insurance.

(e) At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance" shall be provided. The form shall be in the format contained in Appendix C of the Long-Term Care Insurance Model Regulation adopted by the National Association of Insurance Commissioners in not less than 12-point type.

(f) If the insurer or other entity marketing long-term care insurance determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the insurer or other entity marketing long-term care insurance may reject the application. In the alternative, the insurer or other entity marketing long-term care insurance shall send the applicant a letter similar to Appendix D of the Long-Term Care Insurance Model Regulation adopted by the National Association of Insurance Commissioners. However, if the applicant has declined to provide financial information, the insurer or other entity marketing long-term care insurance may use some other method to verify the applicant's intent. The applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.

Subd. 3. **Reports.** The insurer or other entity marketing long-term care insurance shall report annually to the commissioner the total number of applications received from

residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of those who chose to confirm after receiving a suitability letter.

Subd. 4. **Application.** This section shall not apply to life insurance policies that accelerate benefits for long-term care.

Sec. 20. **[62S.315] PRODUCER TRAINING.**

The commissioner shall approve insurer and producer training requirements in accordance with the NAIC Long-Term Care Insurance Model Act provisions. The commissioner of human services shall provide technical assistance and information to the commissioner in accordance with Public Law 109-171, section 6021.

ARTICLE 16

MISCELLANEOUS

HEALTH AND HUMAN SERVICES

Section 1. **[152.126] ALL SCHEDULES PRESCRIPTION ELECTRONIC REPORTING PROGRAM.**

Subdivision 1. **Definitions.** For purposes of this section, the terms defined in this subdivision have the meanings given.

(a) "Board" means the Minnesota State Board of Pharmacy established under chapter 151.

(b) "Controlled substances" means those substances listed in section 152.02, subdivisions 3 to 6, and those substances defined by the board pursuant to section 152.02, subdivisions 7, 8, and 12.

(c) "Dispense" or "dispensing" has the meaning given in section 151.01, subdivision 30.

(d) "Dispenser" means a person authorized by law to dispense, pursuant to a valid prescription, a controlled substance. A dispenser does not include a licensed hospital pharmacy that distributes controlled substances for inpatient hospital care.

(e) "Prescriber" means a licensed health care professional who is authorized to prescribe a controlled substance under section 152.12, subdivision 1.

(f) "Prescription" has the meaning given in section 151.01, subdivision 16.

Subd. 2. **Establishment of a prescription electronic reporting program.** (a) The board shall establish by January 1, 2008, an electronic system for reporting the information required under subdivision 4 for all controlled substances dispensed within the state.

(b) The board may contract with a vendor for the purpose of obtaining technical assistance in the design, implementation, and maintenance of the electronic reporting system. The vendor's role shall be limited to providing technical support to the board concerning the software, databases, and computer systems required to interface with the existing systems currently used by pharmacies to dispense prescriptions and transmit prescription data to other third parties.

Subd. 3. **Prescription Electronic Reporting Advisory Committee.** (a) The board may convene an advisory committee. If the board convenes a committee, the committee must include at least one representative of:

(1) the Department of Health;

(2) the Department of Human Services;

(3) each health-related licensing board that licenses prescribers;

(4) a professional medical association, which may include an association of pain management and chemical dependency specialists;

(5) a professional pharmacy association;

(6) a consumer privacy or security advocate; and

(7) a consumer or patient rights organization.

(b) The advisory committee shall advise the board on the development and operation of the electronic reporting system, including, but not limited to:

(1) technical standards for electronic prescription drug reporting;

(2) proper analysis and interpretation of prescription monitoring data; and

(3) an evaluation process for the program.

Subd. 4. **Reporting requirements.** (a) Each dispenser must submit the following data to the board or its designated vendor:

(1) name of the prescriber;

(2) national provider identifier of the prescriber;

(3) name of the dispenser;

(4) national provider identifier of the dispenser;

(5) name of the patient for whom the prescription was written;

(6) date of birth of the patient for whom the prescription was written;

(7) date the prescription was written;

(8) date the prescription was filled;

(9) name and strength of the controlled substance;

(10) quantity of controlled substance prescribed; and

(11) quantity of controlled substance dispensed.

(b) The dispenser must submit the required information by a procedure and in a format established by the board.

(c) A dispenser is not required to submit this data for those controlled substance prescriptions dispensed for individuals residing in licensed skilled nursing or intermediate care facilities.

Subd. 5. **Use of data by board.** The board shall develop and maintain a database of the data reported under subdivision 4 and shall use the database for the identification of:

(1) individuals receiving prescriptions for controlled substances from prescribers who subsequently obtain controlled substances from dispensers in quantities or with a frequency inconsistent with generally recognized standards of dosage for those controlled substances; and

(2) individuals presenting forged or otherwise false or altered prescriptions for controlled substances to dispensers.

Subd. 6. **Access to prescription electronic reporting program data.** (a) Except as indicated in this subdivision, the data submitted to the board under subdivision 4 is private data on individuals as defined in section 13.02, subdivision 12.

(b) The board may provide data submitted under subdivision 4 for public research, policy or education purposes, to the extent that any information that is likely to reveal the identity of the patient or other person who is the subject of the data has been removed.

(c) The following persons shall be considered permissible users and may access the data submitted under subdivision 4 in the same or similar manner, and for the same or similar purposes, as those persons who are authorized to access similar private data on individuals under federal and state law:

(1) a prescriber, to the extent the information relates specifically to a current patient of the prescriber, to whom the practitioner is prescribing or considering prescribing any controlled substance;

(2) a dispenser to the extent the information relates specifically to a current patient to whom that dispenser is dispensing or considering dispensing any controlled substance;

(3) an individual who is the recipient of a controlled substance prescription for which data was submitted under subdivision 4;

(4) personnel of the board specifically assigned to conduct investigations related to controlled substances laws under the jurisdiction of the board;

(5) personnel of the board engaged in the collection of controlled substance prescription information as part of the assigned duties and responsibilities of their employment;

(6) authorized personnel of a vendor under contract with the board who are engaged in the design, implementation, and maintenance of the electronic reporting system as part of the assigned duties and responsibilities of their employment, provided that access to data is limited to the minimum amount necessary to test and maintain the system databases;

(7) a designated representative of a health-related licensing board responsible for the licensure, regulation, or discipline of prescribers or dispensers provided that the requested data relates to a bona fide investigation of a specific licensee;

(8) federal, state, and local law enforcement authorities engaged in a bona fide investigation of a specific person; and

(9) personnel of the medical assistance program assigned to use the data collected under this section to identify recipients whose usage of controlled substances may warrant restriction to a single primary care physician, a single outpatient pharmacy, or a single hospital.

(d) Any permissible user identified in paragraph (c) that directly accesses the data electronically shall implement and maintain a comprehensive information security program that contains administrative, technical, and physical safeguards that are appropriate to the user's size and complexity, and the sensitivity of the personal information obtained. The permissible user shall identify reasonably foreseeable internal and external risks to the security, confidentiality, and integrity of personal information that could result in the unauthorized disclosure, misuse, or other compromise of the information and assess the sufficiency of any safeguards in place to control the risks.

(e) The board shall not release data submitted under this section unless it is provided with evidence, satisfactory to the board, that the person requesting the information is entitled to receive the data. Access to the data by law enforcement authorities must be accompanied by a valid search warrant.

(f) The board shall maintain a log of all persons who access the data and shall ensure that any permissible user complies with paragraph (d) prior to attaining direct access to the data.

Subd. 7. **Disciplinary action.** (a) A dispenser who knowingly fails to submit data to the board as required under this section is subject to disciplinary action by the appropriate health-related licensing board.

(b) A prescriber or dispenser authorized to access the data who knowingly discloses the data in violation of state or federal laws relating to the privacy of healthcare data shall be subject to disciplinary action by the appropriate health-related licensing board.

Subd. 8. **Evaluation and reporting.** (a) The board shall evaluate the prescription electronic reporting program to determine if the program is cost-effective. The board may contract with a vendor to design and conduct the evaluation.

(b) The board shall submit the evaluation of the program to the legislature by January 15, 2009.

EFFECTIVE DATE. This section is effective July 1, 2006, or upon receiving sufficient nonstate funds to implement the prescription electronic reporting program, whichever is later. In the event that nonstate funds are not secured by the Board of Pharmacy to adequately fund the implementation of the prescription electronic reporting program, the board is not required to implement section 1, without a subsequent appropriation from the legislature.

Sec. 2. **FEDERAL GRANTS.**

The Board of Pharmacy shall apply for any applicable federal grants or other nonstate funds to establish and fully implement the prescription electronic reporting program.

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

ARTICLE 17

CHILDREN AND FAMILIES PROGRAMS AND SERVICES

Section 1. Minnesota Statutes 2004, section 119B.011, is amended by adding a subdivision to read:

Subd. 23. **Work participation rate enhancement program.** "Work participation rate enhancement program" means the program established under section 256J.575.

Sec. 2. Minnesota Statutes 2004, section 119B.03, subdivision 4, is amended to read:

Subd. 4. **Funding priority.** (a) First priority for child care assistance under the basic sliding fee program must be given to eligible non-MFIP families who do not have a high school or general equivalency diploma or who need remedial and basic skill courses in order to pursue employment or to pursue education leading to employment and who need child care assistance to participate in the education program. Within this priority, the following subpriorities must be used:

(1) child care needs of minor parents;

(2) child care needs of parents under 21 years of age; and

(3) child care needs of other parents within the priority group described in this paragraph.

(b) Second priority must be given to parents who have completed their MFIP or DWP transition year, or parents who are no longer receiving or eligible for diversionary work program supports.

(c) Third priority must be given to families who are eligible for portable basic sliding fee assistance through the portability pool under subdivision 9.

(d) Fourth priority must be given to families in which at least one parent is a veteran as defined under section 197.447.

(e) Families under paragraph (b) must be added to the basic sliding fee waiting list on the date they begin the transition year under section 119B.011, subdivision 20, and must be moved into the basic sliding fee program as soon as possible after they complete their transition year.

Sec. 3. Minnesota Statutes 2004, section 119B.05, subdivision 1, is amended to read:

Subdivision 1. **Eligible participants.** Families eligible for child care assistance under the MFIP child care program are:

(1) MFIP participants who are employed or in job search and meet the requirements of section 119B.10;

(2) persons who are members of transition year families under section 119B.011, subdivision 20, and meet the requirements of section 119B.10;

(3) families who are participating in employment orientation or job search, or other employment or training activities that are included in an approved employability development plan under section 256J.95;

(4) MFIP families who are participating in work job search, job support, employment, or training activities as required in their employment plan, or in appeals, hearings, assessments, or orientations according to chapter 256J;

(5) MFIP families who are participating in social services activities under chapter 256J as required in their employment plan approved according to chapter 256J;

(6) families who are participating in services or activities that are included in an approved family stabilization plan under section 256J.575;

(7) families who are participating in programs as required in tribal contracts under section 119B.02, subdivision 2, or 256.01, subdivision 2; and

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

Sec. 4. Minnesota Statutes 2005 Supplement, section 119B.13, subdivision 1, is amended to read:

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

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

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

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

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

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

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

(b) The maximum rate paid for child care assistance under the child care fund must be adjusted annually and may not exceed the 75th percentile rate for like-care arrangements in a county, region, or category the commissioner deems to be similar as surveyed by the commissioner.

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

(d) The department shall monitor the effect of this paragraph on provider rates. The county shall pay the provider's full charges for every child in care up to the maximum established. The commissioner shall determine the maximum rate for each type of care on an hourly, full-day, and weekly basis, including special needs and handicapped care. The commissioner shall also determine the maximum rate for school age care on a half-day basis.

(e) When the provider charge is greater than the maximum provider rate allowed, the parent is responsible for payment of the difference in the rates in addition to any family co-payment fee.

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

Sec. 5. Minnesota Statutes 2004, section 119B.13, is amended by adding a subdivision to read:

Subd. 3a. **Provider rate differential for accreditation.** A family child care provider or child care center shall be paid a 15 percent differential above the maximum rate established in subdivision 1, up to the actual provider rate, if the provider or center holds a current early childhood development credential or is accredited. For a family child care provider, early childhood development credential and accreditation includes an individual who has earned a child development associate degree, a diploma in child development from a Minnesota state technical college, or a bachelor's degree in early childhood education from an accredited college or university, or who is accredited by the National Association for Family Child Care or the Competency Based Training and Assessment Program. For a child care center, accreditation includes accreditation by the National Association for the Education of Young Children, the Council on Accreditation, the National Early Childhood Program Accreditation, the National School-Age Care Association, or the National Head Start Association Program of Excellence. For Montessori programs, accreditation includes the American Montessori Society, Association of Montessori International-USA, or the National Center for Montessori Education.

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

Sec. 6. **[256.029] DOMESTIC VIOLENCE INFORMATIONAL BROCHURE.**

(a) The commissioner shall provide a domestic violence informational brochure that provides information about the existence of domestic violence waivers for eligible public assistance applicants to all general assistance, general assistance medical care, Minnesota family investment program, medical assistance, and MinnesotaCare. The

brochure must explain that eligible applicants may be temporarily waived from certain program requirements due to domestic violence. The brochure must provide information about services and other programs to help victims of domestic violence.

(b) The brochure must be funded with TANF funds.

EFFECTIVE DATE. This section is effective upon federal approval.

Sec. 7. **[256D.0515] ASSET LIMITATIONS FOR FOOD STAMP HOUSEHOLDS.**

All food stamp households must be determined eligible for the benefit discussed under section 256.029. Food stamp households must demonstrate that:

(1) their gross income meets the federal Food Stamp requirements under United States Code, title 7, section 2014(c); and

(2) they have financial resources, excluding vehicles, of less than $7,000.

EFFECTIVE DATE. This section is effective upon federal approval.

Sec. 8. Minnesota Statutes 2004, section 256J.01, is amended by adding a subdivision to read:

Subd. 6. **Legislative approval to move programs or activities.** The commissioner shall not move programs or activities funded with MFIP or TANF maintenance of effort funds to other funding sources unless specifically approved by law.

Sec. 9. Minnesota Statutes 2004, section 256J.021, is amended to read:

256J.021 ~~SEPARATE~~ STATE ~~PROGRAM FOR USE OF STATE MONEY~~ PROGRAMS.

(a) Beginning October 1, ~~2001~~ 2006, and each year thereafter, the commissioner of human services must treat MFIP expenditures made to or on behalf of any minor child under section 256J.02, subdivision 2, clause (1), who is a resident of this state under section 256J.12, and who is part of a two-parent eligible household as expenditures under a ~~separately funded state~~ program ~~and report those expenditures to the federal Department of Health and Human Services as separate state program expenditures under Code of Federal Regulations, title 45, section 263.5~~. These expenditures shall not count toward the state's maintenance of effort (MOE) requirements under the federal Temporary Assistance to Needy Families (TANF) program, except if counting certain families would allow the commissioner to avoid a federal penalty. Families receiving assistance under this section must comply with all applicable requirements in chapter 256J.

(b) Beginning October 1, 2006, and each year thereafter, the commissioner of human services must treat MFIP expenditures made to or on behalf of any minor child under section 256J.02, subdivision 2, clause (1), who is a resident of this state under section 256J.12, and who is part of a household participating in the work participation rate enhancement program under section 256J.575, as expenditures under a program funded with state nonmaintenance of effort funds. These expenditures shall not count toward the state's maintenance of effort (MOE) requirements under the federal Temporary Assistance to Needy Families (TANF) program, except if counting certain families would allow the commissioner to avoid a federal penalty. Families receiving assistance under this section must comply with all applicable requirements in chapter 256J.

