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HOUSE FILE NO. 297

FIRST COMMITTEE ENGROSSMENT

January 22, 2007
Authored by Huntley, Abeler, Walker, Thissen, Otremba and others
The bill was read for the first time and referred to the Committee on Health and Human Services
March 19, 2007
Committee Recommendation and Adoption of Report:
To Pass as Amended and re-referred to the Committee on Finance

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Referred by Chair to Health Care and Human Services Finance Division.
March 30, 2007
Returned to the Committee on Finance as Amended.

A bill for an act

relating to state government; making changes to health and human services programs; changing children and family provisions; modifying licensing provisions; amending health care law; modifying continuing care provisions; amending mental health provisions; changing Department of Health provisions; establishing a children's health security program; amending MinnesotaCare, medical assistance, and general assistance medical care; instituting health care reform; establishing the Minnesota Health Insurance Exchange; requiring Section 125 Plans; modifying health insurance provisions; regulating anatomical gifts; establishing family supportive services; providing rate increases for certain providers; changing health records information provisions; making technical changes; providing civil and criminal penalties; establishing task forces; requiring reports; appropriating money for human services and health; amending Minnesota Statutes 2006, sections 16A.10, by adding a subdivision; 16A.724, subdivision 2; 43A.316; 62A.65, subdivision 3; 62E.141; 62H.02; 62J.04, subdivision 3; 62J.17, subdivisions 2, 4a, 7; 62J.41, subdivision 1; 62J.495; 62J.52, subdivisions 1, 2; 62J.60, subdivisions 2, 3; 62J.692, subdivisions 1, 4, 7a, 8, 10; 62J.81, subdivision 1; 62J.82; 62L.12, subdivision 2; 62Q.165, subdivisions 1, 2; 62Q.80, subdivisions 3, 4, 13, 14, by adding a subdivision; 119B.05, subdivision 1; 144.05, by adding a subdivision; 144.3345; 144.565; 144.651, subdivision 26; 144.698, subdivision 1; 144.699, by adding a subdivision; 144A.071, subdivision 4c; 145C.05; 145C.07, by adding a subdivision; 148.235, by adding a subdivision; 151.37, subdivision 2; 152.11, by adding a subdivision; 157.16, subdivision 1; 179A.03, subdivision 7; 245.462, subdivision 20; 245.4874; 245.50, subdivision 5; 245.98, subdivisions 2, 5; 245A.035; 245A.16, subdivisions 1, 3; 245C.02, by adding a subdivision; 245C.04, subdivision 1; 245C.05, subdivisions 1, 4, 5, 7, by adding a subdivision; 245C.08, subdivisions 1, 2; 245C.10, by adding a subdivision; 245C.11, subdivisions 1, 2; 245C.12; 245C.16, subdivision 1; 245C.17, by adding a subdivision; 245C.21, by adding a subdivision; 245C.23, subdivision 2; 245C.24, subdivision 2; 246.54, subdivision 1; 252.27, subdivision 2a; 252.32, subdivision 3; 252.46, by adding a subdivision; 253B.185, subdivision 2; 254A.03, subdivision 3; 254A.16, subdivision 2; 254B.02, subdivisions 1, 5; 254B.03, subdivisions 1, 3; 254B.06, subdivision 3; 256.01, subdivisions 2, 2b, 4, 18, by adding subdivisions; 256.015, subdivision 7; 256.0471, subdivision 1; 256.476, subdivisions 1, 2, 3, 4, 5, 10; 256.969, subdivisions 3a, 9, by adding a subdivision; 256.974; 256.9741, subdivisions 1, 3; 256.9742, subdivisions 3, 4, 6; 256.9744, subdivision 1; 256.975, subdivision 7; 256.984, subdivision 1; 256B.056, subdivisions 1a, 3, 5c; 256B.057, subdivision 8;

256B.0621, subdivision 11; 256B.0623, subdivision 8; 256B.0625, subdivisions 3f, 13c, 13d, 13e, 17, 18a, 20, 23, 47, by adding subdivisions; 256B.0644; 256B.0911, subdivisions 3a, 3b, 4b, 4c, 6, 7, by adding subdivisions; 256B.0913, subdivisions 4, 5, 5a, 8, 9, 10, 11, 12, 13, 14; 256B.0915; 256B.0917, subdivision 8; 256B.0919, subdivision 3; 256B.0943, subdivisions 6, 9, 11, 12; 256B.095; 256B.0951, subdivision 1; 256B.199; 256B.431, subdivisions 1, 2e, 3f, 17e; 256B.434, subdivision 4, by adding subdivisions; 256B.437, by adding a subdivision; 256B.438, subdivision 3; 256B.439, subdivision 1; 256B.49, subdivision 11, by adding a subdivision; 256B.5012, by adding a subdivision; 256B.69, subdivisions 5g, 5h, 23; 256B.75; 256B.76; 256B.763; 256D.03, subdivision 4; 256D.44, subdivisions 2, 5; 256E.35, subdivision 2; 256I.04, subdivision 3; 256I.05, by adding subdivisions; 256J.01, by adding a subdivision; 256J.02, subdivisions 1, 4; 256J.021; 256J.08, subdivision 65; 256J.21, subdivision 2; 256J.24, subdivision 10; 256J.42, subdivision 1; 256J.425, subdivisions 3, 4; 256J.46, by adding a subdivision; 256J.49, subdivision 13; 256J.521, subdivisions 1, 2, by adding a subdivision; 256J.53, subdivision 2; 256J.55, subdivision 1; 256J.626, subdivisions 1, 2, 3, 4, 5, 6; 256J.751, subdivisions 2, 5; 256J.95, subdivisions 3, 13; 256L.01, subdivision 4; 256L.03, subdivisions 1, 5; 256L.035; 256L.04, subdivisions 1, 12; 256L.11, subdivision 7; 256L.12, subdivision 9a; 259.20, subdivision 2; 259.24, subdivision 3; 259.29, subdivision 1; 259.41; 259.53, subdivisions 1, 2; 259.57, subdivisions 1, 2; 259.67, subdivisions 4, 7; 259.75, subdivision 8; 260.012; 260.755, subdivisions 12, 20; 260.761, subdivision 7; 260.765, subdivision 5; 260.771, subdivisions 1, 2; 260B.157, subdivision 1; 260C.152, subdivision 5; 260C.163, subdivision 1; 260C.201, subdivision 11; 260C.209; 260C.212, subdivisions 1, 2, 4, 9; 260C.317, subdivision 3; 260C.331, subdivision 1; 609.115, subdivision 9; 626.556, subdivisions 2, 3, 10, 10a, 10c, 10f, by adding subdivisions; Laws 2000, chapter 340, section 19; Laws 2005, chapter 98, article 3, section 25; Laws 2006, chapter 282, article 20, section 37; proposing coding for new law in Minnesota Statutes, chapters 16A; 62A; 62J; 62Q; 144; 145; 152; 245A; 245C; 254A; 256B; 256C; 256D; 256F; 256J; 260; proposing coding for new law as Minnesota Statutes, chapters 256N; 525A; repealing Minnesota Statutes 2006, sections 62J.052, subdivision 1; 62J.17, subdivisions 1, 5a, 6a, 8; 144.335; 252.21; 252.22; 252.23; 252.24; 252.25; 252.261; 252.275, subdivision 5; 254A.02, subdivisions 7, 9, 12, 14, 15, 16; 254A.085; 254A.086; 254A.12; 254A.14; 254A.15; 254A.16, subdivision 5; 254A.175; 254A.18; 256.969, subdivision 27; 256.9743; 256B.0913, subdivisions 5b, 5c, 5d, 5e, 5f, 5g, 5h; 256J.24, subdivision 6; 256J.29; 256J.37, subdivision 3b; 256J.561, subdivision 1; 256J.62, subdivision 9; 256J.626, subdivisions 7, 9; 256J.65; 525.921; 525.9211; 525.9212; 525.9213; 525.9214; 525.9215; 525.9216; 525.9217; 525.9218; 525.9219; 525.9221; 525.9222; 525.9223; 525.9224; Minnesota Rules, parts 9503.0035, subpart 2; 9505.0335; 9585.0030.

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

ARTICLE 1
CHILDREN AND FAMILY

Section 1. Minnesota Statutes 2006, section 119B.05, subdivision 1, is amended to read:

Subdivision 1. **Eligible participants.** Families eligible for child care assistance under the MFIP child care program are:

(1) MFIP participants who are employed or in job search and meet the requirements of section 119B.10;

(2) persons who are members of transition year families under section 119B.011, subdivision 20, and meet the requirements of section 119B.10;

(3) families who are participating in employment orientation or job search, or other employment or training activities that are included in an approved employability development plan under ~~section~~ sections 256J.09 and 256J.95;

(4) MFIP families who are participating in work job search, job support, employment, or training activities as required in their employment plan, or in appeals, hearings, assessments, or orientations according to chapter 256J;

(5) MFIP families who are participating in social services activities under chapter 256J as required in their employment plan approved according to chapter 256J;

(6) families who are participating in programs as required in tribal contracts under section 119B.02, subdivision 2, or 256.01, subdivision 2; and

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

Sec. 2. Minnesota Statutes 2006, section 256.01, subdivision 2, is amended to read:

Subd. 2. **Specific powers.** Subject to the provisions of section 241.021, subdivision 2, the commissioner of human services shall carry out the specific duties in paragraphs (a) through (cc):

(a) Administer and supervise all forms of public assistance provided for by state law and other welfare activities or services as are vested in the commissioner. Administration and supervision of human services activities or services includes, but is not limited to, assuring timely and accurate distribution of benefits, completeness of service, and quality program management. In addition to administering and supervising human services activities vested by law in the department, the commissioner shall have the authority to:

(1) require county agency participation in training and technical assistance programs to promote compliance with statutes, rules, federal laws, regulations, and policies governing human services;

(2) monitor, on an ongoing basis, the performance of county agencies in the operation and administration of human services, enforce compliance with statutes, rules, federal laws, regulations, and policies governing welfare services and promote excellence of administration and program operation;

(3) develop a quality control program or other monitoring program to review county performance and accuracy of benefit determinations;

(4) require county agencies to make an adjustment to the public assistance benefits issued to any individual consistent with federal law and regulation and state law and rule and to issue or recover benefits as appropriate;

(5) delay or deny payment of all or part of the state and federal share of benefits and administrative reimbursement according to the procedures set forth in section 256.017;

(6) make contracts with and grants to public and private agencies and organizations, both profit and nonprofit, and individuals, using appropriated funds; and

(7) enter into contractual agreements with federally recognized Indian tribes with a reservation in Minnesota to the extent necessary for the tribe to operate a federally approved family assistance program or any other program under the supervision of the commissioner. The commissioner shall consult with the affected county or counties in the contractual agreement negotiations, if the county or counties wish to be included, in order to avoid the duplication of county and tribal assistance program services. The commissioner may establish necessary accounts for the purposes of receiving and disbursing funds as necessary for the operation of the programs.

(b) Inform county agencies, on a timely basis, of changes in statute, rule, federal law, regulation, and policy necessary to county agency administration of the programs.

(c) Administer and supervise all child welfare activities; promote the enforcement of laws protecting disabled, dependent, neglected and delinquent children, and children born to mothers who were not married to the children's fathers at the times of the conception nor at the births of the children; license and supervise child-caring and child-placing agencies and institutions; supervise the care of children in boarding and foster homes or in private institutions; and generally perform all functions relating to the field of child welfare now vested in the State Board of Control.

(d) Administer and supervise all noninstitutional service to disabled persons, including those who are visually impaired, hearing impaired, or physically impaired or otherwise disabled. The commissioner may provide and contract for the care and treatment of qualified indigent children in facilities other than those located and available at state hospitals when it is not feasible to provide the service in state hospitals.

(e) Assist and actively cooperate with other departments, agencies and institutions, local, state, and federal, by performing services in conformity with the purposes of Laws 1939, chapter 431.

(f) Act as the agent of and cooperate with the federal government in matters of mutual concern relative to and in conformity with the provisions of Laws 1939, chapter 431, including the administration of any federal funds granted to the state to aid in the performance of any functions of the commissioner as specified in Laws 1939, chapter 431,

and including the promulgation of rules making uniformly available medical care benefits to all recipients of public assistance, at such times as the federal government increases its participation in assistance expenditures for medical care to recipients of public assistance, the cost thereof to be borne in the same proportion as are grants of aid to said recipients.

(g) Establish and maintain any administrative units reasonably necessary for the performance of administrative functions common to all divisions of the department.

(h) Act as designated guardian of both the estate and the person of all the wards of the state of Minnesota, whether by operation of law or by an order of court, without any further act or proceeding whatever, except as to persons committed as developmentally disabled. For children under the guardianship of the commissioner or a tribe in Minnesota recognized by the Secretary of the Interior whose interests would be best served by adoptive placement, the commissioner may contract with a licensed child-placing agency or a Minnesota tribal social services agency to provide adoption services. A contract with a licensed child-placing agency must be designed to supplement existing county efforts and may not replace existing county programs or tribal social services, unless the replacement is agreed to by the county board and the appropriate exclusive bargaining representative, tribal governing body, or the commissioner has evidence that child placements of the county continue to be substantially below that of other counties. Funds encumbered and obligated under an agreement for a specific child shall remain available until the terms of the agreement are fulfilled or the agreement is terminated.

(i) Act as coordinating referral and informational center on requests for service for newly arrived immigrants coming to Minnesota.

(j) The specific enumeration of powers and duties as hereinabove set forth shall in no way be construed to be a limitation upon the general transfer of powers herein contained.

(k) Establish county, regional, or statewide schedules of maximum fees and charges which may be paid by county agencies for medical, dental, surgical, hospital, nursing and nursing home care and medicine and medical supplies under all programs of medical care provided by the state and for congregate living care under the income maintenance programs.

(l) Have the authority to conduct and administer experimental projects to test methods and procedures of administering assistance and services to recipients or potential recipients of public welfare. To carry out such experimental projects, it is further provided that the commissioner of human services is authorized to waive the enforcement of existing specific statutory program requirements, rules, and standards in one or more counties. The order establishing the waiver shall provide alternative methods and procedures of administration, shall not be in conflict with the basic purposes, coverage, or

benefits provided by law, and in no event shall the duration of a project exceed four years. It is further provided that no order establishing an experimental project as authorized by the provisions of this section shall become effective until the following conditions have been met:

(1) the secretary of health and human services of the United States has agreed, for the same project, to waive state plan requirements relative to statewide uniformity; and

(2) a comprehensive plan, including estimated project costs, shall be approved by the Legislative Advisory Commission and filed with the commissioner of administration.

(m) According to federal requirements, establish procedures to be followed by local welfare boards in creating citizen advisory committees, including procedures for selection of committee members.

(n) Allocate federal fiscal disallowances or sanctions which are based on quality control error rates for the aid to families with dependent children program formerly codified in sections 256.72 to 256.87, medical assistance, or food stamp program in the following manner:

(1) one-half of the total amount of the disallowance shall be borne by the county boards responsible for administering the programs. For the medical assistance and the AFDC program formerly codified in sections 256.72 to 256.87, disallowances shall be shared by each county board in the same proportion as that county's expenditures for the sanctioned program are to the total of all counties' expenditures for the AFDC program formerly codified in sections 256.72 to 256.87, and medical assistance programs. For the food stamp program, sanctions shall be shared by each county board, with 50 percent of the sanction being distributed to each county in the same proportion as that county's administrative costs for food stamps are to the total of all food stamp administrative costs for all counties, and 50 percent of the sanctions being distributed to each county in the same proportion as that county's value of food stamp benefits issued are to the total of all benefits issued for all counties. Each county shall pay its share of the disallowance to the state of Minnesota. When a county fails to pay the amount due hereunder, the commissioner may deduct the amount from reimbursement otherwise due the county, or the attorney general, upon the request of the commissioner, may institute civil action to recover the amount due; and

(2) notwithstanding the provisions of clause (1), if the disallowance results from knowing noncompliance by one or more counties with a specific program instruction, and that knowing noncompliance is a matter of official county board record, the commissioner may require payment or recover from the county or counties, in the manner prescribed in

clause (1), an amount equal to the portion of the total disallowance which resulted from the noncompliance, and may distribute the balance of the disallowance according to clause (1).

(o) Develop and implement special projects that maximize reimbursements and result in the recovery of money to the state. For the purpose of recovering state money, the commissioner may enter into contracts with third parties. Any recoveries that result from projects or contracts entered into under this paragraph shall be deposited in the state treasury and credited to a special account until the balance in the account reaches $1,000,000. When the balance in the account exceeds $1,000,000, the excess shall be transferred and credited to the general fund. All money in the account is appropriated to the commissioner for the purposes of this paragraph.

(p) Have the authority to make direct payments to facilities providing shelter to women and their children according to section 256D.05, subdivision 3. Upon the written request of a shelter facility that has been denied payments under section 256D.05, subdivision 3, the commissioner shall review all relevant evidence and make a determination within 30 days of the request for review regarding issuance of direct payments to the shelter facility. Failure to act within 30 days shall be considered a determination not to issue direct payments.

(q) Have the authority to establish and enforce the following county reporting requirements:

(1) the commissioner shall establish fiscal and statistical reporting requirements necessary to account for the expenditure of funds allocated to counties for human services programs. When establishing financial and statistical reporting requirements, the commissioner shall evaluate all reports, in consultation with the counties, to determine if the reports can be simplified or the number of reports can be reduced;

(2) the county board shall submit monthly or quarterly reports to the department as required by the commissioner. Monthly reports are due no later than 15 working days after the end of the month. Quarterly reports are due no later than 30 calendar days after the end of the quarter, unless the commissioner determines that the deadline must be shortened to 20 calendar days to avoid jeopardizing compliance with federal deadlines or risking a loss of federal funding. Only reports that are complete, legible, and in the required format shall be accepted by the commissioner;

(3) if the required reports are not received by the deadlines established in clause (2), the commissioner may delay payments and withhold funds from the county board until the next reporting period. When the report is needed to account for the use of federal funds and the late report results in a reduction in federal funding, the commissioner shall

withhold from the county boards with late reports an amount equal to the reduction in federal funding until full federal funding is received;

(4) a county board that submits reports that are late, illegible, incomplete, or not in the required format for two out of three consecutive reporting periods is considered noncompliant. When a county board is found to be noncompliant, the commissioner shall notify the county board of the reason the county board is considered noncompliant and request that the county board develop a corrective action plan stating how the county board plans to correct the problem. The corrective action plan must be submitted to the commissioner within 45 days after the date the county board received notice of noncompliance;

(5) the final deadline for fiscal reports or amendments to fiscal reports is one year after the date the report was originally due. If the commissioner does not receive a report by the final deadline, the county board forfeits the funding associated with the report for that reporting period and the county board must repay any funds associated with the report received for that reporting period;

(6) the commissioner may not delay payments, withhold funds, or require repayment under clause (3) or (5) if the county demonstrates that the commissioner failed to provide appropriate forms, guidelines, and technical assistance to enable the county to comply with the requirements. If the county board disagrees with an action taken by the commissioner under clause (3) or (5), the county board may appeal the action according to sections 14.57 to 14.69; and

(7) counties subject to withholding of funds under clause (3) or forfeiture or repayment of funds under clause (5) shall not reduce or withhold benefits or services to clients to cover costs incurred due to actions taken by the commissioner under clause (3) or (5).

(r) Allocate federal fiscal disallowances or sanctions for audit exceptions when federal fiscal disallowances or sanctions are based on a statewide random sample for the foster care program under title IV-E of the Social Security Act, United States Code, title 42, in direct proportion to each county's title IV-E foster care maintenance claim for that period.

(s) Be responsible for ensuring the detection, prevention, investigation, and resolution of fraudulent activities or behavior by applicants, recipients, and other participants in the human services programs administered by the department.

(t) Require county agencies to identify overpayments, establish claims, and utilize all available and cost-beneficial methodologies to collect and recover these overpayments in the human services programs administered by the department.

(u) Have the authority to administer a drug rebate program for drugs purchased pursuant to the prescription drug program established under section 256.955 after the beneficiary's satisfaction of any deductible established in the program. The commissioner shall require a rebate agreement from all manufacturers of covered drugs as defined in section 256B.0625, subdivision 13. Rebate agreements for prescription drugs delivered on or after July 1, 2002, must include rebates for individuals covered under the prescription drug program who are under 65 years of age. For each drug, the amount of the rebate shall be equal to the rebate as defined for purposes of the federal rebate program in United States Code, title 42, section 1396r-8. The manufacturers must provide full payment within 30 days of receipt of the state invoice for the rebate within the terms and conditions used for the federal rebate program established pursuant to section 1927 of title XIX of the Social Security Act. The manufacturers must provide the commissioner with any information necessary to verify the rebate determined per drug. The rebate program shall utilize the terms and conditions used for the federal rebate program established pursuant to section 1927 of title XIX of the Social Security Act.

(v) Have the authority to administer the federal drug rebate program for drugs purchased under the medical assistance program as allowed by section 1927 of title XIX of the Social Security Act and according to the terms and conditions of section 1927. Rebates shall be collected for all drugs that have been dispensed or administered in an outpatient setting and that are from manufacturers who have signed a rebate agreement with the United States Department of Health and Human Services.

(w) Have the authority to administer a supplemental drug rebate program for drugs purchased under the medical assistance program. The commissioner may enter into supplemental rebate contracts with pharmaceutical manufacturers and may require prior authorization for drugs that are from manufacturers that have not signed a supplemental rebate contract. Prior authorization of drugs shall be subject to the provisions of section 256B.0625, subdivision 13.

(x) Operate the department's communication systems account established in Laws 1993, First Special Session chapter 1, article 1, section 2, subdivision 2, to manage shared communication costs necessary for the operation of the programs the commissioner supervises. A communications account may also be established for each regional treatment center which operates communications systems. Each account must be used to manage shared communication costs necessary for the operations of the programs the commissioner supervises. The commissioner may distribute the costs of operating and maintaining communication systems to participants in a manner that reflects actual usage. Costs may include acquisition, licensing, insurance, maintenance, repair, staff time and

other costs as determined by the commissioner. Nonprofit organizations and state, county, and local government agencies involved in the operation of programs the commissioner supervises may participate in the use of the department's communications technology and share in the cost of operation. The commissioner may accept on behalf of the state any gift, bequest, devise or personal property of any kind, or money tendered to the state for any lawful purpose pertaining to the communication activities of the department. Any money received for this purpose must be deposited in the department's communication systems accounts. Money collected by the commissioner for the use of communication systems must be deposited in the state communication systems account and is appropriated to the commissioner for purposes of this section.

(y) Receive any federal matching money that is made available through the medical assistance program for the consumer satisfaction survey. Any federal money received for the survey is appropriated to the commissioner for this purpose. The commissioner may expend the federal money received for the consumer satisfaction survey in either year of the biennium.

(z) Designate community information and referral call centers and incorporate cost reimbursement claims from the designated community information and referral call centers into the federal cost reimbursement claiming processes of the department according to federal law, rule, and regulations. Existing information and referral centers provided by Greater Twin Cities United Way or existing call centers for which Greater Twin Cities United Way has legal authority to represent, shall be included in these designations upon review by the commissioner and assurance that these services are accredited and in compliance with national standards. Any reimbursement is appropriated to the commissioner and all designated information and referral centers shall receive payments according to normal department schedules established by the commissioner upon final approval of allocation methodologies from the United States Department of Health and Human Services Division of Cost Allocation or other appropriate authorities.

(aa) Develop recommended standards for foster care homes that address the components of specialized therapeutic services to be provided by foster care homes with those services.

(bb) Authorize the method of payment to or from the department as part of the human services programs administered by the department. This authorization includes the receipt or disbursement of funds held by the department in a fiduciary capacity as part of the human services programs administered by the department.

(cc) Have the authority to administer a drug rebate program for drugs purchased for persons eligible for general assistance medical care under section 256D.03, subdivision 3.

For manufacturers that agree to participate in the general assistance medical care rebate program, the commissioner shall enter into a rebate agreement for covered drugs as defined in section 256B.0625, subdivisions 13 and 13d. For each drug, the amount of the rebate shall be equal to the rebate as defined for purposes of the federal rebate program in United States Code, title 42, section 1396r-8. The manufacturers must provide payment within the terms and conditions used for the federal rebate program established under section 1927 of title XIX of the Social Security Act. The rebate program shall utilize the terms and conditions used for the federal rebate program established under section 1927 of title XIX of the Social Security Act.

Effective January 1, 2006, drug coverage under general assistance medical care shall be limited to those prescription drugs that:

(1) are covered under the medical assistance program as described in section 256B.0625, subdivisions 13 and 13d; and

(2) are provided by manufacturers that have fully executed general assistance medical care rebate agreements with the commissioner and comply with such agreements. Prescription drug coverage under general assistance medical care shall conform to coverage under the medical assistance program according to section 256B.0625, subdivisions 13 to 13g.

The rebate revenues collected under the drug rebate program are deposited in the general fund.

Sec. 3. Minnesota Statutes 2006, section 256.01, subdivision 4, is amended to read:

Subd. 4. **Duties as state agency.** (a) The state agency shall:

(1) supervise the administration of assistance to dependent children under Laws 1937, chapter 438, by the county agencies in an integrated program with other service for dependent children maintained under the direction of the state agency;

~~(2) may subpoena witnesses and administer oaths, make rules, and take such action as may be necessary, or desirable for carrying out the provisions of Laws 1937, chapter 438. All rules made by the state agency shall be binding on the counties and shall be complied with by the respective county agencies;~~

~~(3)~~ (2) establish adequate standards for personnel employed by the counties and the state agency in the administration of Laws 1937, chapter 438, and make the necessary rules to maintain such standards;

~~(4)~~ (3) prescribe the form of and print and supply to the county agencies blanks for applications, reports, affidavits, and such other forms as it may deem necessary and advisable;

~~(5)~~ (4) cooperate with the federal government and its public welfare agencies in any reasonable manner as may be necessary to qualify for federal aid for temporary assistance for needy families and in conformity with title I of Public Law 104-193, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 and successor amendments, including the making of such reports and such forms and containing such information as the Federal Social Security Board may from time to time require, and comply with such provisions as such board may from time to time find necessary to assure the correctness and verification of such reports;

~~(6) may cooperate with other state agencies in establishing reciprocal agreements in instances where a child receiving Minnesota family investment program assistance moves or contemplates moving into or out of the state, in order that such child may continue to receive supervised aid from the state moved from until the child shall have resided for one year in the state moved to;~~

~~(7)~~ (5) on or before October 1 in each even-numbered year make a biennial report to the governor concerning the activities of the agency;

~~(8)~~ (6) enter into agreements with other departments of the state as necessary to meet all requirements of the federal government; and

~~(9)~~ (7) cooperate with the commissioner of education to enforce the requirements for program integrity and fraud prevention for investigation for child care assistance under chapter 119B.

(b) The state agency may:

(1) subpoena witnesses and administer oaths, make rules, and take such action as may be necessary or desirable for carrying out the provisions of Laws 1937, chapter 438. All rules made by the state agency shall be binding on the counties and shall be complied with by the respective county agencies;

(2) cooperate with other state agencies in establishing reciprocal agreements in instances where a child receiving Minnesota family investment program assistance moves or contemplates moving into or out of the state, in order that the child may continue to receive supervised aid from the state moved from until the child has resided for one year in the state moved to; and

(3) administer oaths and affirmations, take depositions, certify to official acts, and issue subpoenas to compel the attendance of individuals and the production of documents and other personal property necessary in connection with the administration of programs administered by the Department of Human Services.

(c) The fees for service of a subpoena in paragraph (b), clause (3), must be paid in the same manner as prescribed by law for a service of process issued by a district court. Witnesses must receive the same fees and mileage as in civil actions.

(d) The subpoena in paragraph (b), clause (3), shall be enforceable through the district court in the district where the subpoena is issued.

Sec. 4. Minnesota Statutes 2006, section 256.01, subdivision 18, is amended to read:

Subd. 18. **Immigration status verifications.** (a) Notwithstanding any waiver of this requirement by the secretary of the United States Department of Health and Human Services, effective July 1, 2001, the commissioner shall utilize the Systematic Alien Verification for Entitlements (SAVE) program to conduct immigration status verifications:

(1) as required under United States Code, title 8, section 1642;

(2) for all applicants and recipients at recertification for food assistance benefits, whether under the federal food stamp program, the MFIP ~~or work first program~~, or the Minnesota food assistance program;

(3) for all applicants and recipients at recertification for general assistance medical care, except assistance for an emergency medical condition, for immunization with respect to an immunizable disease, or for testing and treatment of symptoms of a communicable disease; and

(4) for all applicants and recipients at recertification for general assistance, Minnesota supplemental aid, MinnesotaCare, or group residential housing, when the benefits provided by these programs would fall under the definition of "federal public benefit" under United States Code, title 8, section 1642, if federal funds were used to pay for all or part of the benefits.

(b) The commissioner shall comply with the reporting requirements under United States Code, title 42, section 611a, and any federal regulation or guidance adopted under that law.

Sec. 5. Minnesota Statutes 2006, section 256.01, is amended by adding a subdivision to read:

Subd. 23. **Administrative simplification; county cost study.** (a) The commissioner shall establish and convene the first meeting of an advisory committee to identify ways to simplify and streamline human services laws and administrative requirements. The advisory committee shall select its chair from its membership at the first meeting.

(b) The committee shall consist of three senators appointed by the senate Committee on Rules and Administration, three state representatives appointed by the speaker of the

house of representatives, four department staff, and five county representatives appointed by the Association of Minnesota Counties after consultation with other relevant county organizations.

(c) The committee shall annually select up to two topics for review. The goals of the reviews are to discuss opportunities for administrative improvements and increased simplification and streamlining to improve consistency, efficiency, fairness, and to reduce the risk of recipient noncompliance. In reviewing the topics selected, consideration shall be given to:

(1) current challenges in administrative complexity and service delivery and whether the sharing of responsibilities between the state and the county should be altered in any way, including transferring responsibilities from one entity to the other;

(2) methods of reducing inconsistency with similar programs; and

(3) the current funding mechanism, whether funding formulas should be adjusted for special demographic or geographic factors that influence program costs, differences in county property tax contributions and maintenance of effort obligations, and whether the mix of state and county obligations for financial support of this service should be changed.

(d) The committee members shall assume responsibility for reporting progress to the appropriate leadership of the groups they represent. The commissioner, in partnership with the advisory committee, shall report to the legislative committees and divisions with jurisdiction over the Department of Human Services on the findings and recommendations of the advisory committee by December 15 of each year.

(e) This section expires June 30, 2012.

Sec. 6. Minnesota Statutes 2006, section 256.015, subdivision 7, is amended to read:

Subd. 7. **Cooperation required.** Upon the request of the Department of Human Services, any state agency or third party payer shall cooperate with the department in furnishing information to help establish a third party liability. Upon the request of the Department of Human Services or county child support or human service agencies, any employer or third party payer shall cooperate in furnishing information about group health insurance plans or medical benefit plans available to its employees. For purposes of section 176.191, subdivision 4, the Department of Labor and Industry may allow the Department of Human Services and county agencies direct access and data matching on information relating to workers' compensation claims in order to determine whether the claimant has reported the fact of a pending claim and the amount paid to or on behalf of the claimant to the Department of Human Services. The Department of Human Services and county agencies shall limit its use of information gained from agencies, third party

payers, and employers to purposes directly connected with the administration of its public assistance and child support programs. The provision of information by agencies, third party payers, and employers to the department under this subdivision is not a violation of any right of confidentiality or data privacy.

Sec. 7. Minnesota Statutes 2006, section 256.0471, subdivision 1, is amended to read:

Subdivision 1. **Qualifying overpayment.** Any overpayment for assistance granted under chapter 119B, the MFIP program formerly codified under sections 256.031 to 256.0361, and the AFDC program formerly codified under sections 256.72 to 256.871; chapters 256B, 256D, 256I, 256J, ~~and~~ 256K, and 256L; and the food stamp or food support program, except agency error claims, become a judgment by operation of law 90 days after the notice of overpayment is personally served upon the recipient in a manner that is sufficient under rule 4.03(a) of the Rules of Civil Procedure for district courts, or by certified mail, return receipt requested. This judgment shall be entitled to full faith and credit in this and any other state.

Sec. 8. Minnesota Statutes 2006, section 256.984, subdivision 1, is amended to read:

Subdivision 1. **Declaration.** Every application for public assistance under this chapter or chapters 256B, 256D, 256J, and 256L; child care programs under chapter 119B; and food stamps or food support under chapter 393 shall be in writing or reduced to writing as prescribed by the state agency and shall contain the following declaration which shall be signed by the applicant:

"I declare under the penalties of perjury that this application has been examined by me and to the best of my knowledge is a true and correct statement of every material point. I understand that a person convicted of perjury may be sentenced to imprisonment of not more than five years or to payment of a fine of not more than $10,000, or both."

Sec. 9. **[256D.0516] EXPIRATION OF FOOD SUPPORT BENEFITS AND REPORTING REQUIREMENTS.**

Subdivision 1. **Expiration of food support benefits.** Food support benefits shall not be stored off line or expunged from a recipient's account unless the benefits have not been accessed for 12 months after the month they were issued.

Subd. 2. **Food support reporting requirements.** The Department of Human Services shall implement simplified reporting as permitted under the Food Stamp Act of 1977, as amended, and the food stamp regulations in Code of Federal Regulations, title

7, part 273. Food support recipient households required to report periodically shall not be required to report more often than one time every six months. This provision shall not apply to households receiving food benefits under the Minnesota family investment program waiver.

Sec. 10. **[256F.15] GRANT PROGRAM FOR CRISIS NURSERIES.**

Subdivision 1. **Crisis nurseries.** The commissioner of human services shall establish a grant program to assist private and public agencies and organizations to provide crisis nurseries to offer services and temporary care to families experiencing crisis situations including children who are at high risk of abuse and neglect, children who have been abused and neglected, and children who are in families receiving child protective services. This service shall be provided without a fee for a maximum of 30 days in any year. Crisis nurseries shall provide short-term case management, family support services, parent education, crisis intervention, referrals, and resources, as needed.

(a) The crisis nurseries must provide a spectrum of services that may include, but are not limited to:

(1) being available 24 hours a day, seven days a week;

(2) providing services for children up to 72 hours at any one time;

(3) providing short-term case management to bridge the gap between crisis and successful living;

(4) making referrals for parents to counseling services and other community resources to help alleviate the underlying cause of the precipitating stress or crisis;

(5) providing services without a fee for a maximum of 30 days in any year;

(6) providing services to families with children from birth through 12 years of age, as services are available;

(7) providing an immediate response to family needs and strengths with an initial assessment and intake interview, making referrals to appropriate agencies or programs, and providing temporary care of children, as needed;

(8) maintaining the clients' confidentiality to the extent required by law, and also complying with statutory reporting requirements which may mandate a report to child protective services;

(9) providing a volunteer component and support for volunteers;

(10) providing preservice training and ongoing training to providers and volunteers;

(11) evaluating the services provided by documenting use of services, the result of family referrals made to community resources, and how the services reduced the risk of maltreatment;

(12) providing developmental assessments;

(13) providing medical assessments as determined by using a risk screening tool;

(14) providing parent education classes or programs that include parent-child interaction either on site or in collaboration with other community agencies; and

(15) having a multidisciplinary advisory board which may include one or more parents who have used the crisis nursery services.

(b) The crisis nurseries are encouraged to provide opportunities for parents to volunteer, if appropriate.

(c) Parents shall retain custody of their children during placement in a crisis facility.

Subd. 2. **Fund distribution.** In distributing funds, the commissioner shall give priority consideration to agencies and organizations with experience in working with abused or neglected children and their families, and with children at high risk of abuse and neglect and their families, and serve communities which demonstrate the greatest need for these services. Funds shall be distributed to crisis nurseries according to a formula developed by the commissioner in consultation with the Minnesota Crisis Nursery Association. The formula shall include funding for all existing crisis nursery programs that have been previously funded through the Department of Human Services and that meet program requirements as specified in subdivision 1, paragraph (a), and consideration of factors reflecting the need for services in each service area, including but not limited to the number of children 18 years of age and under living in the service area, the percent of children 18 years of age and under living in poverty in the service area, and factors reflecting the cost of providing services, including but not limited to the number of hours of service provided in the previous year.

Sec. 11. Minnesota Statutes 2006, section 256J.01, is amended by adding a subdivision to read:

Subd. 6. **Legislative approval to move programs or activities.** The commissioner shall not move programs or activities funded with MFIP or TANF maintenance of effort funds to other funding sources without legislative approval.

Sec. 12. Minnesota Statutes 2006, section 256J.02, subdivision 1, is amended to read:

Subdivision 1. **Commissioner's authority to administer block grant funds.** The commissioner of human services is authorized to receive, administer, and expend funds available under the TANF block grant authorized under title I of Public Law 104-193, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, and under Public Law 109-171, the Deficit Reduction Act of 2005.

Sec. 13. Minnesota Statutes 2006, section 256J.02, subdivision 4, is amended to read:

Subd. 4. **Authority to transfer.** Subject to limitations of title I of Public Law 104-193, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, as amended, and under Public Law 109-171, the Deficit Reduction Act of 2005, the legislature may transfer money from the TANF block grant to the child care fund under chapter 119B, or the Title XX block grant.

Sec. 14. Minnesota Statutes 2006, section 256J.021, is amended to read:

256J.021 SEPARATE STATE PROGRAM FOR USE OF STATE MONEY.

Families receiving assistance under this section must comply with all applicable requirements in this chapter.

~~(a) Until October 1, 2006, the commissioner of human services must treat MFIP expenditures made to or on behalf of any minor child under section 256J.02, subdivision 2, clause (1), who is a resident of this state under section 256J.12, and who is part of a two-parent eligible household as expenditures under a separately funded state program and report those expenditures to the federal Department of Health and Human Services as separate state program expenditures under Code of Federal Regulations, title 45, section 263.5.~~

~~(b)~~ Beginning October 1, 2006, and each year thereafter, the commissioner of human services must treat MFIP expenditures made to or on behalf of any minor child under section 256J.02, subdivision 2, clause (1), ~~who is a resident of this state under section 256J.12, and~~ who is part of a two-parent ~~eligible~~ household, as expenditures under a separately funded state program. ~~These expenditures shall not count toward the state's maintenance of effort (MOE) requirements under the federal Temporary Assistance to Needy Families (TANF) program except if counting certain families would allow the commissioner to avoid a federal penalty. Families receiving assistance under this section must comply with all applicable requirements in this chapter.~~

Sec. 15. Minnesota Statutes 2006, section 256J.08, subdivision 65, is amended to read:

Subd. 65. **Participant.** (a) "Participant" ~~means~~ includes any of the following:

(1) a person who is currently receiving cash assistance or the food portion available through MFIP~~. A person who fails to withdraw or access electronically any portion of the person's cash and food assistance payment by the end of the payment month, who makes a written request for closure before the first of a payment month and repays cash and food assistance electronically issued for that payment month within that payment month, or~~

~~who returns any uncashed assistance check and food coupons and withdraws from the program is not a participant.~~;

(2) a person who withdraws a cash or food assistance payment by electronic transfer or receives and cashes an MFIP assistance check or food coupons and is subsequently determined to be ineligible for assistance for that period of time is a participant, regardless whether that assistance is repaid~~. The term "participant" includes~~;

(3) the caregiver relative and the minor child whose needs are included in the assistance payment~~.~~;

(4) a person in an assistance unit who does not receive a cash and food assistance payment because the case has been suspended from MFIP ~~is a participant.~~;

(5) a person who receives cash payments under the diversionary work program under section 256J.95 is a participant~~.~~; and

(6) a person who receives cash payments under the family stabilization services program under section 256J.575.

(b) "Participant" does not include a person who fails to withdraw or access electronically any portion of the person's cash and food assistance payment by the end of the payment month, who makes a written request for closure before the first of a payment month and repays cash and food assistance electronically issued for that payment month within that payment month, or who returns any uncashed assistance check and food coupons and withdraws from the program.

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

Sec. 16. Minnesota Statutes 2006, section 256J.21, subdivision 2, is amended to read:

Subd. 2. **Income exclusions.** The following must be excluded in determining a family's available income:

(1) payments for basic care, difficulty of care, and clothing allowances received for providing family foster care to children or adults under Minnesota Rules, parts 9555.5050 to 9555.6265, 9560.0521, and 9560.0650 to 9560.0655, and payments received and used for care and maintenance of a third-party beneficiary who is not a household member;

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

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

(4) all educational assistance, except the county agency must count graduate student teaching assistantships, fellowships, and other similar paid work as earned income and,

after allowing deductions for any unmet and necessary educational expenses, shall count scholarships or grants awarded to graduate students that do not require teaching or research as unearned income;

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

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

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

(ii) federal income tax refunds;

(8)(i) federal earned income credits;

(ii) Minnesota working family credits;

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

(iv) federal or state tax rebates;

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

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

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

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

(13) in-kind income, including any payments directly made by a third party to a provider of goods and services;

(14) assistance payments to correct underpayments, but only for the month in which the payment is received;

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

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

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

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

(19) Supplemental Security Income (SSI), including retroactive SSI payments and other income of an SSI recipient, except as described in section 256J.37, subdivision 3b;

(20) Minnesota supplemental aid, including retroactive payments;

(21) proceeds from the sale of real or personal property;

(22) state adoption assistance payments under section 259.67, and up to an equal amount of county adoption assistance payments;

(23) state-funded family subsidy program payments made under section 252.32 to help families care for children with developmental disabilities, consumer support grant funds under section 256.476, and resources and services for a disabled household member under one of the home and community-based waiver services programs under chapter 256B;

(24) interest payments and dividends from property that is not excluded from and that does not exceed the asset limit;

(25) rent rebates;

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

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

(28) MFIP child care payments under section 119B.05;

(29) all other payments made through MFIP to support a caregiver's pursuit of greater economic stability;

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

(31) reverse mortgages;

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

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

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

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

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

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

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

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

(40) security and utility deposit refunds;

(41) American Indian tribal land settlements excluded under Public Laws 98-123, 98-124, and 99-377 to the Mississippi Band Chippewa Indians of White Earth, Leech Lake, and Mille Lacs reservations and payments to members of the White Earth Band, under United States Code, title 25, chapter 9, section 331, and chapter 16, section 1407;

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

(43) income of the minor parent's parents and stepparents equal to 200 percent of the federal poverty guideline for a family size not including the minor parent and the minor parent's child in households that include a minor parent living with parents or stepparents not on MFIP when determining the grant for the minor parent. The remainder of income is deemed as specified in section 256J.37, subdivision 1b;

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

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

(46) the principal portion of a contract for deed payment~~.~~; and

(47) cash payments to individuals enrolled for full-time service as a volunteer under AmeriCorps programs including AmeriCorps VISTA, AmeriCorps State, AmeriCorps National, and AmeriCorps NCCC.

