House Research Act Summary

CHAPTER: 4

SESSION: 2005 First Special Session

TOPIC: Omnibus Health and Human Services Finance Bill

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Article 1: Human Services Licensing

This article addresses changes in family child care and child care centers; background studies and appeals process; and procedures regarding vulnerable adults and predatory offenders.

1 **Licensing data.** Amends § 13.46, subd. 4. Allows the Department of Human Services (DHS) and the Department of Corrections (DOC) to exchange all nonpublic data for the purposes of regulating services for which DHS and DOC have regulatory authority.

Effective date. This section is effective the day following final enactment.

2 **Health care facility; notice of status.** Amends § 243.166, subd. 4b. Defines "health care facility" as a hospital, boarding care home, supervised living facility, or a nursing home. Also included in the definition are residential facilities licensed by the commissioner of human services to provide adult foster care, adult mental health treatment, adult chemical dependency treatment, or residential services to persons with developmental disabilities.

Effective date. This section is effective the day following final enactment.

3 **Use of data.** Amends § 243.166, subd. 7. Provides that information obtained through the registration of predatory offenders is private data. Adds that state-operated services are authorized to access this data.

Effective date. This section is effective the day following final enactment.

4 **School age child care program.** Amends § 245A.02, subd. 17. Deletes as an exclusion from licensing "scouting, boys clubs, girls clubs, nor sports or art programs" in section 245A.02, subdivision 17, and moves this to the exclusion from licensure section 254A.03, subdivision 2.

5 **Exclusion from licensure.** Amends § 245A.03, subd. 2 (a). Changes the exclusion from licensure for short-term Head Start programs from 31 to 45 days. Adds the exclusion from licensure for scouting, boys clubs, girls clubs, sports or art programs.

6 **Unlicensed programs.** Amends § 245A. 03, subd. 3. Provides that it is a misdemeanor to continue to operate without a license after receiving notice that a license is required. Allows the county attorney or attorney general to begin proceedings to obtain a court order against continued operation of the program.

7 **Grant of emergency license.** Amends § 245A.035, subd. 1. Allows a county agency to make an emergency placement of a child with a relative even if a background study has not been completed.

Effective date. This section is effective the day following final enactment.

8 **Child foster care license application.** Amends § 245A.035, subd. 5. Provides that when a relative is being considered for licensure for child foster care, the county or child-placing

agency must explain the licensing process to the licensee including the background study process and the procedure for reconsideration of an initial disqualification. The agency must also provide the prospective relative licensee with information about legal representation. Provides that if a relative is initially disqualified, the agency must provide notification in writing and must inform the relative of the right to request reconsideration. Directs the commissioner to maintain licensing data regarding relatives separate from that information from other foster care providers.

9 **Issuance of a license; extension of a license.** Amends § 245A.04, subd. 7. Adds that the commissioner shall not issue a license if an individual living in the household where the licensed services will be provided has been disqualified and the disqualification has not been set aside.

10 **Handling funds and property; additional requirements.** Amends § 245A.04, subd. 13. Changes language from "resident" to "person served by the program." Adds that the requirements that govern handling of funds and property of persons receiving services under this subdivision do not apply to programs serving persons with developmental disabilities. Deletes the requirement for providing a statement, at least quarterly, itemizing receipts and disbursements of resident funds or other property.

11 **Family child care and child care centers posting of order.** Amends § 245A.06, by adding subdivision 8. Directs licensed family child care providers and child care centers to post any correction order or order of conditional license. Provides that if a maltreatment investigation memorandum accompanies the order, the memorandum must also be posted.

12 **Sanctions available; appeals; temporary provisional license.** Amends § 245A.07, subd. 1. Creates the category of temporary provisional license. This category of license applies to programs that continue to operate while they appeal the suspension or revocation of their license. Provides that the commissioner can issue a license sanction under this section even if the license holder fails to reapply or closes a license during the course of an investigation.

13 **License suspension, revocation, or fine.** Amends § 245A.07, subd. 3. Provides that the commissioner may suspend or revoke a license or impose a fine if an individual living in the household where the licensed services are provided has a disqualification which has not been set aside.

14 **Family child care and child care centers posting of order.** Amends § 245A.07, by adding subdivision 5. Directs that an order of license suspension, temporary immediate suspension, fine or revocation shall be posted in a conspicuous location in the facility for two years. A maltreatment investigation memorandum, if received, must also be posted.

15 **Consolidated contested case hearings for sanction based on maltreatment determinations and disqualifications.** Amends § 245A.08, subd. 2a. Paragraph (a). Provides that if a license holder is fined based on a maltreatment determination, and the fine is issued at the same time as the maltreatment determination, the license holder can appeal both. The contested case hearing shall consider the maltreatment determination and the fine. A separate consideration of the maltreatment determination will not be provided.

Paragraph (b). Adds family adult day services to the list of consolidated contested case hearings that the county attorney shall defend.

Adds paragraph (f). Provides the scope of review for an administrative law judge.

Adds paragraph (g). Provides the scope of review for an administrative law judge

16 **Notice of commissioner's final order.** Amends § 245A.08, by adding subd. 5a. Adds an exception to the five-year prohibition from granting a license following revocation based on disqualification. Allows a license to be granted when the person with the disqualification no longer resides in the home and is prohibited from residing in or returning to the home.

Provides that if the disqualified person is a minor, the license restriction applies until the minor becomes an adult and permanently moves away from home or five years, whichever is less.

17 **First aid training requirements for staff in child care centers.** Amends § 245A.14, by adding subd. 12. Allows first aid training to be less than eight hours.

Effective date. This section is effective January 1, 2006.

18 **Cardiopulmonary resuscitation (CPR) training requirement.** Amends § 245A.14, by adding subd. 13. Paragraph (a). Provides that when children are present in a child care center or in a family child care home, at least one staff person must be present who has been trained in CPR and in the treatment of obstructed airways. States that CPR training must be repeated at least once every three years.

Paragraph (b). Provides that CPR training may be provided for less than four hours.

Paragraph (c). Provides that individuals approved to provide CPR training include individuals approved as CPR instructors.

Effective date. This section is effective January 1, 2006.

19 **Reduction of risk of sudden infant death syndrome and shaken baby syndrome in child care and child foster care programs.** Amends § 245A.144. Adds that foster care providers who care for infants must receive training on reducing sudden infant death syndrome and shaken baby syndrome.

Effective date. This section is effective January 1, 2006.

20 **Delegation of authority to agencies.** Amends § 245A.16, subd. 1. Adds that county agencies must report, for relative foster care applicants and licensees, the number of relatives and household members disqualified; the disqualifying characteristics; the number of requests for reconsideration; the number of set-asides; and the number of variances issued. This information is to be reported to the commissioner by January 15 of each year.

21 **Enforcement of commissioner's orders.** Amends § 245A.16, subd. 4. Provides that a conflict of interest, under this section, means that the county attorney has a direct or shared financial interest with the license holder or has a personal or family relationship with a party in the licensing sanction.

22 **Child passenger restraint systems; training requirement.** Amends § 245A.18.

Subd. 1. States that a license holder must comply with all seat belt and child passenger restraint system requirements.

Subd. 2. States that providers serving children under age nine must document training that fulfills the requirements of this subdivision. Provides that training must address the proper use and installation of child restraint systems in motor vehicles and that this training must be at least one hour in length, completed at initial training and repeated at least once every five years. Training must be provided by individuals certified by the Department of Public Safety, Office of Traffic Safety.

Effective date. This section is effective January 1, 2006.

23 **Incident.** Amends § 245B.02, subd. 10. Clarifies the definition of "incident" for purposes of provider reporting requirements to include events that require relocation of services for more than 24 hours and circumstances involving a fire department related to health, safety or supervision of a consumer.

24 **Determining number of direct service staff required.** Amends § 245B.055, subd. 7. Provides the formula to be used for a 1:10 staff ratio.

25 **Policies and procedures.** Amends § 245B.07, subd. 8. Modifies this section based on the revised definition of "incident."

26 **Licensed programs.** Amends § 245C.03, subd. 1. Provides that the commissioner shall conduct a background study on prospective employees or contractors who will have direct contact with persons served by the program. Provides that when the commissioner has reasonable cause, a background study shall be completed on an individual who, without providing direct contact services at a licensed program, may have unsupervised access to children or vulnerable adults receiving services from a program.

27 **Study subject affiliated with multiple facilities.** Amends § 245C.07. Clarifies that only one background study is required when individuals provide direct contact services in multiple licensed facilities owned by the same license holder.

28 **Background studies conducted by commissioner of human services.** Amends § 245C.08, subd. 1. Allows the commissioner, for the purpose of background studies, to review county agency findings of maltreatment of minors as indicated through the social service information system. Provides that for the purposes of background studies, the commissioner may consider information, even that has been expunged, from juvenile court records and from the Bureau of Criminal Apprehension unless the commissioner has received notice of the expungement and the court order for expungement is directed specifically to the commissioner.

29 **Background studies conducted by a county or private agency; foster care and family child care.** Amends § 245C.08, subd. 2. Allows counties and private agencies, for the purpose of background studies, to review information, even that has been expunged, from the Bureau of Criminal Apprehension, county attorneys, county sheriffs, courts, county agencies, local police, the National Criminal Records Repository, and criminal records from other states unless the commissioner has received notice of expungement and the order is directed specifically to the commissioner.

30 **Permanent disqualification.** Amends § 245C.15, subd. 1. Makes technical changes. Adds aiding and abetting the listed crimes as a disqualification. Adds that disqualification may be based on a judicial determination other than conviction.

31 **15-year disqualification.** Amends § 245C.15, subd. 2. Adds felony-level crimes that currently are not identified as disqualifications themselves. Adds aiding and abetting the listed crimes as a disqualification. Adds voluntary termination of parental rights as a 15-year disqualification related to child foster care and family child care. Adds that disqualification may be based on a judicial determination other than conviction. Establishes uniform standards for computing the 15-year look back period for background study decisions.

32 **Ten-year disqualification.** Amends § 245C.15, subd. 3. Adds gross misdemeanor-level crimes that currently are not identified as disqualifications themselves. Adds aiding and abetting the listed crimes as a disqualification. Adds that disqualification may be based on a judicial determination other than conviction. Establishes uniform standards for computing the ten-year look back period for background study decisions.

33 **Seven-year disqualification.** Amends § 245C.15, subd. 4. Adds misdemeanor-level crimes that currently are not identified as disqualifications themselves. Adds aiding and abetting the listed crimes as a disqualification. Adds that disqualification may be based on a judicial determination other than conviction. Establishes uniform standards for computing the seven-year look back period for background study decisions.

34 **Time frame for requesting reconsideration of a disqualification.** Amends § 245C.21, subd. 2. Specifies that requests for reconsideration, if mailed, must be postmarked and sent within the specified period. If the request for reconsideration is made by personal service, it

must be received by the commissioner within the specified period.

35 **Preeminent weight given to safety of persons being served.** Amends § 245C.22, subd. 3. Provides that the interests of the persons receiving services must be given preeminent weight over the interests of the disqualified individual.

36 **Risk of harm; set aside.** Amends § 245C.22, subd. 4. Provides that if the individual requests reconsideration on the basis the information relied on was incorrect or inaccurate, and the commissioner determines the information was correct, the commissioner must also determine if the individual poses a risk of harm to persons receiving services.

37 **Classification of certain data as public or private.** Amends § 245C.22, subd. 7. Adds that the identity of a disqualified individual and the reason for disqualification remain public data if the disqualification relates to a license to provide relative child foster care.

Effective date. This section is effective the day following final enactment.

38 **Commissioner's notice of disqualification that is rescinded or set aside.** Amends § 245C.23, subd. 1. Instructs the commissioner to provide written or electronic notice of a decision to rescind a disqualification to the applicant, license holder or other entity. Removes the requirement that the background study subject must provide written consent to disclosure of this information to the license holder. This section is effective the day following final enactment.

Effective date. This section is effective the day following final enactment.

39 **Permanent bar to set aside disqualification.** Amends § 245C.24, subd. 2. Deletes a reference to "provider" and inserts "individual."

Effective date. This section is effective the day following final enactment.

40 **Ten-year bar to set aside disqualification.** Amends § 245C.24, subd. 3. Adds aiding and abetting any of the specified offenses as a bar to set aside disqualification. Adds that the commissioner shall not set aside a disqualification when the individual was disqualified based on a preponderance of evidence determination or an admission and less than ten years have passed since the individual committed the act or admitted to committing the act, whichever is later.

41 **Fair hearing when disqualification is not set aside.** Amends § 245C.27, subd. 1. Provides that disqualification based on a judicial determination is the same as a conviction for the purpose of appeal. Specifies that an individual, disqualified based on a conviction and a preponderance of evidence, may request a fair hearing unless the disqualifications are deemed conclusive. If granted a fair hearing, the scope of the hearing shall be limited to whether the individual poses a risk of harm.

42 **Employees of public employer.** Amends § 245C.28, subd. 3. Provides that if an individual was disqualified based on a conviction or admission to a specified crime, the scope of a contested case hearing shall be limited to whether the individual poses a risk of harm.

43 **License holder variance.** Amends § 245C.30, subd. 1. Adds that a variance must be requested by the license holder except for programs licensed to provide family child care, child foster care in the provider's home, or adult foster care or day services in the provider's home.

Effective date. This section is effective the day following final enactment.

44 **Disclosure of reason for disqualification.** Amends § 245C.30, subd. 2. Provides that a disqualified individual does not need to give consent for the commissioner to disclose the reason for disqualification to the license holder of a program that provides family child care, foster care for children in the provider's home, or foster care or day care services for adults

in the provider's home.

Effective date. This section is effective the day following final enactment.

45 **Notification of set-aside or variance.** Adds § 245C.301. Mandates family child care providers and child care centers to provide written notification to parents of children considering enrollment of a child or parents of an enrolled child if the program employs or has living in the home any individual who is the subject of a set-aside or variance.

46 **Records of patients and residents receiving state-operated services.** Amends § 246.13.

Subd. 1. Powers, duties and authority of the commissioner. Requires that a vulnerable adult prevention plan be developed for, and included in the record of, all residents receiving state-operated services. Directs that DHS shall maintain an adequate and uniform system of patient records and statistics.

Subd. 2. Definitions; risk assessment and management.

- Directs that the commissioner shall have access to medical and criminal history data, as necessary to comply with Minnesota Rules, part 1205.0400.

- Provides that a state operated services treatment facility must make a good faith effort to obtain written authorization from the patient before releasing patient records.

- Provides that if the patient refuses or is unable to give informed consent to release information, then the chief executive officer shall provide appropriate and necessary medical and other records.

- Allows the commissioner of human services access to the National Crime Information Center through the Department of Public Safety.

Subd. 3. Community-based treatment and medical treatment.

Subd. 4. Predatory offender registration notification.

Subd. 5. Procedure for bloodborne pathogens. State-operated services facilities must comply with the limitations on use of bloodborne pathogen test results as outlined in chapter 246.

Effective date. This section is effective the day following final enactment.

47 **Guardian ad litem.** Amends §260B.163, subd. 6. Directs the court that a background study must be done for each guardian ad litem.

Effective date. This section is effective the day following final enactment.

48 **Guardian ad litem.** Amends 260C.163, subd. 5. Directs the court that a background study must be done for each guardian ad litem.

Effective date. This section is effective the day following final enactment.

49 **Database of registered predatory offenders.** Amends § 299C.093. Adds that DHS has

access to the predatory offender database.

Effective date. This section is effective the day following final enactment.

50 **Background study of guardian ad litem.** Amends 518.165, by adding subd. 4. Paragraph (a). Instructs that the court shall initiate a background study on guardians ad litem through the commissioner of human services. Background studies must be updated every three years.

Paragraph (b). Provides details of what information must be included in background study.

Paragraph (c). States that the Minnesota Supreme Court shall pay the commissioner a fee for conducting the background study.

Paragraph (d). Provides that the court may initiate a background study using court data on criminal convictions.

Effective date. This section is effective the day following final enactment.

51 **Procedure, criminal history, and maltreatment records background study.** Adds subd. 5 to § 518.165. Paragraph (a). States that requests for background studies shall be submitted to the Department of Human Services through the department's on-line background study system.

Paragraph (b). States that a set of classifiable fingerprints of the subject must be submitted when a search of the National Criminal Records Repository is requested.

Paragraph (c). Lists the information the commissioner of human services shall provide the court when a background study is completed.

Paragraph (d). Provides that information shall be released to the court if the subject of the background study has been determined to be a perpetrator of maltreatment of a minor or vulnerable adult after the study has been completed.

Effective date. This section is effective the day following final enactment.

52 **Rights.** Adds subd. 6 to § 518.165. Provides that the court shall notify the subject of a background study of specific rights.

Effective date. This section is effective the day following final enactment.

53 **Limitations of order.** Amends § 609A.03, subd. 7. Provides that an expunged record of a conviction may be opened for purposes of a background study unless the court order for expungement is directed to the commissioner of human services.

54 **Administrative reconsideration of final determination of maltreatment and disqualification based on serious or recurring maltreatment; review panel.** Amends § 626.556, subd. 10i. Provides consistency for the standards of requesting reconsideration with other appeal requests in chapters 245A and 245C.

55 **Administrative reconsideration of final disposition of maltreatment and disqualification based on serious or recurring maltreatment; review panel.** Amends § 626.557, subd. 9d. Provides consistency between sections on appeal rights for reconsideration of disqualification based on maltreatment of a vulnerable adult and disqualification based on maltreatment of a minor.

56 **Abuse prevention plan.** Amends § 626.557, subd. 14. Directs that health care facilities, except home health agencies and personal care attendant services providers, develop an

abuse prevention plan to address potential risks an individual may pose to other patients, staff and others. Adds that if the facility knows a vulnerable adult has a history of sexual misconduct or abuse of others, then the individual abuse prevention plan must detail measures that will be taken to minimize the risk to other vulnerable adults, visitors, and person outside the facility whom the vulnerable adult might reasonably be expected to encounter if unsupervised.

Effective date. This section is effective August 1, 2005.

57 **Effective date.** This article is effective August 1, 2005, unless specified otherwise.

Article 2: Mental and Chemical Health

This article contains makes changes to allow for medical assistance coverage for treatment foster care and transitional youth rehabilitative mental health services. It adds mental health telemedicine and psychiatric consultation as covered expenses under MinnesotaCare, general assistance medical care, and medical assistance.

1 **Application process.** Amends § 62J.692, subd. 3**.** Amends the health care cost containment chapter of law, specifically the provision dealing with medical education, by requesting that a medical education program that trains pediatricians include in its program curriculum training in case management and medication management for children suffering from mental illness, in order to be eligible for funds under this section of law.

2 **Budget flexibility.** Amends § 245.4661, subd. 10. Allows the commissioner to make budget transfers that do not increase the state share of costs to effectively implement the restructuring of adult mental health services.

3 **Duties of county board.** Amends § 245.4874. Modifies the duties of the county board by requiring the county board, when referring clients to providers of children's therapeutic services and supports, to identify the noncovered children's therapeutic services and supports and identify several factors related to reimbursement, method of payment, and the payment to the provider.

4 **Admission criteria.** Amends § 245.4885, subd. 1.

- Deletes the word "screen" and substitutes the phrase "determine the needed level of care."
- Adds treatment foster care to the list of programs serving children referred for treatment for severe emotional disturbance. Counties are responsible for determining the appropriate program prior to the child's placement.
- Deletes the requirement that for children being held for emergency treatment, screening must occur within three working days of admission, and moves it to a new section.

Adds that a diagnostic assessment must now include an assessment of the child's need for out-of-home care using a tool approved by the commissioner of human services.

Effective date. This section is effective July 1, 2006.

5 **Emergency admission.** Amends § 245.4885 by adding subd. 1a. Requires a level of care determination to be completed within three working days if a child is admitted for emergency treatment in treatment foster care, a residential treatment facility, an acute care

hospital, or held for emergency treatment under section 253B.05, subdivision 1.

6 **Qualifications.** Amends § 245.4885, subd. 2. Substitutes "level of care determination" for "screening." Adds treatment foster care to the listed services. Makes a technical change removing unused waiver authority.

Effective date. This section is effective July 1, 2006.

7 **Definitions.** Amends § 256B.0622, subd. 2. Modifies the definition of intensive rehabilitative mental health services statute to include the Fairweather Lodge treatment model.

8 **Mental health telemedicine.** Amends § 256B.0625, subd. 46. Expands medical assistance coverage to mental health telemedicine, which allows a two-way interactive video that is medically appropriate to the condition and needs of the person being served.

9 **Treatment foster care services.** Amends § 256B.0625 by adding subd. 47. Adds coverage, effective July 1, 2006, and subject to federal approval, for treatment foster care services to the medical assistance program.

10 **Psychiatric consultation to primary practitioners.** Amends § 256B.0625, subd. 48. Expands medical assistance coverage to include consultation provided by a psychiatrist via telephone, e-mail, facsimile, or other means of communication to primary care practitioners, including pediatricians.

11 **Determination of client eligibility.** Amends § 256B.0943, subd. 3. Allows a client with autism spectrum disorder or pervasive developmental disorder to receive a diagnostic assessment once every three years, at the request of a parent and with the agreement of a mental health professional, to determine continued eligibility for therapeutic support services.

12 **Treatment foster care.** Adds § 256B.0946.

Subd. 1. Covered service. Paragraph (a). Provides that medical assistance covers medically necessary services offered by eligible providers to children placed in treatment foster care.

Paragraph (b). States that services for children in treatment foster care must meet the relevant standards for mental health services. Specific service components to be eligible for medical assistance reimbursement must meet the following standards:

Case management must comply with the Minnesota Rules, parts 9520.0900 to 9520.0926, excluding subparts 6 and 10;

Psychotherapy and skills training must comply with section 256B.0943; and

Family psychoeducation services must be supervised by a mental health professional.

Subd. 2. Determination of client eligibility. Provides that a diagnostic assessment, an evaluation of level of care, and an individual treatment plan are to be used in determining whether a child is eligible for treatment foster care services.

Paragraph (a). Provides the requirements for the diagnostic assessment that must be performed. States that this assessment is to be conducted within 180 days prior to the start of services and must be completed annually until the child is age 18.

Paragraph (b). Provides that the placing county must conduct the level of care

evaluation with an instrument approved by the commissioner.