Sec. 10. Minnesota Statutes 2004, section 256J.08, subdivision 65, is amended to read:

Subd. 65. **Participant.** "Participant" means a person who is currently receiving cash assistance or the food portion available through MFIP. A person who fails to withdraw or access electronically any portion of the person's cash and food assistance payment by the end of the payment month, who makes a written request for closure before the first of a payment month and repays cash and food assistance electronically issued for that payment month within that payment month, or who returns any uncashed assistance check and food coupons and withdraws from the program is not a participant. A person who withdraws a cash or food assistance payment by electronic transfer or receives and cashes an MFIP assistance check or food coupons and is subsequently determined to be ineligible for assistance for that period of time is a participant, regardless whether that assistance is repaid. The term "participant" includes the caregiver relative and the minor child whose needs are included in the assistance payment. A person in an assistance unit who does not receive a cash and food assistance payment because the case has been suspended from MFIP is a participant. A person who receives cash payments under the diversionary work program under section 256J.95 is a participant. A person who receives cash payments under the work participation rate enhancement program under section 256J.575 is a participant.

Sec. 11. Minnesota Statutes 2004, section 256J.521, subdivision 1, is amended to read:

Subdivision 1. **Assessments.** (a) For purposes of MFIP employment services, assessment is a continuing process of gathering information related to employability for the purpose of identifying both participant's strengths and strategies for coping with issues that interfere with employment. The job counselor must use information from the assessment process to develop and update the employment plan under subdivision 2 or 3,

as appropriate, ~~and~~ to determine whether the participant qualifies for a family violence waiver including an employment plan under subdivision 3, and to determine whether the participant should be referred to the work participation rate enhancement program under section 256J.575.

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

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

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

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

(4) a comprehensive review of participation and progress for participants who have received MFIP assistance and have not worked in unsubsidized employment during the past 12 months. The purpose of the review is to determine the need for additional services and supports, including placement in subsidized employment or unpaid work experience under section 256J.49, subdivision 13, or referral to the work participation rate enhancement program under section 256J.575.

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

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

Sec. 12. Minnesota Statutes 2004, section 256J.521, subdivision 2, is amended to read:

Subd. 2. **Employment plan; contents.** (a) Based on the assessment under subdivision 1, the job counselor and the participant must develop an employment plan that includes participation in activities and hours that meet the requirements of section 256J.55, subdivision 1. The purpose of the employment plan is to identify for each participant the most direct path to unsubsidized employment and any subsequent steps that support long-term economic stability. The employment plan should be developed using the highest level of activity appropriate for the participant. Activities must be chosen from clauses (1) to (6), which are listed in order of preference. Notwithstanding this order of preference for activities, priority must be given for activities related to a family violence waiver when developing the employment plan. The employment plan must also list the specific steps the participant will take to obtain employment, including steps necessary for the participant to progress from one level of activity to another, and a timetable for completion of each step. Levels of activity include:

(1) unsubsidized employment;

(2) job search;

(3) subsidized employment or unpaid work experience;

(4) unsubsidized employment and job readiness education or job skills training;

(5) unsubsidized employment or unpaid work experience and activities related to a family violence waiver or preemployment needs; and

(6) activities related to a family violence waiver or preemployment needs.

(b) Participants who are determined to possess sufficient skills such that the participant is likely to succeed in obtaining unsubsidized employment must job search at least 30 hours per week for up to six weeks and accept any offer of suitable employment. The remaining hours necessary to meet the requirements of section 256J.55, subdivision

1, may be met through participation in other work activities under section 256J.49, subdivision 13. The participant's employment plan must specify, at a minimum: (1) whether the job search is supervised or unsupervised; (2) support services that will be provided; and (3) how frequently the participant must report to the job counselor. Participants who are unable to find suitable employment after six weeks must meet with the job counselor to determine whether other activities in paragraph (a) should be incorporated into the employment plan. Job search activities which are continued after six weeks must be structured and supervised.

(c) Beginning July 1, 2004, activities and hourly requirements in the employment plan may be adjusted as necessary to accommodate the personal and family circumstances of participants identified under section 256J.561, subdivision 2, paragraph (d). Participants who no longer meet the provisions of section 256J.561, subdivision 2, paragraph (d), must meet with the job counselor within ten days of the determination to revise the employment plan.

(d) Participants who are determined to have barriers to obtaining or retaining employment that will not be overcome during six weeks of job search under paragraph (b) must work with the job counselor to develop an employment plan that addresses those barriers by incorporating appropriate activities from paragraph (a), clauses (1) to (6). The employment plan must include enough hours to meet the participation requirements in section 256J.55, subdivision 1, unless a compelling reason to require fewer hours is noted in the participant's file.

(e) The job counselor and the participant must sign the employment plan to indicate agreement on the contents. Failure to develop or comply with activities in the plan, or voluntarily quitting suitable employment without good cause, will result in the imposition of a sanction under section 256J.46.

(f) Employment plans must be reviewed at least every three months to determine whether activities and hourly requirements should be revised. The job counselor is encouraged to allow participants who are participating in at least 20 hours of work activities to also participate in employment and training activities in order to meet the federal hourly participation rates.

Sec. 13. Minnesota Statutes 2004, section 256J.53, subdivision 2, is amended to read:

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

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

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

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

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

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

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

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

~~(d)~~ (c) Participants with an approved employment plan in place on July 1, 2003, which includes more than 12 months of postsecondary education or training shall be allowed to complete that plan provided that hourly requirements in section 256J.55, subdivision 1, and conditions specified in paragraph ~~(b)~~ (a), and subdivisions 3 and 5 are met. A participant whose case is subsequently closed for three months or less for reasons other than noncompliance with program requirements and who returns to MFIP shall be allowed to complete that plan provided that hourly requirements in section 256J.55, subdivision 1, and conditions specified in paragraph ~~(b)~~ (a) and subdivisions 3 and 5 are met.

Sec. 14. Minnesota Statutes 2004, section 256J.53, is amended by adding a subdivision to read:

Subd. 2a. **Employment while attending postsecondary education.** For the first 12 months of education, the participant may work, but there is no work requirement. For the subsequent 12 months of education, the participant must work in unsubsidized employment at least 20 hours per week.

Sec. 15. **[256J.575] WORK PARTICIPATION RATE ENHANCEMENT PROGRAM.**

Subdivision 1. **Purpose.** (a) The work participation rate enhancement program (WORK PREP) is Minnesota's cash assistance program to serve families who are not making significant progress within MFIP due to a variety of barriers to employment.

(b) The goal of this program is to stabilize and improve the lives of families at risk of long-term welfare dependency or family instability due to employment barriers such as physical disability, mental disability, age, and caring for a disabled household member. WORK PREP provides services to promote and support families to achieve the greatest possible degree of self-sufficiency.

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

(a) The "work participation rate enhancement program" means the program established under this section.

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

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

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

(1) obtaining and retaining unsubsidized employment;

(2) family stability;

(3) economic stability; and

(4) barrier reduction.

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

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

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

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

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

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

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

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

Subd. 5. **Case management; family stabilization plans; coordinated services.** (a) The county agency shall provide family stabilization services to families through a case management model. A case manager shall be assigned to each participating family within 30 days after the family begins to receive financial assistance as a participant of the work participation rate enhancement program. The case manager, with the full involvement of the family, shall recommend, and the county agency shall establish and modify as necessary, a family stabilization plan for each participating family.

(b) The family stabilization plan shall include:

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

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

(3) an identification of the services, supports, education, training, and accommodations needed to overcome any barriers to enable the family to achieve self-sufficiency and to fulfill each caregiver's personal and family responsibilities.

(c) The case manager and the participant must meet within 30 days of the family's referral to the case manager. The initial family stabilization plan shall be completed within 30 days of the first meeting with the case manager. The case manager shall establish a schedule for periodic review of the family stabilization plan that includes personal contact with the participant at least once per month. In addition, the case manager shall review and modify if necessary the plan under the following circumstances:

(1) there is a lack of satisfactory progress in achieving the goals of the plan;

(2) the participant has lost unsubsidized or subsidized employment;

(3) a family member has failed to comply with a family stabilization plan requirement;

(4) services required by the plan are unavailable; or

(5) changes to the plan are needed to promote the well-being of the children.

(d) Family stabilization plans under this section shall be written for a period of time not to exceed six months.

Subd. 6. **Cooperation with program requirements.** (a) To be eligible, a participant must comply with paragraphs (b) to (f).

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

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

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

(e) Participants who have not increased their participation in work activities sufficient to meet the federal participation requirements of TANF may request a referral to the MFIP program and assignment to a job counselor after 12 months in the program.

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

Subd. 7. **Sanctions.** (a) The financial assistance grant of a participating family shall be reduced, according to section 256J.46, if a participating adult fails without good cause to comply or continue to comply with the family stabilization plan requirements in this subdivision, unless compliance has been excused under subdivision 6, paragraph (f).

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

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

meeting. If a face-to-face meeting is not conducted, the county agency must send the participant a written notice that includes the information required under clause (1):

(1) during the face-to-face meeting, the county agency must:

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

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

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

(iv) explain the consequences of continuing noncompliance;

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

(vi) inform the participant of the right to appeal under section 256J.40; and

(2) if the lack of an identified activity or service can explain the noncompliance, the county must work with the participant to provide the identified activity.

(d) After the requirements of paragraph (c) are met and prior to imposition of a sanction, the county agency shall provide a notice of intent to sanction under section 256J.57, subdivision 2, and, when applicable, a notice of adverse action as provided in section 256J.31.

(e) Section 256J.57 applies to this section except to the extent that it is modified by this subdivision.

Sec. 16. **[256J.621] WORK PARTICIPATION BONUS.**

Upon exiting the diversionary work program (DWP) or upon terminating MFIP cash assistance with earnings, a participant who is employed and working 24 hours a week may be eligible for transitional assistance of $50 per month to assist in meeting the family's basic needs as the participant continues to move toward self-sufficiency.

To be eligible for a transitional assistance payment, the participant must not receive MFIP cash assistance or diversionary work program assistance during the month and must be employed an average of at least 24 hours a week. Transitional assistance shall be available for a maximum of 12 months from the date the participant exited the diversionary work program or terminated MFIP cash assistance.

The commissioner shall establish minimal policies and develop forms to verify eligibility for transitional assistance. The commissioner is authorized to change or modify the provisions of this section in order to comply with federal rules or regulations promulgated as a result of the federal Deficit Reduction Act (DEFRA) of 2005.

Expenditures on the transitional assistance program shall be maintenance of effort state funds. Months in which a participant receives transitional assistance under this section shall not count toward the participant's MFIP 60-month time limit.

Sec. 17. Minnesota Statutes 2004, section 256J.626, subdivision 1, is amended to read:

Subdivision 1. **Consolidated fund.** The consolidated fund is established to support counties and tribes in meeting their duties under this chapter. Counties and tribes must use funds from the consolidated fund to develop programs and services that are designed to improve participant outcomes as measured in section 256J.751, subdivision 2, and to provide case management services to participants of the work participation rate enhancement program. Counties may use the funds for any allowable expenditures under subdivision 2. Tribes may use the funds for any allowable expenditures under subdivision 2, except those in clauses (1) and (6).

Sec. 18. Minnesota Statutes 2004, section 256J.626, subdivision 2, is amended to read:

Subd. 2. **Allowable expenditures.** (a) The commissioner must restrict expenditures under the consolidated fund to benefits and services allowed under title IV-A of the federal Social Security Act. Allowable expenditures under the consolidated fund may include, but are not limited to:

(1) short-term, nonrecurring shelter and utility needs that are excluded from the definition of assistance under Code of Federal Regulations, title 45, section 260.31, for families who meet the residency requirement in section 256J.12, subdivisions 1 and 1a. Payments under this subdivision are not considered TANF cash assistance and are not counted towards the 60-month time limit;

(2) transportation needed to obtain or retain employment or to participate in other approved work activities or activities under a family stabilization plan;

(3) direct and administrative costs of staff to deliver employment services for MFIP ~~or~~, the diversionary work program, or the work participation rate enhancement program; to administer financial assistance~~.~~; and to provide specialized services intended to assist hard-to-employ participants to transition to work or transition from the work participation rate enhancement program to MFIP;

(4) costs of education and training including functional work literacy and English as a second language;

(5) cost of work supports including tools, clothing, boots, and other work-related expenses;

(6) county administrative expenses as defined in Code of Federal Regulations, title 45, section 260(b);

(7) services to parenting and pregnant teens;

(8) supported work;

(9) wage subsidies;

(10) child care needed for MFIP ~~or~~, the diversionary work program, or the work participation rate enhancement program participants to participate in social services;

(11) child care to ensure that families leaving MFIP or diversionary work program will continue to receive child care assistance from the time the family no longer qualifies for transition year child care until an opening occurs under the basic sliding fee child care program; ~~and~~

(12) services to help noncustodial parents who live in Minnesota and have minor children receiving MFIP or DWP assistance, but do not live in the same household as the child, obtain or retain employment; and

(13) services to help families participating in the work participation rate enhancement program achieve the greatest possible degree of self-sufficiency.

(b) Administrative costs that are not matched with county funds as provided in subdivision 8 may not exceed 7.5 percent of a county's or 15 percent of a tribe's allocation under this section. The commissioner shall define administrative costs for purposes of this subdivision.

(c) The commissioner may waive the cap on administrative costs for a county or tribe that elects to provide an approved supported employment, unpaid work, or community work experience program for a major segment of the county's or tribe's MFIP population. The county or tribe must apply for the waiver on forms provided by the commissioner. In no case shall total administrative costs exceed the TANF limits.

Sec. 19. Minnesota Statutes 2004, section 256J.626, subdivision 3, is amended to read:

Subd. 3. **Eligibility for services.** Families with a minor child, a pregnant woman, or a noncustodial parent of a minor child receiving assistance, with incomes below 200 percent of the federal poverty guideline for a family of the applicable size, are eligible for services funded under the consolidated fund. Counties and tribes must give priority to families currently receiving MFIP ~~or~~, the diversionary work program, or the work

participation rate enhancement program, and families at risk of receiving MFIP or diversionary work program.

Sec. 20. Minnesota Statutes 2004, section 256J.626, subdivision 4, is amended to read:

Subd. 4. **County and tribal biennial service agreements.** (a) Effective January 1, 2004, and each two-year period thereafter, each county and tribe must have in place an approved biennial service agreement related to the services and programs in this chapter. In counties with a city of the first class with a population over 300,000, the county must consider a service agreement that includes a jointly developed plan for the delivery of employment services with the city. Counties may collaborate to develop multicounty, multitribal, or regional service agreements.

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

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

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

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

(4) strategies the county or tribe will pursue under the work participation rate enhancement program; and

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

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

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

(e) The commissioner must, within 60 days of receiving each county or tribal service agreement, inform the county or tribe if the service agreement is approved. If the service

agreement is not approved, the commissioner must inform the county or tribe of any revisions needed prior to approval.

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

Sec. 21. Minnesota Statutes 2004, section 256J.626, subdivision 5, is amended to read:

Subd. 5. **Innovation projects.** Beginning January 1, 2005, no more than $3,000,000 of the funds annually appropriated to the commissioner for use in the consolidated fund shall be available to the commissioner for projects testing innovative approaches to improving outcomes for MFIP participants, and persons at risk of receiving MFIP as detailed in subdivision 3, and for providing incentives to counties and tribes that exceed performance. Projects shall be targeted to geographic areas with poor outcomes as specified in section 256J.751, subdivision 5, or to subgroups within the MFIP case load who are experiencing poor outcomes. For purposes of an incentive, a county or tribe exceeds performance if the county or tribe is above the top of the county or tribe's annualized range of expected performance on the three-year self-support index under section 256J.751, subdivision 2, clause (7), and achieve a 50 percent MFIP participation rate under section 256J.751, subdivision 2, clause (8), as averaged across the four quarterly measurements for the most recent year for which the measurements are available.