Sec. 17. Minnesota Statutes 2006, section 256J.24, subdivision 10, is amended to read:

Subd. 10. **MFIP exit level.** The commissioner shall adjust the MFIP earned income disregard to ensure that most participants do not lose eligibility for MFIP until their income reaches at least ~~115~~ 140 percent of the federal poverty guidelines in effect in October of each fiscal year. The adjustment to the disregard shall be based on a household size of three, and the resulting earned income disregard percentage must be applied to all household sizes. The adjustment under this subdivision must be implemented at the same

time as the October food stamp or food support cost-of-living adjustment is reflected in the food portion of MFIP transitional standard as required under subdivision 5a.

Sec. 18. Minnesota Statutes 2006, section 256J.42, subdivision 1, is amended to read:

Subdivision 1. **Time limit.** (a) Except as otherwise provided for in this section, an assistance unit in which any adult caregiver has received 60 months of cash assistance funded in whole or in part by the TANF block grant in this or any other state or United States territory, or from a tribal TANF program, MFIP, the AFDC program formerly codified in sections 256.72 to 256.87, or the family general assistance program formerly codified in sections 256D.01 to 256D.23, funded in whole or in part by state appropriations, is ineligible to receive MFIP. Any cash assistance funded with TANF dollars in this or any other state or United States territory, or from a tribal TANF program, or MFIP assistance funded in whole or in part by state appropriations, that was received by the unit on or after the date TANF was implemented, including any assistance received in states or United States territories of prior residence, counts toward the 60-month limitation. Months during which any cash assistance is received by an assistance unit with a mandatory member who is disqualified for wrongfully obtaining public assistance under section 256.98, subdivision 8, counts toward the time limit for the disqualified member. The 60-month limit applies to a minor caregiver except under subdivision 5. The 60-month time period does not need to be consecutive months for this provision to apply.

(b) The months before July 1998 in which individuals received assistance as part of the field trials as an MFIP, MFIP-R, or MFIP or MFIP-R comparison group family are not included in the 60-month time limit.

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

Sec. 19. Minnesota Statutes 2006, section 256J.425, subdivision 3, is amended to read:

Subd. 3. **Hard-to-employ participants.** An assistance unit subject to the time limit in section 256J.42, subdivision 1, is eligible to receive months of assistance under a hardship extension if the participant who reached the time limit belongs to any of the following groups:

(1) a person who is diagnosed by a licensed physician, psychological practitioner, or other qualified professional, as developmentally disabled or mentally ill, and that condition prevents the person from obtaining or retaining unsubsidized employment;

(2) a person who:

(i) has been assessed by a vocational specialist or the county agency to be unemployable for purposes of this subdivision; or

(ii) has an IQ below 80 who has been assessed by a vocational specialist or a county agency to be employable, but not at a level that makes the participant eligible for an extension under subdivision 4. The determination of IQ level must be made by a qualified professional. In the case of a non-English-speaking person: (A) the determination must be made by a qualified professional with experience conducting culturally appropriate assessments, whenever possible; (B) the county may accept reports that identify an IQ range as opposed to a specific score; (C) these reports must include a statement of confidence in the results;

(3) a person who is determined by a qualified professional to be learning disabled, and the disability severely limits the person's ability to obtain, perform, or maintain suitable employment. For purposes of the initial approval of a learning disability extension, the determination must have been made or confirmed within the previous 12 months. In the case of a non-English-speaking person: (i) the determination must be made by a qualified professional with experience conducting culturally appropriate assessments, whenever possible; and (ii) these reports must include a statement of confidence in the results. If a rehabilitation plan for a participant extended as learning disabled is developed or approved by the county agency, the plan must be incorporated into the employment plan. However, a rehabilitation plan does not replace the requirement to develop and comply with an employment plan under section 256J.521; ~~or~~

(4) a person who has been granted a family violence waiver, and who is complying with an employment plan under section 256J.521, subdivision 3; or

(5) a participant under section 256J.561, subdivision 2, paragraph (d), who is complying with an employment plan tailored to recognize the special circumstances of the caregivers and family, including limitations due to illness or disability, and caregiving needs.

Sec. 20. Minnesota Statutes 2006, section 256J.425, subdivision 4, is amended to read:

Subd. 4. **Employed participants.** (a) An assistance unit subject to the time limit under section 256J.42, subdivision 1, is eligible to receive assistance under a hardship extension if the participant who reached the time limit belongs to:

(1) a one-parent assistance unit in which the participant is participating in work activities for at least 30 hours per week~~, of which an average of at least 25 hours per week every month are spent participating in employment~~;

(2) a two-parent assistance unit in which the participants are participating in work activities for at least 55 hours per week~~, of which an average of at least 45 hours per week every month are spent participating in employment~~; or

(3) an assistance unit in which a participant is participating in employment for fewer hours than those specified in clause (1) or (2), and the participant submits verification from a qualified professional, in a form acceptable to the commissioner, stating that the number of hours the participant may work is limited due to illness or disability, as long as the participant is participating in employment for at least the number of hours specified by the qualified professional. The participant must be following the treatment recommendations of the qualified professional providing the verification. The commissioner shall develop a form to be completed and signed by the qualified professional, documenting the diagnosis and any additional information necessary to document the functional limitations of the participant that limit work hours. If the participant is part of a two-parent assistance unit, the other parent must be treated as a one-parent assistance unit for purposes of meeting the work requirements under this subdivision.

(b) ~~For purposes of this section, employment means:~~

~~(1) unsubsidized employment under section 256J.49, subdivision 13, clause (1);~~

~~(2) subsidized employment under section 256J.49, subdivision 13, clause (2);~~

~~(3) on-the-job training under section 256J.49, subdivision 13, clause (2);~~

~~(4) an apprenticeship under section 256J.49, subdivision 13, clause (1);~~

~~(5) supported work under section 256J.49, subdivision 13, clause (2);~~

~~(6) a combination of clauses (1) to (5); or~~

~~(7) child care under section 256J.49, subdivision 13, clause (7), if it is in combination with paid employment.~~

~~(c)~~ If a participant is complying with a child protection plan under chapter 260C, the number of hours required under the child protection plan count toward the number of hours required under this subdivision.

~~(d)~~ (c) The county shall provide the opportunity for subsidized employment to participants needing that type of employment within available appropriations.

~~(e)~~ (d) To be eligible for a hardship extension for employed participants under this subdivision, a participant must be in compliance for at least ten out of the 12 months the participant received MFIP immediately preceding the participant's 61st month on assistance. If ten or fewer months of eligibility for TANF assistance remain at the time the participant from another state applies for assistance, the participant must be in compliance every month.

~~(f)~~ (e) The employment plan developed under section 256J.521, subdivision 2, for participants under this subdivision must contain at least the minimum number of hours specified in paragraph (a) for the purpose of meeting the requirements for an extension under this subdivision. The job counselor and the participant must sign the employment

plan to indicate agreement between the job counselor and the participant on the contents of the plan.

~~(g)~~ (f) Participants who fail to meet the requirements in paragraph (a), without good cause under section 256J.57, shall be sanctioned or permanently disqualified under subdivision 6. Good cause may only be granted for that portion of the month for which the good cause reason applies. Participants must meet all remaining requirements in the approved employment plan or be subject to sanction or permanent disqualification.

~~(h)~~ (g) If the noncompliance with an employment plan is due to the involuntary loss of employment, the participant is exempt from the hourly employment requirement under this subdivision for one month. Participants must meet all remaining requirements in the approved employment plan or be subject to sanction or permanent disqualification. This exemption is available to each participant two times in a 12-month period.

Sec. 21. Minnesota Statutes 2006, section 256J.46, is amended by adding a subdivision to read:

Subd. 3. **Restrictions on sanctions.** A participant shall not be sanctioned for failure to meet the agreed upon hours in a participant's employment plan under section 256J.521, subdivision 2, when the participant:

(1) fails to meet the agreed upon hours of participation in paid employment because the participant is not eligible for holiday pay and the participant's place of employment is closed for a holiday; or

(2) is otherwise meeting or exceeding the federal TANF work participation rate hourly requirements.

Sec. 22. Minnesota Statutes 2006, section 256J.49, subdivision 13, is amended to read:

Subd. 13. **Work activity.** "Work activity" means any activity in a participant's approved employment plan that leads to employment. For purposes of the MFIP program, this includes activities that meet the definition of work activity under the participation requirements of TANF. Work activity includes:

(1) unsubsidized employment, including work study and paid apprenticeships or internships;

(2) subsidized private sector or public sector employment, including grant diversion as specified in section 256J.69, on-the-job training as specified in section 256J.66, the self-employment investment demonstration program (SEID) as specified in section 256J.65, paid work experience, and supported work when a wage subsidy is provided;

(3) unpaid work experience, including community service, volunteer work, the community work experience program as specified in section 256J.67, unpaid apprenticeships or internships, and supported work when a wage subsidy is not provided. Unpaid work performed in return for cash assistance is prohibited and does not count as a work activity, unless the participant voluntarily agrees, in writing, to engage in unpaid work in return for cash assistance. The participant may terminate the unpaid work arrangement, in writing, at any time;

(4) job search including job readiness assistance, job clubs, job placement, job-related counseling, and job retention services;

(5) job readiness education, including English as a second language (ESL) or functional work literacy classes as limited by the provisions of section 256J.531, subdivision 2, general educational development (GED) course work, high school completion, and adult basic education as limited by the provisions of section 256J.531, subdivision 1;

(6) job skills training directly related to employment, including education and training that can reasonably be expected to lead to employment, as limited by the provisions of section 256J.53;

(7) providing child care services to a participant who is working in a community service program;

(8) activities included in the employment plan that is developed under section 256J.521, subdivision 3; and

(9) preemployment activities including chemical and mental health assessments, treatment, and services; learning disabilities services; child protective services; family stabilization services; or other programs designed to enhance employability.

Sec. 23. Minnesota Statutes 2006, section 256J.521, subdivision 1, is amended to read:

Subdivision 1. **Assessments.** (a) For purposes of MFIP employment services, assessment is a continuing process of gathering information related to employability for the purpose of identifying both participant's strengths and strategies for coping with issues that interfere with employment. The job counselor must use information from the assessment process to develop and update the employment plan under subdivision 2 or 3, as appropriate, ~~and~~ to determine whether the participant qualifies for a family violence waiver including an employment plan under subdivision 3, and to determine whether the participant should be referred to the family stabilization services program under section 256J.575.

(b) The scope of assessment must cover at least the following areas:

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

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

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

(4) a comprehensive review of participation and progress for participants who have received MFIP assistance and have not worked in unsubsidized employment during the past 12 months. The purpose of the review is to determine the need for additional services and supports, including placement in subsidized employment or unpaid work experience under section 256J.49, subdivision 13, or referral to the family stabilization services program under section 256J.575.

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

(d) The job counselor may require the participant to complete a professional chemical use assessment to be performed according to the rules adopted under section 254A.03, subdivision 3, including provisions in the administrative rules which recognize the cultural background of the participant, or a professional psychological assessment as a component of the assessment process, when the job counselor has a reasonable belief, based on objective evidence, that a participant's ability to obtain and retain suitable employment

is impaired by a medical condition. The job counselor may assist the participant with arranging services, including child care assistance and transportation, necessary to meet needs identified by the assessment. Data gathered as part of a professional assessment must be classified and disclosed according to the provisions in section 13.46.

Sec. 24. Minnesota Statutes 2006, section 256J.521, subdivision 2, is amended to read:

Subd. 2. **Employment plan; contents.** (a) Based on the assessment under subdivision 1, the job counselor and the participant must develop an employment plan that includes participation in activities and hours that meet the requirements of section 256J.55, subdivision 1. The purpose of the employment plan is to identify for each participant the most direct path to unsubsidized employment and any subsequent steps that support long-term economic stability. The employment plan should be developed using the highest level of activity appropriate for the participant. Activities must be chosen from clauses (1) to (6), which are listed in order of preference. Notwithstanding this order of preference for activities, priority must be given for activities related to a family violence waiver when developing the employment plan. The employment plan must also list the specific steps the participant will take to obtain employment, including steps necessary for the participant to progress from one level of activity to another, and a timetable for completion of each step. Levels of activity include:

(1) unsubsidized employment;

(2) job search;

(3) subsidized employment or unpaid work experience;

(4) unsubsidized employment and job readiness education or job skills training;

(5) unsubsidized employment or unpaid work experience and activities related to a family violence waiver or preemployment needs; and

(6) activities related to a family violence waiver or preemployment needs.

(b) Participants who are determined to possess sufficient skills such that the participant is likely to succeed in obtaining unsubsidized employment must job search at least 30 hours per week for up to six weeks and accept any offer of suitable employment. The remaining hours necessary to meet the requirements of section 256J.55, subdivision 1, may be met through participation in other work activities under section 256J.49, subdivision 13. The participant's employment plan must specify, at a minimum: (1) whether the job search is supervised or unsupervised; (2) support services that will be provided; and (3) how frequently the participant must report to the job counselor. Participants who are unable to find suitable employment after six weeks must meet with the job counselor to determine whether other activities in paragraph (a) should be

incorporated into the employment plan. Job search activities which are continued after six weeks must be structured and supervised.

(c) Beginning July 1, 2004, activities and hourly requirements in the employment plan may be adjusted as necessary to accommodate the personal and family circumstances of participants identified under section 256J.561, subdivision 2, paragraph (d). Participants who no longer meet the provisions of section 256J.561, subdivision 2, paragraph (d), must meet with the job counselor within ten days of the determination to revise the employment plan.

(d) Participants who are determined to have barriers to obtaining or retaining employment that will not be overcome during six weeks of job search under paragraph (b) must work with the job counselor to develop an employment plan that addresses those barriers by incorporating appropriate activities from paragraph (a), clauses (1) to (6). The employment plan must include enough hours to meet the participation requirements in section 256J.55, subdivision 1, unless a compelling reason to require fewer hours is noted in the participant's file.

(e) The job counselor and the participant must sign the employment plan to indicate agreement on the contents.

(f) Except as provided under paragraphs (g) and (h), failure to develop or comply with activities in the plan, or voluntarily quitting suitable employment without good cause, will result in the imposition of a sanction under section 256J.46. The job counselor is encouraged to allow participants who are participating in at least 20 hours of work activities to also participate in employment and training activities in order to meet the federal hourly participation rates.

(g) When a participant fails to meet the agreed upon hours of participation in paid employment because the participant is not eligible for holiday pay and the participant's place of employment is closed for a holiday, the job counselor shall not impose a sanction or increase the hours of participation in any other activity, including paid employment, to offset the hours that were missed due to the holiday.

(h) The job counselor shall not impose a sanction for failure to meet the agreed upon hours in a participant's employment plan under this subdivision when the participant is otherwise meeting or exceeding the federal TANF work participation rate hourly requirements.

~~(f)~~ (i) Employment plans must be reviewed at least every three months to determine whether activities and hourly requirements should be revised.

Sec. 25. Minnesota Statutes 2006, section 256J.521, is amended by adding a subdivision to read:

Subd. 7. **Employment plan; nonmaintenance of effort; single caregivers.** (a) When a single caregiver is moved to the nonmaintenance of effort state-funded program under section 256J.021, paragraphs (a) and (b), the single caregiver shall develop or revise the employment plan as specified in this subdivision with a job counselor or county. The plan must address issues interfering with employment, including physical and mental health, substance use, and social service issues of the caregiver and the caregiver's family. Job search and employment must also be included in the plan to the extent possible.

(b) Counties must coordinate services by ensuring that all workers involved with the family communicate on a regular basis, and that expectations for the family across service areas lead to common goals.

(c) Activities and hourly requirements in the employment plan may be adjusted as necessary to accommodate the personal and family circumstances of the participant. Participants who no longer meet the criteria for the nonmaintenance of effort state-funded program shall meet with the job counselor or county within ten days of the determination to revise the employment plan.

Sec. 26. Minnesota Statutes 2006, section 256J.53, subdivision 2, is amended to read:

Subd. 2. **Approval of postsecondary education or training.** (a) ~~In order for a postsecondary education or training program to be an approved activity in an employment plan, the participant must be working in unsubsidized employment at least 20 hours per week.~~

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

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

(2) there are suitable employment opportunities that require the specific education or training in the area in which the participant resides or is willing to reside;

(3) the education or training will result in significantly higher wages for the participant than the participant could earn without the education or training;

(4) the participant can meet the requirements for admission into the program; and

(5) there is a reasonable expectation that the participant will complete the training program based on such factors as the participant's MFIP assessment, previous education, training, and work history; current motivation; and changes in previous circumstances.

~~(c) The hourly unsubsidized employment requirement does not apply for intensive education or training programs lasting 12 weeks or less when full-time attendance is required.~~

~~(d)~~ (b) Participants with an approved employment plan in place on July 1, 2003, which includes more than 12 months of postsecondary education or training shall be allowed to complete that plan provided that hourly requirements in section 256J.55, subdivision 1, and conditions specified in paragraph ~~(b)~~ (a), and subdivisions 3 and 5 are met. A participant whose case is subsequently closed for three months or less for reasons other than noncompliance with program requirements and who returns to MFIP shall be allowed to complete that plan provided that hourly requirements in section 256J.55, subdivision 1, and conditions specified in paragraph ~~(b)~~ (a) and subdivisions 3 and 5 are met.

Sec. 27. Minnesota Statutes 2006, section 256J.55, subdivision 1, is amended to read:

Subdivision 1. **Participation requirements.** (a) All caregivers must participate in employment services under sections 256J.515 to 256J.57 concurrent with receipt of MFIP assistance.

(b) Until July 1, 2004, participants who meet the requirements of section 256J.56 are exempt from participation requirements.

(c) Participants under paragraph (a) must develop and comply with an employment plan under section 256J.521 or section 256J.54 in the case of a participant under the age of 20 who has not obtained a high school diploma or its equivalent.

(d) With the exception of participants under the age of 20 who must meet the education requirements of section 256J.54, all participants must meet the hourly participation requirements of TANF or the hourly requirements listed in clauses (1) to (3), whichever is higher.

(1) In single-parent families with no children under six years of age, the job counselor and the caregiver must develop an employment plan that includes ~~30 to 35 hours per week of work activities~~ 130 hours per month of work activities.

(2) In single-parent families with a child under six years of age, the job counselor and the caregiver must develop an employment plan that includes ~~20 to 35 hours per week of work activities~~ 87 hours per month of work activities.

(3) In two-parent families, the job counselor and the caregivers must develop employment plans which result in a combined total of at least 55 hours per week of work activities.

(e) Failure to participate in employment services, including the requirement to develop and comply with an employment plan, including hourly requirements, without good cause under section 256J.57, shall result in the imposition of a sanction under section 256J.46.

Sec. 28. **[256J.575] FAMILY STABILIZATION SERVICES.**

Subdivision 1. **Purpose.** (a) The family stabilization services serve families who are not making significant progress within the Minnesota family investment program (MFIP) due to a variety of barriers to employment.

(b) The goal of the services is to stabilize and improve the lives of families at risk of long-term welfare dependency or family instability due to employment barriers such as physical disability, mental disability, age, or providing care for a disabled household member. These services promote and support families to achieve the greatest possible degree of self-sufficiency.

Subd. 2. **Definitions.** The terms used in this section have the meanings given them in paragraphs (a) to (d).

(a) "Family stabilization services" means the services established under this section.

(b) "Case management" means the services provided by or through the county agency or through the employment services agency to participating families, including assessment, information, referrals, and assistance in the preparation and implementation of a family stabilization plan under subdivision 5.

(c) "Family stabilization plan" means a plan developed by a case manager and the participant, which identifies the participant's most appropriate path to unsubsidized employment, family stability, and barrier reduction, taking into account the family's circumstances.

(d) "Family stabilization services" means programs, activities, and services in this section that provide participants and their family members with assistance regarding, but not limited to:

(1) obtaining and retaining unsubsidized employment;

(2) family stability;

(3) economic stability; and

(4) barrier reduction.

The goal of the services is to achieve the greatest degree of economic self-sufficiency and family well-being possible for the family under the circumstances.

(e) "Case manager" means the county-designated staff person or employment services counselor.

Subd. 3. **Eligibility.** (a) The following MFIP or diversionary work program (DWP) participants are eligible for the services under this section:

(1) a participant identified under section 256J.561, subdivision 2, paragraph (d), who has or is eligible for an employment plan developed under section 256J.521, subdivision 2, paragraph (c);

(2) a participant identified under section 256J.95, subdivision 12, paragraph (b), as unlikely to benefit from the DWP;

(3) a participant who meets the requirements for or has been granted a hardship extension under section 256J.425, subdivision 2 or 3;

(4) a participant who is applying for supplemental security income or Social Security disability insurance;

(5) a participant who is a noncitizen who has been in the United States for 12 or fewer months; and

(6) a new MFIP participant, for the first 30 days the participant receives assistance or when the participant's employment plan is completed, whichever is sooner.

(b) Families must meet all other eligibility requirements for MFIP established in this chapter. Families are eligible for financial assistance to the same extent as if they were participating in MFIP.

(c) A participant under paragraph (a), clause (5), must be provided with English as a second language opportunities and skills training for up to 12 months. After 12 months, the case manager and participant must determine whether the participant should continue with English as a second language classes or skills training, or both, or if the participant should become an MFIP participant.

Subd. 4. **Universal participation.** All caregivers must participate in family stabilization services as defined in subdivision 2.

Subd. 5. **Case management; family stabilization plans; coordinated services.** (a) The county agency shall provide family stabilization services to families through a case management model. A case manager shall be assigned to each participating family within 30 days after the family begins to receive financial assistance as a participant of the family stabilization services. The case manager, with the full involvement of the participant, shall recommend, and the county agency shall establish and modify as necessary, a family stabilization plan for each participating family. If a participant is already assigned to a county case manager or a county-designated case manager in social services, disability services, or housing services that case manager already assigned may be the case manager for purposes of these services.

(b) The family stabilization plan must include:

(1) each participant's plan for long-term self-sufficiency, including an employment goal where applicable;

(2) an assessment of each participant's strengths and barriers, and any special circumstances of the participant's family that impact, or are likely to impact, the participant's progress towards the goals in the plan; and

(3) an identification of the services, supports, education, training, and accommodations needed to reduce or overcome any barriers to enable the family to achieve self-sufficiency and to fulfill each caregiver's personal and family responsibilities.

(c) The case manager and the participant shall meet within 30 days of the family's referral to the case manager. The initial family stabilization plan must be completed within 30 days of the first meeting with the case manager. The case manager shall establish a schedule for periodic review of the family stabilization plan that includes personal contact with the participant at least once per month. In addition, the case manager shall review and, if necessary, modify the plan under the following circumstances:

(1) there is a lack of satisfactory progress in achieving the goals of the plan;

(2) the participant has lost unsubsidized or subsidized employment;

(3) a family member has failed or is unable to comply with a family stabilization plan requirement;

(4) services, supports, or other activities required by the plan are unavailable;

(5) changes to the plan are needed to promote the well-being of the children; or

(6) the participant and case manager determine that the plan is no longer appropriate for any other reason.

Subd. 6. **Cooperation with services requirements.** (a) To be eligible, a participant shall comply with paragraphs (b) to (e).

(b) Participants shall engage in family stabilization plan services for the appropriate number of hours per week that the activities are scheduled and available, unless good cause exists for not doing so, as defined in section 256J.57, subdivision 1. The appropriate number of hours must be based on the participant's plan.

(c) The case manager shall review the participant's progress toward the goals in the family stabilization plan every six months to determine whether conditions have changed, including whether revisions to the plan are needed.

(d) When the participant has increased participation in work-related activities sufficient to meet the federal participation requirements of TANF, the county agency shall refer the participant to the MFIP program and assign the participant to a job counselor. The participant and the job counselor shall meet within 15 days of referral to the MFIP

program to develop an employment plan under section 256J.521. No reapplication is necessary and financial assistance continues without interruption.

(e) A participant's requirement to comply with any or all family stabilization plan requirements under this subdivision is excused when the case management services, training and educational services, and family support services identified in the participant's family stabilization plan are unavailable for reasons beyond the control of the participant, including when money appropriated is not sufficient to provide the services.

Subd. 7. **Sanctions.** (a) The financial assistance grant of a participating family is reduced according to section 256J.46, if a participating adult fails without good cause to comply or continue to comply with the family stabilization plan requirements in this subdivision, unless compliance has been excused under subdivision 6, paragraph (e).

(b) Given the purpose of the family stabilization services in this section and the nature of the underlying family circumstances that act as barriers to both employment and full compliance with program requirements, sanctions are appropriate only when it is clear that there is both the ability to comply and willful noncompliance by the participant, as confirmed by a behavioral health or medical professional.

(c) Prior to the imposition of a sanction, the county agency shall review the participant's case to determine if the family stabilization plan is still appropriate and meet with the participant face-to-face. The participant may bring an advocate to the face-to-face meeting.

During the face-to-face meeting, the county agency must:

(1) determine whether the continued noncompliance can be explained and mitigated by providing a needed family stabilization service, as defined in subdivision 2, paragraph (d);

(2) determine whether the participant qualifies for a good cause exemption under section 256J.57, or if the sanction is for noncooperation with child support requirements, determine if the participant qualifies for a good cause exemption under section 256.741, subdivision 10;

(3) determine whether activities in the family stabilization plan are appropriate based on the family's circumstances;

(4) explain the consequences of continuing noncompliance;

(5) identify other resources that may be available to the participant to meet the needs of the family; and

(6) inform the participant of the right to appeal under section 256J.40.

If the lack of an identified activity or service can explain the noncompliance, the county shall work with the participant to provide the identified activity.

(d) If the participant fails to come to the face-to-face meeting, the case manager or a designee shall attempt at least one home visit. If a face-to-face meeting is not conducted, the county agency shall send the participant a written notice that includes the information under paragraph (c).

(e) After the requirements of paragraphs (c) and (d) are met and prior to imposition of a sanction, the county agency shall provide a notice of intent to sanction under section 256J.57, subdivision 2, and, when applicable, a notice of adverse action under section 256J.31.

(f) Section 256J.57 applies to this section except to the extent that it is modified by this subdivision.

Subd. 8. **Funding.** (a) The commissioner of human services must treat MFIP expenditures made to or on behalf of any minor child under this section, who is part of a household that meets criteria in subdivision 3, as expenditures under a separately funded state program. These expenditures shall not count toward the state's maintenance of effort requirements under the federal TANF program.

(b) A family is no longer part of a separately funded program under this section, if the caregiver no longer meets the criteria for family stabilization services in subdivision 3 or if it is determined at recertification that the caregiver is meeting the federal work participation rate, whichever occurs sooner.

Sec. 29. Minnesota Statutes 2006, section 256J.626, subdivision 1, is amended to read:

Subdivision 1. **Consolidated fund.** The consolidated fund is established to support counties and tribes in meeting their duties under this chapter. Counties and tribes must use funds from the consolidated fund to develop programs and services that are designed to improve participant outcomes as measured in section 256J.751, subdivision 2. Counties may use the funds for any allowable expenditures under subdivision 2, and to provide case management services to participants of the family stabilization services program. Tribes may use the funds for any allowable expenditures under subdivision 2, except those in subdivision 2, paragraph (a), clauses (1) and (6).

Sec. 30. Minnesota Statutes 2006, section 256J.626, subdivision 2, is amended to read:

Subd. 2. **Allowable expenditures.** (a) The commissioner must restrict expenditures under the consolidated fund to benefits and services allowed under title IV-A of the federal Social Security Act. Allowable expenditures under the consolidated fund may include, but are not limited to:

(1) short-term, nonrecurring shelter and utility needs that are excluded from the definition of assistance under Code of Federal Regulations, title 45, section 260.31, for families who meet the residency requirement in section 256J.12, subdivisions 1 and 1a. Payments under this subdivision are not considered TANF cash assistance and are not counted towards the 60-month time limit;

(2) transportation needed to obtain or retain employment or to participate in other approved work activities or activities under a family stabilization plan;

(3) direct and administrative costs of staff to deliver employment services for MFIP ~~or~~, the diversionary work program, or the family stabilization services program; to administer financial assistance~~;~~; and to provide specialized services intended to assist hard-to-employ participants to transition to work or transition from the family stabilization services program to MFIP;

(4) costs of education and training including functional work literacy and English as a second language;

(5) cost of work supports including tools, clothing, boots, telephone service, and other work-related expenses;

(6) county administrative expenses as defined in Code of Federal Regulations, title 45, section 260(b);

(7) services to parenting and pregnant teens;

(8) supported work;

(9) wage subsidies;

(10) child care needed for MFIP ~~or~~, the diversionary work program, or the family stabilization services program participants to participate in social services;

(11) child care to ensure that families leaving MFIP or diversionary work program will continue to receive child care assistance from the time the family no longer qualifies for transition year child care until an opening occurs under the basic sliding fee child care program; ~~and~~

(12) services to help noncustodial parents who live in Minnesota and have minor children receiving MFIP or DWP assistance, but do not live in the same household as the child, obtain or retain employment; and

(13) services to help families participating in the family stabilization services program achieve the greatest possible degree of self-sufficiency.

(b) Administrative costs that are not matched with county funds as provided in subdivision 8 may not exceed 7.5 percent of a county's or 15 percent of a tribe's allocation under this section. The commissioner shall define administrative costs for purposes of this subdivision.

(c) The commissioner may waive the cap on administrative costs for a county or tribe that elects to provide an approved supported employment, unpaid work, or community work experience program for a major segment of the county's or tribe's MFIP population. The county or tribe must apply for the waiver on forms provided by the commissioner. In no case shall total administrative costs exceed the TANF limits.

Sec. 31. Minnesota Statutes 2006, section 256J.626, subdivision 3, is amended to read:

Subd. 3. **Eligibility for services.** Families with a minor child, a pregnant woman, or a noncustodial parent of a minor child receiving assistance, with incomes below 200 percent of the federal poverty guideline for a family of the applicable size, are eligible for services funded under the consolidated fund. Counties and tribes must give priority to families currently receiving MFIP ~~or~~, the diversionary work program, or the family stabilization services program, and families at risk of receiving MFIP or diversionary work program.

Sec. 32. Minnesota Statutes 2006, section 256J.626, subdivision 4, is amended to read:

Subd. 4. **County and tribal biennial service agreements.** (a) Effective January 1, 2004, and each two-year period thereafter, each county and tribe must have in place an approved biennial service agreement related to the services and programs in this chapter. In counties with a city of the first class with a population over 300,000, the county must consider a service agreement that includes a jointly developed plan for the delivery of employment services with the city. Counties may collaborate to develop multicounty, multitribal, or regional service agreements.

(b) The service agreements will be completed in a form prescribed by the commissioner. The agreement must include:

(1) a statement of the needs of the service population and strengths and resources in the community;

(2) numerical goals for participant outcomes measures to be accomplished during the biennial period. The commissioner may identify outcomes from section 256J.751, subdivision 2, as core outcomes for all counties and tribes;

(3) strategies the county or tribe will pursue to achieve the outcome targets. Strategies must include specification of how funds under this section will be used and may include community partnerships that will be established or strengthened; ~~and~~

(4) strategies the county or tribe will pursue under the family stabilization services program; and

(5) other items prescribed by the commissioner in consultation with counties and tribes.

(c) The commissioner shall provide each county and tribe with information needed to complete an agreement, including: (1) information on MFIP cases in the county or tribe; (2) comparisons with the rest of the state; (3) baseline performance on outcome measures; and (4) promising program practices.

(d) The service agreement must be submitted to the commissioner by October 15, 2003, and October 15 of each second year thereafter. The county or tribe must allow a period of not less than 30 days prior to the submission of the agreement to solicit comments from the public on the contents of the agreement.

(e) The commissioner must, within 60 days of receiving each county or tribal service agreement, inform the county or tribe if the service agreement is approved. If the service agreement is not approved, the commissioner must inform the county or tribe of any revisions needed prior to approval.

(f) The service agreement in this subdivision supersedes the plan requirements of section 116L.88.

Sec. 33. Minnesota Statutes 2006, section 256J.626, subdivision 5, is amended to read:

Subd. 5. **Innovation projects.** Beginning January 1, 2005, no more than $3,000,000 of the funds annually appropriated to the commissioner for use in the consolidated fund shall be available to the commissioner for projects testing innovative approaches to improving outcomes for MFIP participants, family stabilization services program participants, and persons at risk of receiving MFIP as detailed in subdivision 3, and for providing incentives to counties and tribes that exceed performance. Projects shall be targeted to geographic areas with poor outcomes as specified in section 256J.751, subdivision 5, or to subgroups within the MFIP case load who are experiencing poor outcomes. For purposes of an incentive, a county or tribe exceeds performance if the county or tribe is above the top of the county's or tribe's annualized range of expected performance on the three-year self-support index under section 256J.751, subdivision 2, clause (7), and achieves a 50 percent TANF participation rate under section 256J.751, subdivision 2, clause (7), as averaged across the four quarterly measurements for the most recent year for which the measurements are available.

Sec. 34. Minnesota Statutes 2006, section 256J.626, subdivision 6, is amended to read:

Subd. 6. **Base allocation to counties and tribes; definitions.** (a) For purposes of this section, the following terms have the meanings given.

(1) "2002 historic spending base" means the commissioner's determination of the sum of the reimbursement related to fiscal year 2002 of county or tribal agency expenditures for the base programs listed in clause (6), items (i) through (iv), and earnings related to calendar year 2002 in the base program listed in clause (6), item (v), and the amount of spending in fiscal year 2002 in the base program listed in clause (6), item (vi), issued to or on behalf of persons residing in the county or tribal service delivery area.

(2) "Adjusted caseload factor" means a factor weighted:

(i) 47 percent on the MFIP cases in each county at four points in time in the most recent 12-month period for which data is available multiplied by the county's caseload difficulty factor; and

(ii) 53 percent on the count of adults on MFIP in each county and tribe at four points in time in the most recent 12-month period for which data is available multiplied by the county or tribe's caseload difficulty factor.

(3) "Caseload difficulty factor" means a factor determined by the commissioner for each county and tribe based upon the self-support index described in section 256J.751, subdivision 2, clause (7).

(4) "Initial allocation" means the amount potentially available to each county or tribe based on the formula in paragraphs (b) through (h).

(5) "Final allocation" means the amount available to each county or tribe based on the formula in paragraphs (b) through (h)~~, after adjustment by subdivision 7~~.

(6) "Base programs" means the:

(i) MFIP employment and training services under Minnesota Statutes 2002, section 256J.62, subdivision 1, in effect June 30, 2002;

(ii) bilingual employment and training services to refugees under Minnesota Statutes 2002, section 256J.62, subdivision 6, in effect June 30, 2002;

(iii) work literacy language programs under Minnesota Statutes 2002, section 256J.62, subdivision 7, in effect June 30, 2002;

(iv) supported work program authorized in Laws 2001, First Special Session chapter 9, article 17, section 2, in effect June 30, 2002;

(v) administrative aid program under section 256J.76 in effect December 31, 2002; and

(vi) emergency assistance program under Minnesota Statutes 2002, section 256J.48, in effect June 30, 2002.

(b) The commissioner shall:

(1) beginning July 1, 2003, determine the initial allocation of funds available under this section according to clause (2);

(2) allocate all of the funds available for the period beginning July 1, 2003, and ending December 31, 2004, to each county or tribe in proportion to the county's or tribe's share of the statewide 2002 historic spending base;

(3) determine for calendar year 2005 the initial allocation of funds to be made available under this section in proportion to the county or tribe's initial allocation for the period of July 1, 2003, to December 31, 2004;

(4) determine for calendar year 2006 the initial allocation of funds to be made available under this section based 90 percent on the proportion of the county or tribe's share of the statewide 2002 historic spending base and ten percent on the proportion of the county or tribe's share of the adjusted caseload factor;

(5) determine for calendar year 2007 the initial allocation of funds to be made available under this section based 70 percent on the proportion of the county or tribe's share of the statewide 2002 historic spending base and 30 percent on the proportion of the county or tribe's share of the adjusted caseload factor; and

(6) determine for calendar year 2008 and subsequent years the initial allocation of funds to be made available under this section based 50 percent on the proportion of the county or tribe's share of the statewide 2002 historic spending base and 50 percent on the proportion of the county or tribe's share of the adjusted caseload factor.

(c) With the commencement of a new or expanded tribal TANF program or an agreement under section 256.01, subdivision 2, paragraph (g), in which some or all of the responsibilities of particular counties under this section are transferred to a tribe, the commissioner shall:

(1) in the case where all responsibilities under this section are transferred to a tribal program, determine the percentage of the county's current caseload that is transferring to a tribal program and adjust the affected county's allocation accordingly; and

(2) in the case where a portion of the responsibilities under this section are transferred to a tribal program, the commissioner shall consult with the affected county or counties to determine an appropriate adjustment to the allocation.

~~(d) Effective January 1, 2005, counties and tribes will have their final allocations adjusted based on the performance provisions of subdivision 7.~~

Sec. 35. Minnesota Statutes 2006, section 256J.751, subdivision 2, is amended to read:

Subd. 2. **Quarterly comparison report.** The commissioner shall report quarterly to all counties on each county's performance on the following measures:

(1) percent of MFIP caseload working in paid employment;

(2) percent of MFIP caseload receiving only the food portion of assistance;

(3) number of MFIP cases that have left assistance;

(4) median placement wage rate;

(5) caseload by months of TANF assistance;

(6) percent of MFIP and diversionary work program (DWP) cases off cash assistance or working 30 or more hours per week at one-year, two-year, and three-year follow-up points from a baseline quarter. This measure is called the self-support index. The commissioner shall report quarterly an expected range of performance for each county, county grouping, and tribe on the self-support index. The expected range shall be derived by a statistical methodology developed by the commissioner in consultation with the counties and tribes. The statistical methodology shall control differences across counties in economic conditions and demographics of the MFIP and DWP case load; and

(7) the ~~MFIP~~ TANF work participation rate, defined as the participation requirements specified ~~in title 1 of Public Law 104-193 applied to all MFIP cases except child only cases~~ under Public Law 109-171, the Deficit Reduction Act of 2005.

Sec. 36. Minnesota Statutes 2006, section 256J.751, subdivision 5, is amended to read:

Subd. 5. **Failure to meet federal performance standards.** (a) If sanctions occur for failure to meet the performance standards specified in title 1 of Public Law 104-193 of the Personal Responsibility and Work Opportunity Act of 1996, and under Public Law 109-171, the Deficit Reduction Act of 2005, the state shall pay 88 percent of the sanction. The remaining 12 percent of the sanction will be paid by the counties. The county portion of the sanction will be distributed across all counties in proportion to each county's percentage of the MFIP average monthly caseload during the period for which the sanction was applied.

(b) If a county fails to meet the performance standards specified in title 1 of Public Law 104-193 of the Personal Responsibility and Work Opportunity Act of 1996, and Public Law 109-171, the Deficit Reduction Act of 2005, for any year, the commissioner shall work with counties to organize a joint state-county technical assistance team to work with the county. The commissioner shall coordinate any technical assistance with other departments and agencies including the Departments of Employment and Economic Development and Education as necessary to achieve the purpose of this paragraph.

(c) For state performance measures, a low-performing county is one that:

(1) performs below the bottom of their expected range for the measure in subdivision 2, clause ~~(7)~~ (6), in an annualized measurement reported in October of each year; or

(2) performs below 40 percent for the measure in subdivision 2, clause ~~(8)~~ (7), as averaged across the four quarterly measurements for the year, or the ten counties with the lowest rates if more than ten are below 40 percent.

(d) Low-performing counties under paragraph (c) must engage in corrective action planning as defined by the commissioner. The commissioner may coordinate technical assistance as specified in paragraph (b) for low-performing counties under paragraph (c).