Paragraph (c). Provides the components of the individual treatment plan.

Subd. 3. Eligible providers. States that a provider agency must have an individual placement agreement for each child and must be a licensed child-placing agency. An agency must be a county, an Indian health services facility, or a noncounty entity under contract with a county board.

Subd. 4. Eligible provider responsibilities. Paragraph (a). Instructs that a provider must develop written policies and procedures.

Paragraph (b). Directs that caseload size must reasonably enable the provider to play an active role in serving the needs of the client, birth family, and foster family.

Subd. 5. Service authorization. Provides that the commissioner will authorize services under this section.

Subd. 6. Excluded services. Paragraph (a). Lists services that are not eligible as components of treatment foster care.

Paragraph (b). States that children receiving treatment foster care services are not eligible for medical assistance reimbursement for case management services under section 256B.0625, subdivision 20, or psychotherapy and skills training under section 256B.0625, subdivision 35b.

13 Transitional youth intensive rehabilitative mental health services. Adds § 256B.0947.

Subd. 1. Scope. Provides that, with federal approval, medical assistance will cover the medically necessary services defined in subdivision 2 for eligible recipients defined in subdivision 3 by providers meeting the standards of this section.

Subd. 2. Definitions. Paragraph (a). Defines "intensive nonresidential rehabilitative mental health services" as children's mental health services provided by a team of multidisciplinary staff for those youth with a serious mental illness who require intensive services.

Paragraph (b). Defines "evidence based practices" as nationally recognized mental health services, proven by substantial research, that are effective in helping individuals with serious mental illness.

Paragraph (c). Defines "treatment team" as all staff who provide services to recipients. Lists the individuals to be included in the treatment team.

Subd. 3. Eligibility for transitional youth. To be eligible for the services in this section, an individual must be age 16 or 17; diagnosed with a medical condition, such as emotional disturbance or traumatic brain injury; have substantial disability and functional impairment so that self-sufficiency in adulthood or emancipation is unlikely; and have had a recent diagnostic assessment indicating that services in this section are medically necessary.

Subd. 4. Provider certification and contract requirements. States that a provider must have a contract with the host county and be certified by the

commissioner of human services. Directs the commissioner to establish procedures for counties and providers to submit contracts and other documentation that will allow the commissioner to determine whether standards in this section are met.

Subd. 5. Standards applicable to nonresidential providers. Paragraph (a). States that services must be provided by a certified provider that is an Indian health services facility or a tribal-owned organization; a county-operated entity; or a noncounty entity recommended for certification by the host county. The provider must meet administrative and clinical infrastructure requirements outlined in section 256B.0943, subdivisions 5 and 6.

Paragraph (b). Directs that the clinical supervisor must be an active member of the treatment team, meeting with the treatment staff at least weekly for recipient-specific case reviews and planning.

Paragraph (c). Provides that a mental health practitioner or mental health professional must be promptly accessible to the treatment staff.

Paragraph (d). Directs that the initial functional assessment must be completed within ten days of intake and updated at least every three months.

Paragraph (e). Directs that the initial individual treatment plan must be completed within ten days of intake and updated at least monthly.

Subd. 6. Additional standards for nonresidential services. Provides the standards for intensive nonresidential rehabilitative mental health services:

- Services must be provided by a team, not an individual.
- The clinical supervisor must function, at least part-time as a practicing clinician.
- The staffing ratio must not exceed ten recipients to one full-time equivalent treatment team position.
- Services must be available at times to meet the client's needs.
- There must be active outreach to the recipient's family and significant others.
- There must be ongoing communication and collaboration between the treatment team, family and significant others.
- Interventions must promote positive interpersonal relationships.

Subd. 7. Medical assistance payment for intensive rehabilitative mental health services. Paragraph (a). States that services shall be based on one daily rate per provider.

Paragraph (b). Provides that payment will not be made to more than one entity for

each recipient on a given day except as indicated in paragraph (c).

Paragraph (c). States that the host county shall recommend to the commissioner one rate for each entity that will bill for medical assistance. Directs the host county to consider the costs for similar services, actual costs incurred by entities providing the services, the intensity and frequency of services to be provided, the degree to which recipients will receive other services, and the costs of other services that will be separately reimbursed.

Paragraph (d). Provides that reimbursement rates must not include medical assistance room and board rate and services, such as partial hospitalization and inpatient services, not covered by this section. Directs that physical services are not a component of the treatment team and may be billed separately.

Paragraph (e). States that case management services must be provided when services are provided by an assertive community team.

Paragraph (f). Provides that a provider's rate must not exceed the rate charged by the provider to other payor's.

Paragraph (g). Directs the commissioner to approve or reject the county's rate recommendation based on the commissioner's own analysis.

Subd. 8. Provider enrollment, rate setting for county-operated entities. Requires counties that employ their own staff to apply directly to the commissioner for enrollment and rate setting.

Effective date. This section is effective July 1, 2006.

14 **Division of cost.** Amends § 256B.19, subd. 1. Modifies the division of costs between the state and counties for the cost of placements that have exceeded 90 days in ICFs/MR that have seven or more beds. Makes the division of costs 90 percent state funds and 10 percent county funds. Makes this section effective the day following final enactment. Under current law, the division of costs is 80 percent state funds and 20 percent county funds.

Effective date. This section is effective the day following final enactment.

15 **General assistance medical care; services.** Amends § 256D.03, subd. 4. Modifies the services covered under general assistance medical care to include mental health telemedicine and psychiatric consultation, consistent with the new services under medical assistance.

Effective date. This section is effective January 1, 2006.

16 **Special needs.** Amends § 265D.44, subd. 5. Amends the general assistance chapter of law, specifically the provision dealing with individuals with special needs who are receiving Minnesota supplemental aid, by allowing individuals who are relocating from an adult mental health residential treatment program to receive the assistance available under this section, in addition to the federal Food Stamp allotment.

Effective date. This section is effective January 1, 2006.

17 **Covered health services.** Amends § 256L.03, subd. 1. Modifies the MinnesotaCare program by adding mental health telemedicine and psychiatric consultation to the list of services covered under MinnesotaCare, consistent with the previous changes in medical

assistance and general assistance medical care.

Effective date. This section is effective January 1, 2006.

18 **Discharge plans; offenders with serious and persistent mental illness.** Amends § 641.155. Requires the Commissioner of Corrections to develop a model discharge planning process for offenders with serious and persistent mental illness who have been convicted and sentenced to serve three or more months and are being released from a county jail or county regional jail.

19 **Priority in janitorial contracts.** Requires the Commissioner of Administration to give priority to supported work vendors when awarding contracts to provide janitorial services for the new Department of Human Services and Department of Health buildings.

20 **Enhanced separation.** Provides that employees covered by AFSCME, who separate from employment at the Willmar Regional Treatment Center after it ceases to be a state operated facility, are governed by the enhanced separation package.

21 **Pension coverage.** Provides that an employee of Willmar Regional Treatment Center whose position changes from state to Kandiyohi County employment during the biennium ending June 30, 2007, remains a member of the Minnesota State Retirement System unless the member elects to become a member of PERA.

22 **Effective date.** (a) Sections 20 and 21 are effective the day following final enactment.

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

Article 3: Family Support

This article makes changes to several programs including the Child Care Assistance, GA, and MFIP programs.

1 **Subsidy restrictions.** Amends § 119B.13, subd. 1. Modifies child care assistance provider reimbursement rates. Provides specifications to the commissioner related to conducting rate surveys. Removes obsolete language.

2 **Absent days.** Amends § 119B.13, by adding a subdivision. Limits the number of absent days for which a provider may be reimbursed to 25 days per child, or 10 consecutive days, in a fiscal year. Allows for an exception if a child has a documented medical condition that causes more frequent absences. Makes this section effective October 1, 2005.

3 **Child care provider training; dangers of shaking infants and young children.** Adds § 245A.1445. Requires the commissioner of health to provide a video presentation to all licensed child care providers as part of their initial and annual training. The commissioner shall also provide child care providers and interested individuals (at cost) a copy of the approved video about the dangers of shaking infants and young children also given to hospitals pursuant to section 144.574. Allows legal nonlicensed child care providers to participate at their option, in a video presentation session.

4 **Annual license or certification fee for programs with licensed capacity.** Amends § 245A.10, subd. 4. Reduces child care center licensing fees by 25 percent.

5 **Contribution amount.** Amends § 252.27, subd. 2a. Modifies the sliding scale for parental fees reducing fees for parents with incomes within certain ranges. Makes this section effective retroactively from July 1, 2005.

6 **Membership terms, compensation, removal and expiration.** Amends § 254A.035, subd. 2. Extends the sunset date for the American Indian Advisory Council to June 30, 2008. States that this section is effective retroactively from June 30, 2001.

7 **Citizens Advisory Council.** Amends § 254A.04. Extends the sunset date for the Alcohol and Other Drug Abuse Advisory Council to June 30, 2008. States that this section is

effective retroactively to June 30, 2001.

8 **American Indian Child Welfare Projects.** Adds subdivision 14b to section 256.01. Paragraph (a). Authorizes the commissioner of human services to provide grants to Minnesota Indian tribes so that they can provide child welfare services to American Indian children and families living on the reservation. Allows that the commissioner may authorize the use of alternative methods of investigating and assessing reports of child maltreatment. States that the commissioner may seek federal approvals necessary to carry out the projects. Allows the commissioner to seek and use any funds available to operate the projects.

Paragraph (b). Defines American Indian child.

Paragraph (c). Provides that to qualify for a project a tribe must be an existing tribe with reservation land; have a tribal court; have a greater number of children who have had a determination of maltreatment; have capacity to respond to allegations of child abuse and neglect; have the ability to provide services to children and families; and have a IV-E agreement.

Paragraph (d). Provides that grants awarded must be used for the nonfederal costs of providing child welfare services.

Paragraph (e). Relieves the county social service agency of responsibility for responding to abuse and neglect allegations for identified American Indian children whose tribe has received a grant under this program.

Paragraph (f). Provides that the tribes must provide information to the state that meets federal and state reporting requirements. Provides that the commissioner shall collect information on the outcomes of the projects.

9 **Eligibility.** Amends § 256B.0924, subd. 3. Adds that an adult who lacks a permanent residence and who has been without a permanent residence for at least one year or on at least four occasions in the past three years may be eligible for targeted case management services if the remaining conditions of this subdivision are met.

10 **State traumatic brain injury program.** Amends § 256B.093, subd. 1. Extends the committee termination date from June 30, 2005 to June 30, 2008.

11 **Eligibility; requirements.** Amends § 256D.06, subd. 5. Makes technical changes in paragraphs (a) and (b).

(c) Removes a requirement that the commissioner adopt rules related to providing special assistance to a GA recipient in processing the recipient's claim for maintenance benefits from another source. Allows the commissioner to contract with specified entities to provide advocacy and support services to process claims for federal disability benefits for applicants or recipients of services or benefits supervised by the commissioner.

(d) Gives the commissioner the authority to provide methods by which counties shall identify, refer, and assist recipients who may be eligible for benefits under federal programs for the disabled. Prior to this change, these methods were established in Minnesota Rules.

(e) Prohibits the total amount of interim assistance recoveries retained for advocacy, support, and claim processing services from exceeding 35 percent of the interim assistance recoveries in the prior fiscal year.

12 **SSI conversions and back claims.** Amends § 256D.06, subd. 7. Removes obsolete

language. Makes technical changes.

13 **Supplementary rate for certain facilities.** Amends § 256I.05, subd. 1e. Increases the supplemental rate a certain GRH provider may receive beginning July 1, 2005. Redistributes the number of beds among three facilities operated by the GRH provider.

14 **Treatment of Supplemental Security Income.** Amends § 256J.37, subd. 3b. Modifies treatment of SSI income under the MFIP program. Makes this section effective the first day of the second month after the date of approval by the USDA.

15 **Overview of employment and training services.** Amends § 256J.515. Adds a requirement that job counselors explain to MFIP participants the probationary employment periods new employees may serve after being hired and any assistance with job retention services that may be available.

16 **Long-term homeless supportive services.** Establishes § 256K.26.

Subd. 1. Establishment and purpose. Requires the commissioner to establish the long-term homeless supportive services fund to provide integrated services needed to stabilize specified persons living in supportive housing developed to further the goals of the working group on supportive housing for long-term homelessness.

Subd. 2. Implementation. Requires the commissioner, in consultation with specified entities, to develop application requirements and make funds available with the goal of providing maximum flexibility in program design.

Subd. 3. Definitions. Defines "long-term homelessness," and "household."

Subd. 4. County eligibility. Makes counties eligible for funding under this section. Gives priority to proposals submitted on behalf of multicounty partnerships.

Subd. 5. Content of proposals. Lists the factors on which proposals will be evaluated.

Subd. 6. Outcomes. Lists the outcomes projects that are selected will be expected to further.

Subd. 7. Eligible services. Specifies the services eligible for funding under this section.

Subd. 8. Families experiencing long-term homelessness. Requires the commissioner, in consultation with others, to assess whether the definition of long-term homelessness impacts the ability of families with minor children experiencing homelessness to obtain services to support housing stability.

Makes this section effective retroactively from July 1, 2005.

17 **American Indian Child Welfare Advisory Council.** Amends § 260.835. Provides that this council expires June 30, 2008. States that this section is effective retroactively from June 30, 2003.

18 **Recommendations on standard statewide child care license fee; report.** Requires the commissioner of human services, with the Minnesota Association of County Social Service Administrators and the Minnesota Licensed Family Child Care Association, to study the feasibility of a statewide standard for setting license and background study fees for licensed child care providers. Requires a report making recommendations on this issue to the senate and house committees with jurisdiction over child care by January 15, 2006.

19 **Parent fee schedule.** Establishes a new parent fee schedule, which reduces co-payments for parents using the child care assistance program. Makes this schedule effective January 1, 2006. Retains in effect the previous parent fee schedule until the schedule in this section is fully implemented. Specifies how a family's monthly co-payment fee is established.

20 **Repealer.** Repeals Laws 2003, First Special Session chapter 14, article 9, section 34; and Minnesota Statutes 2004, sections 119B.074; 256D.54, subdivision 3; and 256M.40, subdivision 2.

21 **Effective date.** Makes the sections in this article effective August 1, 2005, unless otherwise specified.

Article 4: Health Impact Fee

This article creates the health impact fund, provides calculations for the health impact fee, and directs the commissioner of finance to deposit the fees collected into the state treasury to be credited to the health impact fund.

1 **Health impact fund and fund reimbursements.** Creates § 16A.725.

Subd. 1. Health impact fund. Creates a health impact fund in the state treasury.

Subd. 2. Certified tobacco expenditures. Instructs the commissioner of human services to certify the tobacco use attributable health care costs in Minnesota each fiscal year.

Subd. 3. Fund reimbursements. (a) Directs the commissioner of finance each fiscal year to transfer from the health care impact fund to the general fund an amount sufficient to offset the cost of certified tobacco expenditures under subdivision 2, or the balance of the fund, whichever is less.

(b) If any balance remains, the commissioner of finance is to transfer to the health care access fund an amount sufficient to offset the health care access fund costs of the certified expenditures under subdivision 2, or the balance of the fund, whichever is less.

Effective date. This section is effective August 1, 2005**.**

2 **Tobacco health impact fee.** Creates § 256.9658.

Subd. 1. Purpose. States that the purpose of the fee is to recover state health costs related to or caused by tobacco use and to reduce tobacco use, particularly by youth.

Subd. 2. Definitions. Provides the definitions under § 297F.01 apply to this section.

Subd. 3. Fee imposed. Provides calculations for the fee and the circumstances under which the fee is imposed. The fee is set at 75 cents per pack of cigarettes and at 35 percent of the wholesale price of tobacco products.

Subd. 4. Payment. States that the fee must be paid at the same time and in the same manner as provided for payment of tax under chapter 297F.

Subd. 5. Fee on use of unstamped cigarettes. Provides that any person, other than a distributor, who purchases or possesses cigarettes that have not been stamped and on which a fee has not been paid is liable for the fee.

Subd. 6. Administration. States that the audit, assessment, interest, appeal, refund, penalty, enforcement, administrative and collection provisions of chapters 270C and 297F apply to the fee imposed under this section.

Subd. 7. Cigarette stamp. Provides that a stamp must be affixed to each package.

Subd. 8. License revocation. Allows the commissioner of revenue to revoke or suspend the license of a distributor for failure to pay the fee.

Subd. 9. Deposit of revenues. Instructs the commissioner of revenue to deposit revenues in the state treasury and credit them to the health impact fund.

Effective date. This section is effective August 1, 2005.

3 **Revocation of sales and use tax permits.** Amends § 297F.185. Allows the commissioner to revoke a retailer's sales or use permit as provided in 297A.86 if the retailer purchases cigarettes without a stamp affixed.

Effective date. This section is effective August 1, 2005.

4 **Basic cost of cigarettes.** Amends § 325D.32, subd. 9. Adds the word "fee" into the definition of basic cost of cigarettes.

Effective date. This section is effective August 1, 2005.

5 **Floor stock fees.**

Subd. 1. Cigarettes.

- Imposes a floor stocks cigarette fee on every person engaged in the business in this state as a distributor, retailer, subjobber, vendor, manufacturer, or manufacturer's representative of cigarettes, for any products under the person's control at 12:01 a.m. on August 1, 2005.

- Sets out the fee rates.

- Requires each distributor, on or before August 10, 2005, to file a return with the commissioner of revenue showing the stamped cigarettes and unaffixed stamps on hand on 12:01 a.m. on August 1, 2005 and the amount of fee due.

- Requires each retailer, subjobber, vendor, manufacturer, or manufacturer's representative, on or before August 10, 2005, to file a return with the commissioner of revenue showing the cigarettes on hand on 12:01 a.m. on August 1, 2005, and the amount of fee due.

- Requires the fee to be paid on or before September 7, 2005.

Subd. 2. Audit and enforcement. States that a fee is subject to provisions of

chapters 270C and 297F.

Subd. 3. Deposit of proceeds. Instructs the commissioner of revenue to deposit revenues into the state treasury and credit them to the health impact fund.

Effective date. This section is effective August 1, 2005.

6 Tobacco products floor stocks fee.

- Sets out the fee for tobacco products.
- Assesses the fee on each product in the distributor's possession or under the distributor's control at 12:01 a.m. on August 1, 2005.
- Directs each distributor to file a return with the commissioner of finance on or before August 10, 2005, showing the tobacco products on hand at 12:01 a.m. on August 1, 2005, and the fee due.
- States that the fee is to be paid by September 7, 2005.

Effective date. This section is effective August 1, 2005.

Article 5: Miscellaneous

This article creates the cancer drug repository program. It also changes the amounts assessed for background studies and authorizes drug purchasing pools, among various other provisions.

1 Sexual conduct with a former client. Amends § 148D.220. Provides that a social worker must not engage in or suggest sexual contact with a former client for a period of two years following termination of the professional relationship.

2 Cancer drug repository program. Adds § 144.707. Creates a cancer drug repository program.

Subd. 1. Definitions. Defines " board," "cancer drug," "cancer drug repository," "cancer supply," "dispense," "distribute," "donor," "medical facility," "medical supplies," "pharmacist," "pharmacy," "practitioner," "prescription drug," "side effects of cancer," "single-unit-dose packaging," and "tamper-evident unit dose packaging" for the purposes of the program.

Subd. 2. Establishment. Directs the Board of Pharmacy to establish and maintain a cancer drug repository program where cancer drugs and supplies may be donated for use by individuals meeting eligibility requirements established in subdivision 4. The drugs and supplies may be donated on the premises of a participating medical facility or pharmacy meeting the requirements of subdivision 3.

Subd. 3. Requirements for participation by pharmacies and medical facilities. Establishes several requirements that must be met in order for pharmacies and medical facilities to participate in the program in the following paragraphs:

(a) A pharmacy or medical facility must be licensed and in compliance with all applicable federal and state laws and administrative rules.

(b) A pharmacy or medical facility volunteering to participate (the program is voluntary) must submit the following information to the Board of Pharmacy: their

name, address, and telephone number; the name and telephone number of a pharmacist or other person knowledgeable of the pharmacy's or medical facility's participation in the program; and a statement that they meet the eligibility requirements in paragraph (a) and the chosen level of participation under paragraph (c).

(c) A pharmacy or medical facility may participate by either accepting, storing and dispensing or administering the drugs and supplies OR accepting and storing the drugs and supplies and distributing them to a fully participating cancer drug repository under subdivision 8.

(d) A pharmacy or medical facility may withdraw from the program at anytime upon notification of the Board of Pharmacy by telephone or mail.

Subd. 4. Individual eligibility requirements. States that any Minnesota resident diagnosed with cancer is eligible to receive drugs or supplies under the program according to the priorities established in subdivision 6.

Subd. 5. Donations of cancer drugs and supplies. Paragraph (a) states that legally obtained cancer drugs and supplies may be donated by an individual age 18 years or older OR a pharmacy, medical facility, drug manufacturer, or wholesale drug distributor if the drugs or supplies have not been previously dispensed. The cancer drugs and supplies must meet the requirements in paragraph (b) or (c) in order to be donated.

Paragraph (b) sets the criteria for cancer drugs. ***Cancer drugs*** must: (1) be accompanied by a cancer drug repository donor form signed by the person making the donation (or their authorized representative) as required in paragraph (d); (2) have an expiration date at least six months later than the date the drug was donated; (3) be in their original, unopened, tamper-evident unit dose packaging that includes the drug's lot number and expiration date (singe unit doses may be accepted if the single unit dose packaging is unopened); and (4) not be adulterated or misbranded.

Paragraph (c) sets the criteria for cancer supplies. ***Cancer supplies*** must: (1) not be adulterated or misbranded; (2) be in their original, unopened, sealed packaging; and (3) be accompanied by a cancer drug repository donor form signed by the person making the donation (or their authorized representative) as required in paragraph (d).

Paragraph (d) requires that a cancer drug repository donor form be provided by the Board of Pharmacy and made available on the department's website. The form must state, to the best of the donor's knowledge, that the donated drug or supply has been properly stored and that the drug or supply has never been opened, used, tampered with, adulterated, or misbranded.

Paragraph (e) states that drugs and supplies not meeting the requirements of this subdivision are not eligible for donation or acceptance under the program.

Paragraph (f) states that drugs and supplies may be donated on the premises of a cancer drug repository to a pharmacist designated by the repository. A drop box may not be used.