Sec. 22. Minnesota Statutes 2005 Supplement, section 256J.626, subdivision 6, is amended to read:

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

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

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

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

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

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

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

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

(6) "Base programs" means the:

(i) MFIP employment and training services under Minnesota Statutes 2002, section 256J.62, subdivision 1, in effect June 30, 2002;

(ii) bilingual employment and training services to refugees under Minnesota Statutes 2002, section 256J.62, subdivision 6, in effect June 30, 2002;

(iii) work literacy language programs under Minnesota Statutes 2002, section 256J.62, subdivision 7, in effect June 30, 2002;

(iv) supported work program authorized in Laws 2001, First Special Session chapter 9, article 17, section 2, in effect June 30, 2002;

(v) administrative aid program under section 256J.76 in effect December 31, 2002; and

(vi) emergency assistance program under Minnesota Statutes 2002, section 256J.48, in effect June 30, 2002.

(b) The commissioner shall:

(1) beginning July 1, 2003, determine the initial allocation of funds available under this section according to clause (2);

(2) allocate all of the funds available for the period beginning July 1, 2003, and ending December 31, 2004, to each county or tribe in proportion to the county's or tribe's share of the statewide 2002 historic spending base;

(3) determine for calendar year 2005 the initial allocation of funds to be made available under this section in proportion to the county or tribe's initial allocation for the period of July 1, 2003, to December 31, 2004;

(4) determine for calendar year 2006 the initial allocation of funds to be made available under this section based 90 percent on the proportion of the county or tribe's share of the statewide 2002 historic spending base and ten percent on the proportion of the county or tribe's share of the adjusted caseload factor;

(5) determine for calendar year 2007 the initial allocation of funds to be made available under this section based 70 percent on the proportion of the county or tribe's share of the statewide 2002 historic spending base and 30 percent on the proportion of the county or tribe's share of the adjusted caseload factor; and

(6) determine for calendar year 2008 and subsequent years the initial allocation of funds to be made available under this section based 50 percent on the proportion of the county or tribe's share of the statewide 2002 historic spending base and 50 percent on the proportion of the county or tribe's share of the adjusted caseload factor.

(c) With the commencement of a new or expanded tribal TANF program or an agreement under section 256.01, subdivision 2, paragraph (g), in which some or all of the responsibilities of particular counties under this section are transferred to a tribe, the commissioner shall:

(1) in the case where all responsibilities under this section are transferred to a tribal program, determine the percentage of the county's current caseload that is transferring to a tribal program and adjust the affected county's allocation accordingly; and

(2) in the case where a portion of the responsibilities under this section are transferred to a tribal program, the commissioner shall consult with the affected county or counties to determine an appropriate adjustment to the allocation.

~~(d) Effective January 1, 2005, counties and tribes will have their final allocations adjusted based on the performance provisions of subdivision 7.~~

Sec. 23. **[256K.60] RUNAWAY AND HOMELESS YOUTH ACT.**

Subdivision 1. **Definitions.** (a) The definitions of this subdivision apply to this section.

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

(c) "Homeless youth" means a person 21 years or younger who is unaccompanied by a parent or guardian and is without shelter where appropriate care and supervision are available, whose parent or legal guardian is unable or unwilling to provide shelter and care, or who lacks a fixed, regular, and adequate nighttime residence. The following are not fixed, regular, or adequate nighttime residences:

(1) a supervised publicly or privately operated shelter designed to provide temporary living accommodations;

(2) an institution publicly or privately operated shelter designed to provide temporary living accommodations;

(3) transitional housing;

(4) a temporary placement with a peer, friend, or family member that has not offered permanent residence, a residential lease, or temporary lodging for more than 30 days; or

(5) a public or private place not designed for, nor ordinarily used as, a regular sleeping accommodation for human beings.

Homeless youth does not include persons incarcerated or otherwise detained under federal or state law.

(d) "Youth at risk of homelessness" means a person 21 years or younger whose status or circumstances indicate a significant danger of experiencing homelessness in the near future. Status or circumstances that indicate a significant danger may include youth exiting out-of-home placements, youth who previously were homeless, youth whose parents or primary caregivers are or were previously homeless, youth who are exposed to abuse and neglect in their homes, youth who experience conflict with parents due to chemical or alcohol dependency, mental health disabilities, or other disabilities, and runaways.

(e) "Runaway" means an unmarried child under the age of 18 years who is absent from the home of a parent or guardian or other lawful placement without the consent of the parent, guardian, or lawful custodian.

Subd. 2. **Homeless and runaway youth plan.** (a) The commissioner shall develop a comprehensive plan for homeless youth, youth at risk of homelessness, and runaways.

(b) The commissioner shall plan for and coordinate services for homeless, runaway, and at-risk youth. The plan shall include the coordination of services under subdivisions 3 to 5.

Subd. 3. **Street and community outreach and drop-in program.** Youth drop-in centers must provide walk-in access to crisis intervention and on-going supportive services including one-to-one case management services on a self-referral basis. Street and community outreach programs must locate, contact, and provide information, referrals, and services to homeless youth, youth at risk of homelessness, and runaways. Information, referrals, and services provided may include, but are not limited to:

(1) family reunification services;

(2) conflict resolution or mediation counseling;

(3) assistance in obtaining temporary emergency shelter;

(4) assistance in obtaining food, clothing, medical care, or mental health counseling;

(5) counseling regarding violence, prostitution, substance abuse, sexually transmitted diseases, and pregnancy;

(6) referrals to other agencies that provide support to services to homeless youth, youth at risk of homelessness, and runaways;

(7) assistance with education, employment, and independent living skills;

(8) after-care services;

(9) specialized services for highly vulnerable runaways and homeless youth, including teen parents, emotionally disturbed and mentally ill youth, and sexually exploited youth; and

(10) homelessness prevention.

Subd. 4. **Emergency shelter program.** (a) Emergency shelter programs must provide homeless youth and runaways with referral and walk-in access to emergency, short-term residential care. The program shall provide homeless youth and runaways with safe, dignified shelter, including private shower facilities, beds, and at least one meal each day, and shall assist a runaway with reunification with the family or legal guardian when required or appropriate.

(b) The services provided at emergency shelters may include, but are not limited to:

(1) family reunification services;

(2) individual, family, and group counseling;

(3) assistance obtaining clothing;

(4) access to medical and dental care and mental health counseling;

(5) education and employment services;

(6) recreational activities;

(7) advocacy and referral services;

(8) independent living skills training;

(9) after-care and follow-up services;

(10) transportation; and

(11) homelessness prevention.

Subd. 5. **Supportive housing and transitional living programs.** Transitional living programs must help homeless youth and youth at risk of homelessness to find and maintain safe, dignified housing. The program may also provide rental assistance and related supportive services, or refer youth to other organizations or agencies that provide such services. Services provided may include, but are not limited to:

(1) educational assessment and referrals to educational programs;

(2) career planning, employment, work skill training, and independent living skills training;

(3) job placement;

(4) budgeting and money management;

(5) assistance in securing housing appropriate to needs and income;

(6) counseling regarding violence, prostitution, substance abuse, sexually transmitted diseases, and pregnancy;

(7) referral for medical services or chemical dependency treatment;

(8) parenting skills;

(9) self-sufficiency support services or life skill training;

(10) after-care and follow-up services; and

(11) homelessness prevention.

Sec. 24. **[259.86] POSTADOPTION SEARCH SERVICES.**

(a) The commissioner of human services shall develop a specialized curriculum to train department, county agency, and social service agency staff in performing and complying with the postadoption search services developed in the best practices guidelines reported to the legislature in 2006.

(b) All department and county social service agency staff providing postadoption search services, shall complete six hours of postadoption search services training as a specialized curriculum of the child welfare training.

(c) All private agency staff providing postadoption search services, shall complete at least six hours of postadoption search services training.

Sec. 25. Minnesota Statutes 2004, section 259.87, is amended to read:

259.87 RULES.

The commissioner of human services shall make rules as necessary to administer sections 259.79 ~~and~~, 259.83, and 259.86.

Sec. 26. Minnesota Statutes 2004, section 518.551, subdivision 7, is amended to read:

Subd. 7. **Fees ~~and cost recovery fees~~ for IV-D services.** (a) When a recipient of IV-D services is no longer receiving assistance under the state's title IV-A, IV-E foster care, medical assistance, or MinnesotaCare programs, the public authority responsible for child support enforcement must notify the recipient, within five working days of the notification of ineligibility, that IV-D services will be continued unless the public authority is notified to the contrary by the recipient. The notice must include the implications of continuing to receive IV-D services, including the available services and fees, cost recovery fees, and distribution policies relating to fees.

(b) An application fee of $25 shall be paid by the person who applies for child support and maintenance collection services, except persons who are receiving public assistance as defined in section 256.741 and~~, if enacted,~~ the diversionary work program under section 256J.95, persons who transfer from public assistance to nonpublic assistance

status, and minor parents and parents enrolled in a public secondary school, area learning center, or alternative learning program approved by the commissioner of education.

(c) In the case of an individual who has never received assistance under a state program funded under Title IV-A of the Social Security Act and for whom the public authority has collected at least $500 of support, the public authority must impose an annual federal collections fee of $25 for each case in which services are furnished. This fee must be retained by the public authority from support collected on behalf of the individual, but not from the first $500 collected.

(d) When the public authority provides full IV-D services to an obligee who has applied for those services, upon written notice to the obligee, the public authority must charge a cost recovery fee of one percent of the amount collected. This fee must be deducted from the amount of the child support and maintenance collected and not assigned under section 256.741 before disbursement to the obligee. This fee does not apply to an obligee who:

(1) is currently receiving assistance under the state's title IV-A, IV-E foster care, medical assistance, or MinnesotaCare programs; or

(2) has received assistance under the state's title IV-A or IV-E foster care programs, until the person has not received this assistance for 24 consecutive months.

~~(d)~~ (e) When the public authority provides full IV-D services to an obligor who has applied for such services, upon written notice to the obligor, the public authority must charge a cost recovery fee of one percent of the monthly court-ordered child support and maintenance obligation. The fee may be collected through income withholding, as well as by any other enforcement remedy available to the public authority responsible for child support enforcement.

~~(e)~~ (f) Fees assessed by state and federal tax agencies for collection of overdue support owed to or on behalf of a person not receiving public assistance must be imposed on the person for whom these services are provided. The public authority upon written notice to the obligee shall assess a fee of $25 to the person not receiving public assistance for each successful federal tax interception. The fee must be withheld prior to the release of the funds received from each interception and deposited in the general fund.

~~(f)~~ (g) Federal collections fees collected under paragraph (c) and cost recovery fees collected under paragraphs ~~(c) and~~ (d) and (e) shall be considered child support program income according to Code of Federal Regulations, title 45, section 304.50, and shall be deposited in the ~~cost recovery fee~~ special revenue fund account established under paragraph ~~(h)~~ (i). The commissioner of human services must elect to recover costs based on either actual or standardized costs.

~~(g)~~ (h) The limitations of this subdivision on the assessment of fees shall not apply to the extent inconsistent with the requirements of federal law for receiving funds for the programs under Title IV-A and Title IV-D of the Social Security Act, United States Code, title 42, sections 601 to 613 and United States Code, title 42, sections 651 to 662.

~~(h)~~ (i) The commissioner of human services is authorized to establish a special revenue fund account to receive ~~child support~~ the federal collections fees collected under paragraph (c) and cost recovery fees collected under paragraphs (d) and (e). A portion of the nonfederal share of these fees may be retained for expenditures necessary to administer the ~~fee~~ fees and must be transferred to the child support system special revenue account. The remaining nonfederal share of the federal collections fees and cost recovery ~~fee~~ fees must be retained by the commissioner and dedicated to the child support general fund county performance-based grant account authorized under sections 256.979 and 256.9791.

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

Sec. 27. Laws 2005, First Special Session chapter 4, article 7, section 59, is amended to read:

Sec. 59. **REPORT TO LEGISLATURE.**

The commissioner shall report to the legislature by December 15, 2006, on the redesign of case management services. In preparing the report, the commissioner shall consult with representatives for consumers, consumer advocates, counties, labor organizations representing county social service workers, and service providers. The report shall include draft legislation for case management changes that will:

(1) streamline administration;

(2) improve consumer access to case management services;

(3) address the use of a comprehensive universal assessment protocol for persons seeking community supports;

(4) establish case management performance measures;

(5) provide for consumer choice of the case management service vendor; and

(6) provide a method of payment for case management services that is cost-effective and best supports the draft legislation in clauses (1) to (5).

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

Sec. 28. **IMPACT ON REDUCED MEDICAID REIMBURSEMENTS.**

The commissioner of human services shall report to the chair of the house Health Policy and Finance Committee and the chairs of the senate Health and Family Security

Committee and Health and Human Services Budget Division by December 1, 2006, on the impact of reduced Medicaid reimbursements resulting from the federal Deficit Reduction Act of 2005. The report shall include options to restore lost revenues and ensure the continuation of targeted case management and other affected social services.

Sec. 29. **COMMISSIONER AUTHORITY TO PROVIDE GUIDANCE ON FEDERAL REGULATIONS.**

The commissioner shall provide guidance to counties as necessary to comply with Temporary Assistance to Needy Families regulations issued pursuant to Public Law 109-171.

Sec. 30. **PARENT FEE SCHEDULE.**

Notwithstanding Minnesota Rules, part 3400.0100, subpart 4, the parent fee schedule is as follows:

Income Range (as a percent of the federal poverty guidelines)	Co-payment (as a percentage of adjusted gross income)
0-74.99%	$0/month
75.00-99.99%	$5/month
100.00-104.99%	2.61%
105.00-109.99%	2.61%
110.00-114.99%	2.61%
115.00-119.99%	2.61%
120.00-124.99%	2.91%
125.00-129.99%	2.91%
130.00-134.99%	2.91%
135.00-139.99%	2.91%
140.00-144.99%	3.21%
145.00-149.99%	3.21%
150.00-154.99%	3.21%
155.00-159.99%	3.84%
160.00-164.99%	3.84%
165.00-169.99%	4.46%

170.00-174.99%	4.76%
175.00-179.99%	5.05%
180.00-184.99%	5.65%
185.00-189.99%	5.95%
190.00-194.99%	6.24%
195.00-199.99%	6.84%
200.00-204.99%	7.58%
205.00-209.99%	8.33%
210.00-214.99%	9.20%
215.00-219.99%	10.07%
220.00-224.99%	10.94%
225.00-229.99%	11.55%
230.00-234.99%	12.16%
235.00-239.99%	12.77%
240.00-244.99%	13.38%
245.00-249.99%	14.00%
250%	ineligible

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

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

Sec. 31. **REPEALER.**

Minnesota Statutes 2004, sections 256J.37, subdivision 3a; and 256J.626, subdivision 9, and Minnesota Statutes 2005 Supplement, sections 119B.13, subdivision 7; and 256J.626, subdivision 7, are repealed.

(b) Laws 2003, First Special Session chapter 14, article 9, section 36; is repealed.

ARTICLE 18

MENTAL HEALTH AND CHEMICAL HEALTH

Section 1. Minnesota Statutes 2004, section 245.465, is amended by adding a subdivision to read:

Subd. 3. **Responsibility not duplicated.** For individuals who have health care coverage, the county board is not responsible for providing mental health services which are covered by the entity that administers the health care coverage.

Sec. 2. **[245.4682] MENTAL HEALTH SERVICE DELIVERY AND FINANCE REFORM.**

Subdivision 1. **Policy.** The commissioner of human services shall undertake a series of reforms to improve the underlying structural, financing, and organizational problems in Minnesota's mental health system with the goal of improving the availability, quality, and accountability of mental health care within the state.

Subd. 2. **General provisions.** In the design and implementation of reforms to the mental health system, the commissioner shall:

(1) consult with consumers, families, counties, tribes, advocates, providers, and other stakeholders;

(2) bring to the legislature, and the State Mental Health Advisory Council by January 15, 2007, recommendations for legislation to update the role of counties and to clarify the case management roles and functions of health plans and counties;

(3) ensure continuity of care for persons affected by these reforms including:

(i) ensuring client choice of provider by requiring broad provider networks;

(ii) allowing clients options to maintain previously established therapeutic relationships; and

(iii) developing mechanisms to facilitate a smooth transition of service responsibilities;

(4) provide accountability for the efficient and effective use of public and private resources in achieving positive outcomes for consumers;

(5) ensure client access to applicable protections and appeals; and

(6) make budget transfers that do not increase the state and county costs to effectively implement improvements to the mental health system and efficiently allocate state funds. When making transfers necessary to implement movement of responsibility for clients and services between counties and health care programs, the commissioner, in consultation with counties, shall ensure that any transfer of state grants to health care programs, including the value of case management transfer grants under section 256B.0625, subdivision 20, does not exceed the value of the services being transferred for the latest 12-month period for which data is available. The commissioner may make quarterly adjustments based on the availability of additional data during the first four quarters after the transfers first occur.