Sec. 37. Minnesota Statutes 2006, section 256J.95, subdivision 3, is amended to read:

Subd. 3. **Eligibility for diversionary work program.** (a) Except for the categories of family units listed below, all family units who apply for cash benefits and who meet MFIP eligibility as required in sections 256J.11 to 256J.15 are eligible and must participate in the diversionary work program. Family units that are not eligible for the diversionary work program include:

(1) child only cases;

(2) a single-parent family unit that includes a child under 12 weeks of age. A parent is eligible for this exception once in a parent's lifetime and is not eligible if the parent has already used the previously allowed child under age one exemption from MFIP employment services;

(3) a minor parent without a high school diploma or its equivalent;

(4) an 18- or 19-year-old caregiver without a high school diploma or its equivalent who chooses to have an employment plan with an education option;

(5) a caregiver age 60 or over;

(6) family units with a caregiver who received DWP benefits in the 12 months prior to the month the family applied for DWP, except as provided in paragraph (c);

(7) family units with a caregiver who received MFIP within the 12 months prior to the month the family unit applied for DWP;

(8) a family unit with a caregiver who received 60 or more months of TANF assistance; ~~and~~

(9) a family unit with a caregiver who is disqualified from DWP or MFIP due to fraud~~.~~; and

(10) refugees as defined in Code of Federal Regulations, title 45, chapter IV, section 444.43, who arrived in the United States in the 12 months prior to the date of application for family cash assistance.

(b) A two-parent family must participate in DWP unless both caregivers meet the criteria for an exception under paragraph (a), clauses (1) through (5), or the family unit includes a parent who meets the criteria in paragraph (a), clause (6), (7), (8), or (9).

(c) Once DWP eligibility is determined, the four months run consecutively. If a participant leaves the program for any reason and reapplies during the four-month period, the county must redetermine eligibility for DWP.

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

Sec. 38. Minnesota Statutes 2006, section 256J.95, subdivision 13, is amended to read:

Subd. 13. **Immediate referral to employment services.** Within one working day of determination that the applicant is eligible for the diversionary work program, but before benefits are issued to or on behalf of the family unit, the county shall refer all caregivers to employment services. The referral to the DWP employment services must be in writing and must contain the following information:

(1) notification that, as part of the application process, applicants are required to develop an employment plan or the DWP application will be denied;

(2) the employment services provider name and phone number;

~~(3) the date, time, and location of the scheduled employment services interview;~~

~~(4)~~ (3) the immediate availability of supportive services, including, but not limited to, child care, transportation, and other work-related aid; and

~~(5)~~ (4) the rights, responsibilities, and obligations of participants in the program, including, but not limited to, the grounds for good cause, the consequences of refusing or failing to participate fully with program requirements, and the appeal process.

Sec. 39. Minnesota Statutes 2006, section 259.24, subdivision 3, is amended to read:

Subd. 3. **Child.** When the child to be adopted is over 14 years of age, the child's written consent to adoption by a particular person is also ~~shall be~~ necessary. A child of any age who is under the guardianship of the commissioner and is legally available for adoption may not refuse or waive the commissioner's agent's exhaustive efforts to recruit, identify, and place the child in an adoptive home required under section 260C.317, subdivision 3, paragraph (b), or sign a document relieving county social services agencies of all recruitment efforts on the child's behalf.

Sec. 40. Minnesota Statutes 2006, section 259.53, subdivision 1, is amended to read:

Subdivision 1. **Notice to commissioner; referral for postplacement assessment.** (a) Upon the filing of a petition for adoption of a child who is:

(1) under the guardianship of the commissioner or a licensed child-placing agency according to section 260C.201, subdivision 11, or 260C.317;

(2) placed by the commissioner, commissioner's agent, or licensed child-placing agency after a consent to adopt according to section 259.24 or under an agreement conferring authority to place for adoption according to section 259.25; or

(3) placed by preadoptive custody order for a direct adoptive placement ordered by the district court under section 259.47,

the court administrator shall immediately transmit a copy of the petition to the commissioner of human services.

(b) The court shall immediately refer the petition to the agency specified below for completion of a postplacement assessment and report as required by subdivision 2.

(1) If the child to be adopted has been committed to the guardianship of the commissioner or an agency under section 260C.317 or an agency has been given authority to place the child under section 259.25, the court shall refer the petition to that agency, unless another agency is supervising the placement, in which case the court shall refer the petition to the supervising agency.

(2) If the child to be adopted has been placed in the petitioner's home by a direct adoptive placement, the court shall refer the petition to the agency supervising the placement under section 259.47, subdivision 3, paragraph (a), clause (6).

(3) If the child is to be adopted by an individual who is related to the child as defined by section 245A.02, subdivision 13, and in all other instances not described in clause (1) or (2), the court shall refer the petition to the local social services agency of the county in which the prospective adoptive parent lives.

Sec. 41. Minnesota Statutes 2006, section 259.57, subdivision 1, is amended to read:

Subdivision 1. **Findings; orders.** Upon the hearing,

(a) if the court finds that it is in the best interests of the child that the petition be granted, a decree of adoption shall be made and recorded in the office of the court administrator, ordering that henceforth the child shall be the child of the petitioner. In the decree the court may change the name of the child if desired. After the decree is granted for a child who is:

(1) under the guardianship of the commissioner or a licensed child-placing agency according to section 260C.201, subdivision 11, or 260C.317;

(2) placed by the commissioner, commissioner's agent, or licensed child-placing agency after a consent to adopt according to section 259.24 or under an agreement conferring authority to place for adoption according to section 259.25; or

(3) adopted after a direct adoptive placement ordered by the district court under section 259.47,

the court administrator shall immediately mail a copy of the recorded decree to the commissioner of human services;

(b) if the court is not satisfied that the proposed adoption is in the best interests of the child, the court shall deny the petition, and shall order the child returned to the custody of the person or agency legally vested with permanent custody or certify the case for appropriate action and disposition to the court having jurisdiction to determine the custody and guardianship of the child.

Sec. 42. Minnesota Statutes 2006, section 259.67, subdivision 4, is amended to read:

Subd. 4. **Eligibility conditions.** (a) The placing agency shall use the AFDC requirements as specified in federal law as of July 16, 1996, when determining the child's eligibility for adoption assistance under title IV-E of the Social Security Act. If the child does not qualify, the placing agency shall certify a child as eligible for state funded adoption assistance only if the following criteria are met:

(1) Due to the child's characteristics or circumstances it would be difficult to provide the child an adoptive home without adoption assistance.

(2)(i) A placement agency has made reasonable efforts to place the child for adoption without adoption assistance, but has been unsuccessful; or

(ii) the child's licensed foster parents desire to adopt the child and it is determined by the placing agency that the adoption is in the best interest of the child.

(3)(i) The child has been a ward of the commissioner, a Minnesota-licensed child-placing agency, or a tribal social service agency of Minnesota recognized by the Secretary of the Interior; or (ii) the child will be adopted according to tribal law without a termination of parental rights or relinquishment, provided that the tribe has documented the valid reason why the child cannot or should not be returned to the home of the child's parent. The placing agency shall not certify a child who remains under the jurisdiction of the sending agency pursuant to section 260.851, article 5, for state-funded adoption assistance when Minnesota is the receiving state.

(b) For purposes of this subdivision, the characteristics or circumstances that may be considered in determining whether a child is a child with special needs under United States Code, title 42, chapter 7, subchapter IV, part E, or meets the requirements of paragraph (a), clause (1), are the following:

(1) The child is a member of a sibling group to be placed as one unit in which at least one sibling is older than 15 months of age or is described in clause (2) or (3).

(2) The child has documented physical, mental, emotional, or behavioral disabilities.

(3) The child has a high risk of developing physical, mental, emotional, or behavioral disabilities.

~~(4) The child is adopted according to tribal law without a termination of parental rights or relinquishment, provided that the tribe has documented the valid reason why the child cannot or should not be returned to the home of the child's parent.~~

(4) The child is five years of age or older.

(c) When a child's eligibility for adoption assistance is based upon the high risk of developing physical, mental, emotional, or behavioral disabilities, payments shall not be made under the adoption assistance agreement unless and until the potential disability manifests itself as documented by an appropriate health care professional.

Sec. 43. Minnesota Statutes 2006, section 259.67, subdivision 7, is amended to read:

Subd. 7. **Reimbursement of costs.** (a) Subject to rules of the commissioner, and the provisions of this subdivision a child-placing agency licensed in Minnesota or any other state, or local or tribal social services agency shall receive a reimbursement from the commissioner equal to 100 percent of the reasonable and appropriate cost of providing adoption services ~~for a child certified as eligible for adoption assistance under subdivision 4. Such assistance~~. Adoption services under this subdivision may include adoptive family recruitment, counseling, and special training when needed.

(b) An eligible child must have a goal of adoption, which may include an adoption in accordance with tribal law, and meet one of the following criteria:

(1) is a ward of the commissioner of human services or a ward of tribal court pursuant to section 260.755, subdivision 20, who meets one of the criteria in subdivision 4, paragraph (b), clause (1), (2), or (3); or

(2) is under the guardianship of a Minnesota-licensed child-placing agency who meets one of the criteria in subdivision 4, paragraph (b), clause (1) or (2).

(c) A child-placing agency licensed in Minnesota or any other state shall receive reimbursement for adoption services it purchases for or directly provides to an eligible child. Tribal social services shall receive reimbursement for adoption services it purchases for or directly provides to an eligible child. A local ~~or tribal~~ social services agency shall receive ~~such~~ reimbursement only for adoption services it purchases for an eligible child.

~~(b) A child-placing agency licensed in Minnesota or any other state or local or tribal social services agency seeking reimbursement under this subdivision shall enter into~~ Before providing adoption services for which reimbursement will be sought under this subdivision, a reimbursement agreement, on the designated format, must be entered into with the commissioner ~~before providing adoption services for which reimbursement~~

~~is sought~~. No reimbursement under this subdivision shall be made to an agency for services provided prior to entering a reimbursement agreement. Separate reimbursement agreements shall be made for each child and separate records shall be kept on each child for whom a reimbursement agreement is made. The commissioner of human services shall agree that the reimbursement costs are reasonable and appropriate. The commissioner may spend up to $16,000 for each purchase of service agreement. Only one agreement per child is allowed, unless an exception is granted by the commissioner. Funds encumbered and obligated under such an agreement for the child remain available until the terms of the agreement are fulfilled or the agreement is terminated.

~~(c) When a local or tribal social services agency uses a purchase of service agreement to provide services reimbursable under a reimbursement agreement,~~ The commissioner ~~may~~ shall make reimbursement payments directly to the agency providing the service if direct reimbursement is specified by the purchase of service agreement, and if the request for reimbursement is submitted by the local or tribal social services agency along with a verification that the service was provided.

Sec. 44. Minnesota Statutes 2006, section 259.75, subdivision 8, is amended to read:

Subd. 8. **Reasons for deferral.** Deferral of the listing of a child with the state adoption exchange shall be only for one or more of the following reasons:

(a) the child is in an adoptive placement but is not legally adopted;

(b) the child's foster parents or other individuals are now considering adoption;

(c) diagnostic study or testing is required to clarify the child's problem and provide an adequate description; or

(d) the child is currently in a hospital and continuing need for daily professional care will not permit placement in a family setting~~; or~~.

~~(e) the child is 14 years of age or older and will not consent to an adoption plan.~~

Approval of a request to defer listing for any of the reasons specified in paragraph (b) or (c) shall be valid for a period not to exceed 90 days, with no subsequent deferrals for those reasons.

Sec. 45. Minnesota Statutes 2006, section 260.012, is amended to read:

260.012 DUTY TO ENSURE PLACEMENT PREVENTION AND FAMILY REUNIFICATION; REASONABLE EFFORTS.

(a) Once a child alleged to be in need of protection or services is under the court's jurisdiction, the court shall ensure that reasonable efforts, including culturally appropriate services, by the social services agency are made to prevent placement or to eliminate the

need for removal and to reunite the child with the child's family at the earliest possible time, and ~~when a child cannot be reunified with the parent or guardian from whom the child was removed,~~ the court must ensure that the responsible social services agency makes reasonable efforts to finalize an alternative permanent plan for the child as provided in paragraph (e). In determining reasonable efforts to be made with respect to a child and in making those reasonable efforts, the child's best interests, health, and safety must be of paramount concern. Reasonable efforts to prevent placement and for rehabilitation and reunification are always required except upon a determination by the court that a petition has been filed stating a prima facie case that:

(1) the parent has subjected a child to egregious harm as defined in section 260C.007, subdivision 14;

(2) the parental rights of the parent to another child have been terminated involuntarily;

(3) the child is an abandoned infant under section 260C.301, subdivision 2, paragraph (a), clause (2);

(4) the parent's custodial rights to another child have been involuntarily transferred to a relative under section 260C.201, subdivision 11, paragraph (e), clause (1), or a similar law of another jurisdiction; or

(5) the provision of services or further services for the purpose of reunification is futile and therefore unreasonable under the circumstances.

(b) When the court makes one of the prima facie determinations under paragraph (a), either permanency pleadings under section 260C.201, subdivision 11, or a termination of parental rights petition under sections 260C.141 and 260C.301 must be filed. A permanency hearing under section 260C.201, subdivision 11, must be held within 30 days of this determination.

(c) In the case of an Indian child, in proceedings under sections 260B.178 or 260C.178, 260C.201, and 260C.301 the juvenile court must make findings and conclusions consistent with the Indian Child Welfare Act of 1978, United States Code, title 25, section 1901 et seq., as to the provision of active efforts. In cases governed by the Indian Child Welfare Act of 1978, United States Code, title 25, section 1901, the responsible social services agency must provide active efforts as required under United States Code, title 25, section 1911(d).

(d) "Reasonable efforts to prevent placement" means:

(1) the agency has made reasonable efforts to prevent the placement of the child in foster care; or

(2) given the particular circumstances of the child and family at the time of the child's removal, there are no services or efforts available which could allow the child to safely remain in the home.

(e) "Reasonable efforts to finalize a permanent plan for the child" means due diligence by the responsible social services agency to:

(1) reunify the child with the parent or guardian from whom the child was removed;

(2) assess a noncustodial parent's ability to provide day-to-day care for the child and, where appropriate, provide services necessary to enable the noncustodial parent to safely provide the care, as required by section 260C.212, subdivision 4;

(3) conduct a relative search as required under section 260C.212, subdivision 5; and

(4) when the child cannot return to the parent or guardian from whom the child was removed, to plan for and finalize a safe and legally permanent alternative home for the child, and considers permanent alternative homes for the child inside or outside of the state, preferably through adoption or transfer of permanent legal and physical custody of the child.

(f) Reasonable efforts are made upon the exercise of due diligence by the responsible social services agency to use culturally appropriate and available services to meet the needs of the child and the child's family. Services may include those provided by the responsible social services agency and other culturally appropriate services available in the community. At each stage of the proceedings where the court is required to review the appropriateness of the responsible social services agency's reasonable efforts as described in paragraphs (a), (d), and (e), the social services agency has the burden of demonstrating that:

(1) it has made reasonable efforts to prevent placement of the child in foster care;

(2) it has made reasonable efforts to eliminate the need for removal of the child from the child's home and to reunify the child with the child's family at the earliest possible time;

(3) it has made reasonable efforts to finalize an alternative permanent home for the child, and considers permanent alternative homes for the child inside or outside of the state; or

(4) reasonable efforts to prevent placement and to reunify the child with the parent or guardian are not required. The agency may meet this burden by stating facts in a sworn petition filed under section 260C.141, by filing an affidavit summarizing the agency's reasonable efforts or facts the agency believes demonstrate there is no need for reasonable efforts to reunify the parent and child, or through testimony or a certified report required under juvenile court rules.

(g) Once the court determines that reasonable efforts for reunification are not required because the court has made one of the prima facie determinations under paragraph (a), the court may only require reasonable efforts for reunification after a hearing according to section 260C.163, where the court finds there is not clear and convincing evidence of the facts upon which the court based its prima facie determination. In this case when there is clear and convincing evidence that the child is in need of protection or services, the court may find the child in need of protection or services and order any of the dispositions available under section 260C.201, subdivision 1. Reunification of a surviving child with a parent is not required if the parent has been convicted of:

(1) a violation of, or an attempt or conspiracy to commit a violation of, sections 609.185 to 609.20; 609.222, subdivision 2; or 609.223 in regard to another child of the parent;

(2) a violation of section 609.222, subdivision 2; or 609.223, in regard to the surviving child; or

(3) a violation of, or an attempt or conspiracy to commit a violation of, United States Code, title 18, section 1111(a) or 1112(a), in regard to another child of the parent.

(h) The juvenile court, in proceedings under sections 260B.178 or 260C.178, 260C.201, and 260C.301 shall make findings and conclusions as to the provision of reasonable efforts. When determining whether reasonable efforts have been made, the court shall consider whether services to the child and family were:

(1) relevant to the safety and protection of the child;

(2) adequate to meet the needs of the child and family;

(3) culturally appropriate;

(4) available and accessible;

(5) consistent and timely; and

(6) realistic under the circumstances.

In the alternative, the court may determine that provision of services or further services for the purpose of rehabilitation is futile and therefore unreasonable under the circumstances or that reasonable efforts are not required as provided in paragraph (a).

(i) This section does not prevent out-of-home placement for treatment of a child with a mental disability when the child's diagnostic assessment or individual treatment plan indicates that appropriate and necessary treatment cannot be effectively provided outside of a residential or inpatient treatment program.

(j) If continuation of reasonable efforts to prevent placement or reunify the child with the parent or guardian from whom the child was removed is determined by the court to be inconsistent with the permanent plan for the child or upon the court making one of

the prima facie determinations under paragraph (a), reasonable efforts must be made to place the child in a timely manner in a safe and permanent home and to complete whatever steps are necessary to legally finalize the permanent placement of the child.

(k) Reasonable efforts to place a child for adoption or in another permanent placement may be made concurrently with reasonable efforts to prevent placement or to reunify the child with the parent or guardian from whom the child was removed. When the responsible social services agency decides to concurrently make reasonable efforts for both reunification and permanent placement away from the parent under paragraph (a), the agency shall disclose its decision and both plans for concurrent reasonable efforts to all parties and the court. When the agency discloses its decision to proceed on both plans for reunification and permanent placement away from the parent, the court's review of the agency's reasonable efforts shall include the agency's efforts under both plans.

Sec. 46. Minnesota Statutes 2006, section 260.755, subdivision 12, is amended to read:

Subd. 12. **Indian tribe.** "Indian tribe" means an Indian tribe, band, nation, or other organized group or community of Indians recognized as eligible for the services provided to Indians by the secretary because of their status as Indians, including any ~~band~~ Native group under the Alaska Native Claims Settlement Act, United States Code, title 43, section 1602~~, and exercising tribal governmental powers~~.

Sec. 47. Minnesota Statutes 2006, section 260.755, subdivision 20, is amended to read:

Subd. 20. **Tribal court.** "Tribal court" means a court with ~~federally recognized~~ jurisdiction over child custody proceedings and which is either a court of Indian offenses, or a court established and operated under the code or custom of an Indian tribe, or ~~the~~ any other administrative body of a tribe which is vested with authority over child custody proceedings. Except as provided in section 260.771, subdivision 5, nothing in this chapter shall be construed as conferring jurisdiction on an Indian tribe.

Sec. 48. Minnesota Statutes 2006, section 260.761, subdivision 7, is amended to read:

Subd. 7. **Identification of extended family members.** Any agency considering placement of an Indian child shall make ~~reasonable~~ active efforts to identify and locate extended family members.

Sec. 49. Minnesota Statutes 2006, section 260.765, subdivision 5, is amended to read:

Subd. 5. **Identification of extended family members.** Any agency considering placement of an Indian child shall make ~~reasonable~~ active efforts to identify and locate extended family members.

Sec. 50. Minnesota Statutes 2006, section 260.771, subdivision 1, is amended to read:

Subdivision 1. **Indian tribe jurisdiction.** An Indian tribe with a tribal court has exclusive jurisdiction over a child placement proceeding involving an Indian child who resides or is domiciled within the reservation of ~~such~~ the tribe ~~at the commencement of the proceedings~~, except where jurisdiction is otherwise vested in the state by existing federal law. When an Indian child is ~~in the legal custody of a person or agency pursuant to an order of~~ a ward of the tribal court, the Indian tribe retains exclusive jurisdiction, notwithstanding the residence or domicile of the child.

Sec. 51. Minnesota Statutes 2006, section 260.771, subdivision 2, is amended to read:

Subd. 2. **Court determination of tribal affiliation of child.** In any child placement proceeding, the court shall establish whether an Indian child is involved and the identity of the Indian child's tribe. This chapter and the federal Indian Child Welfare Act are applicable without exception in any child custody proceeding, as defined in the federal act, involving an Indian child. This chapter applies to child custody proceedings involving an Indian child whether the child is in the physical or legal custody of an Indian parent, Indian custodian, Indian extended family member, or other person at the commencement of the proceedings. A court shall not determine the applicability of this chapter or the federal Indian Child Welfare Act to a child custody proceeding based upon whether an Indian child is part of an existing Indian family or based upon the level of contact a child has with the child's Indian tribe, reservation, society, or off-reservation community.

Sec. 52. **[260.852] PLACEMENT PROCEDURES.**

Subdivision 1. **Home study.** The state must have procedures for the orderly and timely interstate placement of children that are implemented in accordance with an interstate compact and that, within 60 days after the state receives from another state a request to conduct a study of a home environment for purposes of assessing the safety and suitability of placing a child in the home, the state shall, directly or by contract, conduct and complete a home study and return to the other state a report on the results of the study, which shall address the extent to which placement in the home would meet the needs of the child; except in the case of a home study begun before October 1, 2008, if the state fails to comply with conducting and completing the home study within the 60-day

period and this is as a result of circumstances beyond the control of the state, the state has 75 days to comply if the state documents the circumstances involved and certifies that completing the home study is in the best interests of the child.

This subdivision does not require the completion within the applicable period of the parts of the home study involving the education and training of the prospective foster or adoptive parents.

Subd. 2. **Effect of received report.** The state shall treat any report described in subdivision 1 that is received from another state, an Indian tribe, or a private agency under contract with another state or Indian tribe as meeting any requirements imposed by the state for the completion of a home study before placing a child in the home, unless, within 14 days after receipt of the report, the state determines, based on grounds that are specific to the content of the report, that making a decision in reliance on the report would be contrary to the welfare of the child.

Subd. 3. **Resources.** The state shall make effective use of cross-jurisdictional resources, including through contract for the purchase of services, and shall eliminate legal barriers to facilitate timely adoptive or permanent placements for waiting children. The state shall not impose any restriction on the use of private agencies for the purpose of conducting a home study to meet the 60-day requirement.

Subd. 4. **Incentive eligibility.** Minnesota is an incentive-eligible state and must:

(1) have an approved plan as required by the United States Secretary of Health and Human Services;

(2) be in compliance with the data requirements of the United States Department of Health and Human Services; and

(3) have data that verify that a home study is completed within 30 days.

Subd. 5. **Data requirements.** The state shall provide to the United States Secretary of Health and Human Services a written report, covering the preceding fiscal year, that specifies:

(1) the total number of interstate home studies requested by the state with respect to children in foster care under the responsibility of the state, and with respect to each study, the identity of the other state involved;

(2) the total number of timely interstate home studies completed by the state with respect to children in foster care under the responsibility of other states and, with respect to each study, the identity of the other state involved; and

(3) other information the United States Secretary of Health and Human Services requires in order to determine whether Minnesota is a home study incentive-eligible state.

Subd. 6. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Home study" means an evaluation of a home environment conducted in accordance with applicable requirements of the state in which the home is located, to determine whether a proposed placement of a child would meet the individual needs of the child, including the child's safety; permanency; health; well-being; and mental, emotional, and physical development.

(c) "Interstate home study" means a home study conducted by a state at the request of another state to facilitate an adoptive or foster placement in the state of a child in foster care under the responsibility of the state.

(d) "Timely interstate home study" means an interstate home study completed by a state if the state provides to the state that requested the study, within 30 days after receipt of the request, a report on the results of the study, except that there is no requirement for completion within the 30-day period of the parts of the home study involving the education and training of the prospective foster or adoptive parents.

Subd. 7. **Background study requirements for adoption and foster care.** (a) Background study requirements for an adoption home study must be completed consistent with section 259.41, subdivisions 1, 2, and 3.

(b) Background study requirements for a foster care license must be completed consistent with section 245C.08.

Subd. 8. **Home visits.** If a child has been placed in foster care outside the state in which the home of the parents of the child is located, periodically, but at least every six months, a caseworker on the staff of the agency of the state in which the home of the parents of the child is located or the state in which the child has been placed, or a private agency under contract with either state, must visit the child in the home or institution and submit a report on each visit to the agency of the state in which the home of the parents of the child is located.

Sec. 53. Minnesota Statutes 2006, section 260B.157, subdivision 1, is amended to read:

Subdivision 1. **Investigation.** Upon request of the court the local social services agency or probation officer shall investigate the personal and family history and environment of any minor coming within the jurisdiction of the court under section 260B.101 and shall report its findings to the court. The court may order any minor coming within its jurisdiction to be examined by a duly qualified physician, psychiatrist, or psychologist appointed by the court.

The court shall ~~have~~ order a chemical use assessment conducted when a child is (1) found to be delinquent for violating a provision of chapter 152, or for committing a felony-level violation of a provision of chapter 609 if the probation officer determines

that alcohol or drug use was a contributing factor in the commission of the offense, or (2) alleged to be delinquent for violating a provision of chapter 152, if the child is being held in custody under a detention order. The assessor's qualifications and the assessment criteria shall comply with Minnesota Rules, parts 9530.6600 to 9530.6655. If funds under chapter 254B are to be used to pay for the recommended treatment, the assessment and placement must comply with all provisions of Minnesota Rules, parts 9530.6600 to 9530.6655 and 9530.7000 to 9530.7030. The commissioner of human services shall reimburse the court for the cost of the chemical use assessment, up to a maximum of $100.

The court shall ~~have~~ order a children's mental health screening conducted when a child is found to be delinquent. The screening shall be conducted with a screening instrument approved by the commissioner of human services and shall be conducted by a mental health practitioner as defined in section 245.4871, subdivision 26, or a probation officer who is trained in the use of the screening instrument. If the screening indicates a need for assessment, the local social services agency, in consultation with the child's family, shall have a diagnostic assessment conducted, including a functional assessment, as defined in section 245.4871.

With the consent of the commissioner of corrections and agreement of the county to pay the costs thereof, the court may, by order, place a minor coming within its jurisdiction in an institution maintained by the commissioner for the detention, diagnosis, custody and treatment of persons adjudicated to be delinquent, in order that the condition of the minor be given due consideration in the disposition of the case. Any funds received under the provisions of this subdivision shall not cancel until the end of the fiscal year immediately following the fiscal year in which the funds were received. The funds are available for use by the commissioner of corrections during that period and are hereby appropriated annually to the commissioner of corrections as reimbursement of the costs of providing these services to the juvenile courts.

Sec. 54. Minnesota Statutes 2006, section 260C.152, subdivision 5, is amended to read:

Subd. 5. **Notice to foster parents and preadoptive parents and relatives.** The foster parents, if any, of a child and any preadoptive parent or relative providing care for the child must be provided notice of and ~~an opportunity~~ a right to be heard in any review or hearing to be held with respect to the child. Any other relative may also request, and must be granted, a notice and the opportunity to be heard under this section. This subdivision does not require that a foster parent, preadoptive parent, or relative providing care for the child be made a party to a review or hearing solely on the basis of the notice and ~~opportunity~~ right to be heard.

Sec. 55. Minnesota Statutes 2006, section 260C.163, subdivision 1, is amended to read:

Subdivision 1. **General.** (a) Except for hearings arising under section 260C.425, hearings on any matter shall be without a jury and may be conducted in an informal manner. In all adjudicatory proceedings involving a child alleged to be in need of protection or services, the court shall admit only evidence that would be admissible in a civil trial. To be proved at trial, allegations of a petition alleging a child to be in need of protection or services must be proved by clear and convincing evidence.

(b) Except for proceedings involving a child alleged to be in need of protection or services and petitions for the termination of parental rights, hearings may be continued or adjourned from time to time. In proceedings involving a child alleged to be in need of protection or services and petitions for the termination of parental rights, hearings may not be continued or adjourned for more than one week unless the court makes specific findings that the continuance or adjournment is in the best interests of the child. If a hearing is held on a petition involving physical or sexual abuse of a child who is alleged to be in need of protection or services or neglected and in foster care, the court shall file the decision with the court administrator as soon as possible but no later than 15 days after the matter is submitted to the court. When a continuance or adjournment is ordered in any proceeding, the court may make any interim orders as it deems in the best interests of the minor in accordance with the provisions of sections 260C.001 to 260C.421.

(c) Except as otherwise provided in this paragraph, the court shall exclude the general public from hearings under this chapter and shall admit only those persons who, in the discretion of the court, have a direct interest in the case or in the work of the court.

(d) Adoption hearings shall be conducted in accordance with the provisions of laws relating to adoptions.

(e) In any permanency hearing, including the transition of a child from foster care to independent living, the court shall ensure that any consult with the child is in an age-appropriate manner.

Sec. 56. Minnesota Statutes 2006, section 260C.201, subdivision 11, is amended to read:

Subd. 11. **Review of court-ordered placements; permanent placement determination.** (a) This subdivision and subdivision 11a do not apply in cases where the child is in placement due solely to the child's developmental disability or emotional disturbance, where legal custody has not been transferred to the responsible social services agency, and where the court finds compelling reasons under section 260C.007, subdivision 8, to continue the child in foster care past the time periods specified in this subdivision.

Foster care placements of children due solely to their disability are governed by section 260C.141, subdivision 2a. In all other cases where the child is in foster care or in the care of a noncustodial parent under subdivision 1, the court shall commence proceedings to determine the permanent status of a child not later than 12 months after the child is placed in foster care or in the care of a noncustodial parent. At the admit-deny hearing commencing such proceedings, the court shall determine whether there is a prima facie basis for finding that the agency made reasonable efforts, or in the case of an Indian child active efforts, required under section 260.012 and proceed according to the rules of juvenile court.

For purposes of this subdivision, the date of the child's placement in foster care is the earlier of the first court-ordered placement or 60 days after the date on which the child has been voluntarily placed in foster care by the child's parent or guardian. For purposes of this subdivision, time spent by a child under the protective supervision of the responsible social services agency in the home of a noncustodial parent pursuant to an order under subdivision 1 counts towards the requirement of a permanency hearing under this subdivision or subdivision 11a. Time spent on a trial home visit ~~does not count~~ counts towards the requirement of a permanency hearing under this subdivision ~~or~~ and a permanency review for a child under eight years of age under subdivision 11a.

For purposes of this subdivision, 12 months is calculated as follows:

(1) during the pendency of a petition alleging that a child is in need of protection or services, all time periods when a child is placed in foster care or in the home of a noncustodial parent are cumulated;

(2) if a child has been placed in foster care within the previous five years under one or more previous petitions, the lengths of all prior time periods when the child was placed in foster care within the previous five years are cumulated. If a child under this clause has been in foster care for 12 months or more, the court, if it is in the best interests of the child and for compelling reasons, may extend the total time the child may continue out of the home under the current petition up to an additional six months before making a permanency determination.

(b) Unless the responsible social services agency recommends return of the child to the custodial parent or parents, not later than 30 days prior to the admit-deny hearing required under paragraph (a) and the rules of juvenile court, the responsible social services agency shall file pleadings in juvenile court to establish the basis for the juvenile court to order permanent placement of the child, including a termination of parental rights petition, according to paragraph (d). Notice of the hearing and copies of the pleadings must be provided pursuant to section 260C.152.

(c) The permanency proceedings shall be conducted in a timely fashion including that any trial required under section 260C.163 shall be commenced within 60 days of the admit-deny hearing required under paragraph (a). At the conclusion of the permanency proceedings, the court shall:

(1) order the child returned to the care of the parent or guardian from whom the child was removed; or

(2) order a permanent placement or termination of parental rights if permanent placement or termination of parental rights is in the child's best interests. The "best interests of the child" means all relevant factors to be considered and evaluated. Transfer of permanent legal and physical custody, termination of parental rights, or guardianship and legal custody to the commissioner through a consent to adopt are preferred permanency options for a child who cannot return home.

(d) If the child is not returned to the home, the court must order one of the following dispositions:

(1) permanent legal and physical custody to a relative in the best interests of the child according to the following conditions:

(i) an order for transfer of permanent legal and physical custody to a relative shall only be made after the court has reviewed the suitability of the prospective legal and physical custodian;

(ii) in transferring permanent legal and physical custody to a relative, the juvenile court shall follow the standards applicable under this chapter and chapter 260, and the procedures set out in the juvenile court rules;

(iii) an order establishing permanent legal and physical custody under this subdivision must be filed with the family court;

(iv) a transfer of legal and physical custody includes responsibility for the protection, education, care, and control of the child and decision making on behalf of the child;

(v) the social services agency may bring a petition or motion naming a fit and willing relative as a proposed permanent legal and physical custodian. The commissioner of human services shall annually prepare for counties information that must be given to proposed custodians about their legal rights and obligations as custodians together with information on financial and medical benefits for which the child is eligible; and

(vi) the juvenile court may maintain jurisdiction over the responsible social services agency, the parents or guardian of the child, the child, and the permanent legal and physical custodian for purposes of ensuring appropriate services are delivered to the child and permanent legal custodian or for the purpose of ensuring conditions ordered by the court related to the care and custody of the child are met;

(2) termination of parental rights when the requirements of sections 260C.301 to 260C.328 are met or according to the following conditions:

(i) order the social services agency to file a petition for termination of parental rights in which case all the requirements of sections 260C.301 to 260C.328 remain applicable; and

(ii) an adoption completed subsequent to a determination under this subdivision may include an agreement for communication or contact under section 259.58;

(3) long-term foster care according to the following conditions:

(i) the court may order a child into long-term foster care only if it approves the responsible social service agency's compelling reasons that neither an award of permanent legal and physical custody to a relative, nor termination of parental rights is in the child's best interests;

(ii) further, the court may only order long-term foster care for the child under this section if it finds the following:

(A) the child has reached age 12 and the responsible social services agency has made reasonable efforts to locate and place the child with an adoptive family or with a fit and willing relative who will agree to a transfer of permanent legal and physical custody of the child, but such efforts have not proven successful; or

(B) the child is a sibling of a child described in subitem (A) and the siblings have a significant positive relationship and are ordered into the same long-term foster care home; and

(iii) at least annually, the responsible social services agency reconsiders its provision of services to the child and the child's placement in long-term foster care to ensure that:

(A) long-term foster care continues to be the most appropriate legal arrangement for meeting the child's need for permanency and stability, including whether there is another permanent placement option under this chapter that would better serve the child's needs and best interests;

(B) whenever possible, there is an identified long-term foster care family that is committed to being the foster family for the child as long as the child is a minor or under the jurisdiction of the court;

(C) the child is receiving appropriate services or assistance to maintain or build connections with the child's family and community;

(D) the child's physical and mental health needs are being appropriately provided for; and

(E) the child's educational needs are being met;

(4) foster care for a specified period of time according to the following conditions:

(i) foster care for a specified period of time may be ordered only if:

(A) the sole basis for an adjudication that the child is in need of protection or services is the child's behavior;

(B) the court finds that foster care for a specified period of time is in the best interests of the child; and

(C) the court approves the responsible social services agency's compelling reasons that neither an award of permanent legal and physical custody to a relative, nor termination of parental rights is in the child's best interests;

(ii) the order does not specify that the child continue in foster care for any period exceeding one year; or

(5) guardianship and legal custody to the commissioner of human services under the following procedures and conditions:

(i) there is an identified prospective adoptive home agreed to by the responsible social services agency having legal custody of the child pursuant to court order under this section that has agreed to adopt the child and the court accepts the parent's voluntary consent to adopt under section 259.24, except that such consent executed by a parent under this item, following proper notice that consent given under this provision is irrevocable upon acceptance by the court, shall be irrevocable unless fraud is established and an order issues permitting revocation as stated in item (vii);

(ii) if the court accepts a consent to adopt in lieu of ordering one of the other enumerated permanency dispositions, the court must review the matter at least every 90 days. The review will address the reasonable efforts of the agency to achieve a finalized adoption;

(iii) a consent to adopt under this clause vests all legal authority regarding the child, including guardianship and legal custody of the child, with the commissioner of human services as if the child were a state ward after termination of parental rights;

(iv) the court must forward a copy of the consent to adopt, together with a certified copy of the order transferring guardianship and legal custody to the commissioner, to the commissioner;

(v) if an adoption is not finalized by the identified prospective adoptive parent within 12 months of the execution of the consent to adopt under this clause, the commissioner of human services or the commissioner's delegate shall pursue adoptive placement in another home unless the commissioner certifies that the failure to finalize is not due to either an action or a failure to act by the prospective adoptive parent;

(vi) notwithstanding item (v), the commissioner of human services or the commissioner's designee must pursue adoptive placement in another home as soon as the

commissioner or commissioner's designee determines that finalization of the adoption with the identified prospective adoptive parent is not possible, that the identified prospective adoptive parent is not willing to adopt the child, that the identified prospective adoptive parent is not cooperative in completing the steps necessary to finalize the adoption, or upon the commissioner's determination to withhold consent to the adoption.

(vii) unless otherwise required by the Indian Child Welfare Act, United States Code, title 25, section 1913, a consent to adopt executed under this section, following proper notice that consent given under this provision is irrevocable upon acceptance by the court, shall be irrevocable upon acceptance by the court except upon order permitting revocation issued by the same court after written findings that consent was obtained by fraud.

(e) In ordering a permanent placement of a child, the court must be governed by the best interests of the child, including a review of the relationship between the child and relatives and the child and other important persons with whom the child has resided or had significant contact. When the court has determined that permanent placement of the child away from the parent is necessary, the court shall consider permanent alternative homes that are available both inside and outside the state.

(f) Once a permanent placement determination has been made and permanent placement has been established, further court reviews are necessary if:

(1) the placement is long-term foster care or foster care for a specified period of time;

(2) the court orders further hearings because it has retained jurisdiction of a transfer of permanent legal and physical custody matter;

(3) an adoption has not yet been finalized; or

(4) there is a disruption of the permanent or long-term placement.

(g) Court reviews of an order for long-term foster care, whether under this section or section 260C.317, subdivision 3, paragraph (d), must be conducted at least yearly and must review the child's out-of-home placement plan and the reasonable efforts of the agency to finalize the permanent plan for the child including the agency's efforts to:

(1) ensure that long-term foster care continues to be the most appropriate legal arrangement for meeting the child's need for permanency and stability or, if not, to identify and attempt to finalize another permanent placement option under this chapter that would better serve the child's needs and best interests;

(2) identify a specific long-term foster home for the child, if one has not already been identified;

(3) support continued placement of the child in the identified home, if one has been identified;

(4) ensure appropriate services are provided to address the physical health, mental health, and educational needs of the child during the period of long-term foster care and also ensure appropriate services or assistance to maintain relationships with appropriate family members and the child's community; and

(5) plan for the child's independence upon the child's leaving long-term foster care living as required under section 260C.212, subdivision 1.

(h) In the event it is necessary for a child that has been ordered into foster care for a specified period of time to be in foster care longer than one year after the permanency hearing held under this section, not later than 12 months after the time the child was ordered into foster care for a specified period of time, the matter must be returned to court for a review of the appropriateness of continuing the child in foster care and of the responsible social services agency's reasonable efforts to finalize a permanent plan for the child; if it is in the child's best interests to continue the order for foster care for a specified period of time past a total of 12 months, the court shall set objectives for the child's continuation in foster care, specify any further amount of time the child may be in foster care, and review the plan for the safe return of the child to the parent.

(i) An order permanently placing a child out of the home of the parent or guardian must include the following detailed findings:

(1) how the child's best interests are served by the order;

(2) the nature and extent of the responsible social service agency's reasonable efforts, or, in the case of an Indian child, active efforts to reunify the child with the parent or guardian where reasonable efforts are required;

(3) the parent's or parents' efforts and ability to use services to correct the conditions which led to the out-of-home placement; and

(4) that the conditions which led to the out-of-home placement have not been corrected so that the child can safely return home.

(j) An order for permanent legal and physical custody of a child may be modified under sections 518.18 and 518.185. The social services agency is a party to the proceeding and must receive notice. A parent may only seek modification of an order for long-term foster care upon motion and a showing by the parent of a substantial change in the parent's circumstances such that the parent could provide appropriate care for the child and that removal of the child from the child's permanent placement and the return to the parent's care would be in the best interest of the child. The responsible social services agency may ask the court to vacate an order for long-term foster care upon a prima facie showing that there is a factual basis for the court to order another permanency option under this chapter and that such an option is in the child's best interests. Upon a hearing where

the court determines that there is a factual basis for vacating the order for long-term foster care and that another permanent order regarding the placement of the child is in the child's best interests, the court may vacate the order for long-term foster care and enter a different order for permanent placement that is in the child's best interests. The court shall not require further reasonable efforts to reunify the child with the parent or guardian as a basis for vacating the order for long-term foster care and ordering a different permanent placement in the child's best interests. The county attorney must file pleadings and give notice as required under the rules of juvenile court in order to modify an order for long-term foster care under this paragraph.

(k) The court shall issue an order required under this section within 15 days of the close of the proceedings. The court may extend issuing the order an additional 15 days when necessary in the interests of justice and the best interests of the child.