Paragraph (g) states that donated cancer drugs and supplies must: (1) be stored separately from nondonated drugs and supplies; and (2) be stored in a secure area with the appropriate environmental conditions appropriate for the drugs and supplies.

Subd. 6. Dispensing requirements. Establishes requirements for dispensing the drugs and supplies, including:

- requiring that the drugs and supplies be dispensed by a licensed pharmacist, pursuant to a prescription, and in accordance with Minnesota Statutes, chapter 151;

- requiring that the drugs be inspected by the pharmacist for adulteration, misbranding and the expiration date (drugs that have expired or appear to be adulterated, tampered with or misbranded, may not by dispensed);

- requiring recipients of the donated cancer drugs and supplies to sign a form provided by the Board of Pharmacy (and made available on the department's website) that states that the recipient understands that: (1) the drugs and supplies have been donated and may have been previously dispensed; (2) a pharmacist or practitioner has inspected the drugs; (3) the pharmacist, the dispensing or administering practitioner, the repository, the Board of Pharmacy, and any other program participant cannot guarantee the safety of the drug; and (4) the pharmacist or practitioner has determined that the drug is safe based on visual inspection and the accuracy of the form submitted by the donor; and

- requiring that drugs and supplies be dispensed to individuals meeting the eligibility requirements of subdivision 4 in the following order of priority: (1) uninsured, (2) enrolled in MA, GAMC, MinnesotaCare, Medicare, or other public assistance health care, and (3) all other eligible individuals.

Subd. 7. Handling fees. Allows a cancer drug repository to charge individuals receiving a drug or supply a handling fee of no more than 250 percent of the MA program dispensing fee for each cancer drug or supply dispensed. (The current pharmacy dispensing fee is $3.65, with some exceptions (Minn. Stat. § 256B.0625, subd. 13e.))

Subd. 8. Distribution of donated cancer drugs and supplies. States that cancer drug repositories may distribute donated drugs and supplies to another repository if requested by the other repository. Any repository electing not to dispense drugs and supplies shall distribute any donated drugs and supplies to a participating repository at the request of the other repository. Repositories distributing drugs and supplies under this subdivision shall complete a cancer drug repository form (provided by the Board of Pharmacy) and provide the original donor form (required under subdivision 5) to the receiving repository at the time of the distribution.

Subd. 9. Resale of donated drugs or supplies. States that donated drugs and supplies may not be resold.

Subd. 10. Record-keeping requirements. Requires that cancer drug repository donor and recipient forms be maintained for at least five years. Also requires a record of the destruction of drugs and supplies that were not dispensed to be maintained for at least five years. The record of the destruction must include: the date of destruction; the name, strength, and quantity of the drug destroyed; the name of the person/firm that destroyed the drug; and the source of the drugs or supplies.

Subd. 11. Liability.

- Exempts manufacturers of drugs and supplies (unless they exercise bad faith) from civil or criminal liabilities for injury, death, or loss to a person or property

due to participation in the cancer drug repository program.

- States that a manufacturer is not liable for intentional or unintentional alteration of the drug or supply by a person not under the control of a manufacturer or the failure of a party, not under the control of the manufacturer, to communicate product or consumer information or the expiration date of a donated drug or supply.

- Exempts medical facilities, pharmacies, pharmacists, practitioners, or donors participating in the program from civil liability for an act or omission that causes injury or death of an individual to whom the cancer drug or supply is dispensed. States that no disciplinary action shall be taken against a pharmacist or practitioner so long as the drug or supply is donated, accepted, distributed or dispensed according to the requirements of this section unless there was reckless, wanton, or intentional misconduct, or malpractice unrelated to the quality of the cancer drug or supply.

Effective date. This section is effective August 1, 2005.

3 **Purchasing for prescription drugs.** Amends § 241.01 by adding subd. 10. Allows the commissioner to enter into a contract to purchase prescription drugs for persons confined to institutions. States that local governments may participate in this purchasing pool to purchase drugs for persons confined to local correctional facilities.

Effective date. This section is effective the day following final enactment.

4 **Program design and implementation.** Amends § 245.4661, subd. 2. Adds that pilot projects for adult mental health service delivery can utilize appropriations made to regional treatment centers and state-operated services if appropriated specifically by section 246.0136.

Effective date. This section is effective the day following final enactment.

5 **Duties of commissioner.** Amends § 245.4661, subd. 6. Allows the commissioner, for purposes of pilot projects, to use the resources of regional treatment centers if consistent with section 246.0136.

Effective date. This section is effective the day following final enactment.

6 **Annual license or certification fee for programs without a licensed capacity.** Amends § 245A.10, subd. 5. Adds that licensed programs providing residential-based habilitation services under home and community-based waivered services shall pay an annual license fee with a base rate of $250 plus $38 times the number of clients served. Provides that state-operated programs are exempt.

Effective date. This section is effective August 1, 2005.

7 **Supplemental nursing services agencies.** Amends § 245C.10, subd. 2. Increases the fee for a background study from $8 to $20.

Effective date. This section is effective August 1, 2005.

8 **Personal care provider organizations.** Amends § 245C.10, subd. 3. Increases the fee for a background study from $12 to $20.

Effective date. This section is effective August 1, 2005.

9 **Use.** Amends § 245C.32, subd. 2. Increases the fee that the commissioner of human

services may charge for the costs of conducting a background study from $12 to $20.

Effective date. This section is effective August 1, 2005.

10 **Planning for enterprise activities.** Amends § 246.0136, subd. 1. Adds that the commissioner has authority to implement enterprise activities for adult mental health.

Effective date. This section is effective the day following final enactment.

11 **Minnesota Security Hospital.** Amends § 253.20. Allows the commissioner to erect, equip and maintain buildings to be known as the Minnesota Security Hospital at other geographic locations in addition to St. Peter.

Effective date. This section is effective the day following final enactment.

12 **Specific powers.** Amends § 256.01. Allows the commissioner of human services to authorize payment to or from the department.

Effective date. This section is effective August 1, 2005.

13 **Effect of assignment.** Amends § 256.741, subd. 4. Removes references to the child support collection account in the special revenue fund. This account is repealed.

Effective date. This section is effective August 1, 2005.

14 **Project of regional significance; study.** Amends § 256M.40, subd. 2. Deletes the budgetary appropriation for fiscal years 2006 and 2007.

Effective date. This section is effective the day following final enactment.

15 **Wholesale drug distributor tax.** Amends § 295.582. Clarifies that the provider tax pass-through requirements pertain to pharmacy benefits managers (PBMs), and that the intent of this pass-through is for pharmacies to be able to pass through to PBMs any additional expense that has been transferred to the pharmacy by a wholesale drug distributor to the PBM.

Effective date. This section is effective the day following final enactment.

16 **Provision of long-term care insurance.** Amends § 471.61. Allows any political subdivision to contract with an insurance company for the voluntary purchase of long-term care insurance by employees and dependents.

17 **Medical aid.** Amends § 641.15, subd. 2. States that the county boards shall not pay more than the medical assistance payment rate for medical services provided to its prisoners.

Effective date. This section is effective August 1, 2005.

18 Amends the rider language passed in 2003 that authorizes DHS to increase the fee-for-service payments by the amount of the applicable provider tax rate that the provider pays on public program revenue. Currently, the rider states that the rate must be increased by two percent. With this change, if the provider tax is increased or reduced, the rate increase would be automatically adjusted accordingly.

Effective date. This section is effective the day following final enactment.

19 **Repealer.** Repeals section 119B.074 (special revenue account for child care).

20 **Effective date.** This article is effective August 1, 2005, unless otherwise specified.

Article 6: Health Policy

This article contains a variety of provisions related to the department of health.

1 **Health information technology and infrastructure advisory committee.** Adds § 62J.495. Establishes the Health Information Technology and Infrastructure Advisory Committee. (A similar work group was established in 2004 (Minnesota Laws, ch. 288, art. 7, § 7).

Subd. 1. Establishment; members; duties. Directs the commissioner of health to establish the Health Information Technology and Infrastructure Advisory Committee to advise the commissioner on:

- the use of health information technology by the state, licensed health care providers and facilities, and local public health agencies;
- recommendations for implementing a statewide interoperable health information infrastructure; and
- other related issues requested by the commissioner.

Requires the members of the Health Information Technology and Infrastructure Advisory Committee to include: the commissioners (or their designees) of health, human services, administration, and commerce; and those appointed by the commissioner of health representing local public health agencies, licensed hospitals and other facilities/providers, private purchasers, medical and nursing professionals, health insurers, health plans, the state quality improvement organization, academic and research institutions, consumer advisory organizations, and others identified by the committee.

Subd. 2. Annual report. Requires the commissioner of health to prepare annual reports outlining progress in implementing a statewide health information infrastructure and recommending future projects, due January 30 each year.

Subd. 3. Expiration. States that this section expires June 30, 2009.

Effective date. States that this section is effective the day following final enactment.

2 **Fees for variances.** Amends § 103I.101, subd. 6. Increases the application fee for variances regarding wells and borings to $175 (the current fee is $150).

Effective date. States that this section is effective July 1, 2006.

3 **Well notification fee.** Amends § 103I.208, subd. 1. Increases well notification fees paid by property owners to the following fee levels:

- $175 for new wells (the current fee is $150);
- $35 for each well sealing (the current fee is $30);
- $35 for the single well sealing fee (the current fee is $30);

- $175 for dewatering well construction (the current fee is $175); and

- $875 for dewatering well construction of five or more wells (the current fee is $750).

Effective date. States that this section is effective July 1, 2006.

4 **Permit fee.** Amends § 103I.208, subd. 2. Increases permit fees paid by property owners as follows:

- $150 annually for wells that are not in use under a maintenance permit (the current fee is $125 annually);

- $175 for construction of a monitoring well (the current fee is $150);

- $150 annually for monitoring wells that are unsealed under a maintenance permit (the current fee is $125 annually);

- $175 for monitoring wells used as a leak detection device at single motor fuel retail outlets, single petroleum build storage sites (excluding tank farms) or single agricultural chemical facility sites (the current fee is $150);

- $150 annually for a maintenance permit for unsealed monitoring wells (the current fee is $125);

- $175 for the notification fee for groundwater thermal exchange devices (the current fee is $150);

- $175 for a vertical heat exchanger (the current fee is $150);

- $150 for dewatering unsealed dewatering wells (current fee is $125), except for projects with more than five wells, the fee increases to $750 for a single permit (the current fee is $625; and

- $175 for excavating holes for installing elevator shafts (the current fee is $150).

Effective date. States that this section is effective July 1, 2006.

5 **Disclosure of wells to buyer.** Amends § 103I.235, subd. 1. Increases the fee for a completed well disclosure certificate from $30 to $40, and increases the amount of the fee transmitted to the commissioner of health from $27.50 to $32.50.

Effective date. States that this section is effective July 1, 2006.

6 **License required to make borings.** Amends § 103I.601, subd. 2. Requires a person making an exploratory boring to have an explorer's license by strengthening the language from "may" to "must." Also adds a fee of $75 and states that the license is valid until the date prescribed by the commissioner of health. Creates the following license application requirements:

- requires a person to file an application and renewal application fee to renew the explorer's license by the date stated on the license and adds a renewal license fee

of $75;

- requires a licensee filing after the required renewal date to submit a late fee of $75 and refrain from conducting activities authorized by the license until all the necessary application requirements and sealing reports have been submitted; and

- requires an explorer to designate an individual responsible for overseeing the making of exploratory borings and requires individuals to submit an application and $75 fee to qualify as a responsible individual. Also exempts geoscientists, or professional geologists certified by the American Institute of Professional Geologists, from existing examination requirements (current law allows "certified geologists" to be exempted from the examination requirements).

Effective date. States that this section is effective the day following final enactment.

7 **License, permit, and survey fees.** Amends § 144.122. Increases license fees for hospitals, nursing homes, and outpatient surgical centers for the adverse health care events reporting system as follows:

- JACHO hospitals $7,555 plus $13 per bed (the current fee is $7,055 with no per bed charge);

- non-JACHO hospitals: $5,180 plus $247 per bed (the current fee is $4,680 plus $234 per bed); and

- outpatient surgical centers: $3,349 (the current fee is $1,512).

Codifies certain plumbing examination, registration, license, and inspection fees.

Effective date. States that this section is effective August 1, 2005.

8 **Definition.** Amends § 144.147, subd. 1. Modifies the definition of an "eligible rural hospital" for the purposes of the rural hospital grant program by increasing the population limit for an eligible hospital's community from less than 10,000 to less than 15,000. The increase retains eligibility for current and prospective critical access hospitals.

Effective date. States that this section is effective the day following final enactment.

9 **Grants authorized.** Amends § 144.147, subd. 2, para. (b). Adds "electronic health records system" to the list of possible uses of grants made to eligible rural hospitals under the Rural Hospital Grant Program.

Effective date. States that this section is effective the day following final enactment.

10 **Rural pharmacy planning and transition grant program.** Adds § 144.1476. Establishes the rural pharmacy planning and transition grant program.

Subd. 1. Definitions. Defines "eligible rural community," "health care provider," "pharmacist," and "pharmacy" for the purposes of the program.

Subd. 2. Grants authorized; eligibility. Requires the commissioner of health to award grants to eligible rural communities or health care providers in eligible rural communities for the purpose of planning, establishing, keeping in operation, or providing health services that preserve access to prescription medication and the skills of pharmacists. To be eligible for the grants, applicants must develop a

strategic plan that includes: (1) a needs assessment; (2) a feasibility assessment; and (3) an implementation plan. The grants may be used: (1) to implement transition projects; (2) to develop practices that integrate pharmacy and health care facilities; (3) to establish a pharmacy provider cooperative; or (4) for initiatives that maintain local access to prescription medications and the skills of pharmacists.

Subd. 3. Consideration of grants. Requires the commissioner of health to appoint a committee to determine which applicants will receive grants. The committee members must include, but are not limited to: two rural pharmacists; two rural health care providers; one representative of a statewide pharmacist organization; and one representative of the board of pharmacy. A representative of the commissioner of health may also serve in an ex officio status. When determining who shall receive grants, the committee must take the following into account: improving/maintaining access to prescription medications and the skills of pharmacists; changes in service populations; the extent pharmacy needs are not being met by other providers; financial condition; the integration of pharmacy services into existing health care services; and community support. Allows the commissioner of health to take into account other relevant factors.

Subd. 4. Allocation of grants. Requires the commissioner to establish a deadline for receiving applications and to make a final funding decision within 60 days of the deadline. Requires applicants to file no later than March 1 of each fiscal year for grants made that fiscal year. Allows applicants to apply each year they are eligible. Limits each grant to $50,000 a year and prohibits the use of the funds to retire debt from capital expenditures made prior to the date the program was initiated.

Subd. 5. Evaluation. Requires the commissioner of health to evaluate the overall effectiveness of the program and allows the collection of progress reports and other information needed for the evaluation. The commissioner of health or grantees may request the expertise of an academic institution to assist in the program evaluation. Requires the commissioner of health to compile summaries of successful grant projects and other model community efforts and make the information available to communities seeking to address local pharmacy issues.

Effective date. States that this section is effective August 1, 2005.

11 **Definition.** Amends § 144.148, subd. 1. Paragraph (b) modifies the definition of an "eligible rural hospital" for the purposes of the rural hospital capital improvement grant program by increasing the population limit for an eligible hospital's community from less than 10,000 to less than 15,000. The increase retains eligibility for current and prospective critical access hospitals. Paragraph (c) is modified to add electronic health records system to the definition of "eligible project" for the purposes of the Rural Hospital Capital Improvement Grant Program.

Effective date. States that this section is effective the day following final enactment.

12 **Rural health initiatives.** Amends § 144.1483. Removes clause (2), eliminating the requirement of the commissioner of health to develop and implement a program to help rural communities establish community health centers (the Rural Community Health Center Grant Program is repealed in section 58 of this article).

Effective date. States that this section is effective the day following final enactment.

13 **Definitions.** Amends § 144.1501, subd. 1. Adds a definition for "dentist" and

"pharmacist" for the purposes of the health professional education loan forgiveness program.

Effective date. States that this section is effective August 1, 2005.

14 **Creation of account.** Amends § 144.1501, subd. 2. Adds: (1) dentists agreeing to deliver at least 25 percent of their yearly patient encounters to state public program enrollees or patients receiving sliding fee schedule discounts; (2) pharmacists agreeing to practice in designated rural areas; (3) medical residents specializing in the area of pediatric psychiatry; (4) midlevel practitioners agreeing to teach; and (5) health care technicians agreeing to teach to the list of those eligible for a health professional education loan forgiveness program.

Effective date. States that this section is effective August 1, 2005.

15 **Eligibility.** Amends § 144.1501, subd. 3. Adds dental residents, individuals in dentist programs, and licensed pharmacists to the list of individuals eligible for the health professional education loan forgiveness program. Allows the commissioner to consider dental program graduates who are licensed dentists for the loan forgiveness program if there are not enough applications submitted by dental students or residents to fill the dentist participant slots available.

Effective date. States that this section is effective August 1, 2005.

16 **Loan forgiveness.** Amends § 144.1501, subd. 4. Adds "patient group," "teaching area," or "specialty type" to the list of factors considered by the commissioner in proportionally distributing funds. Modifies the provision allowing the commissioner of health to allocate funds if the commissioner does not receive enough eligible applicants by: (1) adding pediatric psychiatry to the list of uses; (2) removing the reference to urban underserved communities and replacing it with "any eligible profession;" and (3) allowing remaining funds to be allocated proportionally among the other eligible professions according to the vacancy rate for each profession in the required geographic area, patient group, or facility type.

Effective date. States that this section is effective August 1, 2005.

17 **Which services are for fee.** Amends § 144.226, subd. 1. Increases the fee for issuing a certified vital record or a certification that the record cannot be found from $8 to $9. Adds that the fee is nonrefundable.

Paragraph (b) clarifies that the fee for a replacement birth or death record is for processing the request and increases the fee from $20 to $40. Also adds that the fee is nonrefundable and due at the time of application.

Paragraph (c) clarifies that the fee for filing a delayed registration of birth or death is for processing the request and increases the fee from $20 to $40. Adds that the fee is nonrefundable and due at the time of application and that the fee includes one subsequent review of the request if not acceptable upon the initial receipt.

Paragraph (d) clarifies that the fee for amending any vital record is for processing the request and increases the fee from $20 to $40. Adds that the fee is nonrefundable and due at the time of application and that the fee includes one subsequent review of the request if not acceptable upon the initial receipt.

Paragraph (e) clarifies that the fee for verifying information from vital records is for

processing the request and increases the fee from $8 to $9. Adds that the fee is nonrefundable and due at the time of application.

Paragraph (f) clarifies that the fee for issuing a copy of any vital record or statement for which a record cannot be found is for processing the request and increases the fee from $8 to $9. Adds that the fee is nonrefundable and due at the time of application.

Effective date. States that this section is effective August 1, 2005.

18 **Vital records surcharge.** Amends § 144.226, subd. 4. Increases the vital record nonrefundable surcharge fee from $2 to $4 from August 1, 2005 to June 30, 2009.

19 **Electronic verification.** Amends § 144.226 by adding subd. 5. States that a fee for the electronic verification of a vital event, when the information being verified is obtained from a certified birth or death record, shall be established through agreements with local, state, or federal agencies.

Effective date. States that this section is effective August 1, 2005.

20 **Alternative payment methods.** Amends § 144.226 by adding subd. 6. Allows alternative payment methods to be approved by a state or local registrar.

Effective date. States that this section is effective August 1, 2005.

21 **Fee setting.** Amends § 144.3831, subd. 1. Increases the annual fee for every service connection to a public water supply owned or operated by a home rule charter city, a statutory city, a city of the first class, or a town from $5.21 to $6.36.

Effective date. States that this section is effective July 1, 2006.

22 **Restricted construction or modification.** Amends § 144.551, subd. 1. Amends clause (12) to state that notwithstanding section 144.552, 27 beds of which 12 serve mental health needs, may be transferred from Hennepin County Medical Center to Regions Hospital; and adds clause (19) to exempt critical access hospitals (established under § 144.1483, clause (9) and section 1820 of the federal Social Security Act who delicensed beds after the Balanced Budget Act of 1997) from the existing hospital construction moratorium provided they do not exceed the limits established in federal law. Several critical access hospitals reduced the number of licensed beds between 1998 and 2003 to comply with the limit of 15 beds established in federal law in 1997. In 2003, the federal limit was increased to 25; this change would allow hospitals to adjust to the federal change.

Effective date. States that this section is effective the day following final enactment.

23 **Eligibility for license condition.** Amends § 144.562, subd. 2. Allows critical access hospitals without attached nursing homes or that owned a nursing home in the same municipality as of May 1, 2005, to provide up to 2,000 days annually of swing bed care (the current limit is 1,460 days) and the limit on using no more than 10 beds as swing beds at any one time is removed. Critical access hospitals that have attached nursing homes or that owned a nursing home in the same municipality as of May 1, 2005, are allowed swing bed use up to the limits in federal law. The commissioner of health may approve bed usage beyond 2,000 days if the critical access hospital determines there are no skilled nursing facility beds within 25 miles that are willing to admit the patient (the critical access hospitals must maintain documentation that they have contacted facilities within this radius). Critical access hospitals that reach 2,000 days of use may admit six additional swing bed patients without approval from the commissioner of health. Health care systems may allocate their total limit of swing bed days among hospitals within the system, provided that no critical access hospital without an attached nursing home exceeds 2,000 days per

year.

Effective date. States that this section is effective the day following final enactment.

24 **Education about the dangers of shaking infants and young children.** Adds § 144.574. Establishes requirements for hospitals regarding educating parents about the dangers of shaking infants and young children.

Subd. 1. Education by hospitals. Paragraph (a) requires hospitals licensed under sections 144.40 to 144.56 to provide parents of newborns (who delivered in the hospital) a video presentation on the dangers associated with shaking infants and young children. Paragraph (b) requires the video to be obtained from the commissioner of health or approved by the commissioner. The commissioner is responsible for providing the video, at cost, to the hospital and any interested individuals. At the request of a hospital, the commissioner must review other video presentations for possible approval. Prohibits the commissioner from requiring the use of a video that would require hospitals to pay royalties, restrict the viewing, or be subject to other costs or restrictions. Paragraph (c) requires hospitals to, whenever possible, request both parents to view the video. Paragraph (d) states that the showing or distribution of the video shall not subject any person or facility from any action for damages or other relief provided the person or facility acted in good faith.