Subd. 3. **Regional projects for coordination of care.** (a) Consistent with section 256B.69 and chapters 256D and 256L, the commissioner is authorized to solicit, approve, and implement regional projects to demonstrate the integration of physical and mental health services within prepaid health plans and their coordination with social services. The commissioner, in consultation with consumers, families, and their representatives, shall:

(1) determine criteria for approving the regional projects and use those criteria to solicit regional proposals for integrated service networks;

(2) require that each project be based on locally defined partnerships that include at least one health maintenance organization, community integrated service network, or accountable provider network authorized and operating under chapter 62D, 62N, or 62T, or county-based purchasing entity under section 256B.692 that is eligible to contract with the commissioner as a prepaid health plan, and the county or counties within the region;

(3) allow potential bidders at least 90 days to respond to the request for proposals;

(4) waive any administrative rule not consistent with the implementation of the regional projects; and

(5) begin implementation of the regional projects no earlier than January 1, 2008, with not more than 20 percent of the statewide population described in paragraph (b) included during calendar year 2008 and additional individuals included in subsequent years.

(b) Notwithstanding any statute or administrative rule to the contrary, the commissioner shall enroll all medical assistance eligible persons with serious and persistent mental illness or severe emotional disturbance in the prepaid plan of their choice within the project region unless:

(1) an individual has another basis for exclusion from the prepaid plan under section 256B.69, subdivision 4;

(2) an individual has a previously established therapeutic relationship with a provider who is not included in the available prepaid plans; or

(3) the service the individual wishes to use is not included in the available prepaid plans.

(c) If the person with serious and persistent mental illness or severe emotional disturbance declines to choose a plan, the commissioner may preferentially assign that person to the prepaid plan participating in the integrated service network. The commissioner shall implement the enrollment changes within a regional project on the timeline specified in that region's approved application.

(d) The commissioner, in consultation with consumers, families, and their representatives, shall refine the design of the regional service integration projects and

expand the number of regions engaged in the demonstration projects as additional qualified applicant partnerships present themselves.

(e) The commissioner shall apply for any federal waivers necessary to implement these changes.

Sec. 3. **[245.4835] COUNTY MAINTENANCE OF EFFORT.**

Subdivision 1. **Required expenditures.** Counties must maintain a level of expenditures for mental health services under sections 245.461 to 245.484 and 245.487 to 245.4887 so that each year's county expenditures are at least equal to that county's average expenditures for those services for calendar years 2004 and 2005. The commissioner will adjust each county's base level for minimum expenditures in each year by the amount of any increase or decrease in that county's state grants or other noncounty revenues for mental health services under sections 245.461 to 245.484 and 245.487 to 245.4887.

Subd. 2. **Failure to maintain expenditures.** If a county does not comply with subdivision 1, the commissioner shall require the county to develop a corrective action plan according to a format and timeline established by the commissioner. If the commissioner determines that a county has not developed an acceptable corrective action plan within the required timeline, or that the county is not in compliance with an approved corrective action plan, the protections provided to that county under section 245.485 do not apply.

Sec. 4. Minnesota Statutes 2005 Supplement, section 245.4874, is amended to read:

245.4874 DUTIES OF COUNTY BOARD.

Subdivision 1. **Duties of the county board.** (a) The county board must:

(1) develop a system of affordable and locally available children's mental health services according to sections 245.487 to 245.4887;

(2) establish a mechanism providing for interagency coordination as specified in section 245.4875, subdivision 6;

(3) consider the assessment of unmet needs in the county as reported by the local children's mental health advisory council under section 245.4875, subdivision 5, paragraph (b), clause (3). The county shall provide, upon request of the local children's mental health advisory council, readily available data to assist in the determination of unmet needs;

(4) assure that parents and providers in the county receive information about how to gain access to services provided according to sections 245.487 to 245.4887;

(5) coordinate the delivery of children's mental health services with services provided by social services, education, corrections, health, and vocational agencies to

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.

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

Subd. 2. **Responsibility not duplicated.** For individuals that have health care coverage, the county board is not responsible for providing mental health services which are covered by the entity which administers the health care coverage.

Sec. 5. **[245.4889] CHILDREN'S MENTAL HEALTH GRANTS.**

Subdivision 1. **Establishment and authority.** The commissioner is authorized to make grants from available appropriations to assist counties, Indian tribes, children's collaboratives under section 124D.23 or 245.493, or mental health service providers for providing services to children with emotional disturbances as defined in section 245.4871, subdivision 15, and their families; and to young adults meeting the criteria for transition services in section 245.4875, subdivision 8, and their families. Services must be designed to help each child to function and remain with the child's family in the community and delivered consistent with the child's treatment plan. Transition services to eligible young adults must be designed to foster independent living in the community.

Subd. 2. **Grant application and reporting requirements.** To apply for a grant an applicant organization shall submit an application and budget for the use of the money in the form specified by the commissioner. The commissioner shall make grants only to entities whose applications and budgets are approved by the commissioner. In awarding grants, the commissioner shall give priority to applications that indicate plans to collaborate in the development, funding, and delivery of services with other agencies in the local system of care. The commissioner shall specify requirements for reports, including quarterly fiscal reports, according to section 256.01, subdivision 2, paragraph (q). The commissioner shall require collection of data and periodic reports that the commissioner deems necessary to demonstrate the effectiveness of each service.

Sec. 6. Minnesota Statutes 2004, section 246.54, subdivision 1, is amended to read:

Subdivision 1. **County portion for cost of care.** Except for chemical dependency services provided under sections 254B.01 to 254B.09, the client's county shall pay to the state of Minnesota a portion of the cost of care provided in a regional treatment center or a state nursing facility to a client legally settled in that county. A county's payment shall be made from the county's own sources of revenue and payments shall be paid as follows: payments to the state from the county shall equal 20 percent of the cost of care, as determined by the commissioner, for each ~~day~~ of the first 60 days, or the portion thereof, that the client spends at a regional treatment center or a state nursing facility. After the first 60 days, the county share is 50 percent. This increase in the county share of payment shall not apply if the continued placement of the client in the regional treatment center, state nursing facility, or community behavioral health hospital is the result of one of the following:

(1) the individual has been admitted for assessment and treatment under a court order issued under the Rules of Civil Procedure, parts 20.01 and 20.02; or

(2) there has been medical certification by the head of the center, facility, or hospital that the client is in need of continued treatment at a hospital level of care.

If payments received by the state under sections 246.50 to 246.53 exceed 80 percent of the cost of care for the first 60 days or 50 percent of any additional days, the county shall be responsible for paying the state only the remaining amount. The county shall not be entitled to reimbursement from the client, the client's estate, or from the client's relatives, except as provided in section 246.53. ~~No such payments shall be made for any client who was last committed prior to July 1, 1947.~~

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

Sec. 7. Minnesota Statutes 2004, section 246.54, is amended by adding a subdivision to read:

Subd. 3. **Additional exception for community behavioral health hospitals.** Subdivision 1 does not apply to services provided at state-operated community behavioral health hospitals. For services at these facilities, a county's payment shall be made from the county's own sources of revenue and payments shall be paid as follows: payments to the state from the county shall equal 50 percent of the cost of care, as determined by the commissioner, for each day, or the portion thereof, that the client spends at the facility. After the first 60 days, the county share of payment shall not apply if the continued placement of the client in the community behavioral health hospital is the result of one of the following:

(1) the individual has been admitted for assessment and treatment under a court order issued under the Rules of Criminal Procedure, parts 20.01 and 20.02; or

(2) there has been medical certification by the head of the center, facility, or hospital that the client is in need of continued treatment at a hospital level of care.

If payments received by the state under sections 246.50 to 246.53 exceed 50 percent of the cost of care, the county shall be responsible for paying the state only the remaining amount. The county shall not be entitled to reimbursement from the client, the client's estate, or from the client's relatives, except as provided in section 246.53.

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

Sec. 8. **[254A.20] CHEMICAL USE ASSESSMENTS.**

Subdivision 1. **Persons arrested outside of home county.** When a chemical use assessment is required under Minnesota Rules, parts 9530.6600 to 9530.6655, for a person who is arrested and taken into custody by a peace officer outside of the person's county of residence, the assessment must be completed by the person's county of residence no later than three weeks after the assessment is initially requested. If the assessment is not performed within this time limit, the county where the person is to be sentenced shall perform the assessment. The county of financial responsibility must be determined under chapter 256G.

Subd. 2. **Probation officer as contact.** When a chemical use assessment is required under Minnesota Rules, parts 9530.6600 to 9530.6655, for a person who is on probation or under other correctional supervision, the assessor, either orally or in writing, shall contact the person's probation officer to verify or supplement the information provided by the person.

Subd. 3. **Financial conflicts of interest.** (a) Except as provided in paragraph (b), an assessor conducting a chemical use assessment under Minnesota Rules, parts 9530.6600 to 9530.6655, may not have any direct or shared financial interest or referral relationship resulting in shared financial gain with a treatment provider.

(b) A county may contract with an assessor having a conflict described in paragraph (a) if the county documents that:

(1) the assessor is employed by a culturally specific service provider or a service provider with a program designed to treat individuals of a specific age, sex, or sexual preference; or

(2) the county does not employ a sufficient number of qualified assessors and the only qualified assessors available in the county have a direct or shared financial interest or a referral relationship resulting in shared financial gain with a treatment provider.

An assessor under this paragraph may not place clients in treatment. The assessor shall gather required information and provide it to the county along with any required documentation. The county shall make all placement decisions for clients assessed by assessors under this paragraph.

EFFECTIVE DATE. This section is effective July 1, 2006, except for subdivision 3, which is effective July 1, 2008.

Sec. 9. **[254A.25] DUTIES OF COMMISSIONER RELATED TO CHEMICAL HEALTH.**

The commissioner shall:

(1) develop a directory that identifies key characteristics of each licensed chemical dependency treatment program; and

(2) post copies of state licensing reviews at an online location where they may be reviewed by agencies that make client placements.

Sec. 10. Minnesota Statutes 2004, section 256B.0625, subdivision 20, is amended to read:

Subd. 20. **Mental health case management.** (a) To the extent authorized by rule of the state agency, medical assistance covers case management services to persons with serious and persistent mental illness and children with severe emotional disturbance. Services provided under this section must meet the relevant standards in sections 245.461 to 245.4887, the Comprehensive Adult and Children's Mental Health Acts, Minnesota Rules, parts 9520.0900 to 9520.0926, and 9505.0322, excluding subpart 10.

(b) Entities meeting program standards set out in rules governing family community support services as defined in section 245.4871, subdivision 17, are eligible for medical assistance reimbursement for case management services for children with severe emotional disturbance when these services meet the program standards in Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

(c) Medical assistance and MinnesotaCare payment for mental health case management shall be made on a monthly basis. In order to receive payment for an eligible child, the provider must document at least a face-to-face contact with the child, the child's parents, or the child's legal representative. To receive payment for an eligible adult, the provider must document:

(1) at least a face-to-face contact with the adult or the adult's legal representative; or

(2) at least a telephone contact with the adult or the adult's legal representative and document a face-to-face contact with the adult or the adult's legal representative within the preceding two months.

(d) Payment for mental health case management provided by county or state staff shall be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph (b), with separate rates calculated for child welfare and mental health, and within mental health, separate rates for children and adults.

(e) Payment for mental health case management provided by Indian health services or by agencies operated by Indian tribes may be made according to this section or other relevant federally approved rate setting methodology.

(f) Payment for mental health case management provided by vendors who contract with a county or Indian tribe shall be based on a monthly rate negotiated by the host county or tribe. The negotiated rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the county or tribe may negotiate a team rate with a vendor who is a member of the team. The team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county or tribe, except to reimburse the county or tribe for advance funding provided by the county or tribe to the vendor.

(g) If the service is provided by a team which includes contracted vendors, tribal staff, and county or state staff, the costs for county or state staff participation in the team shall be included in the rate for county-provided services. In this case, the contracted vendor, the tribal agency, and the county may each receive separate payment for services provided by each entity in the same month. In order to prevent duplication of services, each entity must document, in the recipient's file, the need for team case management and a description of the roles of the team members.

~~(h) The commissioner shall calculate the nonfederal share of actual medical assistance and general assistance medical care payments for each county, based on the higher of calendar year 1995 or 1996, by service date, project that amount forward to 1999, and transfer one-half of the result from medical assistance and general assistance medical care to each county's mental health grants under section 256E.12 for calendar year 1999. The annualized minimum amount added to each county's mental health grant shall be $3,000 per year for children and $5,000 per year for adults. The commissioner may reduce the statewide growth factor in order to fund these minimums. The annualized total amount transferred shall become part of the base for future mental health grants for each county.~~

~~(i) Any net increase in revenue to the county or tribe as a result of the change in this section must be used to provide expanded mental health services as defined in sections 245.461 to 245.4887, the Comprehensive Adult and Children's Mental Health Acts, excluding inpatient and residential treatment. For adults, increased revenue may also be used for services and consumer supports which are part of adult mental health projects approved under Laws 1997, chapter 203, article 7, section 25. For children, increased revenue may also be used for respite care and nonresidential individualized rehabilitation services as defined in section 245.492, subdivisions 17 and 23. "Increased revenue" has the meaning given in Minnesota Rules, part 9520.0903, subpart 3.~~

~~(j)~~ (h) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for mental health case management shall be provided by the recipient's county of responsibility, as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds used to match other federal funds. If the service is provided by a tribal agency, the nonfederal share, if any, shall be provided by the recipient's tribe. When this service is paid by the state without a federal share through fee-for-service, 50 percent of the cost shall be provided by the recipient's county of responsibility.

(i) Notwithstanding Minnesota Rules to the contrary, prepaid medical assistance, general assistance medical care, and MinnesotaCare include mental health case management. When the service is provided through prepaid capitation, the nonfederal share is paid by the state and there is no county share.

~~(k)~~ (j) The commissioner may suspend, reduce, or terminate the reimbursement to a provider that does not meet the reporting or other requirements of this section. The county of responsibility, as defined in sections 256G.01 to 256G.12, or, if applicable, the tribal agency, is responsible for any federal disallowances. The county or tribe may share this responsibility with its contracted vendors.

~~(l)~~ (k) The commissioner shall set aside a portion of the federal funds earned for county expenditures under this section to repay the special revenue maximization account under section 256.01, subdivision 2, clause (15). The repayment is limited to:

(1) the costs of developing and implementing this section; and

(2) programming the information systems.

~~(m)~~ (l) Payments to counties and tribal agencies for case management expenditures under this section shall only be made from federal earnings from services provided under this section. When this service is paid by the state without a federal share through fee-for-service, 50 percent of the cost shall be provided by the state. Payments to county-contracted vendors shall include ~~both~~ the federal earnings, the state share, and the county share.

~~(n) Notwithstanding section 256B.041, county payments for the cost of mental health case management services provided by county or state staff shall not be made to the commissioner of finance. For the purposes of mental health case management services provided by county or state staff under this section, the centralized disbursement of payments to counties under section 256B.041 consists only of federal earnings from services provided under this section.~~

~~(o)~~ (m) Case management services under this subdivision do not include therapy, treatment, legal, or outreach services.

~~(p)~~ (n) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital, and the recipient's institutional care is paid by medical assistance, payment for case management services under this subdivision is limited to the last 180 days of the recipient's residency in that facility and may not exceed more than six months in a calendar year.