(l) This paragraph applies to proceedings required under this subdivision when the child is on a trial home visit:

(1) if the child is on a trial home visit 12 months after the child was placed in foster care or in the care of a noncustodial parent as calculated in this subdivision, the responsible social services agency may file a report with the court regarding the child's and parent's progress on the trial home visit and its reasonable efforts to finalize the child's safe and permanent return to the care of the parent in lieu of filing the pleadings required under paragraph (b). The court shall make findings regarding reasonableness of the responsible social services efforts to finalize the child's return home as the permanent order in the best interests of the child. The court may continue the trial home visit to a total time not to exceed six months as provided in subdivision 1. If the court finds the responsible social services agency has not made reasonable efforts to finalize the child's return home as the permanent order in the best interests of the child, the court may order other or additional efforts to support the child remaining in the care of the parent; and

(2) if a trial home visit ordered or continued at proceedings under this subdivision terminates, the court shall re-commence proceedings under this subdivision to determine the permanent status of the child not later than 30 days after the child is returned to foster care.

Sec. 57. Minnesota Statutes 2006, section 260C.212, subdivision 1, is amended to read:

Subdivision 1. **Out-of-home placement; plan.** (a) An out-of-home placement plan shall be prepared within 30 days after any child is placed in a residential facility by court order or by the voluntary release of the child by the parent or parents.

For purposes of this section, a residential facility means any group home, family foster home or other publicly supported out-of-home residential facility, including any out-of-home residential facility under contract with the state, county or other political subdivision, or any agency thereof, to provide those services or foster care as defined in section 260C.007, subdivision 18.

(b) An out-of-home placement plan means a written document which is prepared by the responsible social services agency jointly with the parent or parents or guardian of the child and in consultation with the child's guardian ad litem, the child's tribe, if the child is an Indian child, the child's foster parent or representative of the residential facility, and, where appropriate, the child. For a child in placement due solely or in part to the child's emotional disturbance, preparation of the out-of-home placement plan shall additionally include the child's mental health treatment provider. As appropriate, the plan shall be:

(1) submitted to the court for approval under section 260C.178, subdivision 7;

(2) ordered by the court, either as presented or modified after hearing, under section 260C.178, subdivision 7, or 260C.201, subdivision 6; and

(3) signed by the parent or parents or guardian of the child, the child's guardian ad litem, a representative of the child's tribe, the responsible social services agency, and, if possible, the child.

(c) The out-of-home placement plan shall be explained to all persons involved in its implementation, including the child who has signed the plan, and shall set forth:

(1) a description of the residential facility including how the out-of-home placement plan is designed to achieve a safe placement for the child in the least restrictive, most family-like, setting available which is in close proximity to the home of the parent or parents or guardian of the child when the case plan goal is reunification, and how the placement is consistent with the best interests and special needs of the child according to the factors under subdivision 2, paragraph (b);

(2) the specific reasons for the placement of the child in a residential facility, and when reunification is the plan, a description of the problems or conditions in the home of the parent or parents which necessitated removal of the child from home and the changes the parent or parents must make in order for the child to safely return home;

(3) a description of the services offered and provided to prevent removal of the child from the home and to reunify the family including:

(i) the specific actions to be taken by the parent or parents of the child to eliminate or correct the problems or conditions identified in clause (2), and the time period during which the actions are to be taken; and

(ii) the reasonable efforts, or in the case of an Indian child, active efforts to be made to achieve a safe and stable home for the child including social and other supportive services to be provided or offered to the parent or parents or guardian of the child, the child, and the residential facility during the period the child is in the residential facility;

(4) a description of any services or resources that were requested by the child or the child's parent, guardian, foster parent, or custodian since the date of the child's placement in the residential facility, and whether those services or resources were provided and if not, the basis for the denial of the services or resources;

(5) the visitation plan for the parent or parents or guardian, other relatives as defined in section 260C.007, subdivision 27, and siblings of the child if the siblings are not placed together in the residential facility, and whether visitation is consistent with the best interest of the child, during the period the child is in the residential facility;

(6) documentation of steps to finalize the adoption or legal guardianship of the child if the court has issued an order terminating the rights of both parents of the child or of the only known, living parent of the child~~, and~~. At a minimum, the documentation must include child-specific recruitment efforts such as relative search and the use of state, regional, and national adoption exchanges to facilitate orderly and timely placements in and outside of the state. A copy of this documentation shall be provided to the court in the review required under section 260C.317, subdivision 3, paragraph (b);

(7) ~~to the extent available and accessible,~~ the health and educational records of the child including the most recent information available regarding:

(i) the names and addresses of the child's health and educational providers;

(ii) the child's grade level performance;

(iii) the child's school record;

(iv) assurances that the child's placement in foster care takes into account proximity to the school in which the child is enrolled at the time of placement;

(v) a record of the child's immunizations;

(vi) the child's known medical problems, including any known communicable diseases, as defined in section 144.4172, subdivision 2;

(vii) the child's medications; and

(viii) any other relevant health and education information;

(8) an independent living plan for a child age 16 or older who is in placement as a result of a permanency disposition. The plan should include, but not be limited to, the following objectives:

(i) educational, vocational, or employment planning;

(ii) health care planning and medical coverage;

(iii) transportation including, where appropriate, assisting the child in obtaining a driver's license;

(iv) money management;

(v) planning for housing;

(vi) social and recreational skills; and

(vii) establishing and maintaining connections with the child's family and community; and

(9) for a child in placement due solely or in part to the child's emotional disturbance, diagnostic and assessment information, specific services relating to meeting the mental health care needs of the child, and treatment outcomes.

(d) The parent or parents or guardian and the child each shall have the right to legal counsel in the preparation of the case plan and shall be informed of the right at the time of placement of the child. The child shall also have the right to a guardian ad litem. If unable to employ counsel from their own resources, the court shall appoint counsel upon the request of the parent or parents or the child or the child's legal guardian. The parent or parents may also receive assistance from any person or social services agency in preparation of the case plan.

After the plan has been agreed upon by the parties involved or approved or ordered by the court, the foster parents shall be fully informed of the provisions of the case plan and shall be provided a copy of the plan.

Upon discharge from foster care, the parent, adoptive parent, or permanent legal and physical custodian, as appropriate, and the child, if appropriate, must be provided with a current copy of the child's health and education record.

Sec. 58. Minnesota Statutes 2006, section 260C.212, subdivision 4, is amended to read:

Subd. 4. **Responsible social service agency's duties for children in placement.** (a) When a child is in placement, the responsible social services agency shall make diligent efforts to identify, locate, and, where appropriate, offer services to both parents of the child.

(1) The responsible social services agency shall assess whether a noncustodial or nonadjudicated parent is willing and capable of providing for the day-to-day care of the child temporarily or permanently. An assessment under this clause may include, but is not limited to, obtaining information under section 260C.209. If after assessment, the responsible social services agency determines that a noncustodial or nonadjudicated parent is willing and capable of providing day-to-day care of the child, the responsible social services agency may seek authority from the custodial parent or the court to have that parent assume day-to-day care of the child. If a parent is not an adjudicated parent,

the responsible social services agency shall require the nonadjudicated parent to cooperate with paternity establishment procedures as part of the case plan.

(2) If, after assessment, the responsible social services agency determines that the child cannot be in the day-to-day care of either parent, the agency shall:

(i) prepare an out-of-home placement plan addressing the conditions that each parent must meet before the child can be in that parent's day-to-day care; and

(ii) provide a parent who is the subject of a background study under section 260C.209 15 days' notice that it intends to use the study to recommend against putting the child with that parent, as well as the notice provided in section 260C.209, subdivision 4, and the court shall afford the parent an opportunity to be heard concerning the study.

The results of a background study of a noncustodial parent shall not be used by the agency to determine that the parent is incapable of providing day-to-day care of the child unless the agency reasonably believes that placement of the child into the home of that parent would endanger the child's health, safety, or welfare.

(3) If, after the provision of services following an out-of-home placement plan under this section, the child cannot return to the care of the parent from whom the child was removed or who had legal custody at the time the child was placed in foster care, the agency may petition on behalf of a noncustodial parent to establish legal custody with that parent under section 260C.201, subdivision 11. If paternity has not already been established, it may be established in the same proceeding in the manner provided for under chapter 257.

(4) The responsible social services agency may be relieved of the requirement to locate and offer services to both parents by the juvenile court upon a finding of good cause after the filing of a petition under section 260C.141.

(b) The responsible social services agency shall give notice to the parent or parents or guardian of each child in a residential facility, other than a child in placement due solely to that child's developmental disability or emotional disturbance, of the following information:

(1) that residential care of the child may result in termination of parental rights or an order permanently placing the child out of the custody of the parent, but only after notice and a hearing as required under chapter 260C and the juvenile court rules;

(2) time limits on the length of placement and of reunification services, including the date on which the child is expected to be returned to and safely maintained in the home of the parent or parents or placed for adoption or otherwise permanently removed from the care of the parent by court order;

(3) the nature of the services available to the parent;

(4) the consequences to the parent and the child if the parent fails or is unable to use services to correct the circumstances that led to the child's placement;

(5) the first consideration for placement with relatives;

(6) the benefit to the child in getting the child out of residential care as soon as possible, preferably by returning the child home, but if that is not possible, through a permanent legal placement of the child away from the parent;

(7) when safe for the child, the benefits to the child and the parent of maintaining visitation with the child as soon as possible in the course of the case and, in any event, according to the visitation plan under this section; and

(8) the financial responsibilities and obligations, if any, of the parent or parents for the support of the child during the period the child is in the residential facility.

(c) The responsible social services agency shall inform a parent considering voluntary placement of a child who is not developmentally disabled or emotionally disturbed of the following information:

(1) the parent and the child each has a right to separate legal counsel before signing a voluntary placement agreement, but not to counsel appointed at public expense;

(2) the parent is not required to agree to the voluntary placement, and a parent who enters a voluntary placement agreement may at any time request that the agency return the child. If the parent so requests, the child must be returned within 24 hours of the receipt of the request;

(3) evidence gathered during the time the child is voluntarily placed may be used at a later time as the basis for a petition alleging that the child is in need of protection or services or as the basis for a petition seeking termination of parental rights or other permanent placement of the child away from the parent;

(4) if the responsible social services agency files a petition alleging that the child is in need of protection or services or a petition seeking the termination of parental rights or other permanent placement of the child away from the parent, the parent would have the right to appointment of separate legal counsel and the child would have a right to the appointment of counsel and a guardian ad litem as provided by law, and that counsel will be appointed at public expense if they are unable to afford counsel; and

(5) the timelines and procedures for review of voluntary placements under subdivision 3, and the effect the time spent in voluntary placement on the scheduling of a permanent placement determination hearing under section 260C.201, subdivision 11.

(d) When an agency accepts a child for placement, the agency shall determine whether the child has had a physical examination by or under the direction of a licensed physician within the 12 months immediately preceding the date when the child came into

the agency's care. If there is documentation that the child has had an examination within the last 12 months, the agency is responsible for seeing that the child has another physical examination within one year of the documented examination and annually in subsequent years. If the agency determines that the child has not had a physical examination within the 12 months immediately preceding placement, the agency shall ensure that the child has an examination within 30 days of coming into the agency's care and once a year in subsequent years.

(e) If a child leaves foster care by reason of having attained the age of majority under state law, the child must be given at no cost a copy of the child's health and education report.

Sec. 59. Minnesota Statutes 2006, section 260C.212, subdivision 9, is amended to read:

Subd. 9. **Review of certain child placements.** (a) When a developmentally disabled child or emotionally disturbed child needs placement in a residential facility for the sole reason of accessing services or a level of skilled care that cannot be provided in the parent's home, the child must be placed pursuant to a voluntary placement agreement between the responsible social services agency and the child's parent. The voluntary placement agreement must give the responsible social services agency legal responsibility for the child's physical care, custody, and control, but must not transfer legal custody of the child to the agency. The voluntary placement agreement must be executed in a form developed and promulgated by the commissioner of human services. The responsible social services agency shall report to the commissioner the number of children who are the subject of a voluntary placement agreement under this subdivision and other information regarding these children as the commissioner may require.

(b) If a developmentally disabled child or a child diagnosed as emotionally disturbed has been placed in a residential facility pursuant to a voluntary release by the child's parent or parents because of the child's disabling conditions or need for long-term residential treatment or supervision, the social services agency responsible for the placement shall report to the court and bring a petition for review of the child's foster care status as required in section 260C.141, subdivision 2a.

~~(b)~~ (c) If a child is in placement due solely to the child's developmental disability or emotional disturbance, ~~and~~ the court finds compelling reasons not to proceed under section 260C.201, subdivision 11, and custody of the child is not transferred to the responsible social services agency under section 260C.201, subdivision 1, paragraph (a), clause (2), ~~and~~ no petition is required by section 260C.201, subdivision 11.

~~(c)~~ (d) Whenever a petition for review is brought pursuant to this subdivision, a guardian ad litem shall be appointed for the child.

Sec. 60. Minnesota Statutes 2006, section 260C.317, subdivision 3, is amended to read:

Subd. 3. **Order; retention of jurisdiction.** (a) A certified copy of the findings and the order terminating parental rights, and a summary of the court's information concerning the child shall be furnished by the court to the commissioner or the agency to which guardianship is transferred. The orders shall be on a document separate from the findings. The court shall furnish the individual to whom guardianship is transferred a copy of the order terminating parental rights.

(b) The court shall retain jurisdiction in a case where adoption is the intended permanent placement disposition until the child's adoption is finalized, the child is 18 years of age, or the child is otherwise ordered discharged from the jurisdiction of the court. The guardian ad litem and counsel for the child shall continue on the case until an adoption decree is entered. A hearing must be held every 90 days following termination of parental rights for the court to review progress toward an adoptive placement and the specific recruitment efforts the agency has taken to find an adoptive family or other placement living arrangement for the child and to finalize the adoption or other permanency plan.

(c) The responsible social services agency may make a determination of compelling reasons for a child to be in long-term foster care when the agency has made exhaustive efforts to recruit, identify, and place the child in an adoptive home, and the child continues in foster care for at least 24 months after the court has issued the order terminating parental rights. A child of any age who is under the guardianship of the commissioner of the Department of Human Services and is legally available for adoption may not refuse or waive the commissioner's agent's exhaustive efforts to recruit, identify, and place the child in an adoptive home required under paragraph (b) or sign a document relieving county social services agencies of all recruitment efforts on the child's behalf. Upon approving the agency's determination of compelling reasons, the court may order the child placed in long-term foster care. At least every 12 months thereafter as long as the child continues in out-of-home placement, the court shall conduct a permanency review hearing to determine the future status of the child using the review requirements of section 260C.201, subdivision 11, paragraph (g).

(d) The court shall retain jurisdiction through the child's minority in a case where long-term foster care is the permanent disposition whether under paragraph (c) or section 260C.201, subdivision 11.

Sec. 61. Minnesota Statutes 2006, section 260C.331, subdivision 1, is amended to read:

Subdivision 1. **Care, examination, or treatment.** (a) Except where parental rights are terminated,

(1) whenever legal custody of a child is transferred by the court to a responsible social services agency,

(2) whenever legal custody is transferred to a person other than the responsible social services agency, but under the supervision of the responsible social services agency, or

(3) whenever a child is given physical or mental examinations or treatment under order of the court, and no provision is otherwise made by law for payment for the care, examination, or treatment of the child, these costs are a charge upon the welfare funds of the county in which proceedings are held upon certification of the judge of juvenile court.

(b) The court shall order, and the responsible social services agency shall require, the parents or custodian of a child, while the child is under the age of 18, to use the total income and resources attributable to the child for the period of care, examination, or treatment, except for clothing and personal needs allowance as provided in section 256B.35, to reimburse the county for the cost of care, examination, or treatment. Income and resources attributable to the child include, but are not limited to, Social Security benefits, supplemental security income (SSI), veterans benefits, railroad retirement benefits and child support. When the child is over the age of 18, and continues to receive care, examination, or treatment, the court shall order, and the responsible social services agency shall require, reimbursement from the child for the cost of care, examination, or treatment from the income and resources attributable to the child less the clothing and personal needs allowance. Income does not include earnings from a child over the age of 18 who is working as part of a plan under section 260C.212, subdivision 1, paragraph (c), clause (8), to transition from foster care.

(c) If the income and resources attributable to the child are not enough to reimburse the county for the full cost of the care, examination, or treatment, the court shall inquire into the ability of the parents to support the child and, after giving the parents a reasonable opportunity to be heard, the court shall order, and the responsible social services agency shall require, the parents to contribute to the cost of care, examination, or treatment of the child. When determining the amount to be contributed by the parents, the court shall use a fee schedule based upon ability to pay that is established by the responsible social services agency and approved by the commissioner of human services. The income of a stepparent who has not adopted a child shall be excluded in calculating the parental contribution under this section.

(d) The court shall order the amount of reimbursement attributable to the parents or custodian, or attributable to the child, or attributable to both sources, withheld under chapter 518A from the income of the parents or the custodian of the child. A parent or custodian who fails to pay without good reason may be proceeded against for contempt, or the court may inform the county attorney, who shall proceed to collect the unpaid sums, or both procedures may be used.

(e) If the court orders a physical or mental examination for a child, the examination is a medically necessary service for purposes of determining whether the service is covered by a health insurance policy, health maintenance contract, or other health coverage plan. Court-ordered treatment shall be subject to policy, contract, or plan requirements for medical necessity. Nothing in this paragraph changes or eliminates benefit limits, conditions of coverage, co-payments or deductibles, provider restrictions, or other requirements in the policy, contract, or plan that relate to coverage of other medically necessary services.

Sec. 62. Minnesota Statutes 2006, section 626.556, subdivision 2, is amended to read:

Subd. 2. **Definitions.** As used in this section, the following terms have the meanings given them unless the specific content indicates otherwise:

(a) "Family assessment" means a comprehensive assessment of child safety, risk of subsequent child maltreatment, and family strengths and needs that is applied to a child maltreatment report that does not allege substantial child endangerment. Family assessment does not include a determination as to whether child maltreatment occurred but does determine the need for services to address the safety of family members and the risk of subsequent maltreatment.

(b) "Investigation" means fact gathering related to the current safety of a child and the risk of subsequent maltreatment that determines whether child maltreatment occurred and whether child protective services are needed. An investigation must be used when reports involve substantial child endangerment, and for reports of maltreatment in facilities required to be licensed under chapter 245A or 245B; under sections 144.50 to 144.58 and 241.021; in a school as defined in sections 120A.05, subdivisions 9, 11, and 13, and 124D.10; or in a nonlicensed personal care provider association as defined in sections 256B.04, subdivision 16, and 256B.0625, subdivision 19a.

(c) "Substantial child endangerment" means a person responsible for a child's care, <u>and in the case of sexual abuse includes</u> a person who has a significant relationship to the child as defined in section 609.341, or a person in a position of authority as defined in

section 609.341, who by act or omission commits or attempts to commit an act against a child under their care that constitutes any of the following:

(1) egregious harm as defined in section 260C.007, subdivision 14;

(2) sexual abuse as defined in paragraph (d);

(3) abandonment under section 260C.301, subdivision 2;

(4) neglect as defined in paragraph (f), clause (2), that substantially endangers the child's physical or mental health, including a growth delay, which may be referred to as failure to thrive, that has been diagnosed by a physician and is due to parental neglect;

(5) murder in the first, second, or third degree under section 609.185, 609.19, or 609.195;

(6) manslaughter in the first or second degree under section 609.20 or 609.205;

(7) assault in the first, second, or third degree under section 609.221, 609.222, or 609.223;

(8) solicitation, inducement, and promotion of prostitution under section 609.322;

(9) criminal sexual conduct under sections 609.342 to 609.3451;

(10) solicitation of children to engage in sexual conduct under section 609.352;

(11) malicious punishment or neglect or endangerment of a child under section 609.377 or 609.378;

(12) use of a minor in sexual performance under section 617.246; or

(13) parental behavior, status, or condition which mandates that the county attorney file a termination of parental rights petition under section 260C.301, subdivision 3, paragraph (a).

(d) "Sexual abuse" means the subjection of a child by a person responsible for the child's care, by a person who has a significant relationship to the child, as defined in section 609.341, or by a person in a position of authority, as defined in section 609.341, subdivision 10, to any act which constitutes a violation of section 609.342 (criminal sexual conduct in the first degree), 609.343 (criminal sexual conduct in the second degree), 609.344 (criminal sexual conduct in the third degree), 609.345 (criminal sexual conduct in the fourth degree), or 609.3451 (criminal sexual conduct in the fifth degree). Sexual abuse also includes any act which involves a minor which constitutes a violation of prostitution offenses under sections 609.321 to 609.324 or 617.246. Sexual abuse includes threatened sexual abuse.

(e) "Person responsible for the child's care" means (1) an individual functioning within the family unit and having responsibilities for the care of the child such as a parent, guardian, or other person having similar care responsibilities, or (2) an individual functioning outside the family unit and having responsibilities for the care of the child

such as a teacher, school administrator, other school employees or agents, or other lawful custodian of a child having either full-time or short-term care responsibilities including, but not limited to, day care, babysitting whether paid or unpaid, counseling, teaching, and coaching.

(f) "Neglect" means:

(1) failure by a person responsible for a child's care to supply a child with necessary food, clothing, shelter, health, medical, or other care required for the child's physical or mental health when reasonably able to do so;

(2) failure to protect a child from conditions or actions that seriously endanger the child's physical or mental health when reasonably able to do so, including a growth delay, which may be referred to as a failure to thrive, that has been diagnosed by a physician and is due to parental neglect;

(3) failure to provide for necessary supervision or child care arrangements appropriate for a child after considering factors as the child's age, mental ability, physical condition, length of absence, or environment, when the child is unable to care for the child's own basic needs or safety, or the basic needs or safety of another child in their care;

(4) failure to ensure that the child is educated as defined in sections 120A.22 and 260C.163, subdivision 11, which does not include a parent's refusal to provide the parent's child with sympathomimetic medications, consistent with section 125A.091, subdivision 5;

(5) nothing in this section shall be construed to mean that a child is neglected solely because the child's parent, guardian, or other person responsible for the child's care in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the child in lieu of medical care; except that a parent, guardian, or caretaker, or a person mandated to report pursuant to subdivision 3, has a duty to report if a lack of medical care may cause serious danger to the child's health. This section does not impose upon persons, not otherwise legally responsible for providing a child with necessary food, clothing, shelter, education, or medical care, a duty to provide that care;

(6) prenatal exposure to a controlled substance, as defined in section 253B.02, subdivision 2, used by the mother for a nonmedical purpose, as evidenced by withdrawal symptoms in the child at birth, results of a toxicology test performed on the mother at delivery or the child at birth, or medical effects or developmental delays during the child's first year of life that medically indicate prenatal exposure to a controlled substance;

(7) "medical neglect" as defined in section 260C.007, subdivision 6, clause (5);

(8) chronic and severe use of alcohol or a controlled substance by a parent or person responsible for the care of the child that adversely affects the child's basic needs and safety; or

(9) emotional harm from a pattern of behavior which contributes to impaired emotional functioning of the child which may be demonstrated by a substantial and observable effect in the child's behavior, emotional response, or cognition that is not within the normal range for the child's age and stage of development, with due regard to the child's culture.

(g) "Physical abuse" means any physical injury, mental injury, or threatened injury, inflicted by a person responsible for the child's care on a child other than by accidental means, or any physical or mental injury that cannot reasonably be explained by the child's history of injuries, or any aversive or deprivation procedures, or regulated interventions, that have not been authorized under section 121A.67 or 245.825. Abuse does not include reasonable and moderate physical discipline of a child administered by a parent or legal guardian which does not result in an injury. Abuse does not include the use of reasonable force by a teacher, principal, or school employee as allowed by section 121A.582. Actions which are not reasonable and moderate include, but are not limited to, any of the following that are done in anger or without regard to the safety of the child:

(1) throwing, kicking, burning, biting, or cutting a child;

(2) striking a child with a closed fist;

(3) shaking a child under age three;

(4) striking or other actions which result in any nonaccidental injury to a child under 18 months of age;

(5) unreasonable interference with a child's breathing;

(6) threatening a child with a weapon, as defined in section 609.02, subdivision 6;

(7) striking a child under age one on the face or head;

(8) purposely giving a child poison, alcohol, or dangerous, harmful, or controlled substances which were not prescribed for the child by a practitioner, in order to control or punish the child; or other substances that substantially affect the child's behavior, motor coordination, or judgment or that results in sickness or internal injury, or subjects the child to medical procedures that would be unnecessary if the child were not exposed to the substances;

(9) unreasonable physical confinement or restraint not permitted under section 609.379, including but not limited to tying, caging, or chaining; or

(10) in a school facility or school zone, an act by a person responsible for the child's care that is a violation under section 121A.58.

(h) "Report" means any report received by the local welfare agency, police department, county sheriff, or agency responsible for assessing or investigating maltreatment pursuant to this section.

(i) "Facility" means:

(1) a licensed or unlicensed day care facility, residential facility, agency, hospital, sanitarium, or other facility or institution required to be licensed under sections 144.50 to 144.58, 241.021, or 245A.01 to 245A.16, or chapter 245B;

(2) a school as defined in sections 120A.05, subdivisions 9, 11, and 13; and 124D.10; or

(3) a nonlicensed personal care provider organization as defined in sections 256B.04, subdivision 16, and 256B.0625, subdivision 19a.

(j) "Operator" means an operator or agency as defined in section 245A.02.

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

(l) "Practice of social services," for the purposes of subdivision 3, includes but is not limited to employee assistance counseling and the provision of guardian ad litem and parenting time expeditor services.

(m) "Mental injury" means an injury to the psychological capacity or emotional stability of a child as evidenced by an observable or substantial impairment in the child's ability to function within a normal range of performance and behavior with due regard to the child's culture.

(n) "Threatened injury" means a statement, overt act, condition, or status that represents a substantial risk of physical or sexual abuse or mental injury. Threatened injury includes, but is not limited to, exposing a child to a person responsible for the child's care, as defined in paragraph (e), clause (1), who has:

(1) subjected a child to, or failed to protect a child from, an overt act or condition that constitutes egregious harm, as defined in section 260C.007, subdivision 14, or a similar law of another jurisdiction;

(2) been found to be palpably unfit under section 260C.301, paragraph (b), clause (4), or a similar law of another jurisdiction;

(3) committed an act that has resulted in an involuntary termination of parental rights under section 260C.301, or a similar law of another jurisdiction; or

(4) committed an act that has resulted in the involuntary transfer of permanent legal and physical custody of a child to a relative under section 260C.201, subdivision 11, paragraph (d), clause (1), or a similar law of another jurisdiction.

(o) Persons who conduct assessments or investigations under this section shall take into account accepted child-rearing practices of the culture in which a child participates and accepted teacher discipline practices, which are not injurious to the child's health, welfare, and safety.

Sec. 63. Minnesota Statutes 2006, section 626.556, subdivision 3, is amended to read:

Subd. 3. **Persons mandated to report.** (a) A person who knows or has reason to believe a child is being neglected or physically or sexually abused, as defined in subdivision 2, or has been neglected or physically or sexually abused within the preceding three years, shall immediately report the information to the local welfare agency, agency responsible for assessing or investigating the report, police department, or the county sheriff if the person is:

(1) a professional or professional's delegate who is engaged in the practice of the healing arts, social services, hospital administration, psychological or psychiatric treatment, child care, education, correctional supervision, probation and correctional services, or law enforcement; or

(2) employed as a member of the clergy and received the information while engaged in ministerial duties, provided that a member of the clergy is not required by this subdivision to report information that is otherwise privileged under section 595.02, subdivision 1, paragraph (c).

The police department or the county sheriff, upon receiving a report, shall immediately notify the local welfare agency or agency responsible for assessing or investigating the report, orally and in writing. The local welfare agency, or agency responsible for assessing or investigating the report, upon receiving a report, shall immediately notify the local police department or the county sheriff orally and in writing. The county sheriff and the head of every local welfare agency, agency responsible for assessing or investigating reports, and police department shall each designate a person within their agency, department, or office who is responsible for ensuring that the notification duties of this paragraph and paragraph (b) are carried out. Nothing in this subdivision shall be construed to require more than one report from any institution, facility, school, or agency.

(b) Any person may voluntarily report to the local welfare agency, agency responsible for assessing or investigating the report, police department, or the county sheriff if the person knows, has reason to believe, or suspects a child is being or has been neglected or subjected to physical or sexual abuse. The police department or the county sheriff, upon receiving a report, shall immediately notify the local welfare agency or agency responsible for assessing or investigating the report, orally and in writing. The local welfare agency or agency responsible for assessing or investigating the report, upon receiving a report, shall immediately notify the local police department or the county sheriff orally and in writing.

(c) A person mandated to report physical or sexual child abuse or neglect occurring within a licensed facility shall report the information to the agency responsible for licensing the facility under sections 144.50 to 144.58; 241.021; 245A.01 to 245A.16; or chapter 245B; or a nonlicensed personal care provider organization as defined in sections 256B.04, subdivision 16; and 256B.0625, subdivision 19. A health or corrections agency receiving a report may request the local welfare agency to provide assistance pursuant to subdivisions 10, 10a, and 10b. A board or other entity whose licensees perform work within a school facility, upon receiving a complaint of alleged maltreatment, shall provide information about the circumstances of the alleged maltreatment to the commissioner of education. Section 13.03, subdivision 4, applies to data received by the commissioner of education from a licensing entity.

(d) Any person mandated to report shall receive a summary of the disposition of any report made by that reporter, including whether the case has been opened for child protection or other services, or if a referral has been made to a community organization, unless release would be detrimental to the best interests of the child. Any person who is not mandated to report shall, upon request to the local welfare agency, receive a concise summary of the disposition of any report made by that reporter, unless release would be detrimental to the best interests of the child.

(e) For purposes of this ~~subdivision~~ section, "immediately" means as soon as possible but in no event longer than 24 hours.

Sec. 64. Minnesota Statutes 2006, section 626.556, is amended by adding a subdivision to read:

Subd. 3e. **Agency responsibility for assessing or investigating reports of sexual abuse.** The local welfare agency is the agency responsible for investigating allegations of sexual abuse if the alleged offender is the parent, guardian, sibling, or an individual functioning within the family unit as a person responsible for the child's care, or a person with a significant relationship to the child if that person resides in the child's household.

Sec. 65. Minnesota Statutes 2006, section 626.556, is amended by adding a subdivision to read:

Subd. 3f. **Law enforcement agency responsibility for investigating maltreatment.** The local law enforcement agency has responsibility for investigating any report of child maltreatment if a violation of a criminal statute is alleged. Law enforcement and the responsible agency must coordinate their investigations or assessments as required under subdivision 10.

Sec. 66. Minnesota Statutes 2006, section 626.556, subdivision 10, is amended to read:

Subd. 10. **Duties of local welfare agency and local law enforcement agency upon receipt of a report.** (a) Upon receipt of a report, the local welfare agency shall determine whether to conduct a family assessment or an investigation as appropriate to prevent or provide a remedy for child maltreatment. The local welfare agency:

(1) shall conduct an investigation on reports involving substantial child endangerment;

(2) shall begin an immediate investigation if, at any time when it is using a family assessment response, it determines that there is reason to believe that substantial child endangerment or a serious threat to the child's safety exists;

(3) may conduct a family assessment for reports that do not allege substantial child endangerment. In determining that a family assessment is appropriate, the local welfare agency may consider issues of child safety, parental cooperation, and the need for an immediate response; and

(4) may conduct a family assessment on a report that was initially screened and assigned for an investigation. In determining that a complete investigation is not required, the local welfare agency must document the reason for terminating the investigation and notify the local law enforcement agency if the local law enforcement agency is conducting a joint investigation.

If the report alleges neglect, physical abuse, or sexual abuse by a parent, guardian, or individual functioning within the family unit as a person responsible for the child's care, or sexual abuse by a person with a significant relationship to the child when that person resides in the child's household or by a sibling, the local welfare agency shall immediately conduct a family assessment or investigation as identified in clauses (1) to (4). In conducting a family assessment or investigation, the local welfare agency shall gather information on the existence of substance abuse and domestic violence and offer services for purposes of preventing future child maltreatment, safeguarding and enhancing the welfare of the abused or neglected minor, and supporting and preserving family life whenever possible. If the report alleges a violation of a criminal statute involving sexual abuse, physical abuse, or neglect or endangerment, under section 609.378, the local law enforcement agency and local welfare agency shall coordinate the planning and execution of their respective investigation and assessment efforts to avoid a duplication of fact-finding efforts and multiple interviews. Each agency shall prepare a separate report of the results of its investigation. In cases of alleged child maltreatment resulting in death, the local agency may rely on the fact-finding efforts of a law enforcement investigation to make a determination of whether or not maltreatment occurred. When necessary the

local welfare agency shall seek authority to remove the child from the custody of a parent, guardian, or adult with whom the child is living. In performing any of these duties, the local welfare agency shall maintain appropriate records.

If the family assessment or investigation indicates there is a potential for abuse of alcohol or other drugs by the parent, guardian, or person responsible for the child's care, the local welfare agency shall conduct a chemical use assessment pursuant to Minnesota Rules, part 9530.6615. The local welfare agency shall report the determination of the chemical use assessment, and the recommendations and referrals for alcohol and other drug treatment services to the state authority on alcohol and drug abuse.

(b) When a local agency receives a report or otherwise has information indicating that a child who is a client, as defined in section 245.91, has been the subject of physical abuse, sexual abuse, or neglect at an agency, facility, or program as defined in section 245.91, it shall, in addition to its other duties under this section, immediately inform the ombudsman established under sections 245.91 to 245.97. The commissioner of education shall inform the ombudsman established under sections 245.91 to 245.97 of reports regarding a child defined as a client in section 245.91 that maltreatment occurred at a school as defined in sections 120A.05, subdivisions 9, 11, and 13, and 124D.10.

(c) Authority of the local welfare agency responsible for assessing or investigating the child abuse or neglect report, the agency responsible for assessing or investigating the report, and of the local law enforcement agency for investigating the alleged abuse or neglect includes, but is not limited to, authority to interview, without parental consent, the alleged victim and any other minors who currently reside with or who have resided with the alleged offender. The interview may take place at school or at any facility or other place where the alleged victim or other minors might be found or the child may be transported to, and the interview conducted at, a place appropriate for the interview of a child designated by the local welfare agency or law enforcement agency. The interview may take place outside the presence of the alleged offender or parent, legal custodian, guardian, or school official. For family assessments, it is the preferred practice to request a parent or guardian's permission to interview the child prior to conducting the child interview, unless doing so would compromise the safety assessment. Except as provided in this paragraph, the parent, legal custodian, or guardian shall be notified by the responsible local welfare or law enforcement agency no later than the conclusion of the investigation or assessment that this interview has occurred. Notwithstanding rule ~~49.02~~ 32 of the Minnesota Rules of Procedure for Juvenile Courts, the juvenile court may, after hearing on an ex parte motion by the local welfare agency, order that, where reasonable cause exists, the agency withhold notification of this interview from the parent, legal custodian, or

guardian. If the interview took place or is to take place on school property, the order shall specify that school officials may not disclose to the parent, legal custodian, or guardian the contents of the notification of intent to interview the child on school property, as provided under this paragraph, and any other related information regarding the interview that may be a part of the child's school record. A copy of the order shall be sent by the local welfare or law enforcement agency to the appropriate school official.

(d) When the local welfare, local law enforcement agency, or the agency responsible for assessing or investigating a report of maltreatment determines that an interview should take place on school property, written notification of intent to interview the child on school property must be received by school officials prior to the interview. The notification shall include the name of the child to be interviewed, the purpose of the interview, and a reference to the statutory authority to conduct an interview on school property. For interviews conducted by the local welfare agency, the notification shall be signed by the chair of the local social services agency or the chair's designee. The notification shall be private data on individuals subject to the provisions of this paragraph. School officials may not disclose to the parent, legal custodian, or guardian the contents of the notification or any other related information regarding the interview until notified in writing by the local welfare or law enforcement agency that the investigation or assessment has been concluded, unless a school employee or agent is alleged to have maltreated the child. Until that time, the local welfare or law enforcement agency or the agency responsible for assessing or investigating a report of maltreatment shall be solely responsible for any disclosures regarding the nature of the assessment or investigation.

Except where the alleged offender is believed to be a school official or employee, the time and place, and manner of the interview on school premises shall be within the discretion of school officials, but the local welfare or law enforcement agency shall have the exclusive authority to determine who may attend the interview. The conditions as to time, place, and manner of the interview set by the school officials shall be reasonable and the interview shall be conducted not more than 24 hours after the receipt of the notification unless another time is considered necessary by agreement between the school officials and the local welfare or law enforcement agency. Where the school fails to comply with the provisions of this paragraph, the juvenile court may order the school to comply. Every effort must be made to reduce the disruption of the educational program of the child, other students, or school staff when an interview is conducted on school premises.

(e) Where the alleged offender or a person responsible for the care of the alleged victim or other minor prevents access to the victim or other minor by the local welfare agency, the juvenile court may order the parents, legal custodian, or guardian to produce

the alleged victim or other minor for questioning by the local welfare agency or the local law enforcement agency outside the presence of the alleged offender or any person responsible for the child's care at reasonable places and times as specified by court order.

(f) Before making an order under paragraph (e), the court shall issue an order to show cause, either upon its own motion or upon a verified petition, specifying the basis for the requested interviews and fixing the time and place of the hearing. The order to show cause shall be served personally and shall be heard in the same manner as provided in other cases in the juvenile court. The court shall consider the need for appointment of a guardian ad litem to protect the best interests of the child. If appointed, the guardian ad litem shall be present at the hearing on the order to show cause.

(g) The commissioner of human services, the ombudsman for mental health and developmental disabilities, the local welfare agencies responsible for investigating reports, the commissioner of education, and the local law enforcement agencies have the right to enter facilities as defined in subdivision 2 and to inspect and copy the facility's records, including medical records, as part of the investigation. Notwithstanding the provisions of chapter 13, they also have the right to inform the facility under investigation that they are conducting an investigation, to disclose to the facility the names of the individuals under investigation for abusing or neglecting a child, and to provide the facility with a copy of the report and the investigative findings.

(h) The local welfare agency responsible for conducting a family assessment or investigation shall collect available and relevant information to determine child safety, risk of subsequent child maltreatment, and family strengths and needs and share not public information with an Indian's tribal social services agency without violating any law of the state that may otherwise impose duties of confidentiality on the local welfare agency in order to implement the tribal state agreement. The local welfare agency or the agency responsible for investigating the report shall collect available and relevant information to ascertain whether maltreatment occurred and whether protective services are needed. Information collected includes, when relevant, information with regard to the person reporting the alleged maltreatment, including the nature of the reporter's relationship to the child and to the alleged offender, and the basis of the reporter's knowledge for the report; the child allegedly being maltreated; the alleged offender; the child's caretaker; and other collateral sources having relevant information related to the alleged maltreatment. The local welfare agency or the agency responsible for assessing or investigating the report may make a determination of no maltreatment early in an assessment, and close the case and retain immunity, if the collected information shows no basis for a full assessment or investigation.

Information relevant to the assessment or investigation must be asked for, and may include:

(1) the child's sex and age, prior reports of maltreatment, information relating to developmental functioning, credibility of the child's statement, and whether the information provided under this clause is consistent with other information collected during the course of the assessment or investigation;

(2) the alleged offender's age, a record check for prior reports of maltreatment, and criminal charges and convictions. The local welfare agency or the agency responsible for assessing or investigating the report must provide the alleged offender with an opportunity to make a statement. The alleged offender may submit supporting documentation relevant to the assessment or investigation;

(3) collateral source information regarding the alleged maltreatment and care of the child. Collateral information includes, when relevant: (i) a medical examination of the child; (ii) prior medical records relating to the alleged maltreatment or the care of the child maintained by any facility, clinic, or health care professional and an interview with the treating professionals; and (iii) interviews with the child's caretakers, including the child's parent, guardian, foster parent, child care provider, teachers, counselors, family members, relatives, and other persons who may have knowledge regarding the alleged maltreatment and the care of the child; and

(4) information on the existence of domestic abuse and violence in the home of the child, and substance abuse.

Nothing in this paragraph precludes the local welfare agency, the local law enforcement agency, or the agency responsible for assessing or investigating the report from collecting other relevant information necessary to conduct the assessment or investigation. Notwithstanding section 13.384 or 144.335, the local welfare agency has access to medical data and records for purposes of clause (3). Notwithstanding the data's classification in the possession of any other agency, data acquired by the local welfare agency or the agency responsible for assessing or investigating the report during the course of the assessment or investigation are private data on individuals and must be maintained in accordance with subdivision 11. Data of the commissioner of education collected or maintained during and for the purpose of an investigation of alleged maltreatment in a school are governed by this section, notwithstanding the data's classification as educational, licensing, or personnel data under chapter 13.

In conducting an assessment or investigation involving a school facility as defined in subdivision 2, paragraph (i), the commissioner of education shall collect investigative

reports and data that are relevant to a report of maltreatment and are from local law enforcement and the school facility.

(i) Upon receipt of a report, the local welfare agency shall conduct a face-to-face contact with the child reported to be maltreated and with the child's primary caregiver sufficient to complete a safety assessment and ensure the immediate safety of the child. The face-to-face contact with the child and primary caregiver shall occur immediately if substantial child endangerment is alleged and within five calendar days for all other reports. If the alleged offender was not already interviewed as the primary caregiver, the local welfare agency shall also conduct a face-to-face interview with the alleged offender in the early stages of the assessment or investigation. At the initial contact, the local child welfare agency or the agency responsible for assessing or investigating the report must inform the alleged offender of the complaints or allegations made against the individual in a manner consistent with laws protecting the rights of the person who made the report. The interview with the alleged offender may be postponed if it would jeopardize an active law enforcement investigation.