Subd. 2. Education by health care providers. Requires the commissioner to establish a protocol for health care providers to educate parents and primary caregivers about the dangers associated with shaking infants and young children. The commissioner must request that family practice physicians, pediatricians, and other pediatric health care providers review these dangers with parents and primary care givers of infants and young children up to the age of three at each well-baby visit.

Effective date. States that this section is effective August 1, 2005.

25 **Definitions.** Adds § 144.602. Defines "commissioner," "major trauma," and "trauma hospital" for the purposes of sections 144.601 to 144.608.

Effective date. States that this section is effective the day following final enactment.

26 **Statewide trauma system criteria.** Adds § 144.603.

Subd. 1. Criteria established. Requires the commissioner of health to adopt rules establishing criteria to ensure that severely injured people are promptly transported and treated at appropriate trauma centers. Requires certain minimum criteria.

Subd. 2. Basis; verification. Requires the commissioner of health to base establishment, implementation, and modification of the criteria in subdivision 1 on the comprehensive statewide trauma system plan published by the Department of Health. Requires the commissioner of health to seek the advice of the Trauma Advisory Council and use the standards of various trauma experts. Requires the commissioner to modify the standards when appropriate and verify that the criteria are met by each hospital volunteering to participate.

Subd. 3. Rule exemption and report to the legislature. Exempts the commissioner from Minnesota Statutes, chapter 14, in developing and adopting criteria under this section. Requires the commissioner to report to the legislature by

September 1, 2009, on the implementation of the voluntary trauma system, including the recommendations on the need for including the trauma system criteria in rule.

Effective date. States that this section is effective the day following final enactment.

27 **Trauma triage and transportation.** Adds § 144.604.

Subd. 1. Transport requirement. Requires an ambulance service to transport major trauma patients from the scene to the highest state-designated trauma hospital within 30 minutes' transport time (unless the Emergency Medical Services Board has approved a deviation to the guidelines established under section 144E.101, subdivision 14).

Subd. 2. Ground ambulance exceptions. Requires ground ambulances to meet the following requirements: (1) patients with compromised airways must be transported to the nearest designated trauma hospital; and (2) level II trauma hospitals capable of providing definitive trauma care may not be bypassed in order to reach a level I trauma hospital.

Subd. 3. Undesignated hospitals. Prohibits trauma patients from being transported to an undesignated trauma hospital unless no trauma hospital is available within 30 minutes' transport time.

Effective date. States that this section is effective July 1, 2009.

28 **Designating trauma hospitals.** Adds § 144.605.

Subd. 1. Naming privileges. Prohibits a hospital from using the terms "trauma center" or "trauma hospital" in its name or advertising, or otherwise indicating that it has trauma capabilities unless the hospital has been designated a trauma hospital by the commissioner of health.

Subd. 2. Designation; reverification. Requires the commissioner of health to designate four levels of trauma hospitals. Requires the commissioner to verify/reverify that hospitals applying for designation meet the requirements, and designate those meeting the requirements as the appropriate level trauma hospital for a period of three years. Hospitals volunteering to meet the requirements must apply for designation/reverification every three years. Prior to the three-year expiration of the trauma designation, a hospital must apply and either be awaiting a site visit or the results. Provides provisions for 18-month extensions in certain circumstances.

Subd. 3. ACS verification. Requires the commissioner of health to grant level I, II, and III trauma designations to hospitals (meeting the appropriate American College of Surgeons' (ACS) standards) that have submitted verification documentation and that have formerly notified the Trauma Advisory Council of its ACS verification.

Subd. 4. Level III designation; not ACS verified. Establishes provisions for granting level III trauma designations to hospitals that are not ACS verified. Requires hospitals to complete and submit an application to the Trauma Advisory Council for review and verify that they meet the criteria of a level III trauma hospital. Requires a site visit and a submission of recommendations by a review team to the Trauma Advisory Council who must provide written recommendations on the designation to

the commissioner who grants final approval.

Subd. 5. Level IV designation. Establishes provisions for granting level IV trauma designations. Requires hospitals to complete and submit an application to the Trauma Advisory Council for review and verify that they meet the criteria of a level IV trauma hospital. Requires the Trauma Advisory Council to review the application and, if it approves, submit recommendations to the commissioner who grants final approval. When granting a level IV designation, the commissioner must arrange a site visit within three years, and every three years afterwards.

Subd. 6. Changes in designation. Requires hospitals to report changes in their ability to meet trauma level designation criteria to the Trauma Advisory Council, other regional hospitals, local emergency medical services providers, and authorities. If a hospital cannot meet its trauma level designation within six months, the hospital may apply for redesignation at a different level.

Subd. 7. Higher designation. Allows a trauma hospital to apply for a higher trauma designation once during a three-year designation period by completing the appropriate level's designation process.

Subd. 8. Loss of designation. Allows the commissioner to refuse or revoke trauma designations to hospitals who do not meet the criteria or who deny or refuse a reasonable request by the commissioner or commissioner's designee to verify information.

Effective date. States that this section is effective the day following final enactment.

29 Interhospital transfers. Adds § 144.606.

Subd. 1. Written procedures required. Requires level III and IV trauma centers to have predetermined, written procedures for rapidly and efficiently transferring major trauma patients to definitive care.

Subd. 2. Transfer agreements. Allows level III and IV hospitals to transfer patients to trauma hospitals that they have current written transfer agreements with. Requires level III and IV trauma centers to have a current transfer agreement with a hospital that has special capabilities in the treatment of burn injuries as well as a secondary hospital should the primary hospital be unable to accept a burn patient.

Effective date. States that this section is effective the day following final enactment.

30 Trauma registry. Adds § 144.607.

Subd. 1. Registry participation required. Requires trauma hospitals to participate in the statewide trauma registry.

Subd. 2. Trauma reporting. Requires trauma hospitals to report major trauma injuries as part of the traumatic brain injury registry under sections 144.661 to 144.665.

Subd. 3. Application of other law. States that sections 144.661 to 144.665 (traumatic brain injury and spinal cord injury registry statutes) apply to major trauma reported to the statewide trauma system except section 144.662, clause (2) and

section 144.664, subdivision 3, which require persons with traumatic brain/spinal cord injuries (or their families) to be notified of available rehabilitative resources and services in Minnesota.

Effective date. States that this section is effective the day following final enactment.

31 **Trauma advisory council.** Adds § 144.608.

Subd. 1. Trauma advisory council established. Establishes the Trauma Advisory Council to consult with and make recommendations to the commissioner on the development, maintenance, and improvement of a statewide trauma system. Requires the council to consist of 15 members with various backgrounds. Allows a member whose membership depends upon their practice at a level III or IV trauma hospital to be appointed to an initial term based upon statements that their hospital intends to become a level III or IV facility by July 1, 2009.

Subd. 2. Council administration. Requires the council to meet at least twice a year. The council is governed under section 15.059, but expires on June 30, 2015. Allows the council to appoint subcommittees (consisting of members only) and work groups (which may include non-members to be compensated for expenses only and governed under section 15.059).

Subd. 3. Regional trauma advisory councils. Permits the formation of regional trauma advisory councils as needed. Requires the regional trauma advisory councils to consult with and make recommendations to the state Trauma Advisory Council on regional modifications to the statewide trauma criteria. Limits the number of members of a regional trauma advisory council to 15 to be named by the commissioner in consultation with the Emergency Medical Services Regulatory Board. Members are permitted to receive compensation in the manner and amount authorized and adopted under section 43A.18, subdivision 2.

Effective date. States that this section is effective the day following final enactment.

32 **Lead risk assessment.** Amends § 144.9504, subd. 2. Lowers the blood lead level that requires a lead risk assessment in children (from 20 micrograms to 15 micrograms of lead per deciliter) and pregnant women (from 70 micrograms to 60 micrograms of lead per deciliter).

Effective date. States that this section is effective August 1, 2005.

33 **Fees.** Amends § 144.98, subd. 3. Modifies environmental laboratory certification fees. Increases the base certification fee from $1,200 to $1,600 and eliminates the reference to the fee being nonrefundable. Adds a sample preparation techniques fee of $100 per technique. Increases the test category certification fees as follows:

- Clean water program bacteriology, safe drinking water program bacteriology, clean water program inorganic chemistry, and safe drinking water program inorganic chemistry categories are all increased from $600 to $800;

- Clean water program chemistry metals, safe drinking water program chemistry metals, resource conservation and recovery program chemistry metals categories are all increased from $800 to $1,200;

- Clean water program volatile organic compounds, safe drinking water program volatile organic compounds, resource conservation and recovery program volatile organic compounds, underground storage tank program volatile organic compounds, clean water program other organic compounds, safe drinking water program other organic compounds, and resource conservation and recovery program other organic compounds categories are all increased from $1,200 to $1,500; and

- Adds the following four new test categories with a $2,500 fee: clean water program radiochemistry, safe drinking water program radiochemistry, resource conservation and recovery program agricultural contaminants, and resource conservation and recovery program emerging contaminants.

Increases the additional fee charged to laboratories outside of the state that require an on-site inspection (current law states "on-site survey") from $2,500 to $3,750. The language is also strengthened from "will" to "shall" be assessed.

Effective date. States that this section is effective August 1, 2005.

34 **Trauma triage and transport guidelines.** Amends § 144E.101 by adding subd. 14. Requires, by July 1, 2009, ambulance service licensees to have written, age appropriate trauma triage and transport guidelines consistent with the criteria established by the Trauma Advisory Council and approved by the board. Permits the board to allow certain deviations if they are in the best interest of the patient.

Effective date. States that this section is effective the day following final enactment.

35 **Informed consent.** Amends § 145.4242. Adds to the criteria for an abortion to be considered voluntary and informed that a woman be informed, for abortions after 20 weeks gestational, whether or not an anesthetic or analgesic would eliminate or alleviate organic pain in the unborn child caused by the abortion and the benefits and risks associated with the anesthetic or analgesic. Requires that the physician disclose any additional costs associated with the administration of the anesthetic or analgesic, and that the physician administer or arrange to have the anesthetic or analgesic administered if the woman consents.

Effective date. States that this section is effective August 1, 2005.

36 **Community-based programs.** Amends § 145.56, subd. 2. Modifies the requirement that the commissioner of health establish a community-based grant program, by making this contingent on the extent to which funds are appropriated.

Effective date. States that this section is effective the day following final enactment.

37 **Periodic evaluations; biennial reports.** Amends § 145.56, subd. 5. Modifies the requirement that the commissioner of health conduct periodic evaluations of the impacts and outcomes of the state's suicide prevention plan, by making this contingent on the extent to which funds are appropriated.

Effective date. States that this section is effective the day following final enactment.

38 **Postpartum depression education and information.** Adds § 145.906. Paragraph (a) requires the commissioner of health to work with health care facilities and licensed health care and mental health professionals, mental health advocates, consumers and families in Minnesota to develop materials and information about postpartum depression. Paragraph (b) requires physicians, traditional midwives, and other licensed health care professionals

providing prenatal care to women to have available to women and their families information about postpartum depression. Paragraph (c) requires hospitals and other health care facilities to provide departing new mothers and fathers, and other family members as appropriate, with written information about postpartum depression including its symptoms, methods of coping with the illness, and treatment resources.

Effective date. States that this section is effective August 1, 2005.

39 **Community clinic grants.** Amends § 145.9268. Modifies various provisions of the Rural Community Clinic Grant Program in order to combine it with the Rural Community Health Center Grant Program.

Subd. 1. Definitions. Modifies and adds the types of entities used to define "eligible community clinics" for the purposes of community clinic grants.

- Changes clause (1) by modifying the first entity type, limiting eligibility to *nonprofit* clinics, and changing the requirements of the clinic to include that the clinic was established to provide health care services to low income or rural population groups, and that the clinic provides medical, preventative, dental, or mental health primary care services. The clinic's options for determining eligibility are also expanded to include "other procedures" or procedures that ensure that no person will be denied services because they are unable to pay. (In current law, a sliding fee scale is the only procedure eligible.)

- Changes clause (2) by modifying the second entity type, adding "government entity" as an eligible service unit and requiring that the service unit provides services and utilizes a sliding fee scale or other procedure (as expanded in clause 1).

- Adds clause (4) which adds to the list of eligible entities, a nonprofit, tribal or government entity proposing to establish a clinic that will provide services and that will use a sliding fee or other procedure (as expanded in clause 1).

Subd. 2. Grants authorized. Modifies the use of grants made to eligible community clinics by adding to "plan, establish, or operate services."

Subd. 3. Allocation of grants. Adds "a process for documenting and evaluating results" to the required minimum components of the grant application. Modifies the list of criteria used to review the grant applications for eligibility by:

- changing one criteria from the "priority level" of a project to the "eligibility" of a project;

- adding "a description of the population demographics and service area of the proposed project" to the list of criteria; and

- expanding the degree to which grant funds will be used to support services that increase access to health care services to also include the degree to which funds "maintain" access to health care services.

Subd. 3a. Awarding grants. Adds subdivision 3a, creating a separate subdivision for the grant awarding process and making modifications to the grant awarding process to be followed by the commissioner. The modifications include:

- eliminating the prioritization order of project activities the commissioner shall use in awarding grants;
- adding electronic health records systems to the list of project activities the commissioner may award grants for; and
- adding building or expanding an existing facility to the list of project activities the commissioner may award grants for.

Subd. 4. Evaluation and report. Modifies the components of the required evaluation done by the commissioner to include the needs of community clinics and recommendations for changing eligible activities. (Current law requires the commissioner's evaluation to include priority areas. The prioritization of activities is eliminated in subdivision 3a of this section.)

Effective date. States that this section is effective the day following final enactment.

40 **Exemptions.** Amends § 147A.08. Makes conforming changes to correct references displaced by section 13 of this article.

Effective date. States that this section is effective August 1, 2005.

41 **Donated dental services.** Amends § 150A.22. Changes the responsibility of the donated dental services program from the Board of Dentistry to the commissioner of health.

Effective date. States that this section is effective retroactively from July 1, 2005.

42 **Rule exemption.** Amends § 157.011 by adding subd. 3. States that notwithstanding any rule to the contrary, a food establishment is not required to acquire equipment or change construction solely because ownership changed.

Effective date. States that this section is effective the day following final enactment.

43 **Statewide hospitality fee.** Amends § 157.15 by adding subd. 19. Defines "statewide hospitality fee" as a fee to fund statewide food, beverage, and lodging program development activities.

Effective date. States that this section is effective August 1, 2005.

44 **License renewal.** Amends § 157.16, subd. 2. Increases from $25 to $50 the penalty added to a license fee for food and beverage service establishments operating without a license (for less than 30 days) as a mobile food unit or seasonal temporary or permanent food stand, or a special event food stand. Increases from $50 to $100 the penalty added to a license fee for all restaurants, food carts, hotels, motels, lodging establishments, and resorts operating without a license (for less than 30 days). States that a late fee of $300 shall be added to the license fee for establishments operating without a license for more than 30 days.

Effective date. States that this section is effective August 1, 2005.

45 **Food manager certification.** Amends § 157.16 by adding subd. 2a. Requires applicants for certification or renewal of a food manager certificate to submit a $28 nonrefundable certification fee to the Department of Health.

Effective date. States that this section is effective August 1, 2005.

46 **Establishment fees; definitions.** Amends § 157.16, subd. 3. Paragraph (a) requires food and beverage establishments and establishments serving alcohol to pay the highest applicable fee under paragraph (d); this corrects a cross-reference.

Paragraph (b) increases the annual base fee for food and beverage establishments (except for special event food stands, hotels, motels, lodging establishments and resorts) from $145 to 150.

Paragraph (c) increases the flat fee charged to special event food stands from $35 annually to $40 annually.

Paragraph (d) increases the following fee categories added to the base fee under paragraph (b) as follows (except for special event food stands): limited food menu selection from $40 to $50; small establishments from $75 to $100; medium establishments from $210 to $260; large establishments from $350 to $460; other food and beverage service from $40 to $50; beer or wine table service from $40 to $50; alcoholic beverage service (other than beer or wine table service) from $105 to $135; lodging per sleeping accommodation unit from $6 to $8, with a maximum charge of $800 (increased from $600); first public swimming pool from $140 to $180, with each additional pool at $100 (up from $80); first spa from $80 to $110, with each additional spa at $50 (up from $40); private sewer or water from $40 to $50; adds an "additional food service" category with a fee of $130 which applies to locations at food service establishments other than the primary food preparation and service area; and adds an "additional inspection fee" of $300 for school inspections requiring a second inspection under the Richard B. Russell National School Lunch Act.

Paragraph (e) increases the fee charged for the review of construction plans from $150 to $350 and modifies the list of entities to which the fee applies.

Paragraph (f) increases the remodeling plan fee from $150 to $250 and requires that a fee of $250 be submitted for new construction or remodeling of a restaurant with a limited food menu selection, a seasonal permanent food stand, a mobile food unit, or a food cart, or for a hotel, motel, resort or lodging establishment addition of less than five sleeping units.

Effective date. States that this section is effective August 1, 2005.

47 **Statewide hospitality fee.** Amends § 157.16 by adding subd. 3a. Requires every person, firm, or corporation operating a licensed boarding establishment, food and beverage service establishment, seasonal temporary or permanent food stand, special event food stand, mobile food unit, food cart, resort, hotel, motel, or lodging establishment in Minnesota to submit an annual $35 statewide hospitality fee. If the establishment is licensed by the Department of Health, the fee is due at the same time the licensure fee is due. If the establishment is licensed by local governments, the fee is due by July 1 of each year.

Effective date. States that this section is effective August 1, 2005.

48 **Inspection frequency.** Amends § 157.20, subd. 2. Clarifies that inspections of high-risk establishments must be conducted once every 12 months (current laws reads "once a year"), and that inspections of low-risk establishments must be conducted once every 24 months (current law reads "every two years").

Effective date. States that this section is effective August 1, 2005.

49 **Risk categories.** Amends § 157.20, subd. 2a. Adds a risk category for schools for the

purpose of food and beverage establishment inspections. Requires elementary and secondary school food service establishments to be inspected based on the frequency assigned by their risk category, or the Richard B. Russell National School Lunch Act, whichever is more restrictive in order to conform to the new federal requirements.

Effective date. States that this section is effective August 1, 2005.

50 **Fees.** Amends § 326.42, subd. 2. Clarifies the elements of plumbing plan reviews and audits subject to fees to include catch basin design (current law reads "catch basin").

Effective date. States that this section is effective the day following final enactment.

51 **Commissioner of health.** Amends Minnesota Laws 2005, chapter 107, article 1, section 6. Changes the purpose of the appropriation from the implementation of section 144.1498 (the low-income loan repayment program for nurses passed in the higher education omnibus bill, which is repealed in section 58 of this article) to section 144.1501 (the health professional education loan forgiveness program).

Effective date. States that this section is effective the day following final enactment.

52 **Cervical cancer elimination study.** Requires the commissioner of health to develop a cervical cancer prevention plan that includes activities that identify and implement methods to improve cervical cancer screening rates, including, but not limited to: (1) identifying and disseminating evidenced-based screening guidelines; (2) increasing the use of such screening methods and monitoring the results; and (3) reducing the number of women who are not screened but should be. Requires the commissioner to identify and examine the limitations/barriers in providing screening, diagnostic tools and treatment including, but not limited to, medical care reimbursements, costs, and insurance availability. Allows the commissioner to work with nonprofit quality improvement organizations and convene an advisory committee. Requires the commissioner to submit a report by January 15, 2006, on the plan, methods for monitoring results and recommendations.

Effective date. States that this section is effective August 1, 2005.

53 **Public health information network.** Requires the commissioner of health to work with local public health departments to develop a public health information network. Requires the commissioner to work with the commissioner of human services to determine how data from care systems can be utilized to assist with population health needs assessments and target prevention efforts. Requires the commissioner of health to submit a progress report to the legislature before the next biennium.

Effective date. States that this section is effective the day following final enactment.

54 **Report to legislature on swing bed usage.** Requires the commissioner of health to study swing bed issues and report to the legislature by January 31, 2007.

Effective date. States that this section is effective the day following final enactment.

55 **Implementation of an electronic health records system.** Requires the commissioner of health to develop a statewide plan for all hospitals and physician group practices to have in place an interpoerable electronic health records system by January 1, 2015.

56 **Rule amendment.** Requires the commissioner of health to amend Minnesota Rules, part 4626.2015, subparts 3 item c and 6, item b (related to food manager qualifications) to conform with section 45 of this article. Allows the commissioner to use the good cause exemption (Minn. Stat. § 14.388, subd. 1, clause (3)). States that section 14.386 does not apply, except as provided in section 14.388.

Effective date. States that this section is effective August 1, 2005.

57 **Direction to commissioner; dental review.** Requires the commissioner of health, in consultation with dental associations, licensed dental and public health professionals, and others, to review the leadership and advisory role of the department of health including the usefulness of utilizing a dental director.

Effective date. States that this section is effective the day following final enactment.

58 **Repealer.** Paragraph (a) repeals the following: § 144.1502, the dentist loan forgiveness program; § 144.1486, the Rural Community Health Centers Grant Program; and § 157.215, the pilot project involving food and beverage service establishment HACCP quality assurance practices effective the day following final enactment.

Paragraph (b) repeals Minnesota Laws 2005, chapter 107, article 2, section 51 (the low-income loan repayment program for nurses) effective the day following final enactment.

Article 7: Long-Term Care and Continuing Care

This article makes changes to long-term care and continuing care programs.

1 **Project amendment authorized.** Amends § 144A.073, subd. 3d. Allows two Duluth nursing facilities that received moratorium exceptions from the Commissioner of Health in 2002 to downsize their projects.

2 **Extension of approval of moratorium exception.** Amends § 144A.073, subd. 10. Extends the project approval for all nursing home moratorium projects approved by the Commissioner of Health between July 1, 2001, and June 30, 2003, for an additional 18 months, for a total extension of 36 months. (All of these projects were extended for 18 months by prior legislative action.)

3 **Required report.** Adds § 256B.0185. Requires the commissioner, by December 15 of both 2005 and 2006, to report information for counties in which MA applications for those 65 or older are pending for more than 45 days and applications for persons who are disabled are pending for more than 60 days. The report must include recommendations on how counties can shorten the time it takes to act on applications.