~~(q)~~ (o) Payment for case management services under this subdivision shall not duplicate payments made under other program authorities for the same purpose.

~~(r) By July 1, 2000, the commissioner shall evaluate the effectiveness of the changes required by this section, including changes in number of persons receiving mental health case management, changes in hours of service per person, and changes in caseload size.~~

~~(s) For each calendar year beginning with the calendar year 2001, the annualized amount of state funds for each county determined under paragraph (h) shall be adjusted by the county's percentage change in the average number of clients per month who received case management under this section during the fiscal year that ended six months prior to the calendar year in question, in comparison to the prior fiscal year.~~

~~(t) For counties receiving the minimum allocation of $3,000 or $5,000 described in paragraph (h), the adjustment in paragraph (s) shall be determined so that the county receives the higher of the following amounts:~~

~~(1) a continuation of the minimum allocation in paragraph (h); or~~

~~(2) an amount based on that county's average number of clients per month who received case management under this section during the fiscal year that ended six months prior to the calendar year in question, times the average statewide grant per person per month for counties not receiving the minimum allocation.~~

~~(u) The adjustments in paragraphs (s) and (t) shall be calculated separately for children and adults.~~

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

Sec. 11. Minnesota Statutes 2004, section 256B.0625, subdivision 28, is amended to read:

Subd. 28. **Certified nurse practitioner services.** Medical assistance covers services performed by a certified pediatric nurse practitioner, a certified family nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological nurse practitioner, a certified neonatal nurse practitioner, ~~or~~ a certified geriatric nurse practitioner, a clinical nurse specialist in mental health, or a certified psychiatric nurse practitioner in independent practice, if:

(1) the service provided on an inpatient basis is not included as part of the cost for inpatient services included in the operating payment rate;

(2) the service is otherwise covered under this chapter as a physician service; and

(3) the service is within the scope of practice of the nurse practitioner's license as a registered nurse, as defined in section 148.171.

Sec. 12. Minnesota Statutes 2004, section 256B.0945, subdivision 1, is amended to read:

Subdivision 1. **Provider qualifications.** Counties must arrange to provide residential services for children with severe emotional disturbance according to sections 245.4882, 245.4885, and this section. Services must be provided by a facility that is licensed according to section 245.4882 and administrative rules promulgated thereunder, and under contract with the county. ~~Facilities providing services under subdivision 2, paragraph (a), must be accredited as a psychiatric facility by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of~~

~~Rehabilitation Facilities, or the Council on Accreditation. Accreditation is not required for facilities providing services under subdivision 2, paragraph (b).~~

Sec. 13. Minnesota Statutes 2004, section 256B.0945, subdivision 4, is amended to read:

Subd. 4. **Payment rates.** (a) Notwithstanding sections 256B.19 and 256B.041, payments to counties for residential services provided by a residential facility shall only be made of federal earnings for services provided under this section, and the nonfederal share of costs for services provided under this section shall be paid by the county from sources other than federal funds or funds used to match other federal funds. Payment to counties for services provided according to this section shall be a proportion of the per day contract rate that relates to rehabilitative mental health services and shall not include payment for costs or services that are billed to the IV-E program as room and board.

(b) Per diem rates paid to providers under this section by prepaid plans shall be the proportion of the per day contract rate that relates to rehabilitative mental health services and shall not include payment for costs or services that are billed to the IV-E program as room and board.

(c) The commissioner shall set aside a portion not to exceed five percent of the federal funds earned for county expenditures under this section to cover the state costs of administering this section. Any unexpended funds from the set-aside shall be distributed to the counties in proportion to their earnings under this section.

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

Sec. 14. Minnesota Statutes 2005 Supplement, section 256B.0946, subdivision 1, is amended to read:

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

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

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

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

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

Sec. 15. Minnesota Statutes 2004, section 256B.69, subdivision 5g, is amended to read:

Subd. 5g. **Payment for covered services.** For services rendered on or after January 1, 2003, the total payment made to managed care plans for providing covered services under the medical assistance and general assistance medical care programs is reduced by .5 percent from their current statutory rates. This provision excludes payments for nursing home services, home and community-based waivers, ~~and~~ payments to demonstration projects for persons with disabilities, and mental health services added as covered benefits after December 31, 2006.

Sec. 16. Minnesota Statutes 2004, section 256B.69, subdivision 5h, is amended to read:

Subd. 5h. **Payment reduction.** In addition to the reduction in subdivision 5g, the total payment made to managed care plans under the medical assistance program is reduced 1.0 percent for services provided on or after October 1, 2003, and an additional 1.0 percent for services provided on or after January 1, 2004. This provision excludes payments for nursing home services, home and community-based waivers, ~~and~~ payments to demonstration projects for persons with disabilities, and mental health services added as covered benefits after December 31, 2006.

Sec. 17. **[256B.763] CRITICAL ACCESS MENTAL HEALTH RATE INCREASE.**

(a) For services defined in paragraph (b) and rendered on or after July 1, 2007, payment rates shall be increased by 23.7 percent over the rates in effect on January 1, 2006, for:

(1) psychiatrists and advanced practice registered nurses with a psychiatric specialty;

(2) community mental health centers under section 256B.0625, subdivision 5; and

(3) mental health clinics and centers certified under Minnesota Rules, parts 9520.0750 to 9520.0870, or hospital outpatient psychiatric departments that are designated as essential community providers under section 62Q.19.

(b) This increase applies to group skills training when provided as a component of children's therapeutic services and support, psychotherapy, medication management, evaluation and management, diagnostic assessment, explanation of findings, psychological

testing, neuropsychological services, direction of behavioral aides, and inpatient consultation.

(c) This increase does not apply to rates that are governed by section 256B.0625, subdivision 30, or 256B.761, paragraph (b), other cost-based rates, rates that are negotiated with the county, rates that are established by the federal government, or rates that increased between January 1, 2004, and January 1, 2005.

(d) The commissioner shall adjust rates paid to prepaid health plans under contract with the commissioner to reflect the rate increases provided in paragraph (a). The prepaid health plan must pass this rate increase to the providers identified in paragraph (a).

Sec. 18. Minnesota Statutes 2005 Supplement, section 256D.03, subdivision 4, is amended to read:

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

(1) inpatient hospital services;

(2) outpatient hospital services;

(3) services provided by Medicare certified rehabilitation agencies;

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

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

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

(7) hearing aids;

(8) prosthetic devices;

(9) laboratory and X-ray services;

(10) physician's services;

(11) medical transportation except special transportation;

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

(13) podiatric services;

(14) dental services as covered under the medical assistance program;

(15) ~~outpatient services provided by a mental health center or clinic that is under contract with the county board and is established under section 245.62~~ mental health services covered under chapter 256B;

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

~~(17)~~ (16) prescribed medications for persons who have been diagnosed as mentally ill as necessary to prevent more restrictive institutionalization;

~~(18) psychological services;~~ (17) medical supplies and equipment, and Medicare premiums, coinsurance and deductible payments;

~~(19)~~ (18) medical equipment not specifically listed in this paragraph when the use of the equipment will prevent the need for costlier services that are reimbursable under this subdivision;

~~(20)~~ (19) services performed by a certified pediatric nurse practitioner, a certified family nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological nurse practitioner, a certified neonatal nurse practitioner, or a certified geriatric nurse practitioner in independent practice, if (1) the service is otherwise covered under this chapter as a physician service, (2) the service provided on an inpatient basis is not included as part of the cost for inpatient services included in the operating payment rate, and (3) the service is within the scope of practice of the nurse practitioner's license as a registered nurse, as defined in section 148.171;

~~(21)~~ (20) services of a certified public health nurse or a registered nurse practicing in a public health nursing clinic that is a department of, or that operates under the direct authority of, a unit of government, if the service is within the scope of practice of the public health nurse's license as a registered nurse, as defined in section 148.171; and

~~(22)~~ (21) telemedicine consultations, to the extent they are covered under section 256B.0625, subdivision 3b~~; and~~.

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

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

(b) Effective August 1, 2005, sex reassignment surgery is not covered under this subdivision.

(c) In order to contain costs, the commissioner of human services shall select vendors of medical care who can provide the most economical care consistent with high medical standards and shall where possible contract with organizations on a prepaid capitation basis to provide these services. The commissioner shall consider proposals by counties and vendors for prepaid health plans, competitive bidding programs, block grants, or other vendor payment mechanisms designed to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are

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

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

(1) $25 for eyeglasses;

(2) $25 for nonemergency visits to a hospital-based emergency room;

(3) $3 per brand-name drug prescription and $1 per generic drug prescription, subject to a $12 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness; and

(4) 50 percent coinsurance on restorative dental services.

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

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

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

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

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

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

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

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

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

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

(o) Fee-for-service payments for nonpreventive visits shall be reduced by $3 for services provided on or after January 1, 2006. For purposes of this subdivision, a visit means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, advance practice nurse, audiologist, optician, or optometrist.

(p) Payments to managed care plans shall not be increased as a result of the removal of the $3 nonpreventive visit co-payment effective January 1, 2006.

(q) Payments for mental health services added as covered benefits after December 31, 2006, are not subject to the reductions in paragraphs (i), (k), (l), and (m).

EFFECTIVE DATE. This section is effective January 1, 2007, except mental health case management under paragraph (a)(i)(15) is effective January 1, 2008.

Sec. 19. Minnesota Statutes 2005 Supplement, section 256L.03, subdivision 1, is amended to read:

Subdivision 1. **Covered health services.** For individuals under section 256L.04, subdivision 7, with income no greater than 75 percent of the federal poverty guidelines or for families with children under section 256L.04, subdivision 1, all subdivisions of this section apply. "Covered health services" means the health services reimbursed

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

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

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

EFFECTIVE DATE. This section is effective January 1, 2007, except mental health case management under subdivision 1 is effective January 1, 2008.

Sec. 20. Minnesota Statutes 2005 Supplement, section 256L.035, is amended to read:

256L.035 LIMITED BENEFITS COVERAGE FOR CERTAIN SINGLE ADULTS AND HOUSEHOLDS WITHOUT CHILDREN.

(a) "Covered health services" for individuals under section 256L.04, subdivision 7, with income above 75 percent, but not exceeding 175 percent, of the federal poverty guideline means:

(1) inpatient hospitalization benefits with a ten percent co-payment up to $1,000 and subject to an annual limitation of $10,000;

(2) physician services provided during an inpatient stay; and

(3) physician services not provided during an inpatient stay; outpatient hospital services; freestanding ambulatory surgical center services; chiropractic services; lab and diagnostic services; diabetic supplies and equipment; mental health services as covered under chapter 256B; and prescription drugs; subject to the following co-payments:

(i) $50 co-pay per emergency room visit;

(ii) $3 co-pay per prescription drug; and

(iii) $5 co-pay per nonpreventive visit.

The services covered under this section may be provided by a physician, physician ancillary, chiropractor, psychologist, ~~or~~ licensed independent clinical social worker, or other mental health providers covered under chapter 256B if the services are within the scope of practice of that health care professional.

For purposes of this section, "a visit" means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by any health care provider identified in this paragraph.

Enrollees are responsible for all co-payments in this section.

(b) Reimbursement to the providers shall be reduced by the amount of the co-payment, except that reimbursement for prescription drugs shall not be reduced once a recipient has reached the $20 per month maximum for prescription drug co-payments. The provider collects the co-payment from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment, except as provided in paragraph (c).

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

EFFECTIVE DATE. This section is effective January 1, 2007, except mental health case management under paragraph (a), clause (3), is effective January 1, 2008.

Sec. 21. Minnesota Statutes 2004, section 256L.12, subdivision 9a, is amended to read:

Subd. 9a. **Rate setting; ratable reduction.** For services rendered on or after October 1, 2003, the total payment made to managed care plans under the MinnesotaCare program is reduced 1.0 percent. This provision excludes payments for mental health services added as covered benefits after December 31, 2006.

Sec. 22. **MENTAL HEALTH PILOT PROGRAM FOR UNSHELTERED INDIVIDUALS.**

Subdivision 1. **Pilot project program components.** The commissioner of human services shall establish two pilot projects, one in Ramsey County and one in Hennepin County, which shall:

(1) operate two ten-bed facilities in separate locations;

(2) provide community support to individuals who have been living homeless for at least one year;

(3) provide 24-hour supervision; and

(4) provide on-site mental health services which focus on the mental health needs of individuals who have lived unsheltered.

Subd. 2. **Group residential housing.** Notwithstanding Minnesota Statutes, section 256I.05, subdivisions 1a and 1c, a county agency shall negotiate a supplementary rate in addition to the rate specified in Minnesota Statutes, section 256I.05, subdivision 1, not to exceed $700 per month, including any legislatively authorized inflationary adjustments for a group residential program that meets the components under subdivision 1, and for the independent living component of the program under subdivision 3.

Subd. 3. **Independent living.** An individual who has lived in one of the facilities under subdivision 1, and who is being transitioned to independent living as part of the program plan, continues to be eligible for group residential housing and the supplementary service rate negotiated with the county under subdivision 2.

Subd. 4. **Effective date.** This section is effective July 1, 2006, through June 30, 2008.

Sec. 23. **RECOMMENDATIONS ON CHANGING THE CONSOLIDATED CHEMICAL DEPENDENCY TREATMENT FUND.**

The commissioner shall report to the legislature by January 15, 2007, on recommendations which analyze the merits of changing the statutory maintenance of effort provisions in the chemical dependency treatment fund.

Sec. 24. **PLAN FOR IMPROVING COMMUNITY-BASED SUBSTANCE ABUSE TREATMENT AND OTHER ISSUES RELATED TO IMPROVING CHEMICAL HEALTH.**

(a) The commissioner of human services shall present a plan to the legislature by January 15, 2007, for improving the availability of community-based substance abuse treatment.

(b) The commissioner of human services shall also report back on the merits, feasibility, and cost of:

(1) posting treatment program peer reviews at an online location where they can be viewed by agencies that make client placements;

(2) annually distributing information to chemical health assessors on best practices in assessments, including model instruments for adults and adolescents;

(3) monitoring the compliance of local agencies with assessment and referral rules;

(4) working with the commissioner of health to develop guidelines and training materials for health care organizations on the use of brief interventions for alcohol abuse;

(5) providing local agencies with examples of best practices for addressing needs of persons being considered for repeat placements into publicly funded treatment;

(6) identifying best practices to help local agencies monitor the progress of clients placed in treatment; and

(7) periodically providing local agencies with statewide information on treatment outcomes.

Sec. 25. **REVISOR'S INSTRUCTION.**

In the next edition of Minnesota Statutes, the revisor of statutes shall change the reference to sections 245.487 to 245.4887, the Children's Mental Health Act, wherever it appears in statutes or rules to sections 245.487 to 245.4889.

Sec. 26. **REPEALER.**

Minnesota Statutes 2004, sections 245.465, subdivision 2; 256B.0945, subdivisions 5, 6, 7, 8, and 9; and 256B.83, are repealed.

ATTACHMENT "A"

Senator ..... moves to amend S.F. No. ..... as follows:

Page ..., after line ..., insert:

"Sec. .... Minnesota Statutes 2004, section 253B.02, subdivision 2, is amended to read:

Subd. 2. **Chemically dependent person.** "Chemically dependent person" means any person (a) determined as being incapable of self-management or management of personal affairs by reason of the habitual and excessive use of alcohol, drugs, or other mind-altering substances; and (b) whose recent conduct as a result of habitual and excessive use of alcohol, drugs, or other mind-altering substances poses a substantial likelihood of physical harm to self or others as demonstrated by (i) a recent attempt or threat to physically harm self or others, (ii) evidence of recent serious physical problems, or (iii) a failure to obtain necessary food, clothing, shelter, or medical care. "Chemically dependent person" also means a pregnant woman who has engaged during the pregnancy in habitual or excessive use, for a nonmedical purpose, of any of the following controlled substances or their derivatives: opium, cocaine, heroin, phencyclidine, methamphetamine, or amphetamine."