(j) When conducting an investigation, the local welfare agency shall use a question and answer interviewing format with questioning as nondirective as possible to elicit spontaneous responses. For investigations only, the following interviewing methods and procedures must be used whenever possible when collecting information:

(1) audio recordings of all interviews with witnesses and collateral sources; and

(2) in cases of alleged sexual abuse, audio-video recordings of each interview with the alleged victim and child witnesses.

(k) In conducting an assessment or investigation involving a school facility as defined in subdivision 2, paragraph (i), the commissioner of education shall collect available and relevant information and use the procedures in paragraphs (i), (k), and subdivision 3d, except that the requirement for face-to-face observation of the child and face-to-face interview of the alleged offender is to occur in the initial stages of the assessment or investigation provided that the commissioner may also base the assessment or investigation on investigative reports and data received from the school facility and local law enforcement, to the extent those investigations satisfy the requirements of paragraphs (i) and (k), and subdivision 3d.

Sec. 67. Minnesota Statutes 2006, section 626.556, subdivision 10a, is amended to read:

Subd. 10a. ~~**Abuse outside family unit**~~ **Law enforcement agency responsibility for investigation; welfare agency reliance on law enforcement fact-finding; welfare**

agency offer of services. (a) If the report alleges neglect, physical abuse, or sexual abuse by a person who is not a parent, guardian, sibling, person responsible for the child's care functioning ~~outside~~ within the family unit, or a person who lives in the child's household and who has a significant relationship to the child, in a setting other than a facility as defined in subdivision 2, the local welfare agency shall immediately notify the appropriate law enforcement agency, which shall conduct an investigation of the alleged abuse or neglect if a violation of a criminal statute is alleged.

(b) The local agency may rely on the fact-finding efforts of the law enforcement investigation conducted under this subdivision to make a determination whether or not threatened harm or other maltreatment has occurred under subdivision 2 if an alleged offender has minor children or lives with minors.

(c) The local welfare agency shall offer appropriate social services for the purpose of safeguarding and enhancing the welfare of the abused or neglected minor.

Sec. 68. Minnesota Statutes 2006, section 626.556, subdivision 10c, is amended to read:

Subd. 10c. **Duties of local social service agency upon receipt of a report of medical neglect.** If the report alleges medical neglect as defined in section 260C.007, subdivision ~~4~~ 6, clause (5), the local welfare agency shall, in addition to its other duties under this section, immediately consult with designated hospital staff and with the parents of the infant to verify that appropriate nutrition, hydration, and medication are being provided; and shall immediately secure an independent medical review of the infant's medical charts and records and, if necessary, seek a court order for an independent medical examination of the infant. If the review or examination leads to a conclusion of medical neglect, the agency shall intervene on behalf of the infant by initiating legal proceedings under section 260C.141 and by filing an expedited motion to prevent the withholding of medically indicated treatment.

Sec. 69. Minnesota Statutes 2006, section 626.556, subdivision 10f, is amended to read:

Subd. 10f. **Notice of determinations.** Within ten working days of the conclusion of a family assessment, the local welfare agency shall notify the parent or guardian of the child of the need for services to address child safety concerns or significant risk of subsequent child maltreatment. The local welfare agency and the family may also jointly agree that family support and family preservation services are needed. Within ten working days of the conclusion of an investigation, the local welfare agency or agency responsible for assessing or investigating the report shall notify the parent or guardian of the child, the

person determined to be maltreating the child, and if applicable, the director of the facility, of the determination and a summary of the specific reasons for the determination. The notice must also include a certification that the information collection procedures under subdivision 10, paragraphs (h), (i), and (j), were followed and a notice of the right of a data subject to obtain access to other private data on the subject collected, created, or maintained under this section. In addition, the notice shall include the length of time that the records will be kept under subdivision 11c. The investigating agency shall notify the parent or guardian of the child who is the subject of the report, and any person or facility determined to have maltreated a child, of their appeal or review rights under this section or section 256.022. The notice must also state that a finding of maltreatment may result in denial of a license application or background study disqualification under chapter 245C related to employment or services that are licensed by the Department of Human Services under chapter 245A, the Department of Health under chapter 144 or 144A, the Department of Corrections under section 241.021, and from providing services related to an unlicensed personal care provider organization under chapter 256B.

Sec. 70. **KINSHIP NAVIGATOR PROGRAM; DEMONSTRATION GRANT.**

(a) The commissioner of human services shall fund a two-year demonstration grant to be transferred to a nonprofit organization experienced in kinship advocacy and policy that has:

(1) experience working with grandparents and relatives who are raising kinship children;

(2) an established statewide outreach network;

(3) established kinship support groups;

(4) an intergenerational approach to programming; and

(5) a board of directors consisting of 50 percent grandparents and relatives raising kinship children.

(b) The purpose of the grant is to provide support to grandparents or relatives raising kinship children. One site must be in the metropolitan area, and the other in the Bemidji region. One-stop services may include, but are not limited to, legal services, education, information, family activities, support groups, mental health access, advocacy, mentors, and information related to foster care licensing. Funds may also be used for a media campaign to inform kinship families about available information and services, support sites, and other program development.

Sec. 71. **MFIP PILOT PROGRAM; WORKFORCE U.**

Subdivision 1. **Establishment.** A pilot program is established in Stearns and Benton Counties to expand the Workforce U program administered by the Stearns-Benton Employment and Training Council.

Subd. 2. **Evaluation.** The Workforce U pilot program must be evaluated by a research and evaluation organization with experience evaluating welfare programs. The evaluation must include information on the total number of persons served, percentage of participants exiting the program, percentage of former participants reentering the program, average wages of program participants, and recommendations to the legislature for possible statewide implementation of the program. The evaluation must be presented to the legislature by February 15, 2011.

Subd. 3. **Expiration.** The Workforce U pilot program expires on June 30, 2011.

Sec. 72. **LEECH LAKE YOUTH TREATMENT CENTER PROPOSAL.**

(a) The commissioner of human services shall provide a planning grant to address the unmet need for local, effective, culturally relevant alcohol and drug treatment for American Indian youth, and develop a plan for a family-based youth treatment center in the Leech Lake area. The planning grant must be provided to a volunteer board consisting of at least four members appointed by the commissioner, to include at least the following:

(1) two members of the Leech Lake Tribal Council or their designees;

(2) one member appointed by the Cass County Social Services administrator; and

(3) one member appointed by the Cass Lake-Bena Public School superintendent.

(b) The plan must include:

(1) an interest, feasibility, and suitability of location study;

(2) defining scope of programs and services to be offered;

(3) defining site use limitations and restrictions, including physical and capacity;

(4) defining facilities required for programs and services offered;

(5) identifying partners, partnership roles, and partner resources;

(6) developing proposed operating and maintenance budgets;

(7) identifying funding sources;

(8) developing a long-term funding plan; and

(9) developing a formal steering committee, structure, and bylaws.

(c) The plan is due to the legislative committees having jurisdiction over chemical health issues no later than September 2008 in order to provide the 12 months necessary to complete the plan.

Sec. 73. **MINNESOTA FOOD SUPPORT PROGRAM SIMPLIFIED APPLICATION.**

The Department of Human Services shall create a simplified application for the Minnesota food support program for persons over the age of 60 and persons with disabilities. The application must be no longer than three pages in length.

Sec. 74. **REPEALER.**

Minnesota Statutes 2006, sections 256J.24, subdivision 6; 256J.29; 256J.37, subdivision 3b; and 256J.626, subdivisions 7 and 9, are repealed.

ARTICLE 2
LICENSING

Section 1. Minnesota Statutes 2006, section 245A.035, is amended to read:

245A.035 ~~RELATIVE FOSTER CARE;~~ UNLICENSED EMERGENCY ~~LICENSE~~ RELATIVE PLACEMENT.

Subdivision 1. **~~Grant of~~ Emergency ~~license~~ placement.** Notwithstanding section 245A.03, subdivision 2a, or 245C.13, subdivision 2, a county agency may place a child ~~for foster care~~ with a relative who is not licensed to provide foster care, provided the requirements of ~~subdivision 2~~ this section are met. As used in this section, the term "relative" has the meaning given it under section 260C.007, subdivision 27.

Subd. 2. **Cooperation with emergency ~~licensing~~ placement process.** (a) A county agency that places a child with a relative who is not licensed to provide foster care must ~~begin the process of securing an emergency license for the relative as soon as possible and must~~ conduct the initial inspection required by subdivision 3, clause (1), whenever possible, prior to placing the child in the relative's home, but no later than three working days after placing the child in the home. A child placed in the home of a relative who is not licensed to provide foster care must be removed from that home if the relative fails to cooperate with the county agency ~~in securing an emergency foster care license. The commissioner may issue an emergency foster care license to a relative with whom the county agency wishes to place or has placed a child for foster care, or to a relative with whom a child has been placed by court order~~.

(b) If a child is to be placed in the home of a relative not licensed to provide foster care, either the placing agency or the county agency in the county in which the relative lives shall conduct the emergency ~~licensing~~ placement process as required in this section.

Subd. 3. **Requirements for emergency ~~license~~ placement.** Before an emergency ~~license~~ placement may be ~~issued~~ made, the following requirements must be met:

(1) the county agency must conduct an initial inspection of the premises where the ~~foster care~~ placement is to be ~~provided~~ made to ensure the health and safety of any child placed in the home. The county agency shall conduct the inspection using a form developed by the commissioner;

(2) at the time of the inspection or placement, whichever is earlier, the county agency must provide the relative being considered for an emergency ~~license shall receive~~ placement an application form for a child foster care license;

(3) whenever possible, prior to placing the child in the relative's home, the relative being considered for an emergency ~~license~~ placement shall provide the information required by section 245C.05; and

(4) if the county determines, prior to the ~~issuance of an~~ emergency ~~license~~ placement, that anyone requiring a background study ~~may be~~ prior to licensure of the home is disqualified under ~~section 245C.14 and~~ chapter 245C, and the disqualification is one which the commissioner cannot set aside, an emergency ~~license shall~~ placement must not be ~~issued~~ made.

Subd. 4. **Applicant study.** When the county agency has received the information required by section 245C.05, the county agency shall ~~begin an applicant study according to the procedures in chapter 245C. The commissioner may issue an emergency license upon recommendation of the county agency once the initial inspection has been successfully completed and the information necessary to begin the applicant background study has been provided. If the county agency does not recommend that the emergency license be granted, the agency shall notify the relative in writing that the agency is recommending denial to the commissioner; shall remove any child who has been placed in the home prior to licensure; and shall inform the relative in writing of the procedure to request review pursuant to subdivision 6. An emergency license shall be effective until a child foster care license is granted or denied, but shall in no case remain in effect more than 120 days from the date of placement~~ submit the information to the commissioner according to section 245C.05.

Subd. 5. **Child foster care license application.** (a) The relatives with whom the emergency ~~license holder~~ placement has been made shall complete the child foster care license application and necessary paperwork within ten days of the placement. The county agency shall assist the ~~emergency license holder~~ applicant to complete the application. The granting of a child foster care license to a relative shall be under the procedures in this chapter and according to the standards ~~set forth by foster care rule~~ in Minnesota Rules, chapter 2960. In licensing a relative, the commissioner shall consider the importance of maintaining the child's relationship with relatives as an additional significant factor in determining whether ~~to~~ a background study disqualification should be set aside ~~a licensing~~

~~disqualifier~~ under section 245C.22, or ~~to grant~~ a variance ~~of licensing requirements~~ should be granted under ~~sections 245C.21 to 245C.27~~ section 245C.30.

(b) When the county or private child-placing agency is processing an application for child foster care licensure of a relative as defined in section 260B.007, subdivision 12, or 260C.007, subdivision 27, the county agency or child-placing agency must explain the licensing process to the prospective licensee, including the background study process and the procedure for reconsideration of an initial disqualification for licensure. The county or private child-placing agency must also provide the prospective relative licensee with information regarding appropriate options for legal representation in the pertinent geographic area. If a relative is initially disqualified under section 245C.14, the ~~county or child-placing agency~~ commissioner must provide written notice of the reasons for the disqualification and the right to request a reconsideration by the commissioner as required under section 245C.17.

(c) The commissioner shall maintain licensing data so that activities related to applications and licensing actions for relative foster care providers may be distinguished from other child foster care settings.

~~Subd. 6. **Denial of emergency license.** If the commissioner denies an application for an emergency foster care license under this section, that denial must be in writing and must include reasons for the denial. Denial of an emergency license is not subject to appeal under chapter 14. The relative may request a review of the denial by submitting to the commissioner a written statement of the reasons an emergency license should be granted. The commissioner shall evaluate the request for review and determine whether to grant the emergency license. The commissioner's review shall be based on a review of the records submitted by the county agency and the relative. Within 15 working days of the receipt of the request for review, the commissioner shall notify the relative requesting review in written form whether the emergency license will be granted. The commissioner's review shall be based on a review of the records submitted by the county agency and the relative. A child shall not be placed or remain placed in the relative's home while the request for review is pending. Denial of an emergency license shall not preclude an individual from reapplying for an emergency license or from applying for a child foster care license. The decision of the commissioner is the final administrative agency action.~~

Sec. 2. Minnesota Statutes 2006, section 245A.16, subdivision 1, is amended to read:

Subdivision 1. **Delegation of authority to agencies.** (a) County agencies and private agencies that have been designated or licensed by the commissioner to perform licensing functions and activities under section 245A.04 ~~and~~; background studies for

adult foster care, family adult day services, and family child care under chapter 245C~~,~~; to recommend denial of applicants under section 245A.05~~,~~; to issue correction orders, to issue variances, and recommend a conditional license under section 245A.06~~,~~; or to recommend suspending or revoking a license or issuing a fine under section 245A.07, shall comply with rules and directives of the commissioner governing those functions and with this section. The following variances are excluded from the delegation of variance authority and may be issued only by the commissioner:

(1) dual licensure of family child care and child foster care, dual licensure of child and adult foster care, and adult foster care and family child care;

(2) adult foster care maximum capacity;

(3) adult foster care minimum age requirement;

(4) child foster care maximum age requirement;

(5) variances regarding disqualified individuals except that county agencies may issue variances under section 245C.30 regarding disqualified individuals when the county is responsible for conducting a consolidated reconsideration according to sections 245C.25 and 245C.27, subdivision 2, clauses (a) and (b), of a county maltreatment determination and a disqualification based on serious or recurring maltreatment; and

(6) the required presence of a caregiver in the adult foster care residence during normal sleeping hours.

(b) County agencies must report~~:~~

~~(1)~~ information about disqualification reconsiderations under sections 245C.25 and 245C.27, subdivision 2, ~~clauses~~ paragraphs (a) and (b), and variances granted under paragraph (a), clause (5), to the commissioner at least monthly in a format prescribed by the commissioner~~; and~~.

~~(2) for relative child foster care applicants and license holders, the number of relatives, as defined in section 260C.007, subdivision 27, and household members of relatives who are disqualified under section 245C.14; the disqualifying characteristics under section 245C.15; the number of these individuals who requested reconsideration under section 245C.21; the number of set-asides under section 245C.22; and variances under section 245C.30 issued. This information shall be reported to the commissioner annually by January 15 of each year in a format prescribed by the commissioner.~~

(c) For family day care programs, the commissioner may authorize licensing reviews every two years after a licensee has had at least one annual review.

(d) For family adult day services programs, the commissioner may authorize licensing reviews every two years after a licensee has had at least one annual review.

(e) A license issued under this section may be issued for up to two years.

Sec. 3. Minnesota Statutes 2006, section 245A.16, subdivision 3, is amended to read:

Subd. 3. **Recommendations to the commissioner.** The county or private agency shall not make recommendations to the commissioner regarding licensure without first conducting an inspection, and for adult foster care, family adult day services, and family child care, a background study of the applicant~~, and evaluation pursuant to~~ under chapter 245C. The county or private agency must forward its recommendation to the commissioner regarding the appropriate licensing action within 20 working days of receipt of a completed application.

Sec. 4. Minnesota Statutes 2006, section 245C.02, is amended by adding a subdivision to read:

Subd. 14a. **Private agency.** "Private agency" has the meaning given in section 245A.02, subdivision 12.

Sec. 5. Minnesota Statutes 2006, section 245C.04, subdivision 1, is amended to read:

Subdivision 1. **Licensed programs.** (a) The commissioner shall conduct a background study of an individual required to be studied under section 245C.03, subdivision 1, at least upon application for initial license for all license types.

(b) The commissioner shall conduct a background study of an individual required to be studied under section 245C.03, subdivision 1, at reapplication for a license for family child care, ~~child foster care, and~~ adult foster care, and family adult day services.

(c) The commissioner is not required to conduct a study of an individual at the time of reapplication for a license if the individual's background study was completed by the commissioner of human services for an adult foster care license holder that is also:

(1) registered under chapter 144D; or

(2) licensed to provide home and community-based services to people with disabilities at the foster care location and the license holder does not reside in the foster care residence; and

(3) the following conditions are met:

(i) a study of the individual was conducted either at the time of initial licensure or when the individual became affiliated with the license holder;

(ii) the individual has been continuously affiliated with the license holder since the last study was conducted; and

(iii) the last study of the individual was conducted on or after October 1, 1995.

(d) From July 1, 2007, to June 30, 2009, the commissioner of human services shall conduct a study of an individual required to be studied under section 245C.03, at

the time of reapplication for a child foster care license. The county or private agency shall collect and forward to the commissioner the information required under section 245C.05, subdivisions 1, paragraphs (a) and (b), and 5, paragraphs (a) and (b). The background study conducted by the commissioner of human services under this paragraph must include a review of the information required under section 245C.08, subdivisions 1, paragraph (a), clauses (1) to (4), and 3.

(e) The commissioner of human services shall conduct a background study of an individual specified under section 245C.03, subdivision 1, paragraph (a), clauses (2) to (6), who is newly affiliated with a child foster care license holder. The county or private agency shall collect and forward to the commissioner the information required under section 245C.05, subdivisions 1 and 5. The background study conducted by the commissioner of human services under this paragraph must include a review of the information required under section 245C.08, subdivisions 1, paragraph (a), and 3.

(f) Applicants for licensure, license holders, and other entities as provided in this chapter must submit completed background study forms to the commissioner before individuals specified in section 245C.03, subdivision 1, begin positions allowing direct contact in any licensed program.

~~(e)~~ (g) For purposes of this section, a physician licensed under chapter 147 is considered to be continuously affiliated upon the license holder's receipt from the commissioner of health or human services of the physician's background study results.

Sec. 6. Minnesota Statutes 2006, section 245C.05, subdivision 1, is amended to read:

Subdivision 1. **Individual studied.** (a) The individual who is the subject of the background study must provide the applicant, license holder, or other entity under section 245C.04 with sufficient information to ensure an accurate study, including:

(1) the individual's first, middle, and last name and all other names by which the individual has been known;

(2) home address, city, and state of residence;

(3) zip code;

(4) sex;

(5) date of birth; and

(6) Minnesota driver's license number or state identification number.

(b) Every subject of a background study conducted or initiated by counties or private agencies under this chapter must also provide the home address, city, county, and state of residence for the past five years.

(c) Every subject of a background study related to child foster care licensed through a private agency shall also provide the commissioner a signed consent for the release of any information received from national crime information databases to the private agency that initiated the background study.

(d) The subject of a background study shall provide fingerprints as required in subdivision 5, paragraph (c).

Sec. 7. Minnesota Statutes 2006, section 245C.05, is amended by adding a subdivision to read:

Subd. 2a. **County or private agency.** For background studies related to child foster care, county and private agencies must collect the information under subdivision 1 and forward it to the commissioner.

Sec. 8. Minnesota Statutes 2006, section 245C.05, subdivision 4, is amended to read:

Subd. 4. **Electronic transmission.** For background studies conducted by the Department of Human Services, the commissioner shall implement a system for the electronic transmission of:

(1) background study information to the commissioner; ~~and~~

(2) background study results to the license holder~~.~~; and

(3) background study results to county and private agencies for background studies conducted by the commissioner for child foster care.

Sec. 9. Minnesota Statutes 2006, section 245C.05, subdivision 5, is amended to read:

Subd. 5. **Fingerprints.** (a) Except as provided in paragraph (c), for any background study completed under this chapter, when the commissioner has reasonable cause to believe that further pertinent information may exist on the subject of the background study, the subject shall provide the commissioner with a set of classifiable fingerprints obtained from an authorized ~~law enforcement~~ agency.

(b) For purposes of requiring fingerprints, the commissioner has reasonable cause when, but not limited to, the:

(1) information from the Bureau of Criminal Apprehension indicates that the subject is a multistate offender;

(2) information from the Bureau of Criminal Apprehension indicates that multistate offender status is undetermined; or

(3) commissioner has received a report from the subject or a third party indicating that the subject has a criminal history in a jurisdiction other than Minnesota.

(c) Except as specified under section 245C.04, subdivision 1, paragraph (d), for background studies conducted by the commissioner for child foster care, the subject of the background study shall provide the commissioner with a set of classifiable fingerprints obtained from an authorized agency.

Sec. 10. Minnesota Statutes 2006, section 245C.05, subdivision 7, is amended to read:

Subd. 7. **Probation officer and corrections agent.** (a) A probation officer or corrections agent shall notify the commissioner of an individual's conviction if the individual is:

(1) affiliated with a program or facility regulated by the Department of Human Services or Department of Health, a facility serving children or youth licensed by the Department of Corrections, or any type of home care agency or provider of personal care assistance services; and

(2) convicted of a crime constituting a disqualification under section 245C.14.

(b) For the purpose of this subdivision, "conviction" has the meaning given it in section 609.02, subdivision 5.

(c) The commissioner, in consultation with the commissioner of corrections, shall develop forms and information necessary to implement this subdivision and shall provide the forms and information to the commissioner of corrections for distribution to local probation officers and corrections agents.

(d) The commissioner shall inform individuals subject to a background study that criminal convictions for disqualifying crimes will be reported to the commissioner by the corrections system.

(e) A probation officer, corrections agent, or corrections agency is not civilly or criminally liable for disclosing or failing to disclose the information required by this subdivision.

(f) Upon receipt of disqualifying information, the commissioner shall provide the notice required under section 245C.17, as appropriate, to agencies on record as having initiated a background study or making a request for documentation of the background study status of the individual.

(g) This subdivision does not apply to family child care ~~and child foster care~~ programs.

Sec. 11. Minnesota Statutes 2006, section 245C.08, subdivision 1, is amended to read:

Subdivision 1. **Background studies conducted by commissioner of human services.** (a) For a background study conducted by the commissioner, the commissioner shall review:

(1) information related to names of substantiated perpetrators of maltreatment of vulnerable adults that has been received by the commissioner as required under section 626.557, subdivision 9c, paragraph (i);

(2) the commissioner's records relating to the maltreatment of minors in licensed programs, and from ~~county agency~~ findings of maltreatment of minors as indicated through the social service information system;

(3) information from juvenile courts as required in subdivision 4 for individuals listed in section 245C.03, subdivision 1, clauses (2), (5), and (6); ~~and~~

(4) information from the Bureau of Criminal Apprehension~~.~~;

(5) except as provided in clause (6), information from the national crime information system when the commissioner has reasonable cause as defined under section 245C.05, subdivision 5; and

(6) for a background study related to a child foster care application for licensure, the commissioner shall also review:

(i) information from the child abuse and neglect registry for any state in which the background study subject has resided in for the past five years; and

(ii) information from national crime information databases.

(b) Notwithstanding expungement by a court, the commissioner may consider information obtained under paragraph (a), clauses (3) and (4), unless the commissioner received notice of the petition for expungement and the court order for expungement is directed specifically to the commissioner.

Sec. 12. Minnesota Statutes 2006, section 245C.08, subdivision 2, is amended to read:

Subd. 2. **Background studies conducted by a county ~~or private~~ agency.** (a) For a background study conducted by a county ~~or private~~ agency for ~~child foster care,~~ adult foster care, family adult day services, and family child care homes, the commissioner shall review:

(1) information from the county agency's record of substantiated maltreatment of adults and the maltreatment of minors;

(2) information from juvenile courts as required in subdivision 4 for individuals listed in section 245C.03, subdivision 1, clauses (2), (5), and (6);

(3) information from the Bureau of Criminal Apprehension; and

(4) arrest and investigative records maintained by 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.

(b) If the individual has resided in the county for less than five years, the study shall include the records specified under paragraph (a) for the previous county or counties of residence for the past five years.

(c) Notwithstanding expungement by a court, the county ~~or private~~ agency may consider information obtained under paragraph (a), clauses (3) and (4), unless the commissioner received notice of the petition for expungement and the court order for expungement is directed specifically to the commissioner.

Sec. 13. Minnesota Statutes 2006, section 245C.10, is amended by adding a subdivision to read:

Subd. 4. **Temporary personnel agencies, educational programs, and professional services agencies.** The commissioner shall recover the cost of the background studies initiated by temporary personnel agencies, educational programs, and professional services agencies that initiate background studies under section 245C.03, subdivision 4, through a fee of no more than $20 per study charged to the agency. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 14. Minnesota Statutes 2006, section 245C.11, subdivision 1, is amended to read:

Subdivision 1. **Adult foster care; criminal conviction data.** For individuals who are required to have background studies under section 245C.03, subdivisions 1 and 2, and who have been continuously affiliated with ~~a~~ an adult foster care provider that is licensed in more than one county, criminal conviction data may be shared among those counties in which the adult foster care programs are licensed. A county agency's receipt of criminal conviction data from another county agency shall meet the criminal data background study requirements of this chapter.

Sec. 15. Minnesota Statutes 2006, section 245C.11, subdivision 2, is amended to read:

Subd. 2. **Jointly licensed programs.** A county agency may accept a background study completed by the commissioner under this chapter in place of the background study required under section 245A.16, subdivision 3, in programs with joint licensure as home and community-based services and adult foster care for people with developmental disabilities when the license holder does not reside in the adult foster care residence and

the subject of the study has been continuously affiliated with the license holder since the date of the commissioner's study.

Sec. 16. Minnesota Statutes 2006, section 245C.12, is amended to read:

245C.12 BACKGROUND STUDY; TRIBAL ORGANIZATIONS.

(a) For the purposes of background studies completed by tribal organizations performing licensing activities otherwise required of the commissioner under this chapter, after obtaining consent from the background study subject, tribal licensing agencies shall have access to criminal history data in the same manner as county licensing agencies and private licensing agencies under this chapter.

(b) Tribal organizations may contract with the commissioner to obtain background study data on individuals under tribal jurisdiction related to adoptions according to section 245C.34. Tribal organizations may also contract with the commissioner to obtain background study data on individuals under tribal jurisdiction related to child foster care according to section 245C.34.

Sec. 17. Minnesota Statutes 2006, section 245C.16, subdivision 1, is amended to read:

Subdivision 1. **Determining immediate risk of harm.** (a) If the commissioner determines that the individual studied has a disqualifying characteristic, the commissioner shall review the information immediately available and make a determination as to the subject's immediate risk of harm to persons served by the program where the individual studied will have direct contact.

(b) The commissioner shall consider all relevant information available, including the following factors in determining the immediate risk of harm:

(1) the recency of the disqualifying characteristic;

(2) the recency of discharge from probation for the crimes;

(3) the number of disqualifying characteristics;

(4) the intrusiveness or violence of the disqualifying characteristic;

(5) the vulnerability of the victim involved in the disqualifying characteristic;

(6) the similarity of the victim to the persons served by the program where the individual studied will have direct contact; and

(7) whether the individual has a disqualification from a previous background study that has not been set aside.

(c) This section does not apply when the subject of a background study is regulated by a health-related licensing board as defined in chapter 214, and the subject is determined to be responsible for substantiated maltreatment under section 626.556 or 626.557.

(d) This section does not apply to a background study related to an initial application for a child foster care license.

(e) If the commissioner has reason to believe, based on arrest information or an active maltreatment investigation, that an individual poses an imminent risk of harm to persons receiving services, the commissioner may order that the person be continuously supervised or immediately removed pending the conclusion of the maltreatment investigation or criminal proceedings.

Sec. 18. Minnesota Statutes 2006, section 245C.17, is amended by adding a subdivision to read:

Subd. 5. **Notice to county or private agency.** For studies on individuals related to a license to provide child foster care, the commissioner shall also provide a notice of the background study results to the county or private agency that initiated the background study.

Sec. 19. Minnesota Statutes 2006, section 245C.21, is amended by adding a subdivision to read:

Subd. 1a. **Submission of reconsideration request to county or private agency.** (a) For disqualifications related to studies conducted by county agencies, and for disqualifications related to studies conducted by the commissioner for child foster care, the individual shall submit the request for reconsideration to the county or private agency that initiated the background study.

(b) A reconsideration request shall be submitted within the time frames specified in subdivision 2.

(c) The county or private agency shall forward the individual's request for reconsideration and provide the commissioner with a recommendation whether to set aside the individual's disqualification.

Sec. 20. Minnesota Statutes 2006, section 245C.23, subdivision 2, is amended to read:

Subd. 2. **Commissioner's notice of disqualification that is not set aside.** (a) The commissioner shall notify the license holder of the disqualification and order the license holder to immediately remove the individual from any position allowing direct contact with persons receiving services from the license holder if:

(1) the individual studied does not submit a timely request for reconsideration under section 245C.21;

(2) the individual submits a timely request for reconsideration, but the commissioner does not set aside the disqualification for that license holder under section 245C.22;

(3) an individual who has a right to request a hearing under sections 245C.27 and 256.045, or 245C.28 and chapter 14 for a disqualification that has not been set aside, does not request a hearing within the specified time; or

(4) an individual submitted a timely request for a hearing under sections 245C.27 and 256.045, or 245C.28 and chapter 14, but the commissioner does not set aside the disqualification under section 245A.08, subdivision 5, or 256.045.

(b) If the commissioner does not set aside the disqualification under section 245C.22, and the license holder was previously ordered under section 245C.17 to immediately remove the disqualified individual from direct contact with persons receiving services or to ensure that the individual is under continuous, direct supervision when providing direct contact services, the order remains in effect pending the outcome of a hearing under sections 245C.27 and 256.045, or 245C.28 and chapter 14.

(c) For background studies related to child foster care, the commissioner shall also notify the county or private agency that initiated the study of the results of the reconsideration.

Sec. 21. Minnesota Statutes 2006, section 245C.24, subdivision 2, is amended to read:

Subd. 2. **Permanent bar to set aside a disqualification.** (a) Except as provided in paragraph (b), the commissioner may not set aside the disqualification of any individual disqualified pursuant to this chapter, in connection with a license to provide family child care for children, foster care for children in the provider's home, or foster care or day care services for adults in the provider's home regardless of how much time has passed, if the individual was disqualified for a crime or conduct listed in section 245C.15, subdivision 1.

(b) For an individual in the chemical dependency field who was disqualified for a crime or conduct listed under section 245C.15, subdivision 1, and whose disqualification was set aside prior to July 1, 2005, the commissioner must consider granting a variance pursuant to section 245C.30 for the license holder for a program dealing primarily with adults. A request for reconsideration evaluated under this paragraph must include a letter of recommendation from the license holder that was subject to the prior set-aside decision addressing the individual's quality of care to children or vulnerable adults and the circumstances of the individual's departure from that service.

Sec. 22. **[245C.33] ADOPTION BACKGROUND STUDY REQUIREMENTS.**

Subdivision 1. **Background studies conducted by commissioner.** Before placement of a child for purposes of adoption, the commissioner shall conduct a background study on individuals listed in section 259.41, subdivision 3, for county agencies and private agencies licensed to place children for adoption.

Subd. 2. **Information and data provided to county or private agency.** The subject of the background study shall provide the following information to the county or private agency:

(1) the information specified in section 245C.05;

(2) a set of classifiable fingerprints obtained from an authorized agency; and

(3) for studies initiated by a private agency, a signed consent for the release of information received from national crime information databases to the private agency.

Subd. 3. **Information and data provided to commissioner.** The county or private agency shall forward the data collected under subdivision 2 to the commissioner.

Subd. 4. **Information commissioner reviews.** (a) The commissioner shall review the following information regarding the background study subject:

(1) the information under section 245C.08, subdivisions 1, 3, and 4;

(2) information from the child abuse and neglect registry for any state in which the subject has resided for the past five years; and

(3) information from national crime information databases.

(b) The commissioner shall provide any information collected under this subdivision to the county or private agency that initiated the background study. The commissioner shall indicate if the information collected shows that the subject of the background study has a conviction listed in United States Code, title 42, section 671(a)(20)(A).

Sec. 23. **[245C.34] ADOPTION AND CHILD FOSTER CARE BACKGROUND STUDIES; TRIBAL ORGANIZATIONS.**

Subdivision 1. **Background studies may be conducted by commissioner.** (a) Tribal organizations may contract with the commissioner under section 245C.12 to obtain background study data on individuals under tribal jurisdiction related to adoptions.

(b) Tribal organizations may contract with the commissioner under section 245C.12 to obtain background study data on individuals under tribal jurisdiction related to child foster care.

(c) Background studies initiated by tribal organizations under paragraphs (a) and (b) must be conducted as provided in subdivisions 2 and 3.

Subd. 2. **Information and data provided to tribal organization.** The background study subject must provide the following information to the tribal organization:

(1) for background studies related to adoptions, the information under section 245C.05;

(2) for background studies related to child foster care, the information under section 245C.05;

(3) a set of classifiable fingerprints obtained from an authorized agency; and

(4) a signed consent for the release of information received from national crime information databases to the tribal organization.

Subd. 3. **Information and data provided to commissioner.** The tribal organization shall forward the data collected under subdivision 2 to the commissioner.

Subd. 4. **Information commissioner reviews.** (a) The commissioner shall review the following information regarding the background study subject:

(1) the information under section 245C.08, subdivisions 1, 3, and 4;

(2) information from the child abuse and neglect registry for any state in which the subject has resided for the past five years; and

(3) information from national crime information databases.

(b) The commissioner shall provide any information collected under this subdivision to the tribal organization that initiated the background study. The commissioner shall indicate if the information collected shows that the subject of the background study has a conviction listed in United States Code, title 42, section 671(a)(20)(A).

Sec. 24. Minnesota Statutes 2006, section 259.20, subdivision 2, is amended to read:

Subd. 2. **Other applicable law.** (a) Portions of chapters 245A, 245C, 257, 260, and 317A may also affect the adoption of a particular child.

(b) Provisions of the Indian Child Welfare Act, United States Code, title 25, chapter 21, sections 1901-1923, may also apply in the adoption of an Indian child, and may preempt specific provisions of this chapter.

(c) Consistent with section 245C.33 and Public Law 109-248, a completed background study is required before the approval of any foster or adoptive placement in a related or an unrelated home.

Sec. 25. Minnesota Statutes 2006, section 259.29, subdivision 1, is amended to read:

Subdivision 1. **Best interests of the child.** (a) The policy of the state of Minnesota is to ensure that the best interests of the child are met by requiring individualized determination of the needs of the child and of how the adoptive placement will serve the needs of the child.

(b) Among the factors the agency shall consider in determining the needs of the child are those specified under section 260C.193, subdivision 3, paragraph (b).

(c) Except for emergency placements provided for in section 245A.035, a completed background study is required under section 245C.33 before the approval of an adoptive placement in a home.

Sec. 26. Minnesota Statutes 2006, section 259.41, is amended to read:

259.41 ADOPTION STUDY.

Subdivision 1. **Study required before placement; certain relatives excepted.** (a) An approved adoption study; completed background study, as required under section 245C.33; and written report must be completed before the child is placed in a prospective adoptive home under this chapter, except as allowed by section 259.47, subdivision 6. In an agency placement, the report must be filed with the court at the time the adoption petition is filed. In a direct adoptive placement, the report must be filed with the court in support of a motion for temporary preadoptive custody under section 259.47, subdivision 3, or, if the study and report are complete, in support of an emergency order under section 259.47, subdivision 6. The study and report shall be completed by a licensed child-placing agency and must be thorough and comprehensive. The study and report shall be paid for by the prospective adoptive parent, except as otherwise required under section 259.67 or 259.73.

(b) A placement for adoption with an individual who is related to the child, as defined by section 245A.02, subdivision 13, is not subject to this section except as required by ~~section~~ sections 245C.33 and 259.53, subdivision 2, paragraph (c).

(c) In the case of a licensed foster parent seeking to adopt a child who is in the foster parent's care, any portions of the foster care licensing process that duplicate requirements of the home study may be submitted in satisfaction of the relevant requirements of this section.

Subd. 2. **Form of study.** (a) The adoption study must include at least one in-home visit with the prospective adoptive parent. At a minimum, the study must ~~include~~ document the following information about the prospective adoptive parent:

(1) a background ~~check~~ study as required by subdivision 3 and section 245C.33, ~~and~~ including:

(i) an ~~evaluation~~ assessment of the data and information provided by section 245C.33, subdivision 4, to determine if the prospective adoptive parent and any other person over the age of 13 living in the home has a felony conviction consistent with subdivision 3 and section 471(a)(2) of the Social Security Act; and

(ii) an assessment of the effect of ~~a~~ any conviction or finding of substantiated maltreatment on the ~~ability to~~ capacity of the prospective adoptive parent to safely care for and parent a child;

(2) a medical and social history and assessment of current health;

(3) an assessment of potential parenting skills;

(4) an assessment of ability to provide adequate financial support for a child; and

(5) an assessment of the level of knowledge and awareness of adoption issues including, where appropriate, matters relating to interracial, cross-cultural, and special needs adoptions.

(b) The adoption study is the basis for completion of a written report. The report must be in a format specified by the commissioner and must contain recommendations regarding the suitability of the subject of the study to be an adoptive parent.

Subd. 3. **Background ~~check; affidavit of history~~ study.** (a) At the time an adoption study is commenced, each prospective adoptive parent must:

(1) authorize access by the agency to any private data needed to complete the study;

(2) provide all addresses at which the prospective adoptive parent and anyone in the household over the age of 13 has resided in the previous five years; and

(3) disclose any names used previously other than the name used at the time of the study.

(b) When the requirements of paragraph (a) have been met, the agency shall immediately ~~begin~~ initiate a background ~~check,~~ study under section 245C.33 to be completed by the commissioner on each person over the age of 13 living in the home~~;~~ ~~consisting, at a minimum, of the following:~~. As required under section 245C.33 and Public Law 109-248, a completed background study is required before the approval of any foster or adoptive placement in a related or an unrelated home. The required background study must be completed as part of the home study.

~~(1) a check of criminal conviction data with the Bureau of Criminal Apprehension and local law enforcement authorities;~~

~~(2) a check for data on substantiated maltreatment of a child or vulnerable adult and domestic violence data with local law enforcement and social services agencies and district courts; and~~

~~(3) for those persons under the age of 25, a check of juvenile court records.~~

~~Notwithstanding the provisions of section 260B.171 or 260C.171, the Bureau of Criminal Apprehension, local law enforcement and social services agencies, district courts, and juvenile courts shall release the requested information to the agency completing the adoption study.~~

~~(c) When paragraph (b) requires checking the data or records of local law enforcement and social services agencies and district and juvenile courts, the agency shall check with the law enforcement and social services agencies and courts whose jurisdictions cover the addresses under paragraph (a), clause (2). In the event that the agency is unable to complete any of the record checks required by paragraph (b), the agency shall document the fact and the agency's efforts to obtain the information.~~

~~(d) For a study completed under this section, when the agency has reasonable cause to believe that further information may exist on the prospective adoptive parent or household member over the age of 13 that may relate to the health, safety, or welfare of the child, the prospective adoptive parent or household member over the age of 13 shall provide the agency with a set of classifiable fingerprints obtained from an authorized law enforcement agency and the agency may obtain criminal history data from the National Criminal Records Repository by submitting fingerprints to the Bureau of Criminal Apprehension. The agency has reasonable cause when, but not limited to, the:~~

~~(1) information from the Bureau of Criminal Apprehension indicates that the prospective adoptive parent or household member over the age of 13 is a multistate offender;~~

~~(2) information from the Bureau of Criminal Apprehension indicates that multistate offender status is undetermined;~~

~~(3) the agency has received a report from the prospective adoptive parent or household member over the age of 13 or a third party indicating that the prospective adoptive parent or household member over the age of 13 has a criminal history in a jurisdiction other than Minnesota; or~~

~~(4) the prospective adoptive parent or household member over the age of 13 is or has been a resident of a state other than Minnesota in the prior five years.~~

~~(e) At any time prior to completion of the background check required under paragraph (b), a prospective adoptive parent may submit to the agency conducting the study a sworn affidavit stating whether they or any person residing in the household have been convicted of a crime. The affidavit shall also state whether the adoptive parent or any other person residing in the household is the subject of an open investigation of, or have been the subject of a substantiated allegation of, child or vulnerable-adult maltreatment within the past ten years. A complete description of the crime, open investigation, or substantiated abuse, and a complete description of any sentence, treatment, or disposition must be included. The affidavit must contain an acknowledgment that if, at any time before the adoption is final, a court receives evidence leading to a conclusion that a prospective adoptive parent knowingly gave false information in the affidavit, it shall be~~

~~determined that the adoption of the child by the prospective adoptive parent is not in the best interests of the child.~~

~~(f) For the purposes of subdivision 1 and section 259.47, subdivisions 3 and 6, an adoption study is complete for placement, even though the background checks required by paragraph (b) have not been completed, if each prospective adoptive parent has completed the affidavit allowed by paragraph (e) and the other requirements of this section have been met. The background checks required by paragraph (b) must be completed before an adoption petition is filed. If an adoption study has been submitted to the court under section 259.47, subdivision 3 or 6, before the background checks required by paragraph (b) were complete, an updated adoption study report which includes the results of the background check must be filed with the adoption petition. In the event that an agency is unable to complete any of the records checks required by paragraph (b), the agency shall submit with the petition to adopt an affidavit documenting the agency's efforts to complete the checks.~~

(c) A home study under paragraph (b) used to consider placement of any child on whose behalf Title IV-E adoption assistance payments are to be made must not be approved if a background study reveals a felony conviction at any time for:

(1) child abuse or neglect;

(2) spousal abuse;

(3) a crime against children, including child pornography; or

(4) a crime involving violence, including rape, sexual assault, or homicide, but not including other physical assault or battery.