4 **Employed persons with disabilities.** Amends § 256B.057, subd. 9. Provides that inflation adjustments for Social Security benefits do not count as income for MA-EPD enrollees until July 1 of each year.

5 **Long-term care partnership.** Adds § 256B.0571. Directs the commissioner to establish a long-term care partnership program to finance long-term care through a combination of private insurance and MA, and specifies program criteria.

Subds. 1 to 7. Define terms.

Subd. 8. Program established. Requires the commissioner of human services, in cooperation with the commissioner of commerce, to establish the Minnesota partnership for long-term care program. In order to participate, requires an individual to be a Minnesota resident, purchase and maintain a partnership policy that is delivered, issued, or renewed on or after the effective date of the program, and exhaust the minimum benefits under the policy.

Subd. 9. MA eligibility. Requires the commissioner, when determining MA eligibility for partnership program participants, to disregard in addition to the MA

asset limit an additional amount of assets equal to the dollar amount of coverage used under the partnership policy.

Subd. 10. Dollar-for-dollar asset protection policies. Specifies minimum coverage standards for a dollar-for-dollar asset protection policy.

Subd. 11. Total asset protection policies. Specifies minimum coverage standards for a total asset protection policy. (This type of policy has higher minimum coverage standards than a dollar-for-dollar asset protection policy.)

Subd. 12. Compliance with federal law. Requires issuers of partnership policies to comply with any federal laws and regulations authorizing partnership policies in Minnesota.

Subd. 13. Limitations on estate recovery. (a) Limits MA recoveries against the estates of persons who exhaust the minimum benefits of a dollar-for-dollar asset protection policy to an amount that exceeds the dollar amount of coverage used under the partnership policy.

(b) Prohibits MA recoveries against the estates of persons who exhaust the minimum benefits of a total asset protection policy.

Subd. 14. Implementation. (a) Allows the commissioner, in consultation with the commissioner of commerce, to alter partnership program requirements in order to conform with federal law or waiver authority.

(b) Authorizes the commissioner to suspend implementation until the next legislative session, if the commissioner determines that the federal legislation or waiver is likely to impose substantial unforeseen costs on the state budget.

(c) Requires the commissioner to take action under paragraphs (a) or (b) within 45 days of federal authorization.

(d) Requires the commissioner to notify the appropriate legislative committees of action taken, within 50 days of federal authorization.

(e) Requires the commissioner to publish notice of implementation decisions in the State Register.

Effective date. (a) Provides that if any provision of the section is prohibited by federal law, no provision of the section shall be implemented until federal law allows full implementation. Specifies notice requirements.

(b) Requires the commissioner to apply for a waiver, if federal law is changed to permit a waiver of any provisions prohibited by federal law. Specifies notice requirements.

6 **Targeted case management; definitions.** Amends § 256B.0621, subd. 2. Modifies the definition of "relocation targeted case management" to include both county targeted case management and public or private vendor service coordination.

7 **Eligibility.** Amends § 256B.0621, subd. 3. Modifies eligibility provisions for relocation targeted case management or home care targeted case management.

8 **Relocation targeted county case management provider qualifications.** Amends §

256B.0621, subd. 4. Specifies that the provider qualifications listed apply to county case management providers. Provides that counties must require contracted providers to provide information on all conflicts of interest and obtain the recipient's informed consent or provide the recipient with alternatives.

9 **Home care targeted case management and relocation service coordination provider qualifications.** Amends § 256B.0621, subd. 5. Specifies the provider qualifications for providers of home care targeted case management and relocation service coordination.

10 **Eligible services.** Amends § 256B.0621, subd. 6. (a) Modifies the services eligible for MA reimbursement as targeted case management.

(b) Specifies what is included in relocation targeted county case management, relocation service coordination, and home care targeted case management.

11 **Time lines.** Amends § 256B.0621, subd. 7. Specifies that eligible recipients must be assigned a county case manager for relocation targeted case management. Allows a recipient to obtain relocation service coordination from a qualified provider if the county, county's contractor, or tribe does not provide case management services as required.

12 **Data use agreement and notice of relocation targeted case management availability.** Amends § 256B.0621, by adding subd. 11. Requires the commissioner to execute a data use agreement with CMS to obtain the long-term care minimum data set data to assist residents of nursing facilities who have indicated a desire to live in the community. Requires the commissioner to enter into an agreement with the Centers for Independent Living to provide information about assistance for persons who want to move to the community.

13 **Skilled and intermediate nursing care.** Amends § 256B.0625, subd. 2. Provides an exemption from the requirement that a hospital be classified under federal law as a sole community provider in order to receive MA payments for swing bed services. This exemption applies to facilities that had an agreement with the commissioner, as of January 1, 2004, to provide swing bed services. Background: Federal law defines a sole community provider as a hospital that is located more than 35 miles from other hospitals, or meets other specified criteria related to patient use of other hospitals, distance or travel time, or lack of access to other hospitals. Federal law requires sole community providers to be reimbursed under the Medicare prospective payment system. Critical access hospitals are exempt from this prospective payment system and are reimbursed on a cost basis. A determination has therefore been made that critical access hospitals no longer qualify for swing bed services under current state law, since they cannot be classified as sole community providers. Provides that the section is effective the day following final enactment and applies to swing bed services provided on or after July 1, 2005.

14 **Personal care.** Amends § 256B.0625, subd. 19c. Strengthens regulation of the personal care assistant (PCA) program. It requires PCA services to be included in a statement of need by a physician and sets requirements for these determinations.

15 **Definition.** Amends § 256B.0627, subd. 1. Modifies several definitions relating to PCA services. It requires PCAs to keep daily written records of actual services provided. It strengthens regulation of personal care provider organizations (PCPOs). It places restrictions on the delegation of authority by a responsible party to another person.

16 **Personal care assistant services.** Amends § 256B.0627, subd. 4. Prohibits payment for PCA services provided without a physician's statement of need. This section also requires PCPOs to meet certain standards in order to be paid for PCA services. This section requires DHS to establish an ongoing audit process for potential fraud and abuse in the PCA program.

17 **Limitation on payments.** Amends § 256B.0627, subd. 5. Requires a new physician's statement of need if a request is made for a modification of PCA services due to a change in

the recipient's medical condition.

18 **Option for flexible use of PCA hours.** Amends § 256B.0627, subd. 9. Tightens administration of the PCA option for flexible use of authorized hours. Flexible use of hours must be prior authorized for periods covering no more than six months, and unused hours may not be carried over. The involved parties must determine if flexible use is appropriate for the client. A written month-to-month plan for use of PCA hours must be developed, monitored, and enforced. Requires the provider to notify specified persons if the monthly amount of hours authorized is likely to be exceeded. Requires the commissioner to revoke the flexible use authorization under certain circumstances. Allows the recipient or responsible party to stop the flexible use of hours. Allows the recipient or responsible party to appeal the commissioner's action.

19 **Oversight of enrolled PCA services providers.** Amends § 256B.0627, subd. 18. Authorizes DHS to request information from PCA service providers and to sanction providers who fail to comply.

20 **Eligibility for services.** Amends § 256B.0913, subd. 2. Makes alternative care services available to persons age 65 or older who would be MA-eligible within 135 days of admission to a nursing facility. Prior to this change, alternative care services were available to persons who became MA-eligible within 180 days of admission to a nursing facility.

21 **Eligibility for funding for services for nonmedical assistance recipients.** Amends § 256B.0913, subd. 4. Changes the length of time within which a person must become eligible for MA from 180 days to 135 days of admission to a nursing facility.

22 **Services covered under alternative care.** Amends § 256B.0913, subd. 5. Eliminates alternative care program coverage of adult foster care, assisted living, and residential care services.

23 **Services; service definitions; service standards.** Amends § 256B.0913, subd. 5a. Makes a conforming change related to section 22.

24 **Quality assurance system established.** Amends § 256B.095. Extends the sunset date for the quality assurance system from June 30, 2007, to June 30, 2009. Makes this section effective retroactive to July 1, 2005.

25 **Membership.** Amends § 256B.0951, subd. 1. Extends the sunset date for the Quality Assurance Commission from June 30, 2007, to June 30, 2009. Makes this section effective retroactive to July 1, 2005.

26 **Quality assurance teams.** Amends § 256B.0952, subd. 5. Modifies per diem payments for quality assurance team members for time spent on alternative quality assurance process matters. Prior to this change, only team members who did not receive a salary or wages from an employer could receive per diem payments from the county. The new law allows for any team member to be paid a per diem for time spent on alternative quality assurance process matters. Makes this section effective retroactive to July 1, 2005.

27 **Process components.** Amends § 256B.0953, subd. 1. Modifies the random sample of program consumers by reducing the minimum sample size from three to two consumers. Makes this section effective retroactive to July 1, 2005.

28 **Policy, applicability, purpose, and construction; definition.** Amends § 256B.15, subd. 1. States that all provisions in section 256B.15, subdivisions 1, 1d, 1f, 1g, 1h, 1i, and 1j that relate to the continuation of a recipient's life estate or joint tenancy interests in real property after death of the recipient, for purposes of recovering medical assistance, are effective only for life estates and joint tenancies established on or after August 1, 2003. States that medical assistance does not include alternative care for purposes of this paragraph.

Effective date. Provides a retroactive effective date of August 1, 2003.

29 **Other survivors.** Amends § 256B.15, subd. 4. Clarifies that for purposes of MA recoveries, if a decedent who was single or the surviving spouse is survived by specified

individuals, a claim against the estate is payable first from the value of nonhomestead property. States that the section is effective August 1, 2005 and applies to persons dying on or after that date, and probates commenced on or after that date.

30 **Establishment of a life estate or joint tenancy interest.** Amends § 256B.15, subd. 6. Specifies when a life estate or joint tenancy interest is established.

Effective date. Provides a retroactive effective date of August 1, 2003.

31 **Lien notices.** Amends § 256B.15, subd. 8. States that lien notices against life estate or joint tenancy interests established prior to August 1, 2003, end and become unenforceable upon the death of the life tenant or joint tenant and shall be disregarded by examiners of title and not carried forward. States that this subdivision does not apply if the terms of the life estate provide otherwise.

32 **Immunity.** Amends § 256B.15, subd. 9. Provides the commissioner of human services, county agencies, elected officials and their employees with immunity from liability for actions taken pursuant to the 2003 act that continued life estate and joint tenancy interests.

Effective date. Provides a retroactive effective date of August 1, 2003.

33 **Nursing facility rate increases for October 1, 2005, and October 1, 2006.** Amends § 256B.431, by adding subd. 41. Increases nursing facility total operating payment rates by 2.2553 percent for the rate period beginning October 1, 2005, and by 1.2553 percent for the rate year beginning October 1, 2006. Seventy-five percent of the new money must be used for employee wage and benefit improvements implemented under procedures that have been applied to previous rate increases. Facilities that incurred new costs for employee salaries and benefits after July 1, 2003, are allowed to count those costs towards the first year's increase.

34 **Incentive to establish single-bed rooms.** Amends § 256B.431, by adding subd. 42. Establishes an incentive for nursing facilities to establish single-bed rooms, by increasing nursing facility operating payment rates beginning July 1, 2005, by 20 percent multiplied by the ratio of new single-bed rooms divided by the number of active beds. Allows the commissioner to implement rate adjustments for up to 3,000 new single-bed rooms each year. Prohibits a nursing facility from discharging residents to establish single-bed rooms and requires the commissioner to deny rate adjustments if this occurs. If more than 4,000 nursing home beds are removed from service before December 31, 2007, requires a portion of the appropriation for nursing homes to be transferred to the alternative care program.

35 **Definitions.** Amends § 256B.432, subd. 1. Modifies the definition of nursing facility for purposes of determining allocation of central, affiliated, or corporate office costs

36 **Effective date.** Amends § 256B.432, subd. 2. Specifies that the provisions related to allocating central, affiliated, or corporate office costs also apply to facilities reimbursed under the alternative payment system and the new nursing facility reimbursement system.

37 **Allocation; costs allocable on a functional basis.** Amends § 256B.432, subd. 4a. Requires costs not directly identified to be allocated to nursing facilities on a basis designed to equitably allocate the costs to facilities or activities receiving the benefit of the costs, and on a functional basis where practical and the amounts are material. Specifies the procedures that must be followed if the central office wishes to change its allocation bases.

38 **Allocation of remaining costs; allocation ratio.** Amends § 256B.432, subd. 5. If remaining costs (after allocation of costs that can be directly identified) are partially attributable to the start-up of home and community-based services intended to fill a gap identified by the local agency, allows the facility to assign these costs to the appropriate cost category of the facility for up to two years.

39 **Related organization costs.** Amends § 256B.432, by adding subd. 6a. Specifies that costs

applicable to services, capital assets, and supplies furnished to a nursing facility by a related organization may be included in the allowable cost of the facility at the purchase price paid and at the cost incurred by the related organization, if these prices or costs do not exceed that of comparable services, assets, or supplies that could be purchased elsewhere. States that the related organization's costs must not include markup or profit. If the related organization makes sales to nonrelated organizations, states that the cost to the nursing facility is the nonrelated organization's price, if sales to such organizations are at least 50 percent of total annual sales.

40 **Duration and termination of contracts.** Amends § 256B.434, subd. 3. Increases the term of contracts under the alternative payment system from one year to a term not to exceed four years.

41 **Alternate rates for nursing facilities.** Amends § 256B.434, subd. 4. Provides that the annual inflation adjustment for nursing facilities under the alternative payment system applies only to the property-related payment rate, for the rate years beginning July 1, 2005 through July 1, 2008. Also provides that beginning in 2005, the property rate adjustment for nursing homes reimbursed under both the alternative payment and cost-based systems shall be effective October 1. Allows facilities in the alternative payment system to receive property rate adjustments for building projects. Eliminates language directing the commissioner to develop incentive-based payments tied to outcomes. Makes this section effective retroactive to July 1, 2005.

42 **Facilities without APS contracts as of October 1, 2006.** Amends § 256B.434, by adding subd. 19. Effective October 1, 2006, eliminates property payment rates under the rule 50 cost-based system.

43 **Nursing facility reimbursement system effective October 1, 2007.** Adds § 256B.441.

Subd. 1. In general. (a) Requires the commissioner to establish a value-based nursing facility reimbursement system with facility-specific, prospective rates. Requires rates to be determined using an annual statistical and cost report, using a total payment rate comprised of: direct care services, support services, external fixed, and property-related rate components. Requires the total payment rate to be adjusted for quality of services, recognition of staffing levels, geographic variation in labor costs, and resident acuity.

(b) Specifies that rates are rebased annually, and that the cost reporting year begins October 1 and ends on the following September 30. Requires a statistical and cost report to be filed by each facility, beginning January 15, 2006. Requires notice of rates to be distributed by August 15, with rates taking effect October 1.

(c) Requires the commissioner to phase-in the new system beginning October 1, 2007, with full phase-in completed by October 1, 2011.

Subd. 2 through 42. Provide definitions related to the new reimbursement system.

"Direct care costs category" means costs for nursing services, activities, and social services.

"External fixed costs category" means costs related to the nursing home surcharge, licensure fees, long-term care consultation fees, family advisory council fees, scholarships, planned closure rate adjustments, property taxes and property insurance, and PERA.

"Facility average case mix index (CMI)" means a numerical score that describes the relative resource use of residents, computed as standardized days divided by total days for all residents.

"Normalized direct care costs per day" means direct care costs divided by standardized days, and is the cost per day for direct care services associated with a RUGs index of 1.00.

"Peer groups" means: (1) C and NC/short stay/R80 – facilities that have three or more admissions per bed per year, are hospital-attached, or are licensed under Minnesota Rules to serve persons with physical disabilities; (2) boarding care homes – facilities that have more than 50 percent of beds licensed as boarding care homes; and (3) standard – all other facilities.

"Standardized days" means the sum of resident days by case mix category multiplied by the RUG index for each category.

"Support services costs category" means costs for dietary, housekeeping, laundry, maintenance, and administration.

Subd. 43. Reporting of statistical and cost information. Specifies requirements for reporting of statistical and cost information by facilities. Allows the commissioner to grant extensions and requires the commissioner to reduce reimbursement payments until information is filed. Allows facilities, within 12 months of the due date of a report, to file an amendment to correct errors or omissions if this would result in a rate increase of at least .15 percent of the statewide weighted average operating payment rate, and requires facilities to file at any time an amendment that would result in a rate reduction of at least .15 percent of the statewide weighted average operating payment rate. Requires the commissioner to make retroactive rate adjustments. States that retroactive rate adjustments are not applied to private pay residents. Requires the commissioner to recover overpayments resulting from inaccurate or false information or failure to amend a report, and allows the commissioner to take other action against the facility.

Subd. 44. Calculation of a quality score. (a) Requires the commissioner to determine a quality score for each facility, using the quality measures established, according to methods determined by the commissioner in consultation with stakeholders and experts. Exempts these measures from chapter 14.

(b) Requires a score to be determined for each quality measure and the scores for all quality measures totaled. Allows the commissioner to annually revise the determination of quality measures used and the methods of calculating scores.

(c) For the initial rate year, requires the following quality measures to be used: (1) staff turnover; (2) staff retention; (3) use of pool staff; (4) quality indicators from the minimum data set; (5) survey deficiencies.

(d) Specifies procedures for revising and establishing quality scores.

Subd. 45. Calculation of operating payment rate for direct care and support services. Requires the commissioner to provide recommendations to the legislature by February 15, 2006, on a methodology for a payment rate for direct care and support services that does not increase expenditures beyond the limits of the appropriation. Also requires the commissioner to include recommendations on options to recognize changes in staffing and services that may require a supplemental appropriation.

Subd. 46. Calculation of quality add-on. States that the payment rate for the quality add-on is a variable amount based on each facility's quality score. For the rate year beginning October 1, 2006, provides that the maximum quality add-on is 2.4 percent and that the add-on is not subject to the phase-in. Allows the commissioner to increase the maximum quality add-on as new quality measures are incorporated and existing measures updated or improved. Specifies the methodology to be used to calculate the quality add-on.

Subd. 47. Audit authority. Establishes procedures and criteria for desk and field audits by the commissioner.

44 **Services and supports.** Amends § 256B.49, subd. 16. Requires a transitional supports allowance to be available to all persons under a home and community-based waiver who are moving from a licensed setting to a community setting. Defines transitional supports allowance. Lists covered costs. Makes this section effective upon federal approval and to the extent approved as a federal waiver amendment.

45 **ICF/MR rate increases beginning October 1, 2005, and October 1, 2006.** Amends § 256B.5012, by adding subd. 6. Increases ICF/MR total operating payment rates by 2.2553 percent, for the rate years beginning October 1, 2005 and October 1, 2006. Seventy-five percent of the new money must be used for employee wage and benefit improvements under procedures that have been applied to previous rate increases.

46 **Alternative integrated long-term care services; elderly and disabled persons.** Amends § 256B.69, subd. 23.

A new paragraph (e) allows the commissioner of human services, in consultation with the commissioners of commerce and health, to approve and implement programs for all-inclusive care for the elderly (PACE), according to federal laws and regulations governing the program and state law or rules applicable to participating providers. Provides that the process for approval of programs can begin only after the commissioner receives grant money sufficient to cover the state share of actuarial and administrative costs for FYs 2006 and 2007. Specifies the following:

- a PACE provider is not required to be licensed or certified as a health plan company
- persons age 55 and older who have been screened and found eligible for elderly waiver or CADI waiver services, or who are already Medicaid eligible and meet the level of care criteria for waiver services may enroll in PACE
- Medicare and Medicaid services will be provided according to this subdivision and federal requirements
- PACE enrollees will receive Medicaid home and community-based services through a PACE provider as an alternative to waiver services and regular MA services

The commissioner shall establish Medicaid rates for PACE providers that do not exceed costs under fee-for-service or relevant managed care programs.

A new paragraph (f) directs the commissioner to seek federal approval to expand the Minnesota disability health options (MnDHO) program in stages, first to regional population centers outside the metro area and then to all areas of the state.

A new paragraph (g) makes health plans providing services under this section responsible for home care targeted case management and relocation targeted case management.

47 **Reimbursement for health care services.** Adds § 256B.762. Increases MA reimbursement rates by five percent for the following services, when the services are provided as home health services:

(1) skilled nursing visit;

(2) physical therapy visit;

(3) occupational therapy visit;

(4) speech therapy visit; and

(5) home health aide visit.

These rates are effective for services provided on or after October 1, 2005.

48 **Community living adjustment.** Amends § 256I.06, by adding subd. 9. Makes available a group residential housing community living adjustment of $12 per month for persons eligible for and residing in group residential housing.

49 **Time limits; claim limits; liens on life estates and joint tenancies.** Amends § 514.981, subd. 6. Amends a section dealing with MA liens, to provide that all provisions related to the continuation of a recipient's life estate or joint tenancy interests in real property after death of the recipient, for purposes of recovering medical assistance but not alternative care, are effective only for life estates and joint tenancies established on or after August 1, 2003.

Effective date. Provides a retroactive effective date of August 1, 2003.

50 **Consumer-directed community supports methodology.** Upon federal approval, requires the commissioner of human services to allow exceptions to exceed the state set budget formula amount when certain requirements are met, for specified persons using the CDCS option.

51 **Costs associated with physical activities.** Upon federal approval, requires that costs associated with physical exercise or other physical activities be allowable expenses for adults under the CDCS option.

52 **Waiver amendment.** Requires the commissioner of human services to submit a waiver amendment to CMS consistent with sections 50 and 51 by October 1, 2005.

53 **Independent evaluation and review of unallowable items.** Requires the commissioner of human services to include specified participation, recommendations, and review in the independent evaluation of the CDCS option. Makes this section effective the day following final enactment.

54 **Federal approval.** Requires the commissioner of human services, by August 1, 2005, to request any federal approval and plan amendments necessary to implement the transitional supports allowance and the choice of case management service coordination provisions.

55 **Community services provider rate increases.** Increases reimbursement rates for specified

community-based long-term care providers by 2.2553 percent, for the rate years beginning October 1, 2005, and October 1, 2006. Seventy-five percent of the increase must be used for employee wage and benefit improvements under procedures that have been applied to previous rate increases.