ATTACHMENT "B"

Senator ..... moves to amend S.F. No. ..... as follows:

Page .., after line .., insert:

"Sec. ... Minnesota Statutes 2005 Supplement, section 144.551, subdivision 1, is amended to read:

Subdivision 1. **Restricted construction or modification.** (a) The following construction or modification may not be commenced:

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

(2) the establishment of a new hospital.

(b) This section does not apply to:

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

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

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

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

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

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

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

from one physical site or complex to another; or (iii) redistribution of hospital beds within the state or a region of the state;

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

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

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

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

(12) the construction or relocation of hospital beds operated by a hospital having a statutory obligation to provide hospital and medical services for the indigent that does not result in a net increase in the number of hospital beds, notwithstanding section 144.552, 27 beds, of which 12 serve mental health needs, may be transferred from Hennepin County Medical Center to Regions Hospital under this clause;

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

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

(15) a construction project involving the addition of 20 new hospital beds used for rehabilitation services in an existing hospital in Carver County serving the southwest suburban metropolitan area. Beds constructed under this clause shall not be

eligible for reimbursement under medical assistance, general assistance medical care, or MinnesotaCare;

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

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

(18) a project to add 20 licensed beds in existing space at a hospital in Hennepin County that closed 20 rehabilitation beds in 2002, provided that the beds are used only for rehabilitation in the hospital's current rehabilitation building. If the beds are used for another purpose or moved to another location, the hospital's licensed capacity is reduced by 20 beds; ~~or~~

(19) a critical access hospital established under section 144.1483, clause (9), and section 1820 of the federal Social Security Act, United States Code, title 42, section 1395i-4, that delicensed beds since enactment of the Balanced Budget Act of 1997, Public Law 105-33, to the extent that the critical access hospital does not seek to exceed the maximum number of beds permitted such hospital under federal law; or

(20) a project approved under section 144.553.

Sec. ... Minnesota Statutes 2004, section 144.552, is amended to read:

144.552 PUBLIC INTEREST REVIEW.

(a) The following entities must submit a plan to the commissioner:

(1) a hospital seeking to increase its number of licensed beds; or

(2) an organization seeking to obtain a hospital license ~~must submit a plan to the commissioner of health~~ and notified by the commissioner under section 144.553, subdivision 1, paragraph (c), that it is subject to this section.

The plan must include information that includes an explanation of how the expansion will meet the public's interest. When submitting a plan to the commissioner, an applicant shall pay the commissioner for the commissioner's cost of reviewing the plan, as determined by the commissioner and notwithstanding section 16A.1283. Money received by the commissioner under this section is appropriated to the commissioner for the purpose of administering this section.

(b) Plans submitted under this section shall include detailed information necessary for the commissioner to review the plan and reach a finding. The commissioner may request additional information from the hospital submitting a plan under this section and from others affected by the plan that the commissioner deems necessary to review the plan and make a finding.

(c) The commissioner shall review the plan and, within 90 days, but no more than six months if extenuating circumstances apply, issue a finding on whether the plan is in the public interest. In making the recommendation, the commissioner shall consider issues including but not limited to:

(1) whether the new hospital or hospital beds are needed to provide timely access to care or access to new or improved services;

(2) the financial impact of the new hospital or hospital beds on existing acute-care hospitals that have emergency departments in the region;

(3) how the new hospital or hospital beds will affect the ability of existing hospitals in the region to maintain existing staff;

(4) the extent to which the new hospital or hospital beds will provide services to nonpaying or low-income patients relative to the level of services provided to these groups by existing hospitals in the region; and

(5) the views of affected parties.

Prior to making a recommendation, the commissioner shall conduct a public hearing in the affected hospital service area to take testimony from interested persons.

(d) Upon making a recommendation under paragraph (c), the commissioner shall provide a copy of the recommendation to the chairs of the house and senate committees having jurisdiction over health and human services policy and finance.

Sec. ... **[144.553] ALTERNATIVE APPROVAL PROCESS FOR NEW HOSPITAL CONSTRUCTION.**

Subdivision 1. **Letter of intent; publication; acceptance of additional proposals.** (a) An organization seeking to obtain a hospital license must submit a letter of intent to the commissioner, specifying the community in which the proposed hospital would be located and the number of beds proposed for the new hospital. When multiple letters of intent are received, the commissioner shall determine whether they constitute requests for separate projects or are competing proposals to serve the same or a similar service area.

(b) Upon receipt of a letter under paragraph (a), the commissioner shall publish a notice in the State Register that includes the information received from the organization under paragraph (a). The notice must state that another organization interested in seeking a hospital license to serve the same or a similar service area must notify the commissioner within 30 days.

(c) If no responses are received from additional organizations under paragraph (b), the commissioner shall notify the entity seeking a license that it is required to submit a plan under section 144.552 and shall notify the chairs of the house of representatives and

senate committees having jurisdiction over health and human services policy and finance that the project is subject to sections 144.551 and 144.552.

Subd. 2. **Needs assessment.** (a) If one or more responses are received by the commissioner under subdivision 1, paragraph (b), the commissioner shall complete within 90 days a needs assessment to determine if a new hospital is needed in the proposed service area.

(b) The organizations that have filed or responded to a letter of intent under subdivision 1 shall provide to the commissioner within 30 days of a request from the commissioner a statement justifying the need for a new hospital in the service area and sufficient information, as determined by the commissioner, to allow the commissioner to determine the need for a new hospital. The information may include, but is not limited to, a demographic analysis of the proposed service area, the number of proposed beds, the types of hospital services to be provided, and distances and travel times to existing hospitals currently providing services in the service area.

(c) The commissioner shall make a determination of need for the new hospital. If the commissioner determines that a new hospital in the service area is not justified, the commissioner shall notify the applicants in writing, stating the reasons for the decision.

Subd. 3. **Process when hospital need is determined.** (a) If the commissioner determines that a new hospital is needed in the proposed service area, the commissioner shall notify the applicants of that finding and shall select the applicant determined under the process established in this subdivision to be best able to provide services consistent with the review criteria established in this subdivision.

(b) The commissioner shall:

(1) determine market-specific criteria that shall be used to evaluate all proposals. The criteria must include standards regarding:

(i) access to care;

(ii) quality of care;

(iii) cost of care; and

(iv) overall project feasibility;

(2) establish additional criteria at the commissioner's discretion. In establishing the criteria, the commissioner shall consider the need for:

(i) mental health services in the service area, including both inpatient and outpatient services for adults, adolescents, and children;

(ii) a significant commitment to providing uncompensated care, including discounts for uninsured patients and coordination with other providers of care to low-income uninsured persons; and

(iii) coordination with other hospitals so that specialized services are not unnecessarily duplicated and are provided in sufficient volume to ensure the maintenance of high-quality care. The criteria determined under this paragraph shall constitute the sole criteria under which the competing proposals shall be evaluated; and

(3) define a service area for the proposed hospital. The service area shall consist of:

(i) in the 11-county metropolitan area, in St. Cloud, and in Duluth, the zip codes located within a 20-mile radius of the proposed new hospital location; and

(ii) in the remainder of the state, the zip codes within a 30-mile radius of the proposed new hospital location.

(c) The commissioner shall publish the criteria determined under paragraph (b) in the State Register within 60 days of the determination under subdivision 2. Once published, the criteria shall not be modified with respect to the particular project and applicants to which they apply. The commissioner shall publish with the criteria guidelines for a proposal and submission review process.

(d) For 60 days after the publication under paragraph (c), the commissioner shall accept proposals to construct a hospital from organizations that have submitted a letter of intent under subdivision 1, paragraph (a), or have notified the commissioner under subdivision 1, paragraph (b). The proposal must include a plan for the new hospital and evidence of compliance with the criteria specified under paragraph (b). Once submitted, the proposal may not be revised except:

(1) to submit corrections of material facts; or

(2) in response to a request from the commissioner to provide clarification or further information.

(e) The commissioner shall determine within 90 days of the deadline for applications under paragraph (d), which applicant has demonstrated that it is best able to provide services consistent with the published criteria. The commissioner shall make this determination by order following a hearing according to this paragraph. The hearing shall not constitute or be considered to be a contested case hearing under chapter 14 and shall be conducted solely under the procedures specified in this paragraph. The hearing shall commence upon at least 30 days' notice to the applicants by the commissioner. The hearing may be conducted by the commissioner or by a person designated by the commissioner. The designee may be an administrative law judge. The purpose of the hearing shall be to receive evidence to assist the commissioner in determining which applicant has demonstrated that it best meets the published criteria.

The parties to the hearing shall consist only of those applicants who have submitted a completed application. Each applicant shall have the right to be represented by

counsel, to present evidence deemed relevant by the commissioner, and to examine and cross-examine witnesses. Persons who are not parties to the proceeding but who wish to present comments or submit information may do so in the manner determined by the commissioner or the commissioner's designee. Any person who is not a party shall have no right to examine or cross-examine witnesses. The commissioner may participate as an active finder of fact in the hearing and may ask questions to elicit information or clarify answers or responses.

(f) Prior to making a determination selecting an application, the commissioner shall hold a public hearing in the proposed hospital service area to accept comments from members of the public. The commissioner shall take this information into consideration in making the determination. The commissioner must also consider the input and preferences of legislators and local elected officials who represent the service area regarding the selection of the hospital provider. The commissioner shall issue an order selecting an application following the closing of the record of the hearing as determined by the hearing officer. The commissioner's order shall include a statement of the reasons the selected application best meets the published criteria.

(g) Following the determination under paragraph (e), the commissioner shall recommend the selected proposal to the legislature on or before March 1 in an odd-numbered year and within 15 days of the first day of the regular session in an even-numbered year to be accepted or rejected. Legislative acceptance of the commissioner's recommendation constitutes approval of the proposal under section 144.551. Legislative rejection of the recommendation concludes the process but does not prohibit a new application under this section and section 144.552.

(h) In the event of legislative failure to act on the recommendation made under this subdivision, upon the conclusion of the legislative session the commissioner shall make the commissioner's recommendation the final approval of the project. The commissioner's decision to grant final approval to the commissioner's recommendation constitutes approval of the proposal under section 144.551.

(i) For purposes of this subdivision, "legislative acceptance" means the recommended project is approved by law; "legislative rejection" means the recommended project is rejected by law; and "legislative failure to act" means any other action or lack of action taken by the legislature.

Subd. 4. **Payment of commissioner's expenses.** Notwithstanding section 16A.1283, applicants who are a party at any stage of the administrative process established in this section shall pay the cost of that stage of the process, as determined by the commissioner. The cost of the needs assessment, criteria development, and hearing shall

be divided equally among the applicants. Money received by the commissioner under this subdivision is appropriated to the commissioner for the purpose of administering this section."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

ATTACHMENT "C"

Senator ..... moves to amend S.F. No. ..... as follows:

Page .., after line .., insert:

"Sec. .... **REPAYMENT DELAY.**

A county that overspent its allowed amounts in calendar year 2004 or 2005 under the waivered services program for persons with developmental disabilities shall not be required to pay back the amount of overspending until June 30, 2007."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

ATTACHMENT "D"

Senator ..... moves to amend SC4643ART12-17 as follows:

Page ..., after line ..., insert:

"Sec. .... Minnesota Statutes 2004, section 245.50, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Bordering state" means Iowa, North Dakota, South Dakota, or Wisconsin.

(b) "Receiving agency" means a public or private hospital, mental health center, chemical health treatment facility, or other person or organization which provides mental health or chemical health services under this section to individuals from a state other than the state in which the agency is located.

(c) "Receiving state" means the state in which a receiving agency is located.

(d) "Sending agency" means a state or county agency which sends an individual to a bordering state for treatment under this section.

(e) "Sending state" means the state in which the sending agency is located.

Sec. .... Minnesota Statutes 2004, section 245.50, subdivision 2, is amended to read:

Subd. 2. **Purpose and authority.** (a) The purpose of this section is to enable appropriate treatment to be provided to individuals, across state lines from the individual's state of residence, in qualified facilities that are closer to the homes of individuals than are facilities available in the individual's home state.

(b) Unless prohibited by another law and subject to the exceptions listed in subdivision 3, a county board or the commissioner of human services may contract with an agency or facility in a bordering state for mental health or chemical health services for residents of Minnesota, and a Minnesota mental health or chemical health agency or facility may contract to provide services to residents of bordering states. Except as provided in subdivision 5, a person who receives services in another state under this section is subject to the laws of the state in which services are provided. A person who will receive services in another state under this section must be informed of the consequences of receiving services in another state, including the implications of the differences in state laws, to the extent the individual will be subject to the laws of the receiving state.

Sec. .... Minnesota Statutes 2004, section 245.50, subdivision 5, is amended to read:

Subd. 5. **Special contracts; bordering states.** (a) An individual who is detained, committed, or placed on an involuntary basis under chapter 253B may be confined or treated in a bordering state pursuant to a contract under this section. An individual who is detained, committed, or placed on an involuntary basis under the civil law of a bordering state may be confined or treated in Minnesota pursuant to a contract under this section. A

peace or health officer who is acting under the authority of the sending state may transport an individual to a receiving agency that provides services pursuant to a contract under this section and may transport the individual back to the sending state under the laws of the sending state. Court orders valid under the law of the sending state are granted recognition and reciprocity in the receiving state for individuals covered by a contract under this section to the extent that the court orders relate to confinement for treatment or care of mental illness or chemical dependency. Such treatment or care may address other conditions that may be co-occurring with the mental illness or chemical dependency. These court orders are not subject to legal challenge in the courts of the receiving state. Individuals who are detained, committed, or placed under the law of a sending state and who are transferred to a receiving state under this section continue to be in the legal custody of the authority responsible for them under the law of the sending state. Except in emergencies, those individuals may not be transferred, removed, or furloughed from a receiving agency without the specific approval of the authority responsible for them under the law of the sending state.

(b) While in the receiving state pursuant to a contract under this section, an individual shall be subject to the sending state's laws and rules relating to length of confinement, reexaminations, and extensions of confinement. No individual may be sent to another state pursuant to a contract under this section until the receiving state has enacted a law recognizing the validity and applicability of this section.

(c) If an individual receiving services pursuant to a contract under this section leaves the receiving agency without permission and the individual is subject to involuntary confinement under the law of the sending state, the receiving agency shall use all reasonable means to return the individual to the receiving agency. The receiving agency shall immediately report the absence to the sending agency. The receiving state has the primary responsibility for, and the authority to direct, the return of these individuals within its borders and is liable for the cost of the action to the extent that it would be liable for costs of its own resident.

(d) Responsibility for payment for the cost of care remains with the sending agency.

(e) This subdivision also applies to county contracts under subdivision 2 which include emergency care and treatment provided to a county resident in a bordering state."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

State of Minnesota
Office of the Ombudsman for Mental Health and Developmental Disabilities
121 7th Place E. Suite 420 Metro Square Building, St. Paul, Minnesota 55101-2117
Voice: 651-296-3848 or Toll Free: 1-800-657-3506 TTY/Voice – Minnesota Relay Service 711

The Ombudsman is proposing the following technical changes to their operating statute under Minn. Stat. § 245.91-.97

- In 245.94 under powers in paren (c) add the following sentence...*The ombudsman office is a health oversight agency as defined in section 164.605 of part 45 of the Code of Federal Regulations.* Since the implementation of the federal Health Insurance Portability and Accountability Act (HIPAA), there has been a lot of confusion in the provider community. We believe we meet the standard of a health oversight agency as outlined in federal regulations and recommend that this sentence be added for clarification. This would help to improve efficiency by reducing time and phone calls with attorneys.

- Also in 245.94 under powers, paren (f): The rule cited instructs government entities to respond immediately rather than having to go to court to call certain provisions to the court's attention. The data given to the Ombudsman retains its classification under Chapter 13 so the court process step is not necessary. This would result in more efficient operations and not waste valuable court time.

- In the same paragraph, if for any reason the agency has to go to court to enforce its subpoena power, it is more efficient to do so in Ramsey county where the agency and their AG representation is located. This is consistent with and patterned after other state agencies that have subpoena power. This would reduce travel time and associated costs.