(d) A home study under paragraph (b) used to consider placement of any child on whose behalf Title IV-E adoption assistance payments are to be made must not be approved if a background study reveals a felony conviction within the past five years for:

(1) physical assault or battery; or

(2) a drug-related offense.

Subd. 4. **Updates to adoption study; period of validity.** An agency may update an adoption study and report as needed, regardless of when the original study and report or most recent update was completed. An update must be in a format specified by the commissioner and must verify the continuing accuracy of the elements of the original report and document any changes to elements of the original report. An update to a study and report not originally completed under this section must ensure that the study and report, as updated, meet the requirements of this section. An adoption study is valid if the report has been completed or updated within the previous 12 months.

Sec. 27. Minnesota Statutes 2006, section 259.53, subdivision 2, is amended to read:

Subd. 2. **Adoption agencies; postplacement assessment and report.** (a) The agency to which the petition has been referred under subdivision 1 shall conduct a postplacement assessment and file a report with the court within 90 days of receipt of a copy of the adoption petition. The agency shall send a copy of the report to the commissioner at the time it files the report with the court. The assessment and report must evaluate the environment and antecedents of the child to be adopted, the home of the petitioners, whether placement with the petitioners meets the needs of the child as described in section 259.57, subdivision 2. The report must include a recommendation to the court as to whether the petition should or should not be granted.

In making evaluations and recommendations, the postplacement assessment and report must, at a minimum, address the following:

(1) the level of adaptation by the prospective adoptive parents to parenting the child;

(2) the health and well-being of the child in the prospective adoptive parents' home;

(3) the level of incorporation by the child into the prospective adoptive parents' home, extended family, and community; and

(4) the level of inclusion of the child's previous history into the prospective adoptive home, such as cultural or ethnic practices, or contact with former foster parents or biological relatives.

(b) A postplacement adoption report is valid for 12 months following its date of completion.

~~(c) If the petitioner is an individual who is related to the child, as defined by section 245A.02, subdivision 13, the agency, as part of its postplacement assessment and report under paragraph (a), shall conduct a background check meeting the requirements of section 259.41, subdivision 3, paragraph (b). The prospective adoptive parent shall cooperate in the completion of the background check by supplying the information and authorizations described in section 259.41, subdivision 3, paragraph (a).~~

~~(d)~~ (c) If the report recommends that the court not grant the petition to adopt the child, the provisions of this paragraph apply. Unless the assessment and report were completed by the local social services agency, the agency completing the report, at the time it files the report with the court under paragraph (a), must provide a copy of the report to the local social services agency in the county where the prospective adoptive parent lives. The agency or local social services agency may recommend that the court dismiss the petition. If the local social services agency determines that continued placement in the home endangers the child's physical or emotional health, the agency shall seek a court order to remove the child from the home.

~~(c)~~ (d) If, through no fault of the petitioner, the agency to whom the petition was referred under subdivision 1, paragraph (b), fails to complete the assessment and file the report within 90 days of the date it received a copy of the adoption petition, the court may hear the petition upon giving the agency and the local social services agency, if different, five days' notice by mail of the time and place of the hearing.

Sec. 28. Minnesota Statutes 2006, section 259.57, subdivision 2, is amended to read:

Subd. 2. **Protection of child's best interests.** (a) The policy of the state of Minnesota is to ensure that the best interests of children are met by requiring an individualized determination of the needs of the child and how the adoptive placement will serve the needs of the child.

(b) Among the factors the court shall consider in determining the needs of the child are those specified under section 260C.193, subdivision 3, paragraph (b). Consistent with section 245C.33 and Public Law 109-248, a complete background study is required before the approval of an adoptive placement in a home.

(c) In reviewing adoptive placement and in determining appropriate adoption, the court shall consider placement, consistent with the child's best interests and in the following order, with (1) a relative or relatives of the child, or (2) an important friend with whom the child has resided or had significant contact. Placement of a child cannot be delayed or denied based on race, color, or national origin of the adoptive parent or the child. Whenever possible, siblings should be placed together unless it is determined not to be in the best interests of a sibling.

(d) If the child's birth parent or parents explicitly request that relatives and important friends not be considered, the court shall honor that request consistent with the best interests of the child.

If the child's birth parent or parents express a preference for placing the child in an adoptive home of the same or a similar religious background to that of the birth parent or parents, the court shall place the child with a family that also meets the birth parent's religious preference. Only if no family is available as described in clause (a) or (b) may the court give preference to a family described in clause (c) that meets the parent's religious preference.

(e) This subdivision does not affect the Indian Child Welfare Act, United States Code, title 25, sections 1901 to 1923, and the Minnesota Indian Family Preservation Act, sections 260.751 to 260.835.

Sec. 29. Minnesota Statutes 2006, section 260C.209, is amended to read:

260C.209 BACKGROUND CHECKS.

Subdivision 1. **Subjects.** The responsible social services agency must ~~conduct~~ initiate a background ~~check~~ study to be completed by the commissioner under ~~this section of~~ chapter 245C on the following individuals:

(1) a noncustodial parent or nonadjudicated parent who is being assessed for purposes of providing day-to-day care of a child temporarily or permanently under section 260C.212, subdivision 4, and any member of the parent's household who is over the age of 13 when there is a reasonable cause to believe that the parent or household member over age 13 has a criminal history or a history of maltreatment of a child or vulnerable adult which would endanger the child's health, safety, or welfare;

(2) an individual whose suitability for relative placement under section 260C.212, subdivision 5, is being determined and any member of the relative's household who is over the age of 13 when:

(i) the relative must be licensed for foster care; or

(ii) the ~~agency must conduct a~~ background study is required under section 259.53, subdivision 2; or

(iii) the agency or the commissioner has reasonable cause to believe the relative or household member over the age of 13 has a criminal history which would not make transfer of permanent legal and physical custody to the relative under section 260C.201, subdivision 11, in the child's best interest; and

(3) a parent, following an out-of-home placement, when the responsible social services agency has reasonable cause to believe that the parent has been convicted of a crime directly related to the parent's capacity to maintain the child's health, safety, or welfare or the parent is the subject of an open investigation of, or has been the subject of a substantiated allegation of, child or vulnerable-adult maltreatment within the past ten years.

"Reasonable cause" means that the agency has received information or a report from the subject or a third person that creates an articulable suspicion that the individual has a history that may pose a risk to the health, safety, or welfare of the child. The information or report must be specific to the potential subject of the background check and shall not be based on the race, religion, ethnic background, age, class, or lifestyle of the potential subject.

Subd. 2. **General procedures.** (a) When ~~conducting~~ initiating a background check under subdivision 1, the agency ~~may~~ shall require the individual being assessed to provide sufficient information to ensure an accurate assessment under this section, including:

(1) the individual's first, middle, and last name and all other names by which the individual has been known;

(2) home address, zip code, city, county, and state of residence for the past ~~ten~~ five years;

(3) sex;

(4) date of birth; and

(5) driver's license number or state identification number.

(b) When notified by the commissioner or the responsible social services agency that it is conducting an assessment under this section, the Bureau of Criminal Apprehension, commissioners of health and human services, law enforcement, and county agencies must provide the commissioner or the responsible social services agency or county attorney with the following information on the individual being assessed: criminal history data, reports about the maltreatment of adults substantiated under section 626.557, and reports of maltreatment of minors substantiated under section 626.556.

Subd. 3. **Multistate information.** ~~(a)~~ For ~~any assessment~~ every background study completed under this section, ~~if the responsible social services agency has reasonable cause to believe that the individual is a multistate offender, the individual must~~ the subject of the background study shall provide the responsible social services agency ~~or the county attorney~~ with a set of classifiable fingerprints obtained from an authorized ~~law enforcement~~ agency. The responsible social services agency ~~or county attorney may~~ shall provide the fingerprints to the commissioner, and the commissioner shall obtain criminal history data from the National Criminal Records Repository by submitting the fingerprints to the Bureau of Criminal Apprehension.

~~(b) For purposes of this subdivision, the responsible social services agency has reasonable cause when, but not limited to:~~

~~(1) information from the Bureau of Criminal Apprehension indicates that the individual is a multistate offender;~~

~~(2) information from the Bureau of Criminal Apprehension indicates that multistate offender status is undetermined;~~

~~(3) the social services agency has received a report from the individual or a third party indicating that the individual has a criminal history in a jurisdiction other than Minnesota; or~~

~~(4) the individual is or has been a resident of a state other than Minnesota at any time during the prior ten years.~~

Subd. 4. **Notice upon receipt.** The ~~responsible social services agency~~ commissioner must provide the subject of the background study with the results of the study as required

under ~~this section within 15 business days of receipt or at least 15 days prior to the hearing at which the results will be presented, whichever comes first. The subject may provide written information to the agency that the results are incorrect and may provide additional or clarifying information to the agency and to the court through a party to the proceeding. This provision does not apply to any background study conducted under chapters 245A and~~ chapter 245C.

Sec. 30. Minnesota Statutes 2006, section 260C.212, subdivision 2, is amended to read:

Subd. 2. **Placement decisions based on best interest of the child.** (a) The policy of the state of Minnesota is to ensure that the child's best interests are met by requiring an individualized determination of the needs of the child and of how the selected placement will serve the needs of the child being placed. The authorized child-placing agency shall place a child, released by court order or by voluntary release by the parent or parents, in a family foster home selected by considering placement with relatives and important friends in the following order:

(1) with an individual who is related to the child by blood, marriage, or adoption; or

(2) with an individual who is an important friend with whom the child has resided or had significant contact.

(b) Among the factors the agency shall consider in determining the needs of the child are the following:

(1) the child's current functioning and behaviors;

(2) the medical, educational, and developmental needs of the child;

(3) the child's history and past experience;

(4) the child's religious and cultural needs;

(5) the child's connection with a community, school, and church;

(6) the child's interests and talents;

(7) the child's relationship to current caretakers, parents, siblings, and relatives; and

(8) the reasonable preference of the child, if the court, or the child-placing agency in the case of a voluntary placement, deems the child to be of sufficient age to express preferences.

(c) Placement of a child cannot be delayed or denied based on race, color, or national origin of the foster parent or the child.

(d) Siblings should be placed together for foster care and adoption at the earliest possible time unless it is determined not to be in the best interests of a sibling or unless it is not possible after appropriate efforts by the responsible social services agency.

(e) Except for emergency placement as provided for in section 245A.035, a completed background study is required under section 245C.08 before the approval of a foster placement in a related or unrelated home.

ARTICLE 3
HEALTH CARE

Section 1. Minnesota Statutes 2006, section 16A.724, subdivision 2, is amended to read:

Subd. 2. **Transfers.** (a) Notwithstanding section 295.581, to the extent available resources in the health care access fund exceed expenditures in that fund, ~~effective with the biennium beginning July 1, 2007,~~ the commissioner shall transfer funds from the health care access fund to the general fund to offset the costs of MinnesotaCare enrollees shifting to medical assistance due to the implementation of an automated eligibility determination system. The medical assistance costs shall be identified and updated in the November and February forecasts.

(b) In addition to the amounts in paragraph (a), the commissioner of finance shall transfer the 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 fiscal biennium shall not exceed $96,000,000. For the biennium ending June 30, 2011, the transfer shall not exceed $48,000,000.

~~(b)~~ (c) For fiscal years 2006 to 2009, MinnesotaCare shall be a forecasted program, and, if necessary, the commissioner shall reduce these transfers from the health care access fund to the general fund to meet annual MinnesotaCare expenditures or, if necessary, transfer sufficient funds from the general fund to the health care access fund to meet annual MinnesotaCare expenditures.

Sec. 2. Minnesota Statutes 2006, section 62H.02, is amended to read:

62H.02 REQUIRED PROVISIONS.

(a) A joint self-insurance plan must include aggregate excess stop-loss coverage and individual excess stop-loss coverage provided by an insurance company licensed by the state of Minnesota.

(b) Aggregate excess stop-loss coverage must include provisions to cover incurred, unpaid claim liability in the event of plan termination. ~~In addition,~~

(c) The plan of self-insurance must have participating employers fund an amount at least equal to the point at which the excess or stop-loss insurer has contracted to assume 100 percent of additional liability.

(d) A joint self-insurance plan must submit its proposed excess or stop-loss insurance contract to the commissioner of commerce at least 30 days prior to the proposed plan's effective date and at least 30 days subsequent to any renewal date. The commissioner shall review the contract to determine if they meet the standards established by sections 62H.01 to 62H.08 and respond within a 30-day period.

(e) Any excess or stop-loss insurance plan must contain a provision that the excess or stop-loss insurer will give the plan and the commissioner of commerce a minimum of 180 days' notice of termination or nonrenewal. If the plan fails to secure replacement coverage within 60 days after receipt of the notice of cancellation or nonrenewal, the commissioner shall issue an order providing for the orderly termination of the plan.

(f) The commissioner may waive the requirements of this section and of any rule relating to the requirements of this section, if the commissioner determines that a joint self-insurance plan has established alternative arrangements that fully fund the plan's liability or incurred but unpaid claims. The commissioner may not waive the requirement that a joint self-insurance plan have excess stop-loss coverage.

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

Sec. 3. Minnesota Statutes 2006, section 62J.692, subdivision 1, is amended to read:

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

(a) "Accredited clinical training" means the clinical training provided by a medical education program that is accredited through an organization recognized by the Department of Education, the Centers for Medicare and Medicaid Services, or another national body who reviews the accrediting organizations for multiple disciplines and whose standards for recognizing accrediting organizations are reviewed and approved by the commissioner of health in consultation with the Medical Education and Research Advisory Committee.

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

(c) "Clinical medical education program" means the accredited clinical training of physicians (medical students and residents), doctor of pharmacy practitioners, doctors of chiropractic, dentists, advanced practice nurses (clinical nurse specialists, certified registered nurse anesthetists, nurse practitioners, and certified nurse midwives), and physician assistants.

(d) "Sponsoring institution" means a hospital, school, or consortium located in Minnesota that sponsors and maintains primary organizational and financial responsibility

for a clinical medical education program in Minnesota and which is accountable to the accrediting body.

(e) "Teaching institution" means a hospital, medical center, clinic, or other organization that conducts a clinical medical education program in Minnesota.

(f) "Trainee" means a student or resident involved in a clinical medical education program.

(g) "Eligible trainee FTEs" means the number of trainees, as measured by full-time equivalent counts, that are at training sites located in Minnesota with ~~a~~ currently active medical assistance ~~provider number~~ enrollment status and a National Provider Identification (NPI) number where training occurs in either an inpatient or ambulatory patient care setting and where the training is funded, in part, by patient care revenues.

Sec. 4. Minnesota Statutes 2006, section 62J.692, subdivision 4, is amended to read:

Subd. 4. **Distribution of funds.** (a) The commissioner shall annually distribute 90 percent of ~~available medical education~~ funds transferred according to section 256B.69, subdivision 5c, paragraph (a), clause (1), to all qualifying applicants based on a distribution formula that reflects a summation of two factors:

(1) an education factor, which is determined by the total number of eligible trainee FTEs and the total statewide average costs per trainee, by type of trainee, in each clinical medical education program; and

(2) a public program volume factor, which is determined by the total volume of public program revenue received by each training site as a percentage of all public program revenue received by all training sites in the fund pool.

In this formula, the education factor is weighted at 67 percent and the public program volume factor is weighted at 33 percent.

Public program revenue for the distribution formula includes revenue from medical assistance, prepaid medical assistance, general assistance medical care, and prepaid general assistance medical care. Training sites that receive no public program revenue are ineligible for funds available under this paragraph. Total statewide average costs per trainee for medical residents is based on audited clinical training costs per trainee in primary care clinical medical education programs for medical residents. Total statewide average costs per trainee for dental residents is based on audited clinical training costs per trainee in clinical medical education programs for dental students. Total statewide average costs per trainee for pharmacy residents is based on audited clinical training costs per trainee in clinical medical education programs for pharmacy students.

(b) The commissioner shall annually distribute ten percent of ~~total available medical education~~ funds transferred according to section 256B.69, subdivision 5c, paragraph (a), clause (1), to all qualifying applicants based on the percentage received by each applicant under paragraph (a). These funds are to be used to offset clinical education costs at eligible clinical training sites based on criteria developed by the clinical medical education program. Applicants may choose to distribute funds allocated under this paragraph based on the distribution formula described in paragraph (a).

(c) The commissioner shall annually distribute $5,000,000 of the funds dedicated to the commissioner under section 297F.10, subdivision 1, clause (2), plus any federal financial participation on these funds and on funds transferred under subdivision 10, to all qualifying applicants based on a distribution formula that gives 100 percent weight to a public program volume factor, which is determined by the total volume of public program revenue received by each training site as a percentage of all public program revenue received by all training sites in the fund pool. If federal approval is not obtained for federal financial participation on any portion of funds distributed under this paragraph, 90 percent of the unmatched funds shall be distributed by the commissioner based on the formula described in paragraph (a) and ten percent of the unmatched funds shall be distributed by the commissioner based on the formula described in paragraph (b).

(d) The commissioner shall annually distribute $3,060,000 of funds dedicated to the commissioner under section 297F.10, subdivision 1, clause (2), through a formula giving 100 percent weight to an education factor, which is determined by the total number of eligible trainee full-time equivalents and the total statewide average costs per trainee, by type of trainee, in each clinical medical education program. If no matching funds are received on funds distributed under paragraph (c), funds distributed under this paragraph shall be distributed by the commissioner based on the formula described in paragraph (a).

(e) The commissioner shall annually distribute $340,000 of funds dedicated to the commissioner under section 297F.10, subdivision 1, clause (2), to all qualifying applicants based on the percentage received by each applicant under paragraph (a). These funds are to be used to offset clinical education costs at eligible clinical training sites based on criteria developed by the clinical medical education program. Applicants may choose to distribute funds allocated under this paragraph based on the distribution formula described in paragraph (a). If no matching funds are received on funds distributed under paragraph (c), funds distributed under this paragraph shall be distributed by the commissioner based on the formula described in paragraph (b).

~~(c)~~ (f) Funds distributed shall not be used to displace current funding appropriations from federal or state sources.

~~(d)~~ (g) Funds shall be distributed to the sponsoring institutions indicating the amount to be distributed to each of the sponsor's clinical medical education programs based on the criteria in this subdivision and in accordance with the commissioner's approval letter. Each clinical medical education program must distribute funds allocated under paragraph (a) to the training sites as specified in the commissioner's approval letter. Sponsoring institutions, which are accredited through an organization recognized by the Department of Education or the Centers for Medicare and Medicaid Services, may contract directly with training sites to provide clinical training. To ensure the quality of clinical training, those accredited sponsoring institutions must:

(1) develop contracts specifying the terms, expectations, and outcomes of the clinical training conducted at sites; and

(2) take necessary action if the contract requirements are not met. Action may include the withholding of payments under this section or the removal of students from the site.

~~(e)~~ (h) Any funds not distributed in accordance with the commissioner's approval letter must be returned to the medical education and research fund within 30 days of receiving notice from the commissioner. The commissioner shall distribute returned funds to the appropriate training sites in accordance with the commissioner's approval letter.

~~(f)~~ (i) The commissioner shall distribute by June 30 of each year an amount equal to the funds transferred under subdivision 10~~, plus five percent interest~~ to the University of Minnesota Board of Regents for the instructional costs of health professional programs at the Academic Health Center and for interdisciplinary academic initiatives within the Academic Health Center.

~~(g)~~ (j) A maximum of $150,000 of the funds dedicated to the commissioner under section 297F.10, subdivision 1, ~~paragraph (b),~~ clause (2), may be used by the commissioner for administrative expenses associated with implementing this section.

Sec. 5. Minnesota Statutes 2006, section 62J.692, subdivision 7a, is amended to read:

Subd. 7a. **Clinical medical education innovations grants.** (a) The commissioner shall award grants to teaching institutions and clinical training sites for projects that increase dental access for underserved populations and promote innovative clinical training of dental professionals.

(b) The commissioner shall award grants to teaching institutions and clinical training sites for projects that increase mental health access for underserved populations, promote innovative clinical training of mental health professionals, increase the number of mental

health providers in rural or underserved areas, and promote the incorporation of patient safety principles into clinical medical education programs.

(c) In awarding the grants, the commissioner, in consultation with the commissioner of human services, shall consider the following:

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

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

(3) evidence of collaboration between the applicant and local communities;

(4) the efficiency in the use of the funding; ~~and~~

(5) the priority level of the project in relation to state clinical education, access, patient safety, and workforce goals~~.~~; and

(6) the potential of the project to impact the number or distribution of the health care workforce.

~~(b)~~ (d) The commissioner shall periodically evaluate the priorities in awarding the innovations grants in order to ensure that the priorities meet the changing workforce needs of the state.

Sec. 6. Minnesota Statutes 2006, section 62J.692, subdivision 8, is amended to read:

Subd. 8. **Federal financial participation.** (a) The commissioner of human services shall seek to maximize federal financial participation in payments for medical education and research costs. ~~If the commissioner of human services determines that federal financial participation is available for the medical education and research, the commissioner of health shall transfer to the commissioner of human services the amount of state funds necessary to maximize the federal funds available. The amount transferred to the commissioner of human services, plus the amount of federal financial participation, shall be distributed to medical assistance providers in accordance with the distribution methodology described in subdivision 4.~~

(b) For the purposes of paragraph (a), the commissioner shall use physician clinic rates where possible to maximize federal financial participation.

Sec. 7. Minnesota Statutes 2006, section 62J.692, subdivision 10, is amended to read:

Subd. 10. **Transfers from University of Minnesota.** Of the funds dedicated to the Academic Health Center under section 297F.10, subdivision 1, clause (1), $4,850,000 shall be transferred annually to the commissioner of health no later than April 15 of each year for distribution under subdivision 4, paragraph ~~(f)~~ (i).

Sec. 8. Minnesota Statutes 2006, section 256.01, subdivision 2b, is amended to read:

Subd. 2b. **Performance payments.** (a) The commissioner shall develop and implement a pay-for-performance system to provide performance payments to medical groups that demonstrate optimum care in serving individuals with chronic diseases who are enrolled in health care programs administered by the commissioner under chapters 256B, 256D, and 256L. The commissioner may receive any federal matching money that is made available through the medical assistance program for managed care oversight contracted through vendors including consumer surveys, studies, and external quality reviews as required by the Federal Balanced Budget Act of 1997, Title 42, Code of Federal Regulations, Part 438, Subpart E. Any federal money received for managed care oversight is appropriated to the commissioner for this purpose. The commissioner may expend the federal money received in either year of the biennium.

(b) The commissioner shall also develop and implement a patient incentive health program to provide incentives and rewards to patients who are enrolled in health care programs administered by the commissioner under chapters 256B, 256D, and 256L, and who have agreed to and met personal health goals established with their primary care provider to manage a chronic disease or condition, including, but not limited to, diabetes, high blood pressure, and coronary artery disease.

Sec. 9. Minnesota Statutes 2006, section 256.969, subdivision 3a, is amended to read:

Subd. 3a. **Payments.** (a) Acute care hospital billings under the medical assistance program must not be submitted until the recipient is discharged. However, the commissioner shall establish monthly interim payments for inpatient hospitals that have individual patient lengths of stay over 30 days regardless of diagnostic category. Except as provided in section 256.9693, medical assistance reimbursement for treatment of mental illness shall be reimbursed based on diagnostic classifications. Individual hospital payments established under this section and sections 256.9685, 256.9686, and 256.9695, in addition to third party and recipient liability, for discharges occurring during the rate year shall not exceed, in aggregate, the charges for the medical assistance covered inpatient services paid for the same period of time to the hospital. This payment limitation shall be calculated separately for medical assistance and general assistance medical care services. The limitation on general assistance medical care shall be effective for admissions occurring on or after July 1, 1991. Services that have rates established under subdivision 11 or 12, must be limited separately from other services. After consulting with the affected hospitals, the commissioner may consider related hospitals one entity and may merge the payment rates while maintaining separate provider numbers. The operating

and property base rates per admission or per day shall be derived from the best Medicare and claims data available when rates are established. The commissioner shall determine the best Medicare and claims data, taking into consideration variables of recency of the data, audit disposition, settlement status, and the ability to set rates in a timely manner. The commissioner shall notify hospitals of payment rates by December 1 of the year preceding the rate year. The rate setting data must reflect the admissions data used to establish relative values. Base year changes from 1981 to the base year established for the rate year beginning January 1, 1991, and for subsequent rate years, shall not be limited to the limits ending June 30, 1987, on the maximum rate of increase under subdivision 1. The commissioner may adjust base year cost, relative value, and case mix index data to exclude the costs of services that have been discontinued by the October 1 of the year preceding the rate year or that are paid separately from inpatient services. Inpatient stays that encompass portions of two or more rate years shall have payments established based on payment rates in effect at the time of admission unless the date of admission preceded the rate year in effect by six months or more. In this case, operating payment rates for services rendered during the rate year in effect and established based on the date of admission shall be adjusted to the rate year in effect by the hospital cost index.

(b) For fee-for-service admissions occurring on or after July 1, 2002, the total payment, before third-party liability and spenddown, made to hospitals for inpatient services is reduced by .5 percent from the current statutory rates.

(c) In addition to the reduction in paragraph (b), the total payment for fee-for-service admissions occurring on or after July 1, 2003, made to hospitals for inpatient services before third-party liability and spenddown, is reduced five percent from the current statutory rates. Mental health services within diagnosis related groups 424 to 432, ~~and~~ facilities defined under subdivision 16, and, effective for admissions occurring on or after July 1, 2007, a long-term hospital as designated by the Medicare program that is located in a city of the first class as defined in section 410.01, are excluded from this paragraph.

(d) In addition to the reduction in paragraphs (b) and (c), the total payment for fee-for-service admissions occurring on or after July 1, 2005, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 6.0 percent from the current statutory rates. Mental health services within diagnosis related groups 424 to 432 ~~and~~, facilities defined under subdivision 16, and, effective for admissions occurring on or after July 1, 2007, a long-term hospital as designated by the Medicare program that is located in a city of the first class as defined in section 410.01, are excluded from this paragraph. Notwithstanding section 256.9686, subdivision 7, for purposes of this paragraph, medical assistance does not include general assistance medical care. Payments

made to managed care plans shall be reduced for services provided on or after January 1, 2006, to reflect this reduction.

Sec. 10. Minnesota Statutes 2006, section 256.969, subdivision 9, is amended to read:

Subd. 9. **Disproportionate numbers of low-income patients served.** (a) For admissions occurring on or after October 1, 1992, through December 31, 1992, the medical assistance disproportionate population adjustment shall comply with federal law and shall be paid to a hospital, excluding regional treatment centers and facilities of the federal Indian Health Service, with a medical assistance inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined as follows:

(1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service but less than or equal to one standard deviation above the mean, the adjustment must be determined by multiplying the total of the operating and property payment rates by the difference between the hospital's actual medical assistance inpatient utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service; and

(2) for a hospital with a medical assistance inpatient utilization rate above one standard deviation above the mean, the adjustment must be determined by multiplying the adjustment that would be determined under clause (1) for that hospital by 1.1. If federal matching funds are not available for all adjustments under this subdivision, the commissioner shall reduce payments on a pro rata basis so that all adjustments qualify for federal match. The commissioner may establish a separate disproportionate population operating payment rate adjustment under the general assistance medical care program. For purposes of this subdivision medical assistance does not include general assistance medical care. The commissioner shall report annually on the number of hospitals likely to receive the adjustment authorized by this paragraph. The commissioner shall specifically report on the adjustments received by public hospitals and public hospital corporations located in cities of the first class.

(b) For admissions occurring on or after July 1, 1993, the medical assistance disproportionate population adjustment shall comply with federal law and shall be paid to a hospital, excluding regional treatment centers and facilities of the federal Indian Health Service, with a medical assistance inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined as follows:

(1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the

federal Indian Health Service but less than or equal to one standard deviation above the mean, the adjustment must be determined by multiplying the total of the operating and property payment rates by the difference between the hospital's actual medical assistance inpatient utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service;

(2) for a hospital with a medical assistance inpatient utilization rate above one standard deviation above the mean, the adjustment must be determined by multiplying the adjustment that would be determined under clause (1) for that hospital by 1.1. The commissioner may establish a separate disproportionate population operating payment rate adjustment under the general assistance medical care program. For purposes of this subdivision, medical assistance does not include general assistance medical care. The commissioner shall report annually on the number of hospitals likely to receive the adjustment authorized by this paragraph. The commissioner shall specifically report on the adjustments received by public hospitals and public hospital corporations located in cities of the first class;

(3) for a hospital that had medical assistance fee-for-service payment volume during calendar year 1991 in excess of 13 percent of total medical assistance fee-for-service payment volume, a medical assistance disproportionate population adjustment shall be paid in addition to any other disproportionate payment due under this subdivision as follows: $1,515,000 due on the 15th of each month after noon, beginning July 15, 1995. For a hospital that had medical assistance fee-for-service payment volume during calendar year 1991 in excess of eight percent of total medical assistance fee-for-service payment volume and was the primary hospital affiliated with the University of Minnesota, a medical assistance disproportionate population adjustment shall be paid in addition to any other disproportionate payment due under this subdivision as follows: $505,000 due on the 15th of each month after noon, beginning July 15, 1995; and

(4) effective August 1, 2005, the payments in paragraph (b), clause (3), shall be reduced to zero.

(c) The commissioner shall adjust rates paid to a health maintenance organization under contract with the commissioner to reflect rate increases provided in paragraph (b), clauses (1) and (2), on a nondiscounted hospital-specific basis but shall not adjust those rates to reflect payments provided in clause (3).

(d) If federal matching funds are not available for all adjustments under paragraph (b), the commissioner shall reduce payments under paragraph (b), clauses (1) and (2), on a pro rata basis so that all adjustments under paragraph (b) qualify for federal match.

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

(f) For hospital services occurring on or after July 1, 2005, ~~to June 30, 2007,~~ general assistance medical care expenditures for fee-for-service inpatient and outpatient hospital services made by the department and ~~by prepaid health plans participating in general assistance medical care~~ effective July 1, 2007, payments under section 256B.199 shall be considered Medicaid disproportionate share hospital payments, except as limited ~~below:~~ by clauses (1) to (5);

(1) only the portion of Minnesota's disproportionate share hospital allotment under section 1923(f) of the Social Security Act that is not spent on the disproportionate population adjustments in paragraph (b), clauses (1) and (2), may be used ~~for general assistance medical care expenditures~~;

(2) only those ~~general assistance medical care~~ expenditures made to hospitals that qualify for disproportionate share payments under section 1923 of the Social Security Act and the Medicaid state plan may be considered disproportionate share hospital payments;

(3) only those ~~general assistance medical care~~ expenditures made to an individual hospital that would not cause the hospital to exceed its individual hospital limits under section 1923 of the Social Security Act may be considered; ~~and~~

(4) ~~general assistance medical care~~ expenditures may be considered only to the extent of Minnesota's aggregate allotment under section 1923 of the Social Security Act.

All hospitals and prepaid health plans participating in general assistance medical care must provide any necessary expenditure, cost, and revenue information required by the commissioner as necessary for purposes of obtaining federal Medicaid matching funds for ~~general assistance medical care expenditures.~~ Medicaid disproportionate share payments; and

(5) expenditures under general assistance medical care shall be used to the fullest extent before payments under section 256B.199.

(g) Upon federal approval of the related state plan amendment, paragraph (f) is effective retroactively from July 1, 2005, or the earliest effective date approved by the Centers for Medicare and Medicaid Services.

Sec. 11. Minnesota Statutes 2006, section 256.969, is amended by adding a subdivision to read:

Subd. 28. **Long-term hospital payment adjustment.** For admissions occurring on or after July 1, 2009, the commissioner shall increase the medical assistance payments to a long-term hospital with a medical assistance inpatient utilization rate of 17.95

percent of total patient days as of the base year in effect on July 1, 2005, by an amount equal to 13 percent of the total of the operating and property payment rates. Payments made to managed care plans shall not reflect this payment increase. For purposes of this subdivision, medical assistance does not include general assistance medical care. Payments to a hospital under this subdivision shall be reduced by the amount of any payments made under subdivision 27.

Sec. 12. Minnesota Statutes 2006, section 256B.0625, subdivision 3f, is amended to read:

Subd. 3f. **Circumcision ~~for newborns~~.** ~~Newborn~~ Circumcision is not covered, unless the procedure is medically necessary ~~or required because of a well-established religious practice~~.

Sec. 13. Minnesota Statutes 2006, section 256B.0625, is amended by adding a subdivision to read:

Subd. 8d. **Chiropractic services.** Medical assistance covers the following medically necessary chiropractic services: initial and progress exams, manual manipulation of the spine and extremities, and x-rays.

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

Sec. 14. Minnesota Statutes 2006, section 256B.0625, subdivision 13d, is amended to read:

Subd. 13d. **Drug formulary.** (a) The commissioner shall establish a drug formulary. Its establishment and publication shall not be subject to the requirements of the Administrative Procedure Act, but the Formulary Committee shall review and comment on the formulary contents.

(b) The formulary shall not include:

(1) drugs or products for which there is no federal funding;

(2) over-the-counter drugs, except as provided in subdivision 13;

(3) drugs used for weight loss, except that medically necessary lipase inhibitors may be covered for a recipient with type II diabetes;

(4) drugs when used for the treatment of impotence or erectile dysfunction;

(5) drugs for which medical value has not been established; and

(6) drugs from manufacturers who have not signed a rebate agreement with the Department of Health and Human Services pursuant to section 1927 of title XIX of the Social Security Act.

(c) If a single-source drug used by at least two percent of the fee-for-service medical assistance recipients is removed from the formulary due to the failure of the manufacturer to sign a rebate agreement with the Department of Health and Human Services, the commissioner shall notify prescribing practitioners within 30 days of receiving notification from the Centers for Medicare and Medicaid Services (CMS) that a rebate agreement was not signed.

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

Sec. 15. Minnesota Statutes 2006, section 256B.0625, subdivision 13e, is amended to read:

Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall be the lower of the actual acquisition costs of the drugs plus a fixed dispensing fee; the maximum allowable cost set by the federal government or by the commissioner plus the fixed dispensing fee; or the usual and customary price charged to the public. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The pharmacy dispensing fee shall be $3.65 for single-source drugs and $12.92 for multiple-source generic drugs subject to any adjustment by the commissioner as provided under section 34, except that the dispensing fee for intravenous solutions which must be compounded by the pharmacist shall be $8 per bag, $14 per bag for cancer chemotherapy products, and $30 per bag for total parenteral nutritional products dispensed in one liter quantities, or $44 per bag for total parenteral nutritional products dispensed in quantities greater than one liter. An inflation adjustment shall be made annually to the dispensing fee for multiple-source generic prescriptions based on the Consumer Price Index-all items for urban consumers. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. The actual acquisition cost of a drug shall be estimated by the commissioner, at average wholesale price minus 12 percent. The actual acquisition cost of antihemophilic factor drugs shall be estimated at the average wholesale price minus 30 percent. The maximum allowable cost of a multisource generic drug may be set by the commissioner and it shall be comparable to, but no ~~higher than, the maximum amount paid by other third-party payors in this state who have maximum allowable cost programs~~ lower than the price of the drug available to retail pharmacies for purchase from prescription drug wholesalers. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

(b) The commissioner may, within the limits of available appropriation, increase dispensing fees to pharmacists and pharmacies deemed by the commissioner to be critical access pharmacy providers. Reimbursement to a critical access pharmacy provider may be increased by not more than 50 percent above the dispensing fee that would otherwise be paid to the provider. In determining which pharmacists and pharmacies shall be deemed critical access pharmacy providers, the commissioner shall review:

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

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

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

~~(b)~~ (c) An additional dispensing fee of $.30 may be added to the dispensing fee paid to pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities when a unit dose blister card system, approved by the department, is used. Under this type of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National Drug Code (NDC) from the drug container used to fill the blister card must be identified on the claim to the department. The unit dose blister card containing the drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider will be required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse. Over-the-counter medications must be dispensed in the manufacturer's unopened package. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply.

~~(c)~~ (d) Whenever a generically equivalent product is available, payment shall be on the basis of the ~~actual acquisition cost of~~ federal upper limit set for the generic drug, or on the maximum allowable cost established by the commissioner.

~~(d)~~ (e) The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the provider or the amount established for Medicare by the United States Department of Health and Human Services pursuant to title XVIII, section 1847a of the federal Social Security Act.

~~(e)~~ (f) The commissioner may negotiate lower reimbursement rates for specialty pharmacy products than the rates specified in paragraph (a). The commissioner may

require individuals enrolled in the health care programs administered by the department to obtain specialty pharmacy products from providers with whom the commissioner has negotiated lower reimbursement rates. Specialty pharmacy products are defined as those used by a small number of recipients or recipients with complex and chronic diseases that require expensive and challenging drug regimens. Examples of these conditions include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of cancer. Specialty pharmaceutical products include injectable and infusion therapies, biotechnology drugs, high-cost therapies, and therapies that require complex care. The commissioner shall consult with the formulary committee to develop a list of specialty pharmacy products subject to this paragraph. In consulting with the formulary committee in developing this list, the commissioner shall take into consideration the population served by specialty pharmacy products, the current delivery system and standard of care in the state, and access to care issues. The commissioner shall have the discretion to adjust the reimbursement rate to prevent access to care issues.

EFFECTIVE DATE. This section is effective upon implementation of changes to the federal upper reimbursement limit under title VI, chapter IV of the federal Deficit Reduction Act of 2005, United States Code, title 42, section 1396r-8(e)(5).

Sec. 16. Minnesota Statutes 2006, section 256B.0625, is amended by adding a subdivision to read:

Subd. 13i. **Medicare Part D.** Notwithstanding subdivision 13, paragraph (d), for recipients who are enrolled in a Medicare Part D prescription drug plan or Medicare Advantage special needs plan, medical assistance covers co-payments which the recipient is responsible for under a Medicare Part D prescription drug plan or Medicare Advantage special needs plan, once the recipient has paid $12 per month in prescription drug co-payments, and according to the requirements of the plan.

Sec. 17. Minnesota Statutes 2006, section 256B.0625, subdivision 17, is amended to read:

Subd. 17. **Transportation costs.** (a) Medical assistance covers transportation costs incurred solely for obtaining emergency medical care or transportation costs incurred by eligible persons in obtaining emergency or nonemergency medical care when paid directly to an ambulance company, common carrier, or other recognized providers of transportation services.

(b) Medical assistance covers special transportation, as defined in Minnesota Rules, part 9505.0315, subpart 1, item F, if the recipient has a physical or mental impairment that would prohibit the recipient from safely accessing and using a bus, taxi, other commercial transportation, or private automobile.

The commissioner may use an order by the recipient's attending physician to certify that the recipient requires special transportation services. Special transportation includes driver-assisted service to eligible individuals. Driver-assisted service includes passenger pickup at and return to the individual's residence or place of business, assistance with admittance of the individual to the medical facility, and assistance in passenger securement or in securing of wheelchairs or stretchers in the vehicle. Special transportation providers must obtain written documentation from the health care service provider who is serving the recipient being transported, identifying the time that the recipient arrived. Special transportation providers may not bill for separate base rates for the continuation of a trip beyond the original destination. Special transportation providers must take recipients to the nearest appropriate health care provider, using the ~~most direct~~ quickest route available as determined by a commercially available mileage software program approved by the commissioner. The maximum medical assistance reimbursement rates for special transportation services are:

(1) $17 for the base rate and ~~$1.35~~ $1.43 per mile for services to eligible persons who need a wheelchair-accessible van;

(2) $11.50 for the base rate and $1.30 per mile for services to eligible persons who do not need a wheelchair-accessible van; and

(3) $60 for the base rate and $2.40 per mile, and an attendant rate of $9 per trip, for services to eligible persons who need a stretcher-accessible vehicle.

Sec. 18. Minnesota Statutes 2006, section 256B.0625, subdivision 18a, is amended to read:

Subd. 18a. **Access to medical services.** (a) Medical assistance reimbursement for meals for persons traveling to receive medical care may not exceed $5.50 for breakfast, $6.50 for lunch, or $8 for dinner.

(b) Medical assistance reimbursement for lodging for persons traveling to receive medical care may not exceed $50 per day unless prior authorized by the local agency.

(c) Medical assistance direct mileage reimbursement to ~~the~~ an eligible person or ~~the~~ an eligible person's ~~driver may not exceed 20 cents per mile~~ friend, neighbor, or relative that is providing direct transportation to a covered service shall be at 15 cents below the current Internal Revenue Service mileage reimbursement for business purposes.

(d) Medical assistance covers oral language interpreter services when provided by an enrolled health care provider during the course of providing a direct, person-to-person covered health care service to an enrolled recipient with limited English proficiency.

Sec. 19. Minnesota Statutes 2006, section 256B.0625, is amended by adding a subdivision to read:

Subd. 39a. **Influenza vaccine.** The commissioner of human services shall reimburse providers for administration of influenza vaccine to enrollees at the payment rate set by the Medicare program.