56 **Commissioner's duties related to the change in effective date for life estate and joint tenancy interest provisions.** Requires the commissioner of human services and county agencies that have recovered MA or alternative care payments due to the continuation of life estate or joint tenancy interests in real property to refund those recoveries, without interest. Specifies the procedures to be used in providing refunds.

Effective date. Provides a retroactive effective date of August 1, 2003.

57 **Direction to the commissioner; licensing and alternative quality assurance study.** Requires the commissioner of human services to arrange for a study, including recommendations for statewide development and implementation of regional or local quality assurance models for disability services. Specifies what the study shall include. Requires the study to be done in consultation with counties, consumers of service, providers, and representatives of the Quality Assurance Commission. Requires the study to be submitted to the chairs of the legislative committees with jurisdiction over health and human services by July 1, 2006. Requires the commissioner to submit proposed legislation for implementation of a statewide system of quality assurance to the chairs of the legislative committees with jurisdiction over health and human services by December 15, 2006.

58 **Disability services interagency work group.** Requires the Department of Human Services, the Minnesota Housing Finance Agency, and the Minnesota State Council on Disability to convene an interagency work group to make recommendations on specified topics relating to persons with disabilities who are attempting to relocate from or avoid placement in institutional settings. Requires the group to report to each participating state agency and the chairs of legislative health and human services policy and finance committees by October 15, 2006. Makes this section expire October 15, 2006.

59 **Report to legislature.** Requires the commissioner of human services, in consultation with specified parties, to report to the legislature by December 15, 2006 on the redesign of case management services.

60 **Recommendations for property payment system for nursing facilities.** Requires the commissioner of human services to provide recommendations to the legislature by February 15, 2007, on changes to the current nursing facility property system.

61 **Repealer.** Repeals Minnesota Statutes, sections 514.991 through 514.995. These sections were adopted in 2003 and establish Alternative Care liens and procedures for enforcing them. The repealer states that, as of July 1, 2005, all existing AC liens shall be of no force and effect and must be disregarded.

62 **Effective date.** Makes the sections in this article effective August 1, 2005, unless otherwise specified.

Article 8: Health Care – Department of Human Services

This article contains provisions related to eligibility, covered services, cost-sharing, reimbursement, funding, and administration for the Medical Assistance, MinnesotaCare, and General Assistance Medical Care programs.

1 **Health care access fund.** Amends § 16A.724. Directs the commissioner of finance, effective with the biennium beginning July 1, 2007, to transfer excess funds from the health

care access fund to the general fund on June 30 of each year, provided that the amount transferred in any biennium does not exceed $96 million. Classifies MinnesotaCare as a forecasted program for fiscal years 2006 to 2009, and requires the commissioner to reduce transfers from the health care access fund to the general fund to meet annual MinnesotaCare expenditures, or if necessary transfer funds from the general fund to the health care access fund to meet annual MinnesotaCare expenditures.

2 **Hospital charge disclosure.** Adds § 62J.84. Requires the Minnesota Hospital Association to develop a web-based system for reporting charge and other information for each of the 50 most common inpatient diagnosis-related groups and the 25 most common outpatient surgical procedures as specified by the association. Requires the site to be established by October 1, 2006 and updated annually. Allows the commissioner of health to require hospitals to provide the information to the association, and directs the commissioner to provide a link to the information on the department's web site.

3 **Discounted payments.** Amends § 62Q.251, as amended by Laws 2005, chapter 147, article 11, section 3. Modifies provisions that allow health care providers to provide care to patients at discounted payment amounts, by: (1) eliminating the prohibition on the discount reducing payment below Medicare approved payment rates; (2) prohibiting health plan companies and insurers, when determining provider payment rates, from considering care for which a discount is given for hardship situations; (3) eliminating language prohibiting a provider from charging an uninsured person more than the provider charges a health plan company or other insurer; and (4) making a clarifying change related to the provision of charity care.

4 **Human services.** Amends § 62Q.37, subd. 7. Requires the commissioner of human services to report annually to the legislature by December 31 of each year on the number of audits performed by nationally recognized independent organizations that were accepted, partially accepted, or rejected by the commissioner. Provides an effective date of August 1, 2005.

5 **Specific powers.** Amends § 256.01, subd. 2. A new paragraph (bb) gives the commissioner of human services authority to administer a drug rebate program for drugs purchased for GAMC enrollees. Effective January 1, 2006, limits GAMC drug coverage to prescription drugs that are covered under MA and are provided by manufacturers that have executed GAMC rebate agreements. Requires rebates to be deposited in the general fund. Provides an August 1, 2005, effective date.

6 **Authorization for test sites for health care programs.** Amends § 256.01, by adding subd. 2a. Allows the commissioner, in cooperation with county agencies, to test and compare a variety of administrative models to demonstrate and evaluate outcomes of integrating health care program business procedures and points of access. (This is to be done in coordination with the development and implementation of HealthMatch.) Requires the commissioner, based on the evaluation, to recommend the most efficient and effective model for statewide implementation. Provides a retroactive effective date of July 1, 2005.

7 **Retention rates.** Amends § 256.019, subd. 1. Allows counties to keep one-half of the nonfederal share of MinnesotaCare recoveries, if the recovery is collected and posted by the county agency. Provides a retroactive effective date of July 1, 2005.

8 **State agency hearings.** Amends § 256.045, subd. 3. Makes state agency hearings available to applicants aggrieved by an adverse decision to an application or redetermination for a Medicare Part D prescription drug subsidy under section 256B.04, subdivision 4a. Provides a retroactive effective date of July 1, 2005.

9 **Prepaid health plan appeals.** Amends § 256.045, subd. 3a. Eliminates the requirement that a prepaid health plan, when a recipient complaint is filed, notify the ombudsman within three working days. Provides a retroactive effective date of July 1, 2005.

10 **Hearing authority.** Amends § 256.046, subd. 1. Allows DHS, in lieu of a local agency, to

initiate an administrative fraud disqualification hearing when the state agency is directly responsible for administration of the health care program for which benefits were wrongfully obtained. Provides a retroactive effective date of July 1, 2005.

11 **Withholding.** Amends § 256.9657, by adding subd. 7a. Allows DHS, in cases in which a provider required to pay an MA surcharge is more than two months delinquent, to withhold some or all of the amount of the delinquent surcharge, with any interest and penalties, from any money the department owes the provider. Specifies procedures and requirements for prior notice, provider informal objections and appeals, refunds, and written settlement agreements. Classifies all unpaid surcharges and any interest and penalties as overpayments for purposes of section 256B.0641 (provisions that allow the commissioner to recover overpayments). Provides a retroactive effective date of July 1, 2005.

12 **Payments.** Amends § 256.969, subd. 3a. Reduces MA payment rates for inpatient hospital services by six percent for fee-for-service admissions. Excludes certain mental health services and services provided by Indian health service facilities from this reduction. Also exempts GAMC services from the reduction. Requires payments to managed care plans for services provided on or after January 1, 2006, to be reduced to reflect this reduction. Provides an August 1, 2005 effective date.

13 **Disproportionate numbers of low-income patients served.** Amends § 256.969, subd. 9. The amendment to paragraph (b) eliminates disproportionate share hospital (DSH) payments to two hospitals with high MA patient volume (this is related to elimination of an intergovernmental transfer that involves these hospitals). A new paragraph (f) classifies GAMC expenditures for hospital services made by the department and prepaid health plans between July 1, 2005 and June 30, 2007 as Medicaid DSH payments, subject to specified exceptions. Provides that upon federal approval, paragraph (f) is effective retroactively from July 1, 2005 or the earliest effective date approved by CMS.

14 **Greater Minnesota payment adjustment after June 30, 2001.** Amends § 256.969, subd. 26. Eliminates language that allows the commissioner of human services to adjust the MA enhanced diagnosis-related groups (DRG) payment rate to non-metro hospitals, based on the level of funding provided through the inter-governmental transfer under section 256B.195. Provides an effective date of August 1, 2005.

15 **Quarterly payment adjustment.** Amends § 256.969, by adding subd. 27. (a) Effective July 1, 2007, provides the following increases to hospital operating and property payment rates:

- 13 percent for a Minnesota hospital not eligible for a small rural payment adjustment with a MA utilization rate greater than 17.8 percent of total patient days;
- 10 percent for a Minnesota hospital located in a specified urban area outside of the seven-county metro area, and not eligible for a small rural payment adjustment, with a MA utilization rate less than or equal to 17.8 percent of total patient days; and
- 4 percent for a Minnesota hospital not located in a specified urban area with a MA inpatient utilization rate less than or equal to 17.8 percent of total patient days.

(b) Requires the state share of payments under paragraph (a) to be equal to federal reimbursements for nonstate expenditures reported under section 256B.199, and allows the commissioner to ratably reduce or increase payments to comply with this requirement.

(c) Requires payments under paragraph (a) to be paid quarterly beginning July 15, 2007 or upon federal approval of federal reimbursement under section 256B.199, whichever is later.

(d) Prohibits the commissioner from adjusting prepaid health plan rates to reflect the payments under paragraph (a).

(e) Requires the commissioner to maximize the use of available federal DSH money and maximize payments to hospitals. Allows the commissioner to adjust the amounts reported by nonstate entities under section 256B.199, and otherwise adjust the provisions of this subdivision.

(f) Requires the commissioner, beginning January 15, 2006 and each January 15 thereafter, to report to legislative committee chairs estimates of the difference between the Medicare upper payment limit and MA payments for hospital services, the amount of federal DSH money available and the amount expected to be claimed by the state, and the methodology used to determine these results.

(g) States that for purposes of this subdivision, MA does not include GAMC.

(h) States that this section sunsets on June 30, 2009. Requires the commissioner to report to the legislature by December 15, 2008 with recommendations for maximizing federal DSH payments after June 30, 2009.

Provides an August 1, 2005 effective date.

16 **Prescription drug assistance.** Amends § 256.975, subd. 9. Deletes a reference to the enrollment of individuals who are referred to the Prescription Drug Assistance Program from the Prescription Drug Program, which is being repealed. Provides an effective date of January 1, 2006.

17 **Third-party payer.** Amends § 256B.02, subd. 12. States that a third-party payer includes an entity under contract with the recipient to cover all or part of the recipient's medical costs. Also makes technical changes. Provides a retroactive effective date of July 1, 2005.

18 **Medicare prescription drug subsidy.** Amends § 256B.04, by adding subd. 4a. Requires the commissioner to perform all duties necessary to administer eligibility determinations for the Medicare Part D prescription drug subsidy and facilitate the enrollment of eligible MA recipients into Medicare prescription drug plans, as required by the federal Medicare Modernization Act. Provides a retroactive effective date of July 1, 2005.

19 **Persons detained by law.** Amends § 256B.055, by adding subd. 14. Paragraph (a) States that MA may be paid for an inmate of a correctional facility who is conditionally released through work release and who is not housed in a detention facility but at a halfway house, community correctional center, or at home, if the individual meets MA eligibility requirements.

Paragraph (b) states that an individual, regardless of age, who is considered an inmate of a public institution under federal regulations is not eligible for medical assistance.

Provides a retroactive effective date of July 1, 2005.

20 **Reduction of excess assets.** Amends § 256B.056, by adding subd. 3d. Specifies methods of reducing assets to allowable MA program limits (restores rule authority inadvertently repealed). Allows assets to be reduced in the three calendar months before the month of application by: (1) designating burial funds up to $1500 for each applicant, spouse, and MA-eligible dependent child; and (2) paying health service bills incurred in the retroactive period for which the applicant seeks eligibility. Allows assets to be reduced beginning the month of application by: (1) paying bills for health services that would otherwise be paid by MA; and (2) using any means other than a transfer of assets for less than fair market

value. Provides a retroactive effective date of July 1, 2005.

21 **Excess income.** Amends § 256B.056, subd. 5. Requires recipients on a one-month spenddown who chose to pay the spenddown amount in advance to pay the spenddown amount on or before the last business day of the month, in order to be eligible for that payment option for the following month. (Current law requires payment by the 20th of the month.) Provides an effective date of August 1, 2007, or upon HealthMatch implementation, whichever is later.

22 **Individuals on fixed or excluded income.** Amends § 256B.056, subd. 5a. Requires recipients who receive only fixed unearned or excluded income to report and verify their income every 12 months, with the 12-month period beginning the month of application (current law requires this "annually"). Provides an effective date of August 1, 2007, or upon HealthMatch implementation, whichever is later.

23 **Individuals with low income.** Amends § 256B.056, subd. 5b. Requires recipients not residing in a long-term care facility with slightly fluctuating income below the MA limit to report and verify their income every six months, with the six-month period beginning the month of application (current law requires this to be done semiannually). Provides an effective date of August 1, 2007, or upon HealthMatch implementation, whichever is later.

24 **Period of eligibility.** Amends § 256B.056, subd. 7. Provides that MA eligibility for retroactive months is determined independently from eligibility for the month of application and future months. States that the 12-month period for purposes of eligibility redetermination begins the month of application. Provides an effective date of August 1, 2007, or upon HealthMatch implementation, whichever is later.

25 **Notice.** Amends § 256B.056, by adding subd. 9. Requires the state agency to be given notice of monetary claims against a person, entity, or corporation that may be liable to pay all or part of the cost of medical care that the state agency has paid or is liable for. Specifies procedures for giving notice. Provides an effective date of August 1, 2005.

26 **Eligibility verification.** Amends § 256B.056, by adding subd. 10. (a) Requires the commissioner to require women who are applying for a continuation of MA following the 60-day postpartum period to update income and asset information and submit any required income or asset verification.

(b) Requires the commissioner to determine whether auto-newborns are eligible for private-sector health coverage, and pay for private-sector coverage if this is cost-effective.

(c) Directs the commissioner to modify the Minnesota health care programs application to require more detailed information on assets and income, and to verify assets and income for all applicants and for all renewals.

(d) Directs the commissioner to require Minnesota health care program recipients to report new or increased earned employment income within 10 days, verify new or increased earned income that affects eligibility, and disenroll recipients who do not provide this verification.

Provides an effective date of September 1, 2005, with paragraph (a) effective on that date or upon federal approval, whichever is later. Specifies procedures for implementing the section prior to and upon implementation of HealthMatch.

27 **Availability of income for institutionalized persons.** Amends § 256B.0575. For purposes of the provision that allows amounts for reasonable expenses incurred for medical or remedial care to be deducted from an institutionalized person's income, limits "reasonable expenses" to those that have not been previously deducted from income and that are incurred during the current period of eligibility, including retroactive months, for

MA payment of long-term care services. Provides a retroactive effective date of July 1, 2005.

28 **Citizenship requirements.** Amends § 256B.06, subd. 4. Eliminates state-only funded MA coverage for pregnant women who are undocumented or nonimmigrants who have other health insurance. Provides coverage for eligible pregnant women to the extent funding is available under the state children's health insurance program. Provides an effective date of September 1, 2005.

29 **Services provided in a hospital emergency room.** Amends § 256B.0625, by adding subd. 1a. States that MA does not cover visits to a hospital emergency room that are not for emergency and emergency post stabilization care or urgent care, and does not pay for services provided in that setting that are not for those purposes. Provides an effective date of October 1, 2005.

30 **Sex reassignment surgery.** Amends § 256B.0625, subd. 3a. States that MA does not cover sex reassignment surgery, and eliminates language that allowed coverage of gender reassignment surgery and related services if the individual had been receiving gender reassignment services prior to July 1, 1998. Provides an effective date of August 1, 2005.

31 **Circumcision for newborns.** Amends § 256B.0625, by adding subd. 3c. Prohibits MA coverage of newborn circumcision, unless the procedure is medically necessary or required because of a well-established religious practice. Provides an effective date of September 1, 2005.

32 **Dental services.** Amends § 256B.0625, subd. 9. Removes the $500 annual benefit cap on adult dental services in the medical assistance program, restoring the services to services covered prior to 2003. Provides an effective date of January 1, 2006.

33 **Drugs.** Amends § 256B.0625, subd. 13. Effective January 1, 2006, prohibits MA coverage of drugs that are coverable under Medicare Part D, for individuals eligible for drug coverage under that program. Allows MA coverage of drugs from drug classes listed in federal law for which Medicaid programs can exclude or restrict coverage.

34 **Drug utilization review board.** Amends § 256B.0625, subd. 13a. Requires the commissioner, after receiving recommendations from professional medical and pharmacy associations and consumer groups, to designate members of the Drug Utilization Review Board. Strikes language requiring members to be selected from lists submitted by professional organizations. Allows the DHS medical director to serve as an ex officio, nonvoting member. Allows members to be reappointed more than once by the commissioner. Provides that the section is effective the day following final enactment.

35 **Formulary committee.** Amends § 256B.0625, subd. 13c. Requires the drug formulary committee to be staffed by an employee of DHS who services as an ex officio, nonvoting member. Also designates the medical director as an ex officio, nonvoting member. Provides an effective date of the day following final enactment.

36 **Drug formulary.** Amends § 256B.0625, subd. 13d. Prohibits the MA drug formulary from covering drugs when used for the treatment of impotence or erectile dysfunction. Provides a September 1, 2005 effective date.

37 **Payment rates.** Amends § 256B.0625, subd. 13e. Reduces the actual acquisition cost of a drug from average wholesale price (AWP) minus 11.5 percent to AWP minus 12 percent. Also eliminates obsolete language. Provides an effective date of August 1, 2005.

38 **Prior authorization.** Amends § 256B.0625, subd. 13f. The amendment to paragraph (c) requires prior authorization for brand name drugs for mental illness to be automatically granted for 60 days, within 60 days of when a generic drug becomes available provided the brand name drug was part of the recipient's course of treatment when the generically equivalent drug became available. The amendment to paragraph (d) eliminates the July 1, 2005 sunset for a provision that exempts antihemophilic factor drugs, prescribed for the treatment of hemophilia and blood disorders when no generic drug is available, from MA

prior authorization under any supplemental drug rebate program or multistate preferred drug list. Provides an effective date for paragraph (c) of August 1, 2005, and a retroactive effective date for paragraph (d) of June 30, 2005.

39 **Medication therapy management care.** Amends § 256B.0625, by adding subd. 13h. (a) Provides MA and GAMC coverage for medication therapy management for a recipient taking four or more medications to treat or prevent two or more chronic medical conditions, or for a recipient with a drug therapy problem identified or prior authorized by the commissioner that has resulted in or is likely to result in significant nondrug program costs. Allows coverage under MinnesotaCare if the commissioner determines this is cost effective. Defines "medication therapy management" as the provision of specified pharmaceutical care services by a licensed pharmacist to optimize the therapeutic outcomes of the patient's medications. States that nothing in this subdivision shall be construed to expand or modify the scope of practice of a pharmacist.

(b) Lists criteria that pharmacists must meet in order to be eligible for reimbursement for medication therapy management.

(c) Allows the commissioner to enroll individual pharmacists as MA and GAMC providers, for purposes of reimbursement for medication therapy management services. Allows the commissioner to establish contact requirements between the pharmacist and recipient.

(d) Requires the commissioner, after receiving recommendations from specified groups, to establish an eleven-member Medication Therapy Management Advisory Committee, to advise the commissioner on the implementation and administration of medication therapy management services. Specifies membership and governance of the committee.

(e) Requires the commissioner to evaluate the effect of medication therapy management on quality of care, patient outcomes, and program costs, and to include a description of MA and GAMC savings. Requires the evaluation to be submitted to the legislature by December 15, 2007. Allows the commissioner to contract with a vendor or academic institution in order to complete the evaluation.

Provides an effective date of August 1, 2005.

40 **Transportation costs.** Amends § 256B.0625, subd. 17. Reduces MA reimbursement rates for wheelchair-accessible and non-wheelchair-accessible vans and increases rates for stretcher-accessible vehicles. Provides an August 1, 2005 effective date.

41 **Copayments.** Amends § 256B.0631, subd. 1. Reduces the monthly maximum MA copayment for prescription drugs, from $20 to $12. Provides a January 1, 2006 effective date.

42 **Collection.** Amends § 256B.0631, subd. 3. Makes a conforming change related to reduction of the monthly maximum MA copayment for prescription drugs.

43 **Performance reporting and quality improvement system.** Adds § 256B.072. (a) Requires the commissioner to establish a performance reporting system for MA, GAMC, and MinnesotaCare health care providers, with separate reporting for managed care and fee-for-service patients.

(b) Specifies measures and related criteria to be used for reporting by medical groups and inpatient hospitals.

(c) Allows the commissioner to require providers to submit information required as part of performance reporting to a health care reporting organization, or to cooperate with the

information collection procedures of that organization. Allows the commissioner to collaborate with a reporting organization to collect information and prevent duplication.

(d) Beginning October 1, 2007, requires the commissioner to annually report through a public web site the results of performance reporting, and to compare the results by medical groups and hospitals for patients enrolled in public programs and patients enrolled in private health plans. Allows the commissioner to collaborate with a health care reporting organization that operates a web site suitable for this purpose.

Provides an effective date of the day following final enactment.

44 **Fee-for-service.** Amends § 256B.075, subd. 2. Directs the commissioner to develop and implement a pilot intensive care management project for MA 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. Provides an effective date of the day following final enactment.

45 **Definitions.** Amends § 256B.0911, subd. 1a. Deletes a cross reference to the Prescription Drug Program, which is being repealed.

46 **Transitional supports allowance.** Amends § 256B.0916, by adding subd. 10. Requires a transitional supports allowance to be available to all persons under a home and community-based waiver who are moving from a licensed setting to a community setting. Defines transitional supports allowance. Lists covered costs. Makes this section effective upon federal approval and to the extent approved as a federal waiver amendment.

47 **Employee scholarship costs.** Adds § 256B.0918.

Subd. 1. Program criteria. Requires the commissioner, beginning October 1, 2005, and within the limits of appropriations, to fund qualified provider applicants for employee scholarships for a course of study expected to lead to career advancement with the provider or in the field of long-term care, including home care, care of persons with disabilities, or nursing. Specifies additional criteria for scholarships.

Subd. 2. Participating providers. Requires the commissioner to publish a request for proposals by August 15, 2005 specifying provider eligibility requirements, provider selection criteria, and other information. Lists eligible providers.

Subd. 3. Provider selection criteria. Specifies criteria providers must meet to receive funding for scholarships.