- Again in the same paragraph, the agency would add *or nonpublic data as defined in section 13.02 subdivision 9.* This is to clarify that data not about people has the same protection as data about people.

- In 245.97 Ombudsman Committee the provision would change/correct the provision of statute under which the Ombudsman Advisory Committee operates. The provision currently cited governs boards that manage money (such as the Metropolitan Airports Commission). The Ombudsman's Committee does not manage funds in any way, nor do they collect a per diem for their services. The current provision affects whether or not a board member can continue to serve until a replacement is appointed.

April, 2006

ATTACHMENT "E"

Senator ..... moves to amend S.F. No. ..... as follows:

Page ..., after line ...., insert:

"Sec. .... Minnesota Statutes 2004, section 245.94, subdivision 1, is amended to read:

Subdivision 1. **Powers.** (a) The ombudsman may prescribe the methods by which complaints to the office are to be made, reviewed, and acted upon. The ombudsman may not levy a complaint fee.

(b) The ombudsman may mediate or advocate on behalf of a client.

(c) The ombudsman may investigate the quality of services provided to clients and determine the extent to which quality assurance mechanisms within state and county government work to promote the health, safety, and welfare of clients, other than clients in acute care facilities who are receiving services not paid for by public funds. The ombudsman office is a health oversight agency as defined in section 164.501 of part 45 of the Code of Federal Regulation.

(d) At the request of a client, or upon receiving a complaint or other information affording reasonable grounds to believe that the rights of a client who is not capable of requesting assistance have been adversely affected, the ombudsman may gather information about and analyze, on behalf of the client, the actions of an agency, facility, or program.

(e) The ombudsman may examine, on behalf of a client, records of an agency, facility, or program if the records relate to a matter that is within the scope of the ombudsman's authority. If the records are private and the client is capable of providing consent, the ombudsman shall first obtain the client's consent. The ombudsman is not required to obtain consent for access to private data on clients with mental retardation or a related condition. The ombudsman is not required to obtain consent for access to private data on decedents who were receiving services for mental illness, mental retardation or a related condition, or emotional disturbance.

(f) The ombudsman may subpoena a person to appear, give testimony, or produce documents or other evidence that the ombudsman considers relevant to a matter under inquiry. If the subpoena is directed to a government entity governed by chapter 13, the government entity must respond to the subpoena, notwithstanding Minnesota Rules, 1205.0100, subpart 5. The ombudsman may petition the ~~appropriate~~ Ramsey County district court to enforce the subpoena. A witness who is at a hearing or is part of an investigation possesses the same privileges that a witness possesses in the courts or under the law of this state. Data obtained from a person under this paragraph are private data as defined in section 13.02, subdivision 12, or nonpublic data as defined in section 13.02, subdivision 9.

(g) The ombudsman may, at reasonable times in the course of conducting a review, enter and view premises within the control of an agency, facility, or program.

(h) The ombudsman may attend Department of Human Services Review Board and Special Review Board proceedings; proceedings regarding the transfer of patients or residents, as defined in section 246.50, subdivisions 4 and 4a, between institutions operated by the Department of Human Services; and, subject to the consent of the affected client, other proceedings affecting the rights of clients. The ombudsman is not required to obtain consent to attend meetings or proceedings and have access to private data on clients with mental retardation or a related condition.

(i) The ombudsman shall have access to data of agencies, facilities, or programs classified as private or confidential as defined in section 13.02, subdivisions 3 and 12, regarding services provided to clients with mental retardation or a related condition.

(j) To avoid duplication and preserve evidence, the ombudsman shall inform relevant licensing or regulatory officials before undertaking a review of an action of the facility or program.

(k) Sections 245.91 to 245.97 are in addition to other provisions of law under which any other remedy or right is provided.

(l) The ombudsman may classify as confidential the identity of any individual who has provided data or information, if the individual requests the classification.

Sec. .... Minnesota Statutes 2004, section 245.97, subdivision 6, is amended to read:

Subd. 6. **Terms, compensation, and removal.** The membership terms, compensation, and removal of members of the committee and the filling of membership vacancies are governed by section ~~15.0575~~ 15.0559. "

ATTACHMENT "F"

Senator ..... moves to amend S.F. No. ..... as follows:

Page .., after line .., insert:

"Sec. .... **LIST OF COUNTY LONG-TERM CARE FUNCTIONS.**

The commissioner of human services, in consultation with county organizations, shall provide a status report to the legislature by January 15, 2007, that includes a list of core county long-term care functions and an analysis of existing and potential funding sources for these functions."

ATTACHMENT "G"

Senator ..... moves to amend S.F. No. ..... as follows:

Page .., after line .., insert:

"Sec. .... Minnesota Statutes 2004, section 145.925, is amended by adding a subdivision to read:

Subd. 10. **Definition of governmental unit.** For purposes of section 471.59, subdivision 1, nonprofit community health clinics providing family planning services as defined in this section shall be included in the definition of "governmental unit.""

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

ATTACHMENT "H"

Senator ..... moves to amend S.F. No. ..... as follows:

Page .., after line .., insert:

"Sec. .... **[144.366] INTERCONNECTED ELECTRONIC HEALTH RECORD GRANTS.**

Subdivision 1. **Definitions.** The following definitions are used for the purposes of this section.

(a) "Eligible community e-health collaborative" means an existing or newly established collaborative to support the adoption and use of interoperable electronic health records. A collaborative must consist of at least three or more eligible health care entities in at least two of the categories listed in paragraph (b) and have a focus on interconnecting the members of the collaborative for secure and interoperable exchange of health care information.

(b) "Eligible health care entity" means one of the following:

(1) community clinics, as defined under section 145.9268;

(2) hospitals eligible for rural hospital capital improvement grants, as defined in section 144.148;

(3) physician clinics located in a community with a population of less than 50,000 according to United States Census Bureau statistics and outside the seven-county metropolitan area;

(4) nursing facilities licensed under sections 144A.01 to 144A.27;

(5) community health boards as established under chapter 145A;

(6) nonprofit entities with a purpose to provide health information exchange coordination governed by a representative, multi-stakeholder board of directors; and

(7) other providers of health or health care services approved by the commissioner for which interoperable electronic health record capability would improve quality of care, patient safety, or community health.

Subd. 2. **Grants authorized.** The commissioner of health shall award grants to eligible community e-health collaborative projects to improve the implementation and use of interoperable electronic health records including but not limited to the following projects:

(1) collaborative efforts to host and support fully functional interoperable electronic health records in multiple care settings;

(2) electronic medication history and electronic patient registration information;

(3) electronic personal health records for persons with chronic diseases and for prevention services;

(4) rural and underserved community models for electronic prescribing; and

(5) enabling local public health systems to rapidly and electronically exchange information needed to participate in community e-health collaboratives or for public health emergency preparedness and response.

Grant funds may not be used for construction of health care or other buildings or facilities.

Subd. 3. **Allocation of grants.** (a) To receive a grant under this section, an eligible community e-health collaborative must submit an application to the commissioner of health by the deadline established by the commissioner. A grant may be awarded upon the signing of a grant contract. In awarding grants, the commissioner shall give preference to projects benefiting providers located in rural and underserved areas of Minnesota which the commissioner has determined have an unmet need for the development and funding of electronic health records. Applicants may apply for and the commissioner may award grants for one-year, two-year, or three-year periods.

(b) An application must be on a form and contain information as specified by the commissioner but at a minimum must contain:

(1) a description of the purpose or project for which grant funds will be used;

(2) a description of the problem or problems the grant funds will be used to address, including an assessment likelihood of the project occurring absent grant funding;

(3) a description of achievable objectives, a workplan, budget, budget narrative, a project communications plan, a timeline for implementation and completion of processes or projects enabled by the grant, and an assessment of privacy and security issues and a proposed approach to address these issues;

(4) a description of the health care entities and other groups participating in the project, including identification of the lead entity responsible for applying for and receiving grant funds;

(5) a plan for how patients and consumers will be involved in development of policies and procedures related to the access to and interchange of information;

(6) evidence of consensus and commitment among the health care entities and others who developed the proposal and are responsible for its implementation; and

(7) a plan for documenting and evaluating results of the grant.

(c) The commissioner shall review each application to determine whether the application is complete and whether the applicant and the project are eligible for a grant. In evaluating applications, the commissioner shall take into consideration factors, including but not limited to, the following:

(1) the degree to which the proposal interconnects the various providers of care in the applicant's geographic community;

(2) the degree to which the project provides for the interoperability of electronic health records or related health information technology between the members of the collaborative, and presence and scope of a description of how the project intends to interconnect with other providers not part of the project into the future;

(3) the degree to which the project addresses current unmet needs pertaining to interoperable electronic health records in a geographic area of Minnesota and the likelihood that the needs would not be met absent grant funds;

(4) the applicant's thoroughness and clarity in describing the project, how the project will improve patient safety, quality of care, and consumer empowerment, and the role of the various collaborative members;

(5) the recommendations of the Health Information and Technology Infrastructure Advisory Committee; and

(6) other factors that the commissioner deems relevant.

(d) Grant funds shall be awarded on a three-to-one match basis. Applicants shall be required to provide one dollar in the form of cash or in-kind staff or services for each three dollars provided under the grant program.

(e) Grants shall not exceed $900,000 per grant. The commissioner has discretion over the size and number of grants awarded.

Subd. 4. **Evaluation and report.** The commissioner of health shall evaluate the overall effectiveness of the grant program. The commissioner shall collect progress and expenditure reports to evaluate the grant program from the eligible community collaboratives receiving grants. Every two years, as part of this evaluation, the commissioner shall, in coordination with the Health Information Technology and Infrastructure Advisory Committee, report to the legislature on the needs of the community, and provide any recommendations for adding or changing eligible activities."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

ATTACHMENT "I"

Senator ..... moves to amend S.F. No. ..... as follows:

Page .., after line .., insert:

"Sec. .... Minnesota Statutes 2004, section 62Q.19, subdivision 2, is amended to read:

Subd. 2. **Application.** (a) Any provider may apply to the commissioner for designation as an essential community provider by submitting an application form developed by the commissioner. Except as provided in paragraphs (d) and (e), applications must be accepted within two years after the effective date of the rules adopted by the commissioner to implement this section.

(b) Each application submitted must be accompanied by an application fee in an amount determined by the commissioner. The fee shall be no more than what is needed to cover the administrative costs of processing the application.

(c) The name, address, contact person, and the date by which the commissioner's decision is expected to be made shall be classified as public data under section 13.41. All other information contained in the application form shall be classified as private data under section 13.41 until the application has been approved, approved as modified, or denied by the commissioner. Once the decision has been made, all information shall be classified as public data unless the applicant designates and the commissioner determines that the information contains trade secret information.

(d) The commissioner shall accept ~~an application~~ applications for designation as an essential community provider until June 30, ~~2004~~ 2006, from one applicant that is a nonprofit community ~~services agency certified as a medical assistance provider that provides mental health, behavioral health, chemical dependency, employment, and health wellness services to the underserved Spanish-speaking Latino families and individuals with locations in Minneapolis and St. Paul~~ mental health agency located in Hennepin County that partners with the Minneapolis public school system to provide mental health services to school-age children and their families and provides mental health services to immigrant communities, and from one applicant that is a nonprofit, county mental health services center certified as a medical assistance provider that provides behavioral health services and wrap-around eligibility support services to an underserved population with chemical dependency and serious mental illness.

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

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

ATTACHMENT "J"

Senator ..... moves to amend S.F. No. ..... as follows:

Page ..., after line ..., insert:

"Sec. .... Minnesota Statutes 2005 Supplement, section 245C.24, subdivision 2, is amended to read:

Subd. 2. **Permanent bar to set aside a disqualification.** (a) Except as provided in paragraph (b), the commissioner may not set aside the disqualification of any individual disqualified pursuant to this chapter, regardless of how much time has passed, if the individual was disqualified for a crime or conduct listed in section 245C.15, subdivision 1.

(b) For an individual who was disqualified for a crime or conduct listed under section 245C.15, subdivision 1, and whose disqualification was set aside prior to July 1, 2005, the commissioner must consider granting a subsequent set aside for the same or different license holder based on the evaluation under section 245A.22, subdivision 4. A request for reconsideration evaluated under this paragraph must include a letter of recommendation from the license holder that was subject to the prior set aside decision addressing the individual's quality of care to children or vulnerable adults and the circumstances of the individual's departure from that service."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

ATTACHMENT "K"

ARTICLE 19

HEALTH AND HUMAN SERVICES APPROPRIATIONS

Section 1. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

The sums shown in the columns marked "APPROPRIATIONS" are added to or, if shown in parentheses, subtracted from the appropriations in Laws 2005, First Special Session chapter 4, article 9, or other law to the agencies and for the purposes specified in this article. The appropriations are from the general fund or another named fund and are available for the fiscal years indicated for each purpose. The figures "2006" and "2007" used in this article mean that the addition to or subtraction from the appropriation listed under them is available for the fiscal year ending June 30, 2006, or June 30, 2007, respectively. "The first year" is fiscal year 2006. "The second year" is fiscal year 2007. "The biennium" is fiscal years 2006 and 2007. Supplementary appropriations and reductions to appropriations for the fiscal year ending June 30, 2006, are effective the day following final enactment.

SUMMARY BY FUND

	2006	2007	TOTAL
General	$ 33,039,000	$ 59,015,000	$ 92,054,000
Health Care Access	-0-	38,326,000	38,326,000
Special Revenue	514,000	262,000	776,000
Federal TANF	-0-	19,125,000	19,125,000
TOTAL	**$ 33,553,000**	**$ 116,728,000**	**$ 150,281,000**

APPROPRIATIONS

	Available for the Year Ending June 30	
	2006	2007
	$	$

Sec. 2. **COMMISSIONER OF HUMAN SERVICES**

Subdivision 1. **Total appropriation**	30,209,000	99,946,000

Summary by Fund

General	30,209,000	51,909,000
Health Care Access Fund	-0-	28,912,000
TANF	-0-	19,125,000

(a) Transfer from special revenue fund

$900,000 in fiscal year 2007 shall be transferred from the Department of Human Services special revenue fund to the general fund.

(b) TANF maintenance of effort

Notwithstanding Laws 2005, First Special Session chapter 4, article 9, section 2, subdivision 1, the commissioner shall ensure that for fiscal year 2007, the maintenance of effort used by the commissioner of finance for the February and November forecasts required under Minnesota Statutes, section 16A.103, contains expenditures under paragraph (a), clause (1), equal to at least 21 percent of the total required under Code of Federal Regulations, title 45, section 263.1.

The commissioner may use up to $5,000,000 per year of Department of Education qualified spending as TANF maintenance of effort. The commissioner of education shall assist the commissioner in identifying eligible expenditures.

(c) Increased working family credit expenditures to be claimed for TANF maintenance of effort

In addition to the amounts provided in Laws 2005, First Special Session, chapter 4, article

9, section 2, subdivision 1, the commissioner may count the following amounts of working family credit expenditure as TANF maintenance of effort:

(1) fiscal year 2006, $9,774,000;

(2) fiscal year 2007, $12,886,000;

(3) fiscal year 2008, $27,686,000; and

(4) fiscal year 2009, $27,693,000.

Notwithstanding any contrary provision in this article, this paragraph shall expire on June 30, 2009.

(d) Child care and development fund; Federal Deficit Reduction Act of 2005

Increased child care funds from the federal Deficit Reduction Act of 2005 may be allocated by the commissioner for the basic sliding fee child care program.