Sec. 20. Minnesota Statutes 2006, section 256B.0625, is amended by adding a subdivision to read:

Subd. 49. **Community health worker.** (a) Medical assistance covers the care coordination and patient education services provided by a community health worker if the community health worker has:

(1) received a certificate from the Minnesota State Colleges and Universities System approved community health worker curriculum; or

(2) at least five years of supervised experience.

Community health workers eligible for payment under clause (2) must complete the certification program by January 1, 2010, to continue to be eligible for payment.

(b) Community health workers must work under the supervision of a medical assistance enrolled provider.

Sec. 21. Minnesota Statutes 2006, section 256B.0644, is amended to read:

256B.0644 REIMBURSEMENT UNDER OTHER STATE HEALTH CARE PROGRAMS.

(a) A vendor of medical care, as defined in section 256B.02, subdivision 7, and a health maintenance organization, as defined in chapter 62D, must participate as a provider or contractor in the medical assistance program, general assistance medical care program, and MinnesotaCare as a condition of participating as a provider in health insurance plans and programs or contractor for state employees established under section 43A.18, the public employees insurance program under section 43A.316, for health insurance plans offered to local statutory or home rule charter city, county, and school district employees, the workers' compensation system under section 176.135, and insurance plans provided through the Minnesota Comprehensive Health Association under sections 62E.01 to 62E.19. The limitations on insurance plans offered to local government employees shall

not be applicable in geographic areas where provider participation is limited by managed care contracts with the Department of Human Services.

(b) For providers other than health maintenance organizations, participation in the medical assistance program means that:

(1) the provider accepts new medical assistance, general assistance medical care, and MinnesotaCare patients ~~or~~;

(2) for providers other than dental service providers, at least 20 percent of the provider's patients are covered by medical assistance, general assistance medical care, and MinnesotaCare as their primary source of coverage~~, or~~; or

(3) for dental service providers, at least ten percent of the provider's patients are covered by medical assistance, general assistance medical care, and MinnesotaCare as their primary source of coverage, or the provider accepts new medical assistance and MinnesotaCare patients who are children with special health care needs. For purposes of this section, "children with special health care needs" means children up to age 18 who: (i) require health and related services beyond that required by children generally; and (ii) have or are at risk for a chronic physical, developmental, behavioral, or emotional condition, including: bleeding and coagulation disorders; immunodeficiency disorders; cancer; endocrinopathy; developmental disabilities; epilepsy, cerebral palsy, and other neurological diseases; visual impairment or deafness; Down syndrome and other genetic disorders; autism; fetal alcohol syndrome; and other conditions designated by the commissioner after consultation with representatives of pediatric dental providers and consumers.

(c) Patients seen on a volunteer basis by the provider at a location other than the provider's usual place of practice may be considered in meeting ~~this~~ the participation requirement in this section. The commissioner shall establish participation requirements for health maintenance organizations. The commissioner shall provide lists of participating medical assistance providers on a quarterly basis to the commissioner of employee relations, the commissioner of labor and industry, and the commissioner of commerce. Each of the commissioners shall develop and implement procedures to exclude as participating providers in the program or programs under their jurisdiction those providers who do not participate in the medical assistance program. The commissioner of employee relations shall implement this section through contracts with participating health and dental carriers.

Sec. 22. **[256B.0751] CARE COORDINATION FOR CHILDREN WITH HIGH-COST MEDICAL CONDITIONS.**

Subdivision 1. **Care coordination required.** (a) The commissioner of human services shall contract with the U special kids program to provide care coordination, beginning October 1, 2007, for medical assistance enrollees who are children with high-cost medical conditions, and to perform the other duties specified in this section.

(b) For purposes of this section, "care coordination" means collaboration with primary care physicians and specialists to manage care, development of medical management plans for recurrent acute illnesses, oversight and coordination of all aspects of care in partnership with families, organization of medical information into a summary of critical information, coordination and appropriate sequencing of tests and multiple appointments, information and assistance with accessing resources, and telephone triage for acute illnesses or problems.

Subd. 2. **Referrals.** The commissioner shall develop a mechanism to refer children to the U special kids program for care coordination. Beginning October 1, 2007, and subject to the limits on total program enrollment specified in subdivision 3, the commissioner shall refer to the U special kids program children who:

(1) incur medical expenses that exceed the qualifying level specified in subdivision 3;

(2) have medical conditions that involve four or more major systems; require multiple specialists; require use of technology such as G-tube, trach, central line, or oxygen; and require multiple medications;

(3) do not have a medical case manager for cancer, organ transplantation, epilepsy, or bone marrow replacement; and

(4) voluntarily agree to participate in the program.

Subd. 3. **Qualifying level of medical expenses.** (a) For the period October 1, 2007, through September 30, 2008, the commissioner shall refer children for care coordination under this section if they incurred medical expenses of $500,000 or more during the fiscal year ending June 30, 2007.

(b) For the period October 1, 2008, through September 30, 2009, the commissioner shall refer children for care coordination under this section if they incurred medical expenses of $400,000 or more during the fiscal year ending June 30, 2008.

(c) For the period October 1, 2009, through September 30, 2010, the commissioner shall refer children for care coordination under this section if they incurred medical expenses of $300,000 or more during the fiscal year ending June 30, 2009.

(d) Beginning October 1, 2010, the commissioner shall refer children for care coordination under this section if they incurred medical expenses of $250,000 or more during the previous fiscal year.

(e) The commissioner shall limit referrals to the extent necessary to ensure that total enrollment in the U special kids program does not exceed 100 children for the period October 1, 2007, through September 30, 2008, and does not exceed 150 children beginning October 1, 2008.

Subd. 4. **Case management.** Beginning October 1, 2007, the U special kids program shall coordinate all nonmedical case management services provided to children who are required to receive care coordination under this section. The program may require all nonmedical case managers, including, but not limited to, county case managers and case managers for children served under a home and community-based waiver, to submit care plans for approval, and to document client compliance with the care plans. The U special kids program, beginning October 1, 2008, may employ or contract with nonmedical case managers to provide all nonmedical case management services to children required to receive care coordination under this section. The commissioner shall reimburse the U special kids program for case management services through the medical assistance program.

Subd. 5. **Statewide availability of care coordination.** The U special kids program may contract with other entities to provide care coordination services as defined in subdivision 1, in order to ensure the availability of these services in all regions of the state.

Subd. 6. **Advance practice nurse telephone triage system.** The U special kids program shall establish and operate an advance practice nurse telephone triage system that is available statewide, 24 hours a day, seven days per week. The system must provide advance practice nurses with access to a Web-based information system to appropriately triage medical problems, manage care, and reduce unnecessary hospitalizations.

Subd. 7. **Monitoring and evaluation.** The commissioner shall monitor program outcomes and evaluate the extent to which referrals to the U special kids program have improved the quality and coordination of care and provided financial savings to the medical assistance program. The U special kids program shall submit to the commissioner, in the form and manner specified by the commissioner, all data and information necessary to monitor program outcomes and evaluate the program. The commissioner shall present a preliminary evaluation to the legislature by January 15, 2008, and a final evaluation to the legislature by January 15, 2010.

EFFECTIVE DATE. This section is effective October 1, 2007, or upon federal approval, whichever is later.

Sec. 23. **[256B.0752] CARE COORDINATION FOR CHILDREN WITH HIGH-COST MENTAL HEALTH CONDITIONS.**

Subdivision 1. **Care coordination required.** (a) The commissioner of human services shall contract with the U special kids program to provide care coordination, beginning October 1, 2007, for medical assistance enrollees who are children with high-cost mental health conditions and behavioral problems, and to perform the other duties specified in this section.

(b) For purposes of this section, "care coordination" means: collaboration with primary care physicians and specialists to manage care; development of mental health management plans for recurrent mental health issues; oversight and coordination of all aspects of care in partnership with families; organization of medical, treatment, and therapy information into a summary of critical information; coordination and appropriate sequencing of evaluations and multiple appointments; information and assistance with accessing resources; and telephone triage for behavior or other problems.

Subd. 2. **Referrals.** The commissioner shall develop a mechanism to refer children to the program for care coordination. Beginning October 1, 2007, and subject to the limits on total program enrollment specified in subdivision 3, the commissioner shall refer to the U special kids program children who:

(1) incur mental health expenses that exceed the qualifying level specified in subdivision 3;

(2) are currently receiving or at risk of needing inpatient mental health treatment, foster home care, or both; and

(3) voluntarily agree to participate in the program.

Subd. 3. **Qualifying level of medical expenses.** (a) Beginning October 1, 2007, the commissioner shall refer children for care coordination under this section if they incurred medical and mental health expenses of $250,000 or more in the previous fiscal year.

(b) The commissioner shall limit referrals to the extent necessary to ensure that total enrollment in the U special kids program does not exceed 25 children for the period October 1, 2007, through September 30, 2008; does not exceed 75 children for the period October 1, 2008, through September 30, 2009; and does not exceed 125 children beginning October 1, 2009.

Subd. 4. **Case management.** The U special kids program, beginning October 1, 2007, shall coordinate all nonmedical case management services provided to children who are required to receive care coordination under this section. The program may require all nonmedical case managers, including but not limited to county case managers and case managers for children served under a home and community-based waiver, to submit care plans for approval, and to document client compliance with the care plans. The U special kids program, beginning October 1, 2008, may employ or contract with nonmedical case

managers to provide all nonmedical case management services to children required to receive care coordination under this section. The commissioner shall reimburse the U special kids program for case management services through the medical assistance program.

Subd. 5. **Statewide availability of care coordination.** The program may contract with other entities to provide care coordination services as defined in subdivision 1, in order to ensure the availability of these services in all regions of the state.

Subd. 6. **Monitoring and evaluation.** The commissioner shall monitor program outcomes and shall evaluate the extent to which referrals to the U special kids program have improved the quality and coordination of care and provided financial savings to the medical assistance program. The U special kids program shall submit to the commissioner, in the form and manner specified by the commissioner, all data and information necessary to monitor program outcomes and evaluate the program. The commissioner shall present a preliminary evaluation to the legislature by January 15, 2008, and a final evaluation to the legislature by January 15, 2010.

EFFECTIVE DATE. This section is effective October 1, 2007, or upon federal approval, whichever is later. The commissioner shall notify the Office of the Revisor of Statutes when federal approval is obtained.

Sec. 24. **[256B.194] FEDERAL PAYMENTS.**

Subdivision 1. **Payments at actual cost.** If the Centers for Medicare & Medicaid Services (CMS) promulgates a final rule consistent with its stated intent in the proposed rule published at 72 Federal Register, No. 11, January 18, 2007, regarding limiting payments to units of government, and notwithstanding Minnesota Statutes or Minnesota Rules to the contrary, for providers that are units of government, the commissioner may limit medical assistance and MinnesotaCare payments to a provider's actual cost of providing services, in accordance with the CMS final rule. If a final rule is promulgated, the commissioner may also require medical assistance and MinnesotaCare providers to provide any information necessary to determine Medicaid-related costs, and require the cooperation of providers in any audit or review necessary to ensure payments are limited to cost. This section does not apply to providers who are exempt from the provisions of the CMS final rule.

Subd. 2. **Loss of federal financial participation.** For all transfers, certified expenditures, and medical assistance payments listed below, if the commissioner determines that federal financial participation is no longer available for the medical assistance payments listed, then related obligations for the nonfederal share of payments

and the medical assistance payments shall terminate. The commissioner shall notify all affected parties of the loss of federal financial participation, and the resulting payments and obligations that are terminated. If the commissioner determines that federal financial participation is no longer available for any medical assistance payments or contributions to the nonfederal share of medical assistance payments that have already been made, the commissioner may collect the medical assistance payments from providers and return contributions of the nonfederal share to its source. The transfers, certified expenditures, and medical assistance payments subject to this section are those specified in: sections 62J.692, subdivision 7, paragraphs (b) and (c); 256B.19, subdivisions 1c and 1d; 256B.195; 256B.431, subdivision 23; and 256B.69, subdivision 5c, paragraph (a), clauses (2), (3), and (4); Laws 2002, chapter 220, article 17, section 2, subdivision 3; and Laws 2005, First Special Session chapter 4, article 9, section 2, subdivision 1.

Sec. 25. Minnesota Statutes 2006, section 256B.199, is amended to read:

256B.199 PAYMENTS REPORTED BY GOVERNMENTAL ENTITIES.

(a) Hennepin County~~,~~ and Hennepin County Medical Center~~, Ramsey County, Regions Hospital, the University of Minnesota, and Fairview-University Medical Center~~ shall 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) Based on these reports, the commissioner shall apply for federal matching funds. These funds are appropriated to the commissioner for ~~the~~ payments ~~under section 256.969, subdivision 27~~ to Hennepin County Medical Center.

(c) By May 1 of each year, beginning May 1, 2007, the commissioner shall inform the nonstate entities listed in paragraph (a) of the amount of federal disproportionate share hospital payment money expected to be available in the current federal fiscal year.

~~(d) This section sunsets on June 30, 2009. The commissioner shall report to the legislature by December 15, 2008, with recommendations for maximizing federal disproportionate share hospital payments after June 30, 2009.~~

Sec. 26. Minnesota Statutes 2006, section 256B.75, is amended to read:

256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.

(a) For outpatient hospital facility fee payments for services rendered on or after October 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge, or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for which there is a federal maximum allowable payment. Effective for services rendered on or after January 1, 2000, payment rates for nonsurgical outpatient hospital

facility fees and emergency room facility fees shall be increased by eight percent over the rates in effect on December 31, 1999, except for those services for which there is a federal maximum allowable payment. Services for which there is a federal maximum allowable payment shall be paid at the lower of (1) submitted charge, or (2) the federal maximum allowable payment. Total aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare upper limit. If it is determined that a provision of this section conflicts with existing or future requirements of the United States government with respect to federal financial participation in medical assistance, the federal requirements prevail. The commissioner may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial participation resulting from rates that are in excess of the Medicare upper limitations.

(b) Notwithstanding paragraph (a), payment for outpatient, emergency, and ambulatory surgery hospital facility fee services for critical access hospitals designated under section 144.1483, clause (10), shall be paid on a cost-based payment system that is based on the cost-finding methods and allowable costs of the Medicare program. All hospital outpatient services provided by any hospital exclusively devoted to the care of pediatric patients that is located in a Minnesota metropolitan statistical area must be paid for using the methodology established for critical access hospitals at a rate equal to fee-for-service rates plus 93 percent, as limited by allowable costs.

(c) Effective for services provided on or after July 1, 2003, rates that are based on the Medicare outpatient prospective payment system shall be replaced by a budget neutral prospective payment system that is derived using medical assistance data. The commissioner shall provide a proposal to the 2003 legislature to define and implement this provision.

(d) For fee-for-service services provided on or after July 1, 2002, the total payment, before third-party liability and spenddown, made to hospitals for outpatient hospital facility services is reduced by .5 percent from the current statutory rate.

(e) In addition to the reduction in paragraph (d), the total payment for fee-for-service services provided on or after July 1, 2003, made to hospitals for outpatient hospital facility services before third-party liability and spenddown, is reduced five percent from the current statutory rates. Facilities defined under section 256.969, subdivision 16, are excluded from this paragraph.

EFFECTIVE DATE. This section is effective July 1, 2007, and applies to services provided on or after that date.

Sec. 27. Minnesota Statutes 2006, section 256B.76, is amended to read:

256B.76 PHYSICIAN AND DENTAL REIMBURSEMENT.

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

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

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

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

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

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

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

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

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

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

(4) the commissioner shall award grants to community clinics or other nonprofit community organizations, political subdivisions, professional associations, or other

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

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

(ii) the ability to raise matching funds;

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

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

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

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

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

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

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

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

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

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

(c) Effective for dental services rendered on or after January 1, 2002, the commissioner may~~, within the limits of available appropriation,~~ increase reimbursements to dentists and dental clinics deemed by the commissioner to be critical access dental

providers. ~~Reimbursement to a critical access dental provider may be increased by not more than 50 percent above the reimbursement rate that would otherwise be paid to the provider. Payments to~~ For dental services rendered after June 30, 2007, the commissioner shall increase reimbursement by 33 percent above the reimbursement rate that would otherwise be paid to the provider. The commissioner shall pay the health plan companies ~~shall be adjusted~~ in amounts sufficient to reflect increased reimbursements to critical access dental providers as approved by the commissioner. In determining which dentists and dental clinics shall be deemed critical access dental providers, the commissioner shall review:

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

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

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

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

~~The commissioner shall annually establish a reimbursement schedule for critical access dental providers and provider-specific limits on total reimbursement received under the reimbursement schedule, and shall notify each critical access dental provider of the schedule and limit.~~

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

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

Sec. 28. Minnesota Statutes 2006, section 256D.03, subdivision 4, is amended to read:

Subd. 4. **General assistance medical care; services.** (a)(i) For a person who is eligible under subdivision 3, paragraph (a), clause (2), item (i), general assistance medical care covers, except as provided in paragraph (c):

(1) inpatient hospital services;

(2) outpatient hospital services;

(3) services provided by Medicare certified rehabilitation agencies;

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

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

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

(7) hearing aids;

(8) prosthetic devices;

(9) laboratory and X-ray services;

(10) physician's services;

(11) medical transportation except special transportation;

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

(13) podiatric services;

(14) dental services as covered under the medical assistance program;

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

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

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

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

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

(20) services performed by a certified pediatric nurse practitioner, a certified family nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological nurse practitioner, a certified neonatal nurse practitioner, or a certified geriatric nurse practitioner in independent practice, if (1) the service is otherwise covered under this chapter as a physician service, (2) the service provided on an inpatient basis is not included as part of the cost for inpatient services included in the operating payment rate, and (3) the service is within the scope of practice of the nurse practitioner's license as a registered nurse, as defined in section 148.171;

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

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

(23) mental health telemedicine and psychiatric consultation as covered under section 256B.0625, subdivisions 46 and 48.~~;~~ <u>; and</u>

<u>(24) care coordination and patient education services provided by a community health worker according to section 256B.0625, subdivision 49.</u>

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

(b) Effective August 1, 2005, sex reassignment surgery is not covered under this subdivision.

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

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

(d) Effective January 1, 2008, drug coverage under general assistance medical care is limited to prescription drugs that:

(i) are covered under the medical assistance program as described in section 256B.0625, subdivisions 13 and 13d; and

(ii) are provided by manufacturers that have fully executed general assistance medical care rebate agreements with the commissioner and comply with the agreements. Prescription drug coverage under general assistance medical care must conform to coverage under the medical assistance program according to section 256B.0625, subdivisions 13 to 13g.

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

(1) $25 for eyeglasses;

(2) $25 for nonemergency visits to a hospital-based emergency room;

(3) $3 per brand-name drug prescription and $1 per generic drug prescription, subject to a $12 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness; and

(4) 50 percent coinsurance on restorative dental services.

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

~~(f)~~ (g) If it is the routine business practice of a provider to refuse service to an individual with uncollected debt, the provider may include uncollected co-payments

under this section. A provider must give advance notice to a recipient with uncollected debt before services can be denied.

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

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

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

~~(j)~~ (k) The conditions of payment for services under this subdivision are the same as the conditions specified in rules adopted under chapter 256B governing the medical assistance program, unless otherwise provided by statute or rule.

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

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

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

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

~~(o)~~ (p) Fee-for-service payments for nonpreventive visits shall be reduced by $3 for services provided on or after January 1, 2006. For purposes of this subdivision, a visit means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, advance practice nurse, audiologist, optician, or optometrist.

~~(p)~~ (q) Payments to managed care plans shall not be increased as a result of the removal of the $3 nonpreventive visit co-payment effective January 1, 2006.

Sec. 29. Minnesota Statutes 2006, section 256L.11, subdivision 7, is amended to read:

Subd. 7. **Critical access dental providers.** Effective for dental services provided to MinnesotaCare enrollees ~~on or after~~ between January 1, 2007, and June 30, 2007, the commissioner shall increase payment rates to dentists and dental clinics deemed by the commissioner to be critical access providers under section 256B.76, paragraph (c), by 50 percent above the payment rate that would otherwise be paid to the provider. Effective

for dental services provided to MinnesotaCare enrollees on or after July 1, 2007, the commissioner shall increase payment rates to dentists and dental clinics deemed by the commissioner to be critical access providers under section 256B.76, paragraph (c), by 33 percent above the payment rate that would otherwise be paid to the provider. The commissioner shall ~~adjust the rates paid on or after January 1, 2007, to~~ pay the prepaid health plans under contract with the commissioner amounts sufficient to reflect this rate increase. The prepaid health plan must pass this rate increase to providers who have been identified by the commissioner as critical access dental providers under section 256B.76, paragraph (c).

Sec. 30. **AGRICULTURAL COOPERATIVE HEALTH PLAN FOR FARMERS.**

Subdivision 1. **Pilot project requirements.** The commissioner of commerce shall authorize a joint self-insurance pilot project administered by a trust sponsored by one or more agricultural cooperatives organized under Minnesota Statutes, chapter 308A, or under a federal charter for the purpose of offering health coverage to members of the cooperatives and their families, provided the project satisfies the requirements of Minnesota Statutes, chapter 62H, except as follows:

(1) Minnesota Statutes, section 62H.02, subdivision 1, paragraph (b), does not apply;

(2) the notice period required under Minnesota Statutes, section 62H.02, subdivision 1, paragraph (e), is 90 days;

(3) the commissioner shall grant necessary waivers and approve an alternative arrangement that fully funds the plan's liability or incurred but unpaid claims under Minnesota Statutes, section 62H.02, subdivision 1, paragraph (f), unless the commissioner provides evidence demonstrating that the insolvency protection proposed is substantially less than that typically provided by self-insured group plans of a similar size in Minnesota;

(4) notwithstanding Minnesota Statutes, section 62H.04, paragraph (a), the joint self-insurance plan shall be considered a large group and not subject to the small group insurance requirements in Minnesota Statutes, chapter 62L, even if some employer groups enrolled in the plan would be defined as small employers, except that the joint self-insurance plan may elect to treat the sale of a health plan to or for an employer that has only one eligible employee who has not waived coverage as the sale of an individual health plan as allowed under Minnesota Statutes, section 62L.02, subdivision 26;

(5) Minnesota Statutes, section 297I.05, subdivision 12, paragraph (c), does not apply; and

(6) the trust must pay the assessment for the Minnesota comprehensive health association as provided under Minnesota Statutes, section 62E.11.

Subd. 2. **Evaluation and renewal.** The pilot project authorized under this section is for a period of four years from the date of initial enrollment. The commissioner shall grant an extension of four additional years if the trust provides evidence that it remains in compliance with the requirements of this section and other applicable laws and rules. If the commissioner determines that the operation of the trust has not improved access, expanded health plan choices, or improved affordability of health coverage for farm families, or that it has significantly damaged access, choice, or affordability for other consumers not enrolled in the trust, the commissioner shall provide at least 180 days' advance written notice to the trust and to the chairs of the senate and house finance and policy committees with jurisdiction over health and insurance matters of the commissioner's intention not to renew the pilot project at the expiration of a four-year period.

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

Sec. 31. **HENNEPIN COUNTY PILOT PROJECT.**

The commissioner of human services shall support a pilot project in Hennepin County to demonstrate the effectiveness of alternative strategies to redetermine eligibility for certain recipient populations in the medical assistance program. The target populations for the demonstration are persons who are eligible based upon disability or age, who have chronic medical conditions, and who are expected to experience minimal change in income or assets from month to month. The commissioner and the county shall analyze the issues and strategies employed and the outcomes to determine reasonable efforts to streamline eligibility statewide. The commissioner shall apply for any federal waivers needed to implement this section.

Sec. 32. **COUNTY-BASED PURCHASING STUDY.**

The commissioner of health shall study county-based purchasing initiatives established under Minnesota Statutes, section 256B.692, and compare these initiatives to managed care plans serving medical assistance, general assistance medical care, and MinnesotaCare enrollees. The study must:

(1) provide a history and description of county-based purchasing initiatives, including state and federal requirements and any federal waivers Minnesota counties have applied for or received;

(2) provide a history and description of managed care plan participation in the prepaid medical assistance, prepaid general assistance medical care, and prepaid Minnesota programs, and the provision by managed care plans of third-party administrator services for county-based purchasing initiatives;

(3) provide relevant data, including limitations on data, data that was requested but not received, and explanations for why requested data was not received;

(4) provide recommendations for further data collection and research;

(5) summarize successes and challenges of the two service delivery methods;

(6) provide recommendations for possible expansion of county-based purchasing in rural and urban settings; and

(7) identify and describe features of county-based purchasing and managed care plans serving medical assistance, general assistance medical care, and MinnesotaCare enrollees, to provide a comparison of cost, quality, access, and community health improvement that includes, but is not limited to:

(i) descriptions of how health care and social services are integrated and coordinated for persons with complex care needs, including persons with high-risk pregnancies, adolescents, persons who are disabled, persons who are elderly, and persons with chronic health care and social needs;

(ii) use of monetary grants and surpluses to:

(A) increase provider reimbursement, including dental care reimbursement, in order to improve health care access; and

(B) improve community health beyond the requirements of the public health care programs, such as the funding of public education, research, and community initiatives to enhance utilization of preventive services, social services, or mental health care;

(iii) administrative costs, including billing and collection of unpaid fees, co-pays or other charges, and top five management salaries;

(iv) reporting requirements of contracts with the Department of Human Services;

(v) public access to all information about management and administration, including but not limited to provider contracts and reimbursement, models of care management and coordination, utilization review, contracts with consultants and other vendors, handling of monetary grants and surpluses, and health outcomes data;

(vi) provider reimbursement by clinical practice area;

(vii) populations served, described by age, disability, income, race, language, occupation, and other demographic characteristics;

(viii) utilization of community-based prevention interventions, including but not limited to public health nursing visits to new parents, use of nurse-managed interventions to reduce cardiac hospitalizations, and the use of medical homes for chronic disease management;

(ix) utilization of cancer screening;

(x) utilization of interpreter services;

(xi) immunization rates for children age five and under;

(xii) hospitalization rates for conditions related to diabetes, asthma, or cardiac illnesses;

(xiii) rates of rehospitalization within a month of hospital discharge;

(xiv) coordination with county agencies to increase enrollment;

(xv) number of new program enrollees and the rate of enrollment, including the percentage of eligible persons who become enrollees;

(xvi) enrollee satisfaction with their care; and

(xvii) number of enrollees who do not receive care.

Managed care plans, county-based purchasing initiatives, health care providers, counties, and the commissioner of human services shall, upon request, provide data to the commissioner of health that is necessary to complete the study. The commissioner of health shall submit the study to the legislature by December 31, 2007.

Sec. 33. **GRANT FOR TOLL-FREE HEALTH CARE ACCESS NUMBER.**

The commissioner of human services shall award a grant to the Neighborhood Health Care Network to pay the costs of maintaining and staffing a toll-free telephone number to provide callers with information on health coverage options, eligibility for MinnesotaCare and other health care programs, and health care providers that offer free or reduced-cost health care services.

Sec. 34. **IMPLEMENTATION OF PHARMACY DISPENSING FEE INCREASE.**

(a) The commissioner of human services shall fund the increase in the dispensing fee for multiple-source generic drugs under Minnesota Statutes, section 256B.0625, subdivision 13e, paragraph (a), using reductions in program costs for ingredient reimbursement resulting from changes to the federal upper reimbursement limit under title VI, chapter IV of the federal Deficit Reduction Act of 2005, United States Code, title 42, section 1396r-8(e)(5), and related regulations. The commissioner, after consulting with the Pharmacy Payment Reform Advisory Committee established under Laws 2006, chapter 282, article 16, section 15, shall proportionally increase or decrease the dispensing fee for multiple-source generic drugs under Minnesota Statutes, section 256B.0625, subdivision 13e, paragraph (a), to reflect the actual amount of reductions in program cost for ingredient reimbursement savings obtained.

(b) The Pharmacy Payment Reform Advisory Committee shall analyze the savings resulting from changes to the federal upper reimbursement limit, and shall recommend to the commissioner of human services and the legislature, by December 15, 2008, the

level of the dispensing fee for multiple-source generic drugs that should apply beginning July 1, 2010.

EFFECTIVE DATE. This section is effective upon implementation of changes to the federal upper reimbursement limit under title VI, chapter IV of the federal Deficit Reduction Act of 2005, United States Code, title 42, section 1396r-8(e)(5).

Sec. 35. **MEDICAL EQUIPMENT AND SUPPLIES.**

The commissioner of human services shall seek all federal waivers and approvals necessary to allow medical assistance to cover, for enrollees who pay out-of-pocket for medical equipment and supply upgrades, including but not limited to upgrades to prostheses, the cost of the standard, nonupgraded item.

Sec. 36. **REPEALER.**

Minnesota Statutes 2006, section 256.969, subdivision 27, is repealed effective July 1, 2007.

ARTICLE 4
CONTINUING CARE

Section 1. Minnesota Statutes 2006, section 144A.071, subdivision 4c, is amended to read:

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

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

(2) to license and certify 29 beds to be added to an existing 69-bed facility in St. Louis County, provided that the 29 beds must be transferred from active or layaway status at an existing facility in St. Louis County that had 235 beds on April 1, 2003.

The licensed capacity at the 235-bed facility must be reduced to 206 beds, but the payment rate at that facility shall not be adjusted as a result of this transfer. The operating payment rate of the facility adding beds after completion of this project shall be the same as it was

on the day prior to the day the beds are licensed and certified. This project shall not proceed unless it is approved and financed under the provisions of section 144A.073;

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

(4) to license and certify up to 80 beds transferred from an existing state-owned nursing facility in Cass County to a new facility located on the grounds of the Ah-Gwah-Ching campus. The operating cost payment rates for the new facility shall be determined based on the interim and settle-up payment provisions of Minnesota Rules, part 9549.0057, and the reimbursement provisions of section 256B.431. The property payment rate for the first three years of operation shall be $35 per day. For subsequent years, the property payment rate of $35 per day shall be adjusted for inflation as provided in section 256B.434, subdivision 4, paragraph (c), as long as the facility has a contract under section 256B.434~~.~~; and

(5) to license and certify 180 beds transferred from an existing facility in Minneapolis to a new facility in Robbinsdale; provided that the beds are transferred from a 219-bed facility under common ownership that shall be closed following the transfer. The operating payment rate of the new facility after completion of this project shall be adjusted upward by $35 per day and the property payment rate shall be $34.049 per day.

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

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

Sec. 2. Minnesota Statutes 2006, section 252.27, subdivision 2a, is amended to read:

Subd. 2a. **Contribution amount.** (a) The natural or adoptive parents of a minor child, including a child determined eligible for medical assistance without consideration of parental income, must contribute to the cost of services used by making monthly payments on a sliding scale based on income, unless the child is married or has been married, parental rights have been terminated, or the child's adoption is subsidized according to

section 259.67 or through title IV-E of the Social Security Act. The parental contribution is a partial or full payment for medical services provided for diagnostic, therapeutic, curing, treating, mitigating, rehabilitation, and maintenance and personal care services as defined in United States Code, title 26, section 213, needed by the child with a chronic illness or disability.

(b) For households with adjusted gross income equal to or greater than 100 percent of federal poverty guidelines, the parental contribution shall be computed by applying the following schedule of rates to the adjusted gross income of the natural or adoptive parents:

(1) if the adjusted gross income is equal to or greater than 100 percent of federal poverty guidelines and less than 175 percent of federal poverty guidelines, the parental contribution is $4 per month;

(2) if the adjusted gross income is equal to or greater than 175 percent of federal poverty guidelines and less than or equal to 545 percent of federal poverty guidelines, the parental contribution shall be determined using a sliding fee scale established by the commissioner of human services which begins at one percent of adjusted gross income at 175 percent of federal poverty guidelines and increases to 7.5 percent of adjusted gross income for those with adjusted gross income up to 545 percent of federal poverty guidelines;

(3) if the adjusted gross income is greater than 545 percent of federal poverty guidelines and less than 675 percent of federal poverty guidelines, the parental contribution shall be 7.5 percent of adjusted gross income;

(4) if the adjusted gross income is equal to or greater than 675 percent of federal poverty guidelines and less than 975 percent of federal poverty guidelines, the parental contribution shall be determined using a sliding fee scale established by the commissioner of human services which begins at 7.5 percent of adjusted gross income at 675 percent of federal poverty guidelines and increases to ten percent of adjusted gross income for those with adjusted gross income up to 975 percent of federal poverty guidelines; and

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

If the child lives with the parent, the annual ~~adjusted gross income~~ parental contribution is reduced by ~~$2,400 prior to calculating the parental contribution~~ $100 per month. If the child resides in an institution specified in section 256B.35, the parent is responsible for the personal needs allowance specified under that section in addition to the parental contribution determined under this section. The parental contribution is

reduced by any amount required to be paid directly to the child pursuant to a court order, but only if actually paid.

(c) The household size to be used in determining the amount of contribution under paragraph (b) includes natural and adoptive parents and their dependents, including the child receiving services. Adjustments in the contribution amount due to annual changes in the federal poverty guidelines shall be implemented on the first day of July following publication of the changes.

(d) For purposes of paragraph (b), "income" means the adjusted gross income of the natural or adoptive parents determined according to the previous year's federal tax form, except, effective retroactive to July 1, 2003, taxable capital gains to the extent the funds have been used to purchase a home shall not be counted as income.

(e) The contribution shall be explained in writing to the parents at the time eligibility for services is being determined. The contribution shall be made on a monthly basis effective with the first month in which the child receives services. Annually upon redetermination or at termination of eligibility, if the contribution exceeded the cost of services provided, the local agency or the state shall reimburse that excess amount to the parents, either by direct reimbursement if the parent is no longer required to pay a contribution, or by a reduction in or waiver of parental fees until the excess amount is exhausted.

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

(g) Parents of a minor child who do not live with each other shall each pay the contribution required under paragraph (a). An amount equal to the annual court-ordered child support payment actually paid on behalf of the child receiving services shall be deducted from the adjusted gross income of the parent making the payment prior to calculating the parental contribution under paragraph (b).

(h) The contribution under paragraph (b) shall be increased by an additional five percent if the local agency determines that insurance coverage is available but not obtained for the child. For purposes of this section, "available" means the insurance is a benefit of employment for a family member at an annual cost of no more than five percent of the family's annual income. For purposes of this section, "insurance" means health

and accident insurance coverage, enrollment in a nonprofit health service plan, health maintenance organization, self-insured plan, or preferred provider organization.

Parents who have more than one child receiving services shall not be required to pay more than the amount for the child with the highest expenditures. There shall be no resource contribution from the parents. The parent shall not be required to pay a contribution in excess of the cost of the services provided to the child, not counting payments made to school districts for education-related services. Notice of an increase in fee payment must be given at least 30 days before the increased fee is due.

(i) The contribution under paragraph (b) shall be reduced by $300 per fiscal year if, in the 12 months prior to July 1:

(1) the parent applied for insurance for the child;

(2) the insurer denied insurance;

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

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

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

A parent who has requested a reduction in the contribution amount under this paragraph shall submit proof in the form and manner prescribed by the commissioner or county agency, including, but not limited to, the insurer's denial of insurance, the written letter or complaint of the parents, court documents, and the written response of the insurer approving insurance. The determinations of the commissioner or county agency under this paragraph are not rules subject to chapter 14.

Sec. 3. Minnesota Statutes 2006, section 252.32, subdivision 3, is amended to read:

Subd. 3. **Amount of support grant; use.** Support grant amounts shall be determined by the county social service agency. Services and items purchased with a support grant must:

(1) be over and above the normal costs of caring for the dependent if the dependent did not have a disability;

(2) be directly attributable to the dependent's disabling condition; and

(3) enable the family to delay or prevent the out-of-home placement of the dependent.

The design and delivery of services and items purchased under this section must ~~suit the dependent's chronological age and~~ be provided in the least restrictive environment possible, consistent with the needs identified in the individual service plan.

Items and services purchased with support grants must be those for which there are no other public or private funds available to the family. Fees assessed to parents for health or human services that are funded by federal, state, or county dollars are not reimbursable through this program.

In approving or denying applications, the county shall consider the following factors:

(1) the extent and areas of the functional limitations of the disabled child;

(2) the degree of need in the home environment for additional support; and

(3) the potential effectiveness of the grant to maintain and support the person in the family environment.

The maximum monthly grant amount shall be $250 per eligible dependent, or $3,000 per eligible dependent per state fiscal year, within the limits of available funds and as adjusted by any legislatively authorized cost of living adjustment. The county social service agency may consider the dependent's supplemental security income in determining the amount of the support grant.

Any adjustments to their monthly grant amount must be based on the needs of the family and funding availability.

Sec. 4. Minnesota Statutes 2006, section 252.46, is amended by adding a subdivision to read:

Subd. 22. **Provider rate increase; St. Louis County.** A day training and habilitation provider in St. Louis County licensed to provide services to up to 80 individuals shall receive a per diem rate increase that does not exceed 95 percent of the greater of 125 percent of the current statewide median or 125 percent of the regional average per diem rate, whichever is higher.

Sec. 5. Minnesota Statutes 2006, section 256.01, is amended by adding a subdivision to read:

Subd. 24. **Disability linkage line.** The commissioner shall establish the disability linkage line, a statewide consumer information, referral, and assistance system for people with disabilities and chronic illnesses that:

(1) provides information about state and federal eligibility requirements, benefits, and service options;

(2) makes referrals to appropriate support entities;

(3) delivers information and assistance based on national and state standards;

(4) assists people to make well-informed decisions; and

(5) supports the timely resolution of service access and benefit issues.

Sec. 6. Minnesota Statutes 2006, section 256.476, subdivision 1, is amended to read:

Subdivision 1. **Purpose and goals.** The commissioner of human services shall establish a consumer support grant program for individuals with functional limitations and their families who wish to purchase and secure their own supports. ~~The commissioner and local agencies shall jointly develop an implementation plan which must include a way to resolve the issues related to county liability.~~ The program shall:

(1) make support grants available to individuals or families as an effective alternative to the ~~developmental disability~~ family support program, personal care attendant services, home health aide services, and private duty nursing services;

(2) provide consumers more control, flexibility, and responsibility over their services and supports;

(3) promote local program management and decision making; and

(4) encourage the use of informal and typical community supports.

Sec. 7. Minnesota Statutes 2006, section 256.476, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given them:

(a) "County board" means the county board of commissioners for the county of financial responsibility as defined in section 256G.02, subdivision 4, or its designated representative. When a human services board has been established under sections 402.01 to 402.10, it shall be considered the county board for the purposes of this section.

(b) "Family" means the person's birth parents, adoptive parents or stepparents, siblings or stepsiblings, children or stepchildren, grandparents, grandchildren, niece, nephew, aunt, uncle, or spouse. For the purposes of this section, a family member is at least 18 years of age.

(c) "Functional limitations" means the long-term inability to perform an activity or task in one or more areas of major life activity, including self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living. For the purpose of this section, the inability to perform an activity or task results from a mental, emotional, psychological, sensory, or physical disability, condition, or illness.

(d) "Informed choice" means a voluntary decision made by the person ~~or,~~ the person's legal representative, or other authorized representative after becoming familiarized with the alternatives to:

(1) select a preferred alternative from a number of feasible alternatives;

(2) select an alternative which may be developed in the future; and

(3) refuse any or all alternatives.

(e) "Local agency" means the local agency authorized by the county board or, for counties not participating in the consumer grant program by July 1, 2002, the commissioner, to carry out the provisions of this section.

(f) "Person" or "persons" means a person or persons meeting the eligibility criteria in subdivision 3.

(g) "Authorized representative" means an individual designated by the person or their legal representative to act on their behalf. This individual may be a family member, guardian, representative payee, or other individual designated by the person or their legal representative, if any, to assist in purchasing and arranging for supports. For the purposes of this section, an authorized representative is at least 18 years of age.

(h) "Screening" means the screening of a person's service needs under sections 256B.0911 and 256B.092.

(i) "Supports" means services, care, aids, environmental modifications, or assistance purchased by the person ~~or the person's family~~, the person's legal representative, or other authorized representative. Examples of supports include respite care, assistance with daily living, and assistive technology. For the purpose of this section, notwithstanding the provisions of section 144A.43, supports purchased under the consumer support program are not considered home care services.

(j) "Program of origination" means the program the individual transferred from when approved for the consumer support grant program.

Sec. 8. Minnesota Statutes 2006, section 256.476, subdivision 3, is amended to read:

Subd. 3. **Eligibility to apply for grants.** (a) A person is eligible to apply for a consumer support grant if the person meets all of the following criteria:

(1) the person is eligible for and has been approved to receive services under medical assistance as determined under sections 256B.055 and 256B.056 or the person has been approved to receive a grant under the ~~developmental disability~~ family support program under section 252.32;

(2) the person is able to direct and purchase the person's own care and supports, or the person has a family member, legal representative, or other authorized representative who can purchase and arrange supports on the person's behalf;

(3) the person has functional limitations, requires ongoing supports to live in the community, and is at risk of or would continue institutionalization without such supports; and

(4) the person will live in a home. For the purpose of this section, "home" means the person's own home or home of a person's family member. These homes are natural home settings and are not licensed by the Department of Health or Human Services.

(b) Persons may not concurrently receive a consumer support grant if they are:

(1) receiving personal care attendant and home health aide services, or private duty nursing under section 256B.0625; a ~~developmental disability~~ family support grant; or alternative care services under section 256B.0913; or

(2) residing in an institutional or congregate care setting.