Subd. 4. Funding specifics. Within the limits of appropriations, requires the commissioner, for the rate period October 1, 2005 through September 30, 2007, to provide each provider awarded scholarship funds an MA rate increase of up to two-tenths percent of the MA reimbursement rate. Requires providers to repay any portion of the funds awarded that are not used for scholarships. Specifies criteria for targeting funding if applications exceed available funding, and allows the commissioner to recalculate the rate adjustment during subsequent years.

Subd. 5. Reporting requirements. Specifies provider reporting requirements.

Subd. 6. Evaluation. Requires the commissioner to report to the legislature annually, beginning March 15, 2007, on the use of the funding.

48 **Additional portion of nonfederal share.** Amends § 256B.19, subd. 1c. Effective August 1, 2005, reduces Hennepin County's payment under an existing intergovernmental transfer

from $2,066,000 per month to $566,000 per month, and reduces the University of Minnesota's payment from $500,000 per month to zero.

49 **Payments to certain safety net providers.** Amends § 256B.195, subd. 3. Provides that the amount of the inter-governmental transfer (IGT) allocated to non-metro hospital enhanced DRG payments shall not limit the amount of the payments. Provides an effective date of August 1, 2005.

50 **Payments reported by governmental entities.** Adds § 256B.199. (a) Requires Hennepin County, Hennepin County Medical Center, Ramsey County, Regions Hospital, the University of Minnesota, and Fairview-University Medical Center to report quarterly to the commissioner, beginning June 1, 2007, payments made during the second previous quarter that may qualify for reimbursement under federal law.

(b) Requires the commissioner to apply for federal matching funds based on these reports and appropriates these funds to the commissioner for DSH payments under section 256.969, subd. 27.

(c) Requires the commissioner, beginning May 1, 2007 and each May 1 thereafter, to inform the nonstate entities listed in paragraph (a) of the amount of federal DSH payment money expected to be available in the current federal fiscal year.

(d) Provides a June 30, 2009 sunset for the section. Requires the commissioner to present recommendations for maximizing federal DSH payments after June 30, 2009 to the legislature, by December 15, 2008.

51 **Limitation of choice.** Amends § 256B.69, subd. 4. Specifies that the PMAP exemption for persons enrolled in individual health plans applies only to non-Medicare plans. Provides an effective date of September 1, 2005.

52 **GAMC; eligibility.** Amends § 256D.03, subd. 3. The amendment to paragraph (b) eliminates GAMC coverage for applicants and recipients who are adults with dependent children with gross family incomes not exceeding 275 percent of FPG who are not eligible under paragraph (e), effective for applications and renewals processed on or after September 1, 2006.

A new paragraph (c) allows GAMC, effective for applications and renewals processed on or after September 1, 2006, to be paid for a temporary period for applicants and recipients with gross incomes not exceeding 75 percent of FPG and with countable assets that do not exceed $1,000 per assistance unit. Requires enrollees to be enrolled in MinnesotaCare as adults without children, immediately following approval of GAMC, for the rest of the six-month eligibility period, until their six-month renewal.

A new paragraph (d) requires enrollees to complete a new application, to be eligible for GAMC following enrollment in MinnesotaCare under paragraph (c).

A new paragraph (e) exempts the following individuals from the MinnesotaCare enrollment requirements of this subdivision: applicants and recipients receiving General Assistance (except families with children enrolled under MFIP) or for whom Group Residential Housing payments are being made, persons applying on the basis of blindness or disability, and persons who do not meet the MinnesotaCare residency requirements.

The amendments to paragraph (g) require applications and renewals completed by recipients and applicants described under paragraph (c) to be determined for MinnesotaCare eligibility by the county agency, beginning September 1, 2006. If all other eligibility requirements are

met, makes GAMC available while MinnesotaCare eligibility is pending.

Provides a September 1, 2006 effective date.

53 **GAMC; services.** Amends § 256D.03, subd. 4. The amendment to paragraph (a) eliminates the $500 annual benefit cap for adult dental services under GAMC.

The amendment to paragraph (b) states that GAMC does not cover sex reassignment surgery and strikes language that allowed coverage of gender reassignment surgery and related services if the individual began receiving gender reassignment services prior to July 1, 1995.

The amendment to paragraph (d) eliminates the $3 GAMC copayment for nonpreventive visits, reduces the per-month maximum for prescription drug copayments from $20 to $12, and corrects a cross-reference.

The amendment to paragraph (e) makes a conforming change related to the reduction in the per-month maximum for prescription drug copayments.

A new paragraph (o) reduces GAMC fee-for-service payments for nonpreventive visits by $3.

A new paragraph (p) prohibits payments to managed care plans from being increased as a result of removal of the $3 nonpreventive visit copayment.

Provides effective dates of August 1, 2005 for paragraph (b) and January 1, 2006 for paragraph (d).

54 **Social security number required.** Amends § 256D.045. States that GA applicants who refuse to provide a Social Security number because of a well-established religious objection may be eligible for GAMC. Provides an effective date of August 1, 2007, or upon HealthMatch implementation, whichever is later.

55 **Gross individual or gross family income.** Amends § 256L.01, subd. 4. Requires gross income for the non-farm self-employed to be calculated using the net profit or loss reported on the applicant's federal income tax form and using the MA families with children methodology for determining allowable and nonallowable self-employment expenses and countable income. Specifies that gross individual or family income for purposes of MinnesotaCare means income calculated for the six-month period of eligibility. (This is consistent with a recent law change requiring enrollees to renew eligibility every six months, effective October 1, 2004.) Eliminates the requirement that applicants report the most recent financial situation of the family if it has changed from the period of time covered by the federal income tax form. Provides an effective date of August 1, 2007, or upon HealthMatch implementation, whichever is later.

56 **Income.** Amends § 256L.01, subd. 5. The amendment to paragraph (b) requires the commissioner to use reasonable methods to calculate gross earned and unearned income for purposes of MinnesotaCare, including but not limited to projecting income based on income received within the past 30 days, last 90 days, or last 12 months. Provides a July 1, 2005, retroactive effective date.

57 **Covered health services.** Amends § 256L.03, subd. 1. Eliminates the $500 annual benefit cap on adult dental services. Provides a January 1, 2006, effective date.

58 **Pregnant women; eligibility for full MA services.** Amends § 256L.03, subd. 1b. Aligns MinnesotaCare and MA policy regarding when eligibility for benefits as a pregnant woman begins. MinnesotaCare benefits are to begin at the date of conception instead of the date the

pregnancy was diagnosed. Provides a September 1, 2005, effective date.

59 **Co-payments and coinsurance.** Amends § 256L.03, subd. 5. Adds MinnesotaCare copays of $3 per nonpreventive visit and $6 for nonemergency visits to a hospital-based emergency room. Provides a January 1, 2006 effective date.

60 **Limited benefits coverage for certain single adults and households without children.** Amends § 256L.035. Expands coverage under the MinnesotaCare limited benefit set to include diabetic supplies and equipment, eliminates the annual cap on benefits (currently $5,000 as a result of a 2003 rider), and allows covered services to be provided by a physician, physician ancillary, chiropractor, psychologist, or licensed independent clinical social worker, if within the provider's scope of practice. Provides a January 1, 2006 effective date.

61 **Social Security number required.** Amends § 256L.04, by adding subd. 1a. Requires applicants for MinnesotaCare coverage to provide a Social Security number. Prohibits the commissioner from denying eligibility if an applicant is awaiting issuance of a Social Security number. Provides exemptions for newborns and individuals who refuse to provide a number because of well-established religious objections. Provides an effective date of August 1, 2007, or upon HealthMatch implementation, whichever is later.

62 **Cooperation in establishing third-party liability, paternity, and other medical support.** Amends § 256L.04, subd. 2. Includes, in the definition of "cooperation," complying with the requirement that applicants give the state agency notice of any monetary claims against a third party that may be liable to pay for the cost of medical care. Provides an August 1, 2005, effective date.

63 **Applications for other benefits.** Amends § 256L.04, by adding subd. 2a. Requires individuals and families, in order to be eligible for MinnesotaCare, to take all necessary steps to obtain the benefits described in 42 CFR 435.608 (annuities, pensions, retirement, and disability benefits). Provides an effective date of August 1, 2007, or upon HealthMatch implementation, whichever is later.

64 **MinnesotaCare enrollment by county agencies.** Amends § 256L.05, by adding subd. 1b. Beginning September 1, 2006, requires county agencies to enroll single adults and households with no children formerly enrolled in GAMC in MinnesotaCare according to section 52, and perform all duties necessary to administer the program for these enrollees. Provides an effective date of September 1, 2006.

65 **Commissioner's duties.** Amends § 256L.05, subd. 2. Directs the commissioner, in determining MinnesotaCare eligibility, to require applicants and enrollees seeking renewal to verify both earned and unearned income, and to submit names and contact information for employees to verify eligibility for employer subsidized insurance. Classifies data collected as nonpublic. Provides an effective date of September 1, 2005, and specifies procedures for implementing the section prior to and upon implementation of HealthMatch.

66 **Effective date of coverage.** Amends § 256L.05, subd. 3. The amendment to paragraph (a) provides that the effective date of coverage under MinnesotaCare for newly adoptive children is the month of placement, rather than the date of entry into the family. Provides that the effective date of coverage for other new family members is the first day of the month following the month in which the change is reported, rather than the first day of the month following the month in which eligibility is approved or at renewal. A new paragraph (e) specifies that the effective date of coverage for adults without children formerly enrolled in GAMC is the first day of the month following the last day of the GAMC coverage. Provides an effective date of August 1, 2007, or upon HealthMatch implementation, whichever is later for paragraph (a) and an effective date of September 1, 2006, for paragraph (e).

67 **Renewal of eligibility.** Amends § 256L.05, subd. 3a. The amendment to paragraph (b) provides that for purposes of MinnesotaCare eligibility renewal, the first six-month period

of eligibility begins the month the application is received by the commissioner (current law refers to the month after the month the application is approved). A new paragraph (c) provides that for adults without children formerly enrolled in GAMC, the first six-month period of eligibility begins the month the enrollee submitted the application or renewal for GAMC. Provides an effective date of August 1, 2007 or upon HealthMatch implementation, whichever is later for paragraph (b) and an effective date of September 1, 2006, for paragraph (c).

68 **Commissioner's duties and payment.** Amends § 256L.06, subd. 3. Requires the commissioner to develop and implement procedures to adjust MinnesotaCare premiums for both increases and decreases in income, at the time the change in income is reported. Provides an effective date of September 1, 2005 or upon federal approval whichever is later. Specifies procedures for implementing the section prior to and upon implementation of HealthMatch.

69 **General requirements.** Amends § 256L.07, subd. 1. Aligns the income calculation and premium comparison for purposes of determining a child's continued coverage under the Minnesota Comprehensive Health Association exception with the six-month income projection and six-month renewals.

Coverts the income limit for parents from $50,000 annual income to $25,000 for a six-month period.

Provides an effective date of August 1, 2007, or upon HealthMatch implementation, whichever is later.

70 **Must not have access to health coverage through a postsecondary education institution.** Amends § 256L.07, by adding subd. 2a. In order to be eligible for MinnesotaCare, requires an individual under age 21 enrolled in a postsecondary education institution, including an emancipated minor and an emancipated minor's spouse, to not have access to health care coverage through the postsecondary education institution. Provides an effective date of September 1, 2005 or upon federal approval, whichever is later, and specifies procedures for implementing the section prior to and upon implementation of HealthMatch.

71 **Other health coverage.** Amends § 256L.07, subd. 3. The amendment to paragraph (c) clarifies language classifying Medicare Part A and B coverage as health coverage (for purposes of the requirement that MinnesotaCare enrollees have no health coverage while enrolled or for four months prior to application) by specifying that an applicant or enrollee who is entitled to Medicare Part A or enrolled in Medicare Part B is considered to have health coverage. Also provides that an applicant or enrollee who is entitled to premium free Medicare Part A may not refuse to apply for or enroll in the coverage.

The amendment to paragraph (e) clarifies the exemption from the MinnesotaCare four-month uninsured requirement for cost-effective health insurance paid for by MA, by specifying that the exemption does not apply if the insurance continued after MA no longer considered it cost-effective or after MA closed.

Provides a September 1, 2005, effective date.

72 **Exception for certain adults.** Amends § 256L.07, by adding subd. 6. Provides that single adults and households without children formerly enrolled in GAMC and enrolled in MinnesotaCare according to section 52 are eligible for MinnesotaCare without meeting the program's insurance barriers and income limits, until six-month renewal. Specifies an effective date of September 1, 2006.

73 **Rate setting; rateable reduction.** Amends § 256L.12, by adding subd. 9b. For services

provided on or after January 1, 2006, requires MinnesotaCare payment rates to managed care plans to be reduced to reflect a 6 percent reduction in reimbursement for inpatient hospital services. Provides an August 1, 2005, effective date.

74 **Sliding fee scale to determine percentage of monthly gross individual or family income.** Amends § 256L.15, subd. 2. Specifies that sliding fee scale premium determinations under MinnesotaCare are to be based on monthly gross income. Requires the commissioner, when a family or individual reports increased income after enrollment, to adjust premiums at the time the change in income is reported. (Current law prohibits a premium increase until eligibility renewal.)

A new paragraph (c) increases MinnesotaCare premiums by 8 percent (effective September 1, 2005, or upon federal approval, whichever is later).

Provides various effective dates and specifies procedures for implementing the section prior to and upon implementation of HealthMatch.

75 **Exceptions to sliding scale.** Amends § 256L.15, subd. 3. Specifies the MinnesotaCare premium for low-income children as a monthly rather than annual premium. Provides an effective date of August 1, 2007, or upon HealthMatch implementation, whichever is later.

76 **Exception for transitioned adults.** Amends § 256L.15, by adding subd. 4. Requires county agencies to pay premiums for single adults and households without children formerly enrolled in GAMC and enrolled in MinnesotaCare according to section 52 until six-month renewal, and gives the county agency the option of continuing to pay premiums past the six-month renewal. Provides a September 1, 2006 effective date.

77 **Exception for certain adults.** Amends § 256L.17, by adding subd. 7. Exempts single adults and households with no children formerly enrolled in GAMC and enrolled in MinnesotaCare according to section 52 from the MinnesotaCare asset requirement, until six-month renewal. Provides a September 1, 2006 effective date.

78 **Limitations.** Amends § 549.02, by adding subd. 3. Excludes DHS, in cases where DHS is seeking third party recovery, from the statute requiring the plaintiff in district court to pay certain amounts stated in law to a defendant if the defendant prevails. Provides an August 1, 2005, effective date.

79 **Disbursements; taxation and allowance.** Amends § 549.04. Excludes DHS, in cases where DHS is seeking third party recovery, from the statute requiring the plaintiff in district court to reimburse certain expenses of a defendant if the defendant prevails. Provides an August 1, 2005, effective date.

80 **Review of special transportation eligibility criteria and potential cost savings.** Amends Laws 2003, 1st Sp. Session chapter 14, article 12, section 93. Prohibits the commissioner of human services from using a broker or coordinator to manage special transportation services until July 1, 2006. Prohibits the commissioner from extending the initial contract to broker or manage nonemergency medical transportation beyond two years, and from entering into a contract that denies free choice of providers. Provides an effective date of the day following final enactment.

81 **Advisory committee on non-emergency transportation services.** Directs the commissioner of human services to establish a seven-member advisory committee on MA non-emergency transportation services. Specifies membership and requires the committee to monitor and evaluate the provision of these services and present recommendations for any necessary changes to the commissioner. Provides an effective date of the day following final enactment.

82 **Limiting coverage of health care services for MA, GAMC, and MinneostaCare programs.**

Subd. 1. Prior authorization of services. (a) Effective September 1, 2005, requires prior authorization under MA, GAMC, and MinnesotaCare for the services described in subdivision 2.

(b) Requires prior authorization to be conducted under the direction of the medical director of DHS in conjunction with a medical policy advisory council. Requires the medical director to use publicly available evidence-based guidelines developed by specified groups, to the extent these are available. Requires the commissioner to contract for prior authorization, if the commissioner does not have a medical director and medical policy director in place.

(c) Requires prepaid health plans to use prior authorization unless the plan is otherwise using evidence-based practices.

Subd. 2. Services requiring prior authorization. Requires the following services to be prior authorized: (1) elective outpatient high technology imaging, including PET scans, MRI, CT, and nuclear cardiology; (2) spinal fusion, unless in an emergency situation related to trauma; (3) bariatric surgery; (4) cesarean section or insertion of tympanostomy tubes, except in an emergency; (5) hysterectomy; and (6) orthodontia.

Subd. 3. Rate reduction. Reduces the payment rate for services listed in subdivision 2 by ten percent, for services provided on or after September 1, 2005. Specifies that this subdivision expires July 1, 2006, or upon completion of the prior authorization system required under subdivision 1, whichever is earlier.

Subd. 4. Appeals. (a) Requires health care providers, when reviewing initial determinations not to certify a service subject to prior authorization, to follow, when available, published evidence-based health care guidelines established by specified groups.

(b) Requires referees, when deciding appeals of a decision by a prepaid health plan to deny, reduce, or terminate a health care service subject to prior authorization, to base their decision on publicly available evidence-based health care guidelines referred to in subdivision 1 or established by the commissioner of human services, provided that the guidelines meet specified criteria.

Subd. 5. Expiration. States that this section expires July 1, 2007.

Provides an effective date of the day following final enactment.

83 **Oral health care pilot project.** Requires DHS to issue a request for a proposal for a two-year pilot project to provide dental services for Minnesota health care program recipients through a new oral health care delivery system. Provides that the section is effective the day following final enactment.

84 **Sole-source or single plan managed care contract.** States that the commissioner of human services may not reject a county-based purchasing proposal on the basis that the proposal is a sole source plan if the proposal does not limit an enrollee's provider choice and access to services. Requires the commissioner to seek federal approval, if needed. Provides that the section is effective the day following final enactment.

85 **Planning process for managed care.** Requires the commissioner of human services to develop a planning process to implement at least one additional managed care arrangement

to provide services (excluding continuing care services) to MA fee-for-service enrollees, effective January 1, 2007. Specifies membership of an advisory committee and requires the department to seek any additional federal authority necessary to provide basic health care services through contracted managed care arrangements.

86 **Directive to seek federal match for alternative care program.** Requires the commissioner of human services to seek federal matching funds for the alternative care program, during negotiations with the federal government over repeal of intergovernmental transfers under section 256B.19, subd. 1c, paragraph (d). Requires the commissioner to report the results of these negotiations to legislative committee chairs by December 15, 2005.

87 **Federal approval.** Requires the commissioner of human services to seek federal waivers and approvals necessary to allow the commissioner to charge MA recipients with gross family income greater than 175 percent of FPG sliding scale premiums.

88 **Repealer.** (a) Repeals section 256.955 (prescription drug program) effective January 1, 2006.

(b) Repeals section 256B.075, subd. 5 (June 30, 2006, expiration date for DHS disease management initiatives) effective the day following final enactment.

(c) Repeals section 256L.04, subd. 11 (MinnesotaCare outreach grants) effective August 1, 2005.

Article 9: Appropriations

This article contains the human services, health, and health related boards' appropriations.

1 **Health and human services appropriations.** Provides that the sums shown in the columns marked "Appropriations" are appropriated from the general fund, or any other named fund, to the agencies and for the purposes specified in the sections of this article, to be available for the fiscal years indicated for each purpose. Specifies that appropriations are available for the fiscal years ending June 30, 2006, and June 30, 2007. Provides a summary of appropriations by fund.

2 **Commissioner of human services.**

Subd. 1. Total appropriation. Provides a total appropriation for the commissioner of human services.

- **Receipts for system projects.** Requires certain funds for MAXIS, PRISM, MMIS, and SSIS to be deposited in the state system account. Provides that subject to the commissioner's discretion money appropriated for computer projects may be transferred from one project to another and from development to operations. Allows unexpended balance in these appropriations to be available for ongoing development and operations.

- **Systems continuity.** Allows the commissioner to use available grant appropriations to ensure continuity of payments to human services clients in the event of a disruption of technical systems or computer operations.

- **Nonfederal share transfers.** Allows the commissioner to transfer the nonfederal share of activities for which federal administrative reimbursement

is appropriated to the special revenue fund.

- **Gifts.** Allows the commissioner to accept additional funding from sources other than state funds for financing the cost of assistance program grants or nongrant administration.

- **TANF funds appropriated to other entities.** Requires expenditures from the TANF block grant to be expended in accordance with federal laws. Requires the commissioner to ensure that funds are expended in compliance with the requirements and limitations of federal law and that any reporting requirements of federal law are met. Requires entities to which funds are appropriated to implement a memorandum of understanding with the commissioner that provides the necessary assurance of compliance prior to any expenditure of funds. Requires the commissioner to coordinate all interagency accounting transactions necessary to implement the TANF appropriations. Requires that any unexpended TANF funds cancel at the end of the state fiscal year unless appropriating or statutory language permits otherwise.

- **TANF maintenance of effort.** (a) Limits the commissioner to only reporting nonfederal money expended for allowable activities as TANF/MOE expenditures. Lists the allowable activities. (b) Requires the commissioner to ensure that sufficient qualified nonfederal expenditures are made each year to meet Minnesota's TANF/MOE requirements. Specifies the expenditures the commissioner may report. (c) Beginning in fiscal year 2003, requires the commissioner to assure that the MOE used by the commissioner of finance for the February and November forecasts contain certain expenditures that are equal to at least 25 percent of the total required by federal law. (d) Clarifies that grants or aids funded with TANF may not be used to reduce any direct appropriations provided by law. (e) Paragraph (a), clauses (1) to (6), and paragraphs (b) to (d) of this section expire June 30, 2009.

- **Working family credit expenditures as TANF/MOE.** Allows the commissioner to claim as TANF/MOE up to specified amounts of working family credit expenditures for specified years.

- **Increase working family credit expenditures to be claimed for TANF/MOE.** Allows the commissioner to count specified amounts of working family credit expenditure as TANF/MOE.

- **Food Stamps employment and training funds.** Requires certain food stamp employment and training funds to be deposited in the general fund. Allows the commissioner to adjust the level of working family credit expenditures claimed as TANF MOE.

- **Special revenue fund transfer.** Requires the commissioner to transfer $1,139,000 of uncommitted special revenue fund balances to the general fund.