Subd. 2. **Children and economic assistance grants**

	Summary by Fund			
General Fund		(370,000)		1,949,000
Federal TANF		-0-		18,478,000
(a) MFIP/DWP grants				
TANF	-0-		2,681,000	
(b) MFIP child care grants				
TANF	-0-		15,657,000	
(c) Children's services grants			-0-	2,223,000

Of the health care access appropriation, $15,888,000 in fiscal year 2007 is to eliminate the provider rate freeze in Minnesota Statutes,

section 119B.13, subdivision 1; provide an accreditation incentive under Minnesota Statutes, section 119B.13, subdivision 3a; repeal the limitations on payments for absent days in Minnesota Statutes, section 119B.13, subdivision 7; and reduce co-payments. Effective July 1, 2007, these costs shall be paid from the general fund. Notwithstanding any section in this article to the contrary, this paragraph shall not expire.

(d) Children's and community services grants

Notwithstanding Minnesota Statutes, section 256M.50, supplemental social service block grant funds of $153,936 appropriated under the federal 2005 Department of Defense Appropriations Act, Public Law 109-148, shall be allocated proportionately to those counties that served hurricane evacuees and reported those services on the Social Service Information System.

(e) Basic sliding fee allocations; conversion to automated payment system

As determined by the commissioner, counties may use up to six percent of either calendar year 2008 or 2009 allocations under Minnesota Statutes, section 119B.03, to fund accelerated payments that may occur during the preceding calendar year during conversion to the automated child care assistance program system. If conversion occurs over two calendar years, counties may use up to three percent of the combined calendar year allocations to fund accelerated payments. Funding advanced under this paragraph shall be considered part of the

allocation from which it was originally advanced for purposes of setting future allocations under Minnesota Statutes, section 119B.03, subdivisions 6, 6a, 6b, and 8, and shall include funding for administrative costs under Minnesota Statutes, section 119B.15. Notwithstanding any contrary provisions in this article, this paragraph shall sunset on December 31, 2009.

(f) New chance program appropriation

Of the general fund appropriation, $140,000 for fiscal year 2007 is for a grant to the new chance program. The new chance program shall provide comprehensive services through a private, nonprofit agency to young parents in Hennepin County who have dropped out of school and are receiving public assistance. The program administrator shall report annually to the commissioner of human services on skills development, education, job training, and job placement outcomes for program participants. This appropriation shall become part of base level funding for the biennium beginning July 1, 2007.

(g) Other children's and economic assistance grants

General	(370,000)	(452,000)
Federal TANF	-0-	140,000

Food program surplus reduction

The general fund base for the Minnesota food assistance program is reduced by $370,000 in fiscal year 2006, and by $453,000 in fiscal year 2007.

(h) Group residential housing grants		-0-	168,000

Subd. 3. **Children and economic assistance management**

Summary by Fund

General	9,000	26,000
Federal TANF	-0-	647,000

(a) Children and economic assistance administration

General	-0-	7,000
Federal TANF	-0-	406,000

(b) Children and economic assistance operations

General	9,000	19,000
Federal TANF	-0-	241,000

Subd. 4. **Health care grants**

Summary by Fund

General	-0-	4,439,000
Health Care Access	-0-	25,721,000

(a) MinnesotaCare grants health care access	-0-	8,219,000

MinnesotaCare outreach

Of the health care access fund appropriation, $910,000 in fiscal year 2007 is for the MinnesotaCare outreach grants under Minnesota Statutes, section 256L.04, subdivision 4. Of this amount, $750,000 is for grants and $160,000 is for administrative costs.

Transfer to Minnesota pharmacy access account

Notwithstanding Minnesota Statutes, section 295.581, the commissioner of finance shall transfer $218,000 from the health care access fund to the Minnesota pharmacy access account in fiscal year 2007, $3,246,000 in fiscal year 2008, and $916,000 in fiscal year 2009. Notwithstanding any provision in this article to the contrary, this paragraph in this article shall expire on June 30, 2009.

HealthMatch delay

The commissioner shall delay implementation of the HealthMatch program by two months. Of the health care access fund appropriation, $929,000 in fiscal year 2007 is for the administrative costs of the two-month delay.

(b) Medical Assistance Basic Health Care - Families and Children	-0-	75,000
(c) Medical Assistance Basic Health Care - Elderly and Disabled	-0-	(472,000)
(d) General Assistance Medical Care	-0-	4,836,000

Exemption from transfer to general assistance medical care

Of the health care access fund appropriation, $1,810,000 in fiscal year 2007 is for the costs of exempting the following general assistance medical care recipients from the transfer to MinnesotaCare:

(1) persons who are classified as end-stage renal disease beneficiaries in the Medicare program;

(2) persons who are enrolled in private health care coverage as defined in Minnesota Statutes, section 256B.02, subdivision 9;

(3) persons who are eligible under Minnesota Statutes, section 256D.03, subdivision 3, paragraph (j); and

(4) persons who received treatment funded under Minnesota Statutes, section 254B.02.

Effective July 1, 2007, these costs shall be paid by the general fund. Notwithstanding any provision in this article to the contrary, this paragraph shall not expire.

(e) Other health care grants	-0-	17,502,000

Subd. 5. **Health care management**

Summary by Fund		
General	-0-	1,508,000
Health Care Access	-0-	3,191,000

(a) Health care administration		
General	-0-	1,428,000
Health Care Access	-0-	843,000

Dental grants

Of the health care access fund appropriation, $300,000 in fiscal year 2007 is for grants to nonprofit dental providers under Minnesota Statutes, section 256B.76, paragraph (d). This appropriation shall become part of base level funding for the biennium beginning July 1, 2007.

Critical access dental providers

Of the health care access fund appropriation, $3,500,000 in fiscal year 2007 is for critical access dental provider rates. Effective July 1, 2007, these rates shall be included in the medical programs forecast.

(b) Health care operations

General	-0-	80,000
Health Care Access	-0-	2,348,000

Intensive care management

(a) Of the health care access fund appropriation, $1,505,000 for fiscal year 2007 is for the intensive care management pilot program established under Minnesota Statutes, section 256B.075, subdivision 2, paragraph (d), of which $5,000 is for systems costs and the remainder is to be distributed as follows:

(1) $300,000 is to be paid under a contract with the neighborhood health care network for the community care network project that consists of a network of safety net clinics and health centers working in cooperation with a safety net hospital, a health plan, and the Department of Human Services to improve care coordination services;

(2) of the balance remaining after the payment made under clause (1), 60 percent shall be paid in grants to federally qualified health centers, as defined in Minnesota Statutes, section 256B.075, subdivision 2, paragraph (d), in proportion to each center's amount of discounts granted to patients during calendar year 2005 as reported on the federal Uniform Data Systems report in conformance with the Bureau of Primary Health Care Program Expectations Policy Information Notice 98-23, except that each eligible federally qualified health center shall receive at least $10,000 but no more than

20 percent of the total amount of money available under this clause;

(3) the balance remaining after the payments made under clauses (1) and (2) shall be paid in grants to community clinics, as defined in Minnesota Statutes, section 256B.075, subdivision 2, paragraph (d), to be distributed based on each clinic's proportionate amount of contribution to patients as determined in accordance with the clinic's formal policy for sliding fee discounts approved by the clinic's board of directors, as reported by each clinic, except that each eligible community clinic shall receive at least $10,000 but no more than 20 percent of the total amount of money available under this clause; and

(4) the commissioner shall pay the amounts at the beginning of the fiscal year, even if federal approval has not yet been granted.

(b) Base level funding for this activity shall be $1,500,000 each year for the biennium beginning July 1, 2007.

Subd. 6. **Continuing care grants**

	Summary by Fund		
General	-0-	(1,522,000)	
Health Care Access	-0-	-0-	
(a) Aging and adult grants		-0-	25,000

Medicare part D information and assistance reimbursement

Federal administrative reimbursement obtained from information and assistance services provided by the Senior Linkage or

Disability Linkage lines to people who are identified as eligible for medical assistance shall be appropriated to the commissioner for this activity.

(b) Alternative care grants -0- 3,366,000

Alternative care base level adjustment

Base level funding for alternative care grants shall be increased by $2,563,000 in fiscal year 2007.

(c) Medical assistance long-term care facilities -0- (1,903,000)

Temporary rate increase

Of the general fund appropriation, $30,000 in fiscal year 2007 is for a temporary rate increase equivalent to six percent of the operating rate in effect on July 1, 2006, for a day training and habilitation provider in Meeker County providing services to up to 110 individuals. This rate increase shall be in effect only until June 30, 2007.

(d) Medical assistance long-term care waivers -0- (415,000)

Additional waiver allocations

Notwithstanding the waiver growth limits in Laws 2005, First Special Session chapter 4, article 9, section 2, paragraph (d), the commissioner may allocate an additional waiver allocation under Minnesota Statutes, section 256B.49, for a recipient of personal care assistant services who is eligible for and chooses waivered services and received personal care assistant services from a provider who was billing for a service

delivery model for that recipient other than individual or shared care on March 1, 2006.

(e) Mental health grants		-0-	(2,595,000)

Methamphetamine coordinator

The following amounts shall be transferred from the federal chemical health block grant fund to the commissioner of health for the fiscal years indicated for the purposes of Minnesota Statutes, section 144.90: $82,000 in fiscal year 2007; $205,000 in fiscal year 2008; and $205,000 in fiscal year 2009.

Subd. 7. **Continuing care management**			
General	-0-	881,000	
Health Care Access	-0-	-0-	
Subd. 8. **State-operated services**		30,570,000	44,628,000

Minnesota Security Hospital

For the purposes of enhancing the safety of the public, improving supervision, and enhancing community-based mental health treatment, state-operated services may establish additional community capacity for providing treatment and supervision of clients who have been ordered into a less restrictive alternative of care from the state-operated services transition services program consistent with Minnesota Statutes, section 246.014.

Minnesota Security Hospital discharge planning

The commissioner shall study the feasibility of requiring the Minnesota Security Hospital to take full responsibility for the provisional

discharge planning for patients moving from the St. Peter Campus into the community under the process outlined by Minnesota Statutes, section 253B.18, subdivision 8. The commissioner shall report the results of the study to the legislature by January 15, 2007.

State-operated services salary deficit

The state-operated services salary deficit of $6,833,000 in fiscal year 2006, and $10,274,000 in fiscal year 2007 shall be absorbed by the Department of Human Services, excluding state-operated services.

Sec. 3. **COMMISSIONER OF HEALTH**

Subdivision 1. **Total appropriation**	-0-	12,064,000
Summary by Fund		
General	-0-	2,510,000
Health Care Access Fund	-0-	9,414,000
State Government Special Revenue	-0-	140,000

The appropriations in this section are added to appropriations in Laws 2005, First Special Session chapter 4, article 9, section 3.

Subd. 2. **Health protection**

Summary by Fund		
General	-0-	2,510,000
State Government Special Revenue Fund	-0-	140,000

Pandemic influenza preparedness

Of the general fund appropriation, $2,610,000 in fiscal year 2007 is for

preparation, planning, and response to an outbreak of influenza. Of this amount, $2,300,000 is to purchase antivirals; $110,000 is to purchase supplies; $100,000 is for stockpile and distributions planning support; and $100,000 is to support clinics and local public activities. Base level funding for this activity for the biennium beginning July 1, 2007, shall be $1,660,000 each year.

HIV/AIDS prevention

(a) The commissioner shall allocate $135,000 of the federal HIV prevention grant to establish a toll-free telephone line to provide information and counseling on HIV/AIDS, contingent on the approval of the Community Cooperative Council on HIV/AIDS prevention.

(b) The commissioner shall not cap HIV prevention grants. Notwithstanding any provision in this article to the contrary, this paragraph shall not expire.

Subd. 3. **Policy compliance and quality**

	Summary by Fund		
Health Care Access Fund	-0-	9,414,000	

Sec. 4. **VETERANS NURSING HOMES BOARD** 2,830,000 4,596,000

This appropriation is added to appropriations in Laws 2005, First Special Session chapter 4, article 9, section 4.

Sec. 5. **HEALTH-RELATED BOARDS**

	Subdivision 1. **State government special revenue**	514,000	622,000
	Subd. 2. **Board of Chiropractic Examiners**	5,000	5,000

Board of Chiropractic Examiners appropriation increase

(a) This appropriation is added to appropriations in Laws 2005, First Special Session chapter 4, article 9, section 5, subdivision 3. This is a onetime appropriation.

(b) This increase is to correct programming difficulties incurred during implementation of payment processing changes.

	Subd. 3. **Board of Dentistry**	-0-	67,000

Board of Dentistry appropriation increase

(a) This appropriation is added to appropriations in Laws 2005, First Special Session chapter 4, article 9, section 5, subdivision 4.

(b) This increase is to retain a legal analyst as part of the board staff.

	Subd. 4. **Board of Medical Practice**	500,000	500,000

Board of Medical Practice increase

(a) This appropriation is added to appropriations in Laws 2005, First Special Session chapter 4, article 9, section 5, subdivision 7. This is a onetime appropriation.

(b) This increase is to cover higher than expected costs of investigation and legal action.

Subd. 5. **Board of Physical Therapy**		9,000	-0-

Board of Physical Therapy appropriation increase

(a) This appropriation is added to appropriations in Laws 2005, First Special Session chapter 4, article 9, section 5, subdivision 12. This is a onetime appropriation.

(b) This increase is to correct programming difficulties incurred during implementation of payment processing changes.

Subd. 6. **Emergency Medical Services Board**		-0-	50,000

Emergency Medical Services Board appropriation increase

(a) This appropriation is added to appropriations in Laws 2005, First Special Session chapter 4, article 9, section 5, subdivision 12.

(b) This increase is to be spent by the health professional service program from the state government special revenue fund.

Sec. 6. Minnesota Statutes 2004, section 245.771, is amended by adding a subdivision to read:

Subd. 4. **Food stamp bonus awards.** In the event that Minnesota qualifies for the United States Department of Agriculture Food and Nutrition Services Food Stamp Program performance bonus awards, the funding is appropriated to the commissioner. The commissioner shall retain 25 percent of the funding, with the other 75 percent divided among the counties according to a formula that takes into account each county's impact on state performance in the applicable bonus categories.

Sec. 7. Minnesota Statutes 2004, section 256.01, is amended by adding a subdivision to read:

Subd. 24. **Funding from other than state funds.** Notwithstanding sections 16A.013 to 16A.016, the commissioner may accept, on behalf of the state, additional funding from sources other than state funds for the purpose of financing the cost of assistance program grants or nongrant administration. All additional funding under this subdivision is appropriated to the commissioner for use as designated by the grantor of funding.

Sec. 8. Minnesota Statutes 2004, section 256.014, is amended by adding a subdivision to read:

Subd. 5. **Systems account management.** Money appropriated for computer projects approved by the Minnesota Office of Technology, funded by the legislature, and approved by the commissioner of finance, may be transferred from one project to another and from development to operations as the commissioner of human services considers necessary. Any unexpended balance in the appropriation for these projects does not cancel but is available for ongoing development and operations.

Sec. 9. Minnesota Statutes 2004, section 256.014, is amended by adding a subdivision to read:

Subd. 6. **Systems continuity.** In the event of disruption of technical systems or computer operations, the commissioner may use available grant appropriations to ensure continuity of payments for maintaining the health, safety, and well-being of clients served by programs administered by the Department of Human Services. Grant funds must be used in a manner consistent with the original intent of the appropriation.

Sec. 10. Minnesota Statutes 2004, section 518.5852, is amended to read:

518.5852 CENTRAL COLLECTIONS UNIT.

Subdivision 1. **Creation and maintenance.** The commissioner of human services shall create and maintain a central collections unit for the purpose of receiving, processing, and disbursing payments, and for maintaining a record of payments, in all cases in which:

(1) the state or county is a party;

(2) the state or county provides child support enforcement services to a party; or

(3) payment is collected through income withholding.

The commissioner may contract for services to carry out these provisions, provided that the commissioner first meets and negotiates with the affected exclusive representatives.

Subd. 2. **Deposit of payments.** Payments to the commissioner from other governmental units, private enterprises, and individuals for services performed by the central collections unit must be deposited in the state systems account authorized under section 256.014. These payments are appropriated to the commissioner for the operation of the child support payment center or system, according to section 256.014

Sec. 11. **SUNSET OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2007, unless a different expiration date is explicit.