(c) A person or person's family receiving a consumer support grant shall not be charged a fee or premium by a local agency for participating in the program.

(d) Individuals receiving home and community-based waivers under United States Code, title 42, section 1396h(c), are not eligible for the consumer support grant, except for individuals receiving consumer support grants before July 1, 2003, as long as other eligibility criteria are met.

(e) The commissioner shall establish a budgeted appropriation each fiscal year for the consumer support grant program. The number of individuals participating in the program will be adjusted so the total amount allocated to counties does not exceed the amount of the budgeted appropriation. The budgeted appropriation will be adjusted annually to accommodate changes in demand for the consumer support grants.

Sec. 9. Minnesota Statutes 2006, section 256.476, subdivision 4, is amended to read:

Subd. 4. **Support grants; criteria and limitations.** (a) A county board may choose to participate in the consumer support grant program. If a county has not chosen to participate by July 1, 2002, the commissioner shall contract with another county or other entity to provide access to residents of the nonparticipating county who choose the consumer support grant option. The commissioner shall notify the county board in a county that has declined to participate of the commissioner's intent to enter into a contract with another county or other entity at least 30 days in advance of entering into the contract. The local agency shall establish written procedures and criteria to determine the amount and use of support grants. These procedures must include, at least, the availability of respite care, assistance with daily living, and adaptive aids. The local agency may establish monthly or annual maximum amounts for grants and procedures where exceptional resources may be required to meet the health and safety needs of the person on a time-limited basis, however, the total amount awarded to each individual may not exceed the limits established in subdivision 11.

(b) Support grants to a person ~~or a person's family~~, a person's legal representative, or other authorized representative will be provided through a monthly subsidy payment and be in the form of cash, voucher, or direct county payment to vendor. Support grant amounts must be determined by the local agency. Each service and item purchased with a support grant must meet all of the following criteria:

(1) it must be over and above the normal cost of caring for the person if the person did not have functional limitations;

(2) it must be directly attributable to the person's functional limitations;

(3) it must enable the person ~~or the person's family~~, a person's legal representative, or other authorized representative to delay or prevent out-of-home placement of the person; and

(4) it must be consistent with the needs identified in the service agreement, when applicable.

(c) Items and services purchased with support grants must be those for which there are no other public or private funds available to the person ~~or the person's family~~, a person's legal representative, or other authorized representative. Fees assessed to the person or the person's family for health and human services are not reimbursable through the grant.

(d) In approving or denying applications, the local agency shall consider the following factors:

(1) the extent and areas of the person's functional limitations;

(2) the degree of need in the home environment for additional support; and

(3) the potential effectiveness of the grant to maintain and support the person in the family environment or the person's own home.

(e) At the time of application to the program or screening for other services, the person ~~or the person's family~~, a person's legal representative, or other authorized representative shall be provided sufficient information to ensure an informed choice of alternatives by the person, the person's legal representative, or other authorized representative, if any~~, or the person's family~~. The application shall be made to the local agency and shall specify the needs of the person and family, the form and amount of grant requested, the items and services to be reimbursed, and evidence of eligibility for medical assistance.

(f) Upon approval of an application by the local agency and agreement on a support plan for the person or person's family, the local agency shall make grants to the person or the person's family. The grant shall be in an amount for the direct costs of the services or supports outlined in the service agreement.

(g) Reimbursable costs shall not include costs for resources already available, such as special education classes, day training and habilitation, case management, other services to which the person is entitled, medical costs covered by insurance or other health programs, or other resources usually available at no cost to the person or the person's family.

(h) The state of Minnesota, the county boards participating in the consumer support grant program, or the agencies acting on behalf of the county boards in the implementation and administration of the consumer support grant program shall not be liable for damages, injuries, or liabilities sustained through the purchase of support by the individual, the individual's family, or the authorized representative under this section with funds received through the consumer support grant program. Liabilities include but are not limited to: workers' compensation liability, the Federal Insurance Contributions Act (FICA), or the Federal Unemployment Tax Act (FUTA). For purposes of this section, participating county boards and agencies acting on behalf of county boards are exempt from the provisions of section 268.04.

Sec. 10. Minnesota Statutes 2006, section 256.476, subdivision 5, is amended to read:

Subd. 5. **Reimbursement, allocations, and reporting.** (a) For the purpose of transferring persons to the consumer support grant program from the ~~developmental disability~~ family support program and personal care assistant services, home health aide services, or private duty nursing services, the amount of funds transferred by the commissioner between the ~~developmental disability~~ family support program account, the medical assistance account, or the consumer support grant account shall be based on each county's participation in transferring persons to the consumer support grant program from those programs and services.

(b) At the beginning of each fiscal year, county allocations for consumer support grants shall be based on:

(1) the number of persons to whom the county board expects to provide consumer supports grants;

(2) their eligibility for current program and services;

(3) the amount of nonfederal dollars allowed under subdivision 11; and

(4) projected dates when persons will start receiving grants. County allocations shall be adjusted periodically by the commissioner based on the actual transfer of persons or service openings, and the nonfederal dollars associated with those persons or service openings, to the consumer support grant program.

(c) The amount of funds transferred by the commissioner from the medical assistance account for an individual may be changed if it is determined by the county or its agent that the individual's need for support has changed.

(d) The authority to utilize funds transferred to the consumer support grant account for the purposes of implementing and administering the consumer support grant program will not be limited or constrained by the spending authority provided to the program of origination.

(e) The commissioner may use up to five percent of each county's allocation, as adjusted, for payments for administrative expenses, to be paid as a proportionate addition to reported direct service expenditures.

(f) The county allocation for each individual or individual's family cannot exceed the amount allowed under subdivision 11.

(g) The commissioner may recover, suspend, or withhold payments if the county board, local agency, or grantee does not comply with the requirements of this section.

(h) Grant funds unexpended by consumers shall return to the state once a year. The annual return of unexpended grant funds shall occur in the quarter following the end of the state fiscal year.

Sec. 11. Minnesota Statutes 2006, section 256.476, subdivision 10, is amended to read:

Subd. 10. **Consumer responsibilities.** Persons receiving grants under this section shall:

(1) spend the grant money in a manner consistent with their agreement with the local agency;

(2) notify the local agency of any necessary changes in the grant or the items on which it is spent;

(3) notify the local agency of any decision made by the person, ~~the~~ a person's legal representative, ~~or the person's family~~ or other authorized representative that would change their eligibility for consumer support grants;

(4) arrange and pay for supports; and

(5) inform the local agency of areas where they have experienced difficulty securing or maintaining supports.

Sec. 12. Minnesota Statutes 2006, section 256.974, is amended to read:

256.974 OFFICE OF OMBUDSMAN FOR ~~OLDER MINNESOTANS~~ LONG-TERM CARE; LOCAL PROGRAMS.

The ombudsman for ~~older Minnesotans~~ long-term care serves in the classified service under section 256.01, subdivision 7, in an office within the Minnesota Board on Aging that incorporates the long-term care ombudsman program required by the Older Americans Act, ~~Public Law 100-75~~ as amended, United States Code, title 42, section 3027(a)~~(12)~~ (9) and 3058g (a), and established within the Minnesota Board on Aging. The Minnesota Board on Aging may make grants to and designate local programs for the provision of ombudsman services to clients in county or multicounty areas. The local program may not be an agency engaged in the provision of nursing home care, hospital care, or home care services either directly or by contract, or have the responsibility for planning, coordinating, funding, or administering nursing home care, hospital care, or home care services.

Sec. 13. Minnesota Statutes 2006, section 256.9741, subdivision 1, is amended to read:

Subdivision 1. **Long-term care facility.** "Long-term care facility" means a nursing home licensed under sections 144A.02 to 144A.10 ~~or~~; a boarding care home licensed under sections 144.50 to 144.56; or a licensed or registered residential setting which provides or arranges for the provision of home care services.

Sec. 14. Minnesota Statutes 2006, section 256.9741, subdivision 3, is amended to read:

Subd. 3. **Client.** "Client" means an individual who requests, or on whose behalf a request is made for, ombudsman services and is (a) a resident of a long-term care facility or (b) a Medicare beneficiary who requests assistance relating to access, discharge, or denial of inpatient or outpatient services, or (c) an individual reserving, receiving, or requesting a home care service.

Sec. 15. Minnesota Statutes 2006, section 256.9742, subdivision 3, is amended to read:

Subd. 3. **Posting.** Every long-term care facility and acute care facility shall post in a conspicuous place the address and telephone number of the office. A home care service provider shall provide all recipients, including those in ~~elderly~~ housing with services under chapter 144D, with the address and telephone number of the office. Counties shall provide clients receiving ~~a consumer support grant or a service allowance~~ long-term care consultation services under section 256B.0911 or home and community-based services through a state or federally funded program with the name, address, and telephone number of the office. The posting or notice is subject to approval by the ombudsman.

Sec. 16. Minnesota Statutes 2006, section 256.9742, subdivision 4, is amended to read:

Subd. 4. **Access to long-term care and acute care facilities and clients.** The ombudsman or designee may:

(1) enter any long-term care facility without notice at any time;

(2) enter any acute care facility without notice during normal business hours;

(3) enter any acute care facility without notice at any time to interview a patient or observe services being provided to the patient as part of an investigation of a matter that is within the scope of the ombudsman's authority, but only if the ombudsman's or designee's presence does not intrude upon the privacy of another patient or interfere with routine hospital services provided to any patient in the facility;

(4) communicate privately and without restriction with any client ~~in accordance with section 144.651~~, as long as the ombudsman has the client's consent for such communication;

(5) inspect records of a long-term care facility, home care service provider, or acute care facility that pertain to the care of the client according to ~~sections~~ section 144.335 ~~and 144.651~~; and

(6) with the consent of a client or client's legal guardian, the ombudsman or designated staff shall have access to review records pertaining to the care of the client according to ~~sections~~ section 144.335 ~~and 144.651~~. If a client cannot consent and has no legal guardian, access to the records is authorized by this section.

A person who denies access to the ombudsman or designee in violation of this subdivision or aids, abets, invites, compels, or coerces another to do so is guilty of a misdemeanor.

Sec. 17. Minnesota Statutes 2006, section 256.9742, subdivision 6, is amended to read:

Subd. 6. **Prohibition against discrimination or retaliation.** (a) No entity shall take discriminatory, disciplinary, or retaliatory action against an employee or volunteer, or a patient, resident, or guardian or family member of a patient, resident, or guardian for filing in good faith a complaint with or providing information to the ombudsman or designee including volunteers. A person who violates this subdivision or who aids, abets, invites, compels, or coerces another to do so is guilty of a misdemeanor.

(b) There shall be a rebuttable presumption that any adverse action, as defined below, within 90 days of report, is discriminatory, disciplinary, or retaliatory. For the purpose of this clause, the term "adverse action" refers to action taken by the entity involved in a report against the person making the report or the person with respect to whom the report was made because of the report, and includes, but is not limited to:

(1) discharge or transfer from a facility;

(2) termination of service;

(3) restriction or prohibition of access to the facility or its residents;

(4) discharge from or termination of employment;

(5) demotion or reduction in remuneration for services; and

(6) any restriction of rights set forth in section 144.651 ~~or~~, 144A.44, or 144A.751.

Sec. 18. Minnesota Statutes 2006, section 256.9744, subdivision 1, is amended to read:

Subdivision 1. **Classification.** Except as provided in this section, data maintained by the office under sections 256.974 to 256.9744 are private data on individuals or nonpublic data as defined in section 13.02, subdivision 9 or 12, and must be maintained in accordance with the requirements of ~~Public Law 100-75~~ the Older Americans Act, as amended, United States Code, title 42, section ~~3027(a)(12)(D)~~ 3058g(d).

Sec. 19. Minnesota Statutes 2006, section 256.975, subdivision 7, is amended to read:

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

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

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

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

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

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

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

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

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

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

(9) incorporate information about housing with services and consumer rights within the MinnesotaHelp.info network long-term care database to facilitate consumer comparison of services and costs among housing with services establishments and with other in-home services and to support financial self-sufficiency as long as possible. Housing with services establishments and their arranged home care providers shall provide information to the commissioner of human services including delineation of charges for housing, meals, supportive services, adapted daily living services, and health-related services. The commissioner of human services and the commissioner of health shall align data elements required by section 144G.06, the Uniform Consumer Information Guide, and this section, to the extent possible. The commissioner of human services shall provide the data to the Minnesota Board on Aging for inclusion in the MinnesotaHelp.info network long-term care database.

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

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

Sec. 20. Minnesota Statutes 2006, section 256B.056, subdivision 1a, is amended to read:

Subd. 1a. **Income and assets generally.** Unless specifically required by state law or rule or federal law or regulation, the methodologies used in counting income and assets to determine eligibility for medical assistance for persons whose eligibility category is based on blindness, disability, or age of 65 or more years, the methodologies for the supplemental security income program shall be used, except as provided under subdivision 3, paragraph (f). Increases in benefits under title II of the Social Security Act shall not be counted as income for purposes of this subdivision until July 1 of each year. Effective upon federal approval, for children eligible under section 256B.055, subdivision 12, or for home and community-based waiver services whose eligibility for medical assistance is determined without regard to parental income, child support payments, including any payments made by an obligor in satisfaction of or in addition to a temporary or permanent

order for child support, and Social Security payments are not counted as income. For families and children, which includes all other eligibility categories, the methodologies under the state's AFDC plan in effect as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law 104-193, shall be used, except that effective October 1, 2003, the earned income disregards and deductions are limited to those in subdivision 1c. For these purposes, a "methodology" does not include an asset or income standard, or accounting method, or method of determining effective dates.

Sec. 21. Minnesota Statutes 2006, section 256B.056, subdivision 3, is amended to read:

Subd. 3. **Asset limitations for aged, blind, or disabled individuals ~~and families~~.** To be eligible for medical assistance, a person whose eligibility is based on blindness, disability, or age of 65 or more years must not individually own more than ~~$3,000~~ $6,000 in assets, or if a member of a household with two family members, husband and wife, or parent and child, the household must not own more than ~~$6,000~~ $12,000 in assets, plus ~~$200~~ $400 for each additional legal dependent. In addition to these maximum amounts, an eligible individual or family may accrue interest on these amounts, but they must be reduced to the maximum at the time of an eligibility redetermination. The accumulation of the clothing and personal needs allowance according to section 256B.35 must also be reduced to the maximum at the time of the eligibility redetermination. The value of assets that are not considered in determining eligibility for medical assistance is the value of those assets excluded under the supplemental security income program for aged, blind, and disabled persons, with the following exceptions:

(a) Household goods and personal effects are not considered.

(b) Capital and operating assets of a trade or business that the local agency determines are necessary to the person's ability to earn an income are not considered.

(c) Motor vehicles are excluded to the same extent excluded by the supplemental security income program.

(d) Assets designated as burial expenses are excluded to the same extent excluded by the supplemental security income program. Burial expenses funded by annuity contracts or life insurance policies must irrevocably designate the individual's estate as contingent beneficiary to the extent proceeds are not used for payment of selected burial expenses.

(e) Effective upon federal approval, for a person who no longer qualifies as an employed person with a disability due to loss of earnings, assets allowed while eligible for medical assistance under section 256B.057, subdivision 9, are not considered for 12 months, beginning with the first month of ineligibility as an employed person with a

disability, to the extent that the person's total assets remain within the allowed limits of section 256B.057, subdivision 9, paragraph (b).

(f) When a person enrolled in medical assistance under section 256B.057, subdivision 9, reaches age 65 and has been enrolled during each of the 24 consecutive months before the person's 65th birthday, the assets owned by the person and the person's spouse must be disregarded, up to the limits of section 256B.057, subdivision 9, paragraph (b), when determining eligibility for medical assistance under section 256B.055, subdivision 7. The income of a spouse of a person enrolled in medical assistance under section 256B.057, subdivision 9, during each of the 24 consecutive months before the person's 65th birthday must be disregarded when determining eligibility for medical assistance under section 256B.055, subdivision 7, when the person reaches age 65. This paragraph does not apply at the time the person or the person's spouse requests medical assistance payment for long-term care services.

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

Sec. 22. Minnesota Statutes 2006, section 256B.056, subdivision 5c, is amended to read:

Subd. 5c. **Excess income standard.** (a) The excess income standard for families with children is the standard specified in subdivision 4.

(b) The excess income standard for a person whose eligibility is based on blindness, disability, or age of 65 or more years is 70 percent of the federal poverty guidelines for the family size. Effective July 1, 2002, the excess income standard for this paragraph shall equal 75 percent of the federal poverty guidelines. Effective July 1, 2007, the excess income standard for this paragraph shall equal 85 percent of the federal poverty guidelines. The excess income standard for this paragraph shall be increased by five percentage points on July 1 of each of the next three years, so that the excess income standard shall equal 100 percent of the federal poverty guidelines effective July 1, 2010.

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

Sec. 23. Minnesota Statutes 2006, section 256B.0621, subdivision 11, is amended to read:

Subd. 11. **Data use agreement; notice of relocation assistance.** The commissioner shall ~~execute a data use agreement with the Centers for Medicare and Medicaid Services to obtain the long-term care minimum data set data to assist residents of nursing facilities who have~~ establish a process with the Centers for Independent Living that allows a person

residing in a Minnesota nursing facility to receive needed information, consultation, and assistance from one of the centers about the available community support options that may enable the person to relocate to the community, if the person: (1) is under the age of 65, (2) has indicated a desire to live in the community~~. The commissioner shall in turn enter into agreements with the Centers for Independent Living to provide information about assistance for persons who want to move to the community. The commissioner shall work with the Centers for Independent Living on both the content of the information to be provided and privacy protections for the individual residents~~, and (3) has signed a release of information authorized by the person or the person's appointed legal representative. The process established under this subdivision shall be coordinated with the long-term care consultation service activities established in section 256B.0911.

Sec. 24. Minnesota Statutes 2006, section 256B.0625, subdivision 18a, is amended to read:

Subd. 18a. **Access to medical services.** (a) Medical assistance reimbursement for meals for persons traveling to receive medical care may not exceed $5.50 for breakfast, $6.50 for lunch, or $8 for dinner.

(b) Medical assistance reimbursement for lodging for persons traveling to receive medical care may not exceed $50 per day unless prior authorized by the local agency.

(c) Medical assistance direct mileage reimbursement to the eligible person or the eligible person's driver may not exceed 20 cents per mile.

(d) Regardless of the number of employees that an enrolled health care provider may have, medical assistance covers sign and oral language interpreter services when provided by an enrolled health care provider during the course of providing a direct, person-to-person covered health care service to an enrolled recipient with limited English proficiency or who has a hearing loss and uses interpreting services.

Sec. 25. Minnesota Statutes 2006, section 256B.0625, is amended by adding a subdivision to read:

Subd. 49. **Self-directed supports option.** Upon federal approval, medical assistance covers the self-directed supports option as defined under section 256B.0657 and section 6087 of the Federal Deficit Reduction Act of 2005, Public Law 109-171.

EFFECTIVE DATE. This section is effective upon federal approval of the state Medicaid plan amendment. The commissioner of human services shall inform the Office of the Revisor of Statutes when approval is obtained.

Sec. 26. **[256B.0657] SELF-DIRECTED SUPPORTS OPTION.**

Subdivision 1. **Definition.** "Self-directed supports option" means personal assistance, supports, items, and related services purchased under an approved budget plan and budget by a recipient.

Subd. 2. **Eligibility.** (a) The self-directed supports option is available to a person who:

(1) is a recipient of medical assistance as determined under sections 256B.055, 256B.056, and 256B.057, subdivision 9;

(2) is eligible for personal care assistant services under section 256B.0655;

(3) lives in the person's own apartment or home, which is not owned, operated, or controlled by a provider of services not related by blood or marriage;

(4) has the ability to hire, fire, supervise, establish staff compensation for, and manage the individuals providing services, and to choose and obtain items, related services, and supports as described in the participant's plan. If the recipient is not able to carry out these functions but has a legal guardian or parent to carry them out, the guardian or parent may fulfill these functions on behalf of the recipient; and

(5) has not been excluded or disenrolled by the commissioner.

(b) The commissioner may disenroll or exclude recipients, including guardians and parents, under the following circumstances:

(1) recipients who have been restricted by the Primary Care Utilization Review Committee may be excluded for a specified time period; and

(2) recipients who exit the self-directed supports option during the recipient's service plan year shall not access the self-directed supports option for the remainder of that service plan year.

Subd. 3. **Eligibility for other services.** Selection of the self-directed supports option by a recipient shall not restrict access to other medically necessary care and services furnished under the state plan medical assistance benefit, including home care targeted case management, except that a person receiving home and community-based waiver services, a family support grant or a consumer support grant is not eligible for funding under the self-directed supports option.

Subd. 4. **Assessment requirements.** (a) The self-directed supports option assessment must meet the following requirements:

(1) it shall be conducted by the county public health nurse or a certified public health nurse under contract with the county;

(2) it shall be conducted face-to-face in the recipient's home initially, and at least annually thereafter; when there is a significant change in the recipient's condition; and

when there is a change in the need for personal care assistant services. A recipient who is residing in a facility may be assessed for the self-directed support option for the purpose of returning to the community using this option; and

(3) it shall be completed using the format established by the commissioner.

(b) The results of the assessment and recommendations shall be communicated to the commissioner and the recipient by the county public health nurse or certified public health nurse under contract with the county.

Subd. 5. **Self-directed supports option plan requirements.** (a) The plan for the self-directed supports option must meet the following requirements:

(1) the plan must be completed using a person-centered process that:

(i) builds upon the recipient's capacity to engage in activities that promote community life;

(ii) respects the recipient's preferences, choices, and abilities;

(iii) involves families, friends, and professionals in the planning or delivery of services or supports as desired or required by the recipient; and

(iv) addresses the need for personal care assistant services identified in the recipient's self-directed supports option assessment;

(2) the plan shall be developed by the recipient or by the guardian of an adult recipient or by a parent or guardian of a minor child, with the assistance of an enrolled medical assistance home care targeted case manager provider who meets the requirements established for using a person-centered planning process and shall be reviewed at least annually upon reassessment or when there is a significant change in the recipient's condition; and

(3) the plan must include the total budget amount available divided into monthly amounts that cover the number of months of personal care assistant services authorization included in the budget. The amount used each month may vary, but additional funds shall not be provided above the annual personal care assistant services authorized amount unless a change in condition is documented.

(b) The commissioner shall:

(1) establish the format and criteria for the plan as well as the requirements for providers who assist with plan development;

(2) review the assessment and plan and, within 30 days after receiving the assessment and plan, make a decision on approval of the plan;

(3) notify the recipient, parent, or guardian of approval or denial of the plan and provide notice of the right to appeal under section 256.045; and

(4) provide a copy of the plan to the fiscal support entity selected by the recipient.

Subd. 6. **Services covered.** (a) Services covered under the self-directed supports option include:

(1) personal care assistant services under section 256B.0655; and

(2) items, related services, and supports, including assistive technology, that increase independence or substitute for human assistance to the extent expenditures would otherwise be used for human assistance.

(b) Items, supports, and related services purchased under this option shall not be considered home care services for the purposes of section 144A.43.

Subd. 7. **Noncovered services.** Services or supports that are not eligible for payment under the self-directed supports option include:

(1) services, goods, or supports that do not benefit the recipient;

(2) any fees incurred by the recipient, such as Minnesota health care program fees and co-pays, legal fees, or costs related to advocate agencies;

(3) insurance, except for insurance costs related to employee coverage or fiscal support entity payments;

(4) room and board and personal items that are not related to the disability, except that medically prescribed specialized diet items may be covered if they reduce the need for human assistance;

(5) home modifications that add square footage;

(6) home modifications for a residence other than the primary residence of the recipient, or in the event of a minor with parents not living together, the primary residences of the parents;

(7) expenses for travel, lodging, or meals related to training the recipient, the parent or guardian of an adult recipient, or the parent or guardian of a minor child, or paid or unpaid caregivers that exceed $500 in a 12-month period;

(8) experimental treatment;

(9) any service or item covered by other medical assistance state plan services, including prescription and over-the-counter medications, compounds, and solutions and related fees, including premiums and co-payments;

(10) membership dues or costs, except when the service is necessary and appropriate to treat a physical condition or to improve or maintain the recipient's physical condition. The condition must be identified in the recipient's plan of care and monitored by a Minnesota health care program enrolled physician;

(11) vacation expenses other than the cost of direct services;

(12) vehicle maintenance or modifications not related to the disability;

(13) tickets and related costs to attend sporting or other recreational events; and

(14) costs related to Internet access, except when necessary for operation of assistive technology, to increase independence, or to substitute for human assistance.

Subd. 8. **Self-directed budget requirements.** The budget for the provision of the self-directed service option shall be equal to the greater of either:

(1) the annual amount of personal care assistant services under section 256B.0655 that the recipient has used in the most recent 12-month period; or

(2) the amount determined using the consumer support grant methodology under section 256.476, subdivision 11, except that the budget amount shall include the federal and nonfederal share of the average service costs.

Subd. 9. **Quality assurance and risk management.** (a) The commissioner shall establish quality assurance and risk management measures for use in developing and implementing self-directed plans and budgets that (1) recognize the roles and responsibilities involved in obtaining services in a self-directed manner, and (2) assure the appropriateness of such plans and budgets based upon a recipient's resources and capabilities. These measures must include (i) background studies, and (ii) backup and emergency plans, including disaster planning.

(b) The commissioner shall provide ongoing technical assistance and resource and educational materials for families and recipients selecting the self-directed option.

(c) Performance assessments measures, such as of a recipient's satisfaction with the services and supports, and ongoing monitoring of health and well-being shall be identified in consultation with the stakeholder group.

Subd. 10. **Fiscal support entity.** (a) Each recipient shall choose a fiscal support entity provider certified by the commissioner to make payments for services, items, supports, and administrative costs related to managing a self-directed service plan authorized for payment in the approved plan and budget. Recipients shall also choose the payroll, agency with choice, or the fiscal conduit model of financial and service management.

(b) The fiscal support entity:

(1) may not limit or restrict the recipient's choice of service or support providers, including use of the payroll, agency with choice, or fiscal conduit model of financial and service management;

(2) must have a written agreement with the recipient or the recipient's representative that identifies the duties and responsibilities to be performed and the specific related charges;

(3) must provide the recipient and the home care targeted case manager with a monthly written summary of the self-directed supports option services that were billed, including charges from the fiscal support entity;

(4) must be knowledgeable of and comply with Internal Revenue Service requirements necessary to process employer and employee deductions, provide appropriate and timely submission of employer tax liabilities, and maintain documentation to support medical assistance claims;

(5) must have current and adequate liability insurance and bonding and sufficient cash flow and have on staff or under contract a certified public accountant or an individual with a baccalaureate degree in accounting; and

(6) must maintain records to track all self-directed supports option services expenditures, including time records of persons paid to provide supports and receipts for any goods purchased. The records must be maintained for a minimum of five years from the claim date and be available for audit or review upon request. Claims submitted by the fiscal support entity must correspond with services, amounts, and time periods as authorized in the recipient's self-directed supports option plan.

(c) The commissioner shall have authority to:

(1) set or negotiate rates with fiscal support entities;

(2) limit the number of fiscal support entities;

(3) identify a process to certify and recertify fiscal support entities and assure fiscal support entities are available to recipients throughout the state; and

(4) establish a uniform format and protocol to be used by eligible fiscal support entities.

Subd. 11. **Stakeholder consultation.** The commissioner shall consult with a statewide consumer-directed services stakeholder group, including representatives of all types of consumer-directed service users, advocacy organizations, counties, and consumer-directed service providers. The commissioner shall seek recommendations from this stakeholder group in developing:

(1) the self-directed plan format;

(2) requirements and guidelines for the person-centered plan assessment and planning process;

(3) implementation of the option and the quality assurance and risk management techniques; and

(4) standards and requirements, including rates for the personal support plan development provider and the fiscal support entity; policies; training; and implementation. The stakeholder group shall provide recommendations on the repeal of the personal care

assistant choice option, transition issues, and whether the consumer support grant program under section 256.476 should be modified. The stakeholder group shall meet at least three times each year to provide advice on policy, implementation, and other aspects of consumer and self-directed services.

EFFECTIVE DATE. Subdivisions 1 to 10 are effective upon federal approval of the state Medicaid plan amendment. The commissioner of human services shall inform the Office of the Revisor of Statutes when federal approval is obtained. Subdivision 11 is effective July 1, 2007.

Sec. 27. Minnesota Statutes 2006, section 256B.0911, subdivision 3a, is amended to read:

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

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

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

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

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

(f) If the person chooses to use community-based services, the team must provide the person or the person's legal representative with a written community support plan, regardless of whether the individual is eligible for Minnesota health care programs. The person may request assistance in developing a community support plan without participating in a complete assessment.

(g) The person has the right to make the final decision between nursing facility placement and community placement after the screening team's recommendation, except as provided in subdivision 4a, paragraph (c).

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

(1) the need for and purpose of preadmission screening ~~and assessment~~ if the person selects nursing facility placement;

(2) the role of the long-term care consultation assessment and support planning in waiver and alternative care program eligibility determination;

~~(2)~~ (3) information about Minnesota health care programs;

~~(3)~~ (4) the person's freedom to accept or reject the recommendations of the team;

~~(4)~~ (5) the person's right to confidentiality under the Minnesota Government Data Practices Act, chapter 13; and

(6) the long-term care consultant's decision regarding the person's need for nursing facility level of care;

~~(5)~~ (7) the person's right to appeal the decision regarding the need for nursing facility level of care or the county's final decisions regarding public programs eligibility according to section 256.045, subdivision 3.

(i) Face-to-face assessment completed as part of eligibility determination for the alternative care, elderly waiver, community alternatives for disabled individuals, community alternative care, and traumatic brain injury waiver programs under sections 256B.0915, 256B.0917, and 256B.49 is valid to establish service eligibility for no more than 60 calendar days after the date of assessment. The effective eligibility start date for these programs can never be prior to the date of assessment. If an assessment was completed more than 60 days before the effective waiver or alternative care program eligibility start date, assessment and support plan information must be updated in a face-to-face visit and documented in the department's Medicaid Management Information System (MMIS). The effective date of program eligibility in this case cannot be prior to the date the updated assessment is completed.

Sec. 28. Minnesota Statutes 2006, section 256B.0911, subdivision 3b, is amended to read:

Subd. 3b. **Transition assistance.** (a) A long-term care consultation team shall provide assistance to persons residing in a nursing facility, hospital, regional treatment center, or intermediate care facility for persons with developmental disabilities who

request or are referred for assistance. Transition assistance must include assessment, community support plan development, referrals to Minnesota health care programs, and referrals to programs that provide assistance with housing. Transition assistance must also include information about the Centers for Independent Living and about other organizations that can provide assistance with relocation efforts, and information about contacting these organizations to obtain their assistance and support.

(b) The county shall develop transition processes with institutional social workers and discharge planners to ensure that:

(1) persons admitted to facilities receive information about transition assistance that is available;

(2) the assessment is completed for persons within ten working days of the date of request or recommendation for assessment; and

(3) there is a plan for transition and follow-up for the individual's return to the community. The plan must require notification of other local agencies when a person who may require assistance is screened by one county for admission to a facility located in another county.

(c) If a person who is eligible for a Minnesota health care program is admitted to a nursing facility, the nursing facility must include a consultation team member or the case manager in the discharge planning process.

Sec. 29. Minnesota Statutes 2006, section 256B.0911, is amended by adding a subdivision to read:

Subd. 3c. **Transition to housing with services.** (a) Transitional consultation shall be offered to all prospective residents 65 years of age or older regardless of income, assets, or funding sources before housing with services establishments offering or providing assisted living execute a lease or contract with the prospective resident. The purpose of transitional long-term care consultation is to support persons with current or anticipated long-term care needs in making informed choices among options that include the most cost-effective and least restrictive settings, and to delay spenddown to eligibility for publicly funded programs by connecting people to alternative services in their homes before transition to housing with services.

(b) Transitional consultation services are provided as determined by the commissioner of human services in partnership with county long-term care consultation units, and the Area Agencies on Aging, and are a combination of telephone-based and in-person assistance provided under models developed by the commissioner. The consultation is to be performed in a manner which provides objective and complete

information. Transitional consultation must be provided within five working days of the request of the prospective resident as follows:

(1) the consultation must be provided by a qualified professional as determined by the commissioner;

(2) the consultation must include a review of the prospective resident's reasons for considering assisted living, the prospective resident's personal goals, a discussion of the prospective resident's immediate and projected long-term care needs, and alternative community services or assisted living settings that may meet the prospective resident's needs; and

(3) the prospective resident will be informed of the availability of long-term care consultation services described in subdivision 3a that are available at no charge to the prospective resident to assist the prospective resident in assessment and planning to meet the prospective resident's long-term care needs. Regardless of the consultation, prospective residents maintain the right to choose housing with services or assisted living, if that is their choice.

EFFECTIVE DATE. This section is effective October 1, 2008.

Sec. 30. Minnesota Statutes 2006, section 256B.0911, subdivision 4b, is amended to read:

Subd. 4b. **Exemptions and emergency admissions.** (a) Exemptions from the federal screening requirements outlined in subdivision 4a, paragraphs (b) and (c), are limited to:

(1) a person who, having entered an acute care facility from a certified nursing facility, is returning to a certified nursing facility;

(2) a person transferring from one certified nursing facility in Minnesota to another certified nursing facility in Minnesota; and

(3) a person, 21 years of age or older, who satisfies the following criteria, as specified in Code of Federal Regulations, title 42, section 483.106(b)(2):

(i) the person is admitted to a nursing facility directly from a hospital after receiving acute inpatient care at the hospital;

(ii) the person requires nursing facility services for the same condition for which care was provided in the hospital; and

(iii) the attending physician has certified before the nursing facility admission that the person is likely to receive less than 30 days of nursing facility services.

(b) Persons who are exempt from preadmission screening for purposes of level of care determination include:

(1) persons described in paragraph (a);

(2) an individual who has a contractual right to have nursing facility care paid for indefinitely by the veterans' administration;

(3) an individual enrolled in a demonstration project under section 256B.69, subdivision 8, at the time of application to a nursing facility; and

(4) an individual currently being served under the alternative care program or under a home and community-based services waiver authorized under section 1915(c) of the federal Social Security Act~~; and~~.

~~(5) individuals admitted to a certified nursing facility for a short-term stay, which is expected to be 14 days or less in duration based upon a physician's certification, and who have been assessed and approved for nursing facility admission within the previous six months. This exemption applies only if the consultation team member determines at the time of the initial assessment of the six-month period that it is appropriate to use the nursing facility for short-term stays and that there is an adequate plan of care for return to the home or community-based setting. If a stay exceeds 14 days, the individual must be referred no later than the first county working day following the 14th resident day for a screening, which must be completed within five working days of the referral. The payment limitations in subdivision 7 apply to an individual found at screening to not meet the level of care criteria for admission to a certified nursing facility.~~

(c) Persons admitted to a Medicaid-certified nursing facility from the community on an emergency basis as described in paragraph (d) or from an acute care facility on a nonworking day must be screened the first working day after admission.

(d) Emergency admission to a nursing facility prior to screening is permitted when all of the following conditions are met:

(1) a person is admitted from the community to a certified nursing or certified boarding care facility during county nonworking hours;

(2) a physician has determined that delaying admission until preadmission screening is completed would adversely affect the person's health and safety;

(3) there is a recent precipitating event that precludes the client from living safely in the community, such as sustaining an injury, sudden onset of acute illness, or a caregiver's inability to continue to provide care;

(4) the attending physician has authorized the emergency placement and has documented the reason that the emergency placement is recommended; and

(5) the county is contacted on the first working day following the emergency admission.

Transfer of a patient from an acute care hospital to a nursing facility is not considered an emergency except for a person who has received hospital services in the following situations: hospital admission for observation, care in an emergency room without hospital admission, or following hospital 24-hour bed care.

(e) A nursing facility must provide ~~a~~ written ~~notice to persons who satisfy the criteria in paragraph (a), clause (3),~~ information to all persons admitted regarding the person's right to request and receive long-term care consultation services as defined in subdivision 1a. The ~~notice~~ information must be provided prior to the person's discharge from the facility and in a format specified by the commissioner.

Sec. 31. Minnesota Statutes 2006, section 256B.0911, subdivision 4c, is amended to read:

Subd. 4c. **Screening requirements.** (a) A person may be screened for nursing facility admission by telephone or in a face-to-face screening interview. Consultation team members shall identify each individual's needs using the following categories:

(1) the person needs no face-to-face screening interview to determine the need for nursing facility level of care based on information obtained from other health care professionals;

(2) the person needs an immediate face-to-face screening interview to determine the need for nursing facility level of care and complete activities required under subdivision 4a; or

(3) the person may be exempt from screening requirements as outlined in subdivision 4b, but will need transitional assistance after admission or in-person follow-along after a return home.

(b) Persons admitted on a nonemergency basis to a Medicaid-certified nursing facility must be screened prior to admission.

~~(c) The long-term care consultation team shall recommend a case mix classification for persons admitted to a certified nursing facility when sufficient information is received to make that classification. The nursing facility is authorized to conduct all case mix assessments for persons who have been screened prior to admission for whom the county did not recommend a case mix classification. The nursing facility is authorized to conduct all case mix assessments for persons admitted to the facility prior to a preadmission screening. The county retains the responsibility of distributing appropriate case mix forms to the nursing facility.~~

~~(d)~~ (c) The county screening or intake activity must include processes to identify persons who may require transition assistance as described in subdivision 3b.

Sec. 32. Minnesota Statutes 2006, section 256B.0911, subdivision 6, is amended to read:

Subd. 6. **Payment for long-term care consultation services.** (a) The total payment for each county must be paid monthly by certified nursing facilities in the county. The monthly amount to be paid by each nursing facility for each fiscal year must be determined by dividing the county's annual allocation for long-term care consultation services by 12 to determine the monthly payment and allocating the monthly payment to each nursing facility based on the number of licensed beds in the nursing facility. Payments to counties in which there is no certified nursing facility must be made by increasing the payment rate of the two facilities located nearest to the county seat.

(b) The commissioner shall include the total annual payment determined under paragraph (a) for each nursing facility reimbursed under section 256B.431 or 256B.434 according to section 256B.431, subdivision 2b, paragraph (g)~~, or 256B.435~~.

(c) In the event of the layaway, delicensure and decertification, or removal from layaway of 25 percent or more of the beds in a facility, the commissioner may adjust the per diem payment amount in paragraph (b) and may adjust the monthly payment amount in paragraph (a). The effective date of an adjustment made under this paragraph shall be on or after the first day of the month following the effective date of the layaway, delicensure and decertification, or removal from layaway.

(d) Payments for long-term care consultation services are available to the county or counties to cover staff salaries and expenses to provide the services described in subdivision 1a. The county shall employ, or contract with other agencies to employ, within the limits of available funding, sufficient personnel to provide long-term care consultation services while meeting the state's long-term care outcomes and objectives as defined in section 256B.0917, subdivision 1. The county shall be accountable for meeting local objectives as approved by the commissioner in the biennial home and community-based services quality assurance plan on a form provided by the commissioner.

(e) Notwithstanding section 256B.0641, overpayments attributable to payment of the screening costs under the medical assistance program may not be recovered from a facility.

(f) The commissioner of human services shall amend the Minnesota medical assistance plan to include reimbursement for the local consultation teams.

(g) The county may bill, as case management services, assessments, support planning, and follow-along provided to persons determined to be eligible for case management under Minnesota health care programs. No individual or family member shall be charged for an initial assessment or initial support plan development provided under subdivision 3a or 3b.

Sec. 33. Minnesota Statutes 2006, section 256B.0911, is amended by adding a subdivision to read:

Subd. 6a. **Withholding.** If any provider obligated to pay the long-term care consultation amount as described in subdivision 6 is more than two months delinquent in the timely payment of the monthly installment, the commissioner may withhold payments, penalties, and interest in accordance with the methods outlined in section 256.9657, subdivision 7a. Any amount withheld under this provision must be returned to the county to whom the delinquent payments were due.

Sec. 34. Minnesota Statutes 2006, section 256B.0911, subdivision 7, is amended to read:

Subd. 7. **Reimbursement for certified nursing facilities.** (a) Medical assistance reimbursement for nursing facilities shall be authorized for a medical assistance recipient only if a preadmission screening has been conducted prior to admission or the county has authorized an exemption. Medical assistance reimbursement for nursing facilities shall not be provided for any recipient who the local screener has determined does not meet the level of care criteria for nursing facility placement or, if indicated, has not had a level II OBRA evaluation as required under the federal Omnibus Budget Reconciliation Act of 1987 completed unless an admission for a recipient with mental illness is approved by the local mental health authority or an admission for a recipient with developmental disability is approved by the state developmental disability authority.

(b) The nursing facility must not bill a person who is not a medical assistance recipient for resident days that preceded the date of completion of screening activities as required under subdivisions 4a, 4b, and 4c. The nursing facility must include unreimbursed resident days in the nursing facility resident day totals reported to the commissioner.

~~(c) The commissioner shall make a request to the Centers for Medicare and Medicaid Services for a waiver allowing team approval of Medicaid payments for certified nursing facility care. An individual has a choice and makes the final decision between nursing facility placement and community placement after the screening team's recommendation, except as provided in subdivision 4a, paragraph (c).~~

Sec. 35. Minnesota Statutes 2006, section 256B.0913, subdivision 4, is amended to read:

Subd. 4. **Eligibility for