- **Capitation rate increase.** Provides that $2,157,000 of each of the fiscal years' 2006 and 2007 health care access fund appropriation to the University of Minnesota in the higher education omnibus appropriations bill, is to be

used to increase the capitation payments under Minnesota Statutes, section 256B.69. States this provision shall not expire.

Subd. 2. Agency management. Provides the appropriations, and their sources, for the following agency management functions:

- Financial operations
- Legal and regulation operations
- Management operations
- Information technology operations

Subd. 3. Revenue and pass-through expenditures. Lists TANF appropriations.

- **TANF transfer to federal child care and development fund.** Transfers specified amounts to the commissioner for MFIP/Transition Year child care.

Subd. 4. Children and economic assistance grants. Appropriates money for children and economic assistance grant programs including MFIP, support services grants, MFIP child care assistance grants, basic sliding fee child care assistance grants, child care development grants, child support enforcement grants, children's services grants, children and community services grants, general assistance grants, Minnesota supplemental aid grants, group residential housing grants, and other children and economic assistance grants.

- **MFIP Child care; TANF appropriation.** Specifies that the TANF appropriation is a one-time appropriation.
- **TANF transfer to federal child care and development fund.** Appropriates $27,335,000 in fiscal year 2007 to the commissioner, and authorizes the commissioner to transfer sufficient TANF funds to the federal child care and development fund to meet the appropriation.
- **Child care and development fund unexpended balance.** Requires the commissioner to expend $16,254,000 in fiscal year 2006 and $2,085,000 in fiscal year 2007 from the CCDF unexpended balance for Basic Sliding Fee child care.
- **Base adjustment for freeze maximum rates for child care assistance.** Increases the general fund base for basic sliding fee child care assistance by $3,233,000 in fiscal year 2008 and $4,399,000 in fiscal year 2009.
- **Base adjustment for adoption assistance grants.** Increases the base appropriations by $449,000 in each of the fiscal years 2008 and 2009 for adoption assistance grants.
- **Base adjustment for relative custody assistance grants.** Increases the general fund base by $1,042,000 in each of fiscal years 2008 and 2009 for

relative custody assistance grants.

- **Adoption assistance and relative custody assistance.** Allows the commissioner to transfer unencumbered appropriation balances for adoption assistance and relative custody assistance between fiscal years and programs.

- **Privatized adoption grants.** Appropriates federal reimbursement for privatized adoption grant and foster care recruitment grant expenditures to the commissioner for adoption grants and foster care and adoption administrative purposes.

- **Children's mental health grants base adjustment.** Increases the base appropriations in each of the fiscal years 2008 and 2009 by $44,000 for children's mental health grants for costs associated with the long-term care provider cost-of-living adjustment.

- **American Indian child welfare project base adjustment.** Increases the base appropriations by $2,419,000 in each of the fiscal years 2008 and 2009 for the American Indian child welfare project.

- **Children's community service grants base adjustment.** Increases the base appropriations by $3,000 for each of the fiscal years 2008 and 2009 for children's community service grants for costs associated with the long-term care provider cost-of-living adjustment.

- **General assistance standard.** Requires the commissioner to set the monthly standard of assistance for GA units consisting of one adult recipient who is childless and unmarried or living apart from parents or a legal guardian at $203. Allows the commissioner to reduce this amount.

- **Emergency general assistance.** Limits the amount appropriated for emergency general assistance to $7,889,812 in each of the fiscal years 2006 and 2007. Specifies how funds shall be allocated to counties.

- **Emergency Minnesota supplemental aid funds.** Limits the amount appropriated for emergency Minnesota supplemental aid to $1,100,000 in each of the fiscal years 2006 and 2007. Specifies how funds shall be allocated to counties.

- **Transitional housing.** Appropriates $3,238,000 in each of the fiscal years 2006 and 2007 for transitional housing. Specifies that a portion of the appropriation is a one-time appropriation from the federal TANF fund, and that the general fund base for each year for the fiscal 2008-09 biennium is $2,988,000.

Subd. 5. Children and economic assistance management. Appropriates money for children and economic assistance management.

- **Base reductions.** Reduces the general fund base by $50,000, and the health

care access fund base by $12,000 in each of the fiscal years 2008 and 2009.

- **Spending authority for food stamps bonus awards.** Appropriates any United States Department of Agriculture Food and Nutrition Services Food Stamp Program performance bonus awards to the commissioner beginning in federal fiscal year 2004. Requires the commissioner to retain 25 percent of the funding, with the other 75 percent divided among the counties according to a specified formula.

- **Child support payment center.** Requires payments to the commissioner from other specified entities to be deposited into a specified account. Appropriates these payments to the commissioner for the operation of the child support payment center or system.

- **Child support cost recovery fees.** Requires the commissioner to transfer $34,000 of child support cost recovery fees collected in fiscal years 2006 and 2007 to the PRISM special revenue account to offset PRISM system costs of maintaining the fee.

- **Financial institution data match and payment of fees.** Authorizes the commissioner to allocate up to $310,000 each year in fiscal years 2006 and 2007 from the PRISM special revenue account to make payments to financial institutions in exchange for performing data matches between account information held by financial institutions and the public authority's database of child support obligors.

Subd. 6. Basic health care grants. Appropriates money for basic health care grants.

- **Full funding for diagnosis related group payment adjustment.** Appropriates increases for MA Basic Care-Families and Children, MA Basic Care-Elderly and Disabled and GAMC in order to provide full funding for the diagnosis-related groups for hospitals located in Greater Minnesota under Minnesota Statutes, section 256.969, subdivision 26.

- Specifies the appropriations for each program:

  - **MinnesotaCare grants.** Provides $6,411,000 the first year and $96,305,000 the second year for MinnesotaCare costs associated with the 17-month delay in the implementation of HealthMatch. Provides that receipts from federal participation pertaining to administrative costs of the health care reform waiver shall be deposited as nondedicated revenue in the health care access fund. Provides that receipts received as a result of federal participation pertaining to grants shall be deposited in the federal fund and shall offset health care access funds for payments to providers. Allows the commissioner to expend money appropriated from the health care access fund in either year of the biennium.

  - **MA basic health care—families and children.** Provides a hospital

payment delay for fiscal years 2008 and 2009.

- **MA basic health care—elderly and disabled.**

- **General assistance medical care grants.**

- **Prescription drug program grants.** Prescription drug program to Medicare Part D transition. Allows the commissioner, with the approval of the commissioner of finance and after notice to specified committees of both legislative bodies, to transfer fiscal year 2006 appropriations between the medical assistance program and the prescription drug program.

- **Health care grants—other assistance.**

Subd. 7. Health care management. Provides the appropriations, and their sources, for the following operations:

- **Health care policy administration**

  - **Administrative base adjustment.** Decreases the health care access fund base by $1,486,000 in fiscal year 2008 and $1,778,000 in fiscal year 2009 and increases the general fund base by $3,563,000 in fiscal year 2008 and $2,395,000 in fiscal year 2009 for implementation of the business process redesign in health care.

  - **Minnesota senior health options reimbursement.** Appropriates federal administrative reimbursement from the Minnesota senior health options project to the commissioner of finance for this activity.

  - **Utilization review.** Provides that federal administrative reimbursement for utilization review activities by a professional review organization shall be dedicated to the commissioner for these purposes. States that a portion of these funds must be used for activities to decrease unnecessary pharmaceutical costs in medical assistance.

  - **Ticket to work.** Provides that funding made available under the Ticket to Work Medicaid Infrastructure Grant to support outreach and education activities on Medicare Part D for recipients of MA for employed persons with disabilities is appropriated to the commissioner for required grant and administrative activities.

  - **Medical education assignment.** Requires the commissioner to continue to seek approval from the Centers for Medicare and Medicaid Services to transfer 40 percent of the current medical education and research costs assigned to hospitals to physician clinics and report to the legislature regarding this effort.

- **Health care operations.**

  - **Base adjustment.** Increases the health care access fund base by

$1,508,00 in fiscal year 2008 and decreases it by $48,000 in fiscal year 2009.

- **County administrative cost reimbursement.** Appropriates $1,000,000 from the general fund to be allocated to counties for county costs associated with training county workers for enrolling eligible GAMC clients in MinnesotaCare.

Subd. 8. Continuing care grants. Provides the appropriations and the amounts that may be spent for the following purposes:

- **Aging and adult services grant.**

- **Alternative care grants.**

  - **Alternative care transfer.** Provides that any money not spent does not cancel but shall be transferred to the medical assistance account.

  - **Alternative care base.** Increases the alternative care base by $2,704,000 in fiscal year 2008 and by $3,908,000 in fiscal year 2009.

  - **Implementation of alternative care changes.** States that changes to Minnesota Statutes, section 256B.0913, subdivisions 2, 4, paragraph (a), 5, and 5a are effective September 1, 2005, for those found eligible for the alternative care program on or after that date; and that those who are alternative care clients as of August 31, 2005, are subject to Minnesota Statutes, section 256B.0913, subdivision 2, 4, paragraph (a), 5 and 5a, on the annual redetermination of program eligibility, after that date, but no later than January 1, 2006.

- **Medical assistance grants—long-term care facilities.**

  - **Nursing home moratorium exceptions.** States that the commissioner of health may approve moratorium exception projects under Minnesota Statutes, section 144A.073, for which the state share of MA costs does not exceed $1,500,000 during the first year, and those that are less than the remaining $1,500,000 during the second year. Requires that priority be given to proposals based on given criteria.

- **Medical assistance grants—long-term care waivers and home care grants.**

  - **Limiting growth in community alternatives for disabled individuals waiver.** Provides that the commissioner for each year of the biennium ending June 30, 2007, shall make available additional allocations for home- and community-based services. States that the priorities for allocation of funds shall be for individuals anticipated to be discharged from institutional settings or who are at imminent risk of a placement in an institutional setting.

  - **Limiting growth in TBI waiver.** Provides that the commissioner for

each year of the biennium ending June 30, 2007, shall make available additional allocations for home- and community-based services. States that the priorities for allocation of funds shall be for individuals anticipated to be discharged from institutional settings or who are at imminent risk of a placement in an institutional setting.

- **Limiting growth in MR/RC waiver.** Provides that the commissioner for each year of the biennium ending June 30, 2007, shall limit the new diversion caseload growth in the MR/RC waiver to 50 additional allocations. States that the priority for allocations shall be awarded to support individuals whose health and safety needs result in an imminent risk of an institutional placement.

- **Mental health grants.**

  - **Mental health grant base.** Provides base level funding for mental health grants at $428,000 in each of the fiscal years 2008 and 2009.

- **Deaf and hard-of-hearing grants.**

  - **Deaf and hard-of-hearing base funding.** Increases the base level funding for deaf and hard-of-hearing grants by $5,000 in each of the fiscal years 2008 and 2009.

- **Chemical dependency entitlement grants.**

- **Chemical dependency non-entitlement grants.**

- **Other continuing care grants.**

  - **Other continuing care grants base funding.** Increases the base level funding for other continuing care grants by $208,000 in fiscal year 2008 and by $251,000 in fiscal year 2009.

Subd. 9. Continuing care management.

- **Base adjustment.** Decreases the general fund base funding by $341,000 in fiscal year 2008 and by $340,000 in fiscal year 2009.

- **Quality assurance commission.** Provides a $151,000 appropriation in fiscal year 2007 to the commissioner for the quality assurance commission. States that this funding is added to the base appropriation for the fiscal year beginning July 1, 2006.

- **Task force on collaborative services.** Requires the commissioner of human services to work with the commissioner of education to create a task force to discuss the collaboration between schools and mental health providers to promote co-location and integrated services, identify barriers, develop a model contract, identify examples of successful collaboration, and develop recommendations. Provides for the composition of the task force and requires

a report to the legislature by February 1, 2006.

Subd. 10. State-operated services.

- **Base adjustment.** Decreases the general fund base funding by $3,174,000 in fiscal year 2008 and by $6,472,000 in fiscal year 2009.

- **Evidence-based practice for methamphetamine treatment.** Provides a $300,000 appropriation to the commissioner to support development of evidence-based practice for methamphetamine treatment at the chemical dependency program in Willmar.

- **Transfer authority related to state-operated services.** Allows the commissioner to transfer funds between fiscal years of the biennium with the approval of the commissioner of finance.

- **Appropriation limitation.** Prohibits the appropriation to the commissioner for mental health treatment services at the regional treatment centers from being used for the Minnesota sex offender program.

- **Base adjustment for state-operated services utilization.** Increases the base fund by $3,174,000 in fiscal year 2008 and by $6,472,000 in fiscal year 2009 for state-operated services forensic operations with corresponding adjustments to nondedicated revenue estimates.

3 Commissioner of health.

Subd. 1. Provides the total appropriations for the commissioner of health.

- **Rental costs, administrative reductions, fee increases, and revenue transfer.** Appropriates $722,000 the first year and $2,583,000 the second year for the rental costs in the new public health laboratory building. States that the general fund appropriation contains $61,000 the first year and $62,000 the second year department wide administrative reductions. Transfers funds in fiscal years 2006 and 2007 from the state government special revenue fund to the general fund.

- **TANF appropriations.** Appropriates $4,000,000 in TANF funds each year to the commissioner for home visiting and nutritional services. States that funding shall be distributed to community health boards and tribal governments. Appropriates $2,000,000 in TANF funds each year to the commissioner for decreasing racial and ethnic disparities in infant mortality.

- **TANF carry forward.** Allows unexpended monies of the TANF appropriation to carry forward to the second year of the biennium.

Subd. 2. Community and family health promotion.

- **Family planning base reduction.** Decreases the family planning special projects grant program base funding by $1,877,000 each year of the biennium

beginning July 1, 2007, contingent upon the implementation of the family planning project section of the 1115 waiver. Requires the commissioner to give priority to community health care clinics providing family planning services that either serve a high number of women who do not qualify for MA or who are unable to participate in MA in allocating the remaining appropriations.

- **Shaken baby video.** Makes an appropriation of $13,000 in fiscal year 2006 from the special revenue fund to the commissioner to provide a video to hospitals on shaken baby syndrome. States that the commissioner is to assess a fee to the hospitals and to deposit revenue received in the special revenue fund.

Subd. 3. Policy quality and compliance.

- **Base adjustment.** Increases the state government special revenue base for fiscal years 2008 and 2009 by $800,000 each year.

- **Statewide trauma system.** Appropriates $382,000 the first year and $352,000 the second year from the general fund for the development of a statewide trauma system. Requires the commissioner to increase hospital fees a pro rata amount to be deposited in the general fund to cover the costs of the system.

- **Family planning grants.** Appropriates $500,000 from the general fund each year for family planning clinics serving out-state Minnesota that demonstrate financial need.

Subd. 4. Health protection.

- **Base adjustment.** Increases the state government special revenue fund base for fiscal years 2008 and 2009 by $935,000 each year.

Subd. 5. Minority and multicultural health.

Subd. 6. Administrative and support services.

Veterans Nursing Homes Board. Provides appropriations for the board.

Veterans homes special revenue account. Provides that the general fund appropriations may be transferred to a veterans homes special revenue account in the special revenue fund.

Health-related boards.

Subd. 1. Total appropriation. Provides the general appropriations for the boards. States that appropriations are from the special revenue fund except where noted. Provides that funds may not be expended in excess of anticipated revenues.

Subd. 2. Board of Behavioral Health and Therapy.

Subd. 3. Board of Chiropractic Examiners.

- **Board of Chiropractic Examiners appropriations increase.** States that the

appropriation for fiscal years 2008 and 2009 includes a $30,000 increase for the cost of board operations, excluding salaries.

Subd. 4. Board of Dentistry.

- **Board of Dentistry appropriations increase.** States that the appropriation for fiscal years 2008 and 2009 includes a $30,000 increase for the cost of board meetings, board member compensation, and board operations, excluding salaries.

- **Oral health pilot project.** States that $150,000 of the appropriation is to be transferred to the commissioner of human services for an oral health care system pilot project.

Subd. 5. Board of Dietetic and Nutrition Practice. Allows the board to lower its fees by an amount not to exceed $36,000 in years 2006 through 2009.

Subd. 6. Board of Marriage and Family Therapy.

- **Board of Marriage and Family Therapy appropriations increase.** States that the appropriation includes $9,000 the first year and $13,000 the second year to: increase the executive director to a 0.6 FTE; cover increased technology costs related to the small boards' database system; and cover increased costs related to rule changes.

Subd. 7. Board of Medical Practice.

- **Board of Medical Practice appropriations increase.** States that the appropriation includes $125,000 the first year and $165,000 the second year for the added costs of rent, legal and investigative services provided by the board, and service provided by the attorney general's office and the Office of Administrative Hearing for services on behalf of the board.

- **Physician loan forgiveness.** Requires $200,000 each year to be transferred to the health professional education loan forgiveness program account for loan forgiveness for physicians. This amount becomes part of the base level funding for the biennium beginning July 1, 2007.

Subd. 8. Board of Nursing.

- **Base adjustment.** Increases the base for the board of nursing by $141,000 in fiscal year 2008 and by $216,000 in fiscal year 2009.

- **Board of Nursing appropriations increase.** States that the appropriation includes $120,000 the first year and $126,000 the second year for the increased cost of board operations, of which $85,000 each year is to hire an advanced practice registered nurse.

- **Transfers from special revenue fund.** Requires that $392,000 in fiscal year 2006, $864,000 in fiscal year 2007, and $930,000 in fiscal years 2008 and

2009 be transferred from the state government special revenue fund to the general fund to be appropriated for the state share of the MA program costs of the long-term care and home- and community-based care employee scholarship program. Requires that $125,000 the first year and $200,000 the second year be transferred to the health professional education loan forgiveness program for nurses.

Subd. 9. Board of Nursing Home Administrators.

- **Administrative services unit.** States that $418,000 of the appropriation the first year and $421,000 of the appropriation the second year are for the health boards administrative services unit, including $59,0000 each year for a rent increase. Allows the administrative services unit to receive and expend reimbursements for services performed for other agencies.

Subd. 10. Board of Optometry.

Subd. 11. Board of Pharmacy.

- **Board of Pharmacy appropriations increase.** States that the appropriation includes $137,000 the first year and $92,000 the second year for the increased cost of board operations, including retirement payouts and increased costs related to technology, but excludes salary increases.

- **Rural pharmacy program.** States that the appropriation includes $200,000 each year that must be transferred to the commissioner of health for the rural pharmacy planning and transition grant program, of this amount, $20,000 each year may be retained for related administrative costs.

- **Cancer drug repository program.** States that the appropriation includes $25,000 for the cancer drug repository program.

Subd. 12. Board of Physical Therapy.

- **Board of Physical Therapy appropriations increase.** States that the appropriation includes $4,000 the first year and $10,000 the second year for the added costs for the work on electronic access to the small boards' database and to provide flexible staff levels.

Subd. 13. Board of Podiatry.

- **Board of Podiatry appropriations increase.** States that the appropriation includes $4,000 the first year and $8,000 the second year for increased rental costs, board member per diems, and other increases in board operations, excluding salaries.

Subd. 14. Board of Psychology.

Subd. 15. Board of Social Work.

- **Administrative management.** States that the appropriation includes

$105,000 the first year and $100,000 the second year in order to provide administrative management under Minnesota Statutes, section 148B.61, subdivision 4. Requires that the following boards be assessed a prorated amount: the Board of Medical Practice, the Board of Nursing, the Board of Psychology, the Board of Social Work, the Board of Marriage and Family Therapy, and the Board of Behavioral Health and Therapy.

Subd. 16. Board of Veterinary Medicine.

- **Board of veterinary medicine appropriations increase.** States that the appropriation includes $8,000 each year for the increased costs of a growing caseload, rent, and other increased board operating costs, excluding salary increases.

6 **Emergency medical services board.** Provides a $3,027,000 appropriation each year for the board.

Health professional services activities. Allocates $546,000 each year from the state government special revenue fund for health professional services activity, including $50,000 to hire an additional case manager and to continue to employ a part-time student worker.

7 **Council on disability.** Provides a $500,000 appropriation each year for the council.

8 **Ombudsman for mental health and mental retardation.** Provides a $1,462,000 appropriation each year for the ombudsman.

9 **Ombudsman for families.** Provides a $245,000 appropriation each year for the ombudsman.

10 **Laws 2005, chapter 14; effective date.** Amends Minnesota Laws 2005, chapter 159, article 1, section 14. Modifies the effective date of Minnesota Laws 2005, chapter 14, sections 1 and 2.

11 **Basic health care grants.** Amends Minnesota Laws 2003, First Special Session chapter 14, article 13C, section 2, subdivision 6. Increases the amount transferred from the health care access fund to the general fund in fiscal year 2007 and removes certain requirements for the years following fiscal year 2007.

12 **Transfers.**

Subd. 1. Grants. Allows the commissioner of human services, with the approval of the commissioner of finance, and after notification to the chairs of the relevant senate budget division and house finance committee, to transfer unencumbered appropriation balances for the biennium ending June 30, 2007, within fiscal years among MFIP, GA, GAMC, MA, MFIP child care assistance, Minnesota supplemental aid, and group residential housing programs, and the entitlement portion of the consolidated chemical dependency treatment fund.

Subd. 2. Administration. Provides that positions, salary money, and nonsalary administrative money may be transferred within the Departments of Human Services and Health and within the programs operated by the Veterans Nursing Homes Board with the approval of the commissioner of finance.

Subd. 3. Prohibited transfers. Provides that the legislature must approve any grant money transferred within the Departments of Human Services and Health and within the programs operated by the Veterans Nursing Homes Board.

13 **Special revenue transfer for certain programs.** Requires that the balance of the indirect cost reimbursement attributable to federal grants transferred from the Department of Education to the Department of Human Services and the balance of the child care child support recoveries in the special revenue account established under Minnesota Statutes, section 119B.074 that are available at close be transferred to the general fund.

14 **Indirect costs not to fund programs.** States that the commissioners of health and of human services shall not use indirect cost allocations to pay for the operational costs of any program for which they are responsible.

15 **Sunset of uncodified language.** Provides that all uncodified language in this article expires on June 30, 2007, unless a different expiration date is explicit.

16 **Effective date; relationship to other appropriations.** States that the provisions in this article are effective retroactively from July 1, 2005, and supersede and replace funding authorized by order of the Ramsey County District Court in Case No. C9-05-5928, as well as Laws 2005, First Special Session chapter 2, which provided temporary funding through July 14, 2005. States that the language in this article is effective August 1, 2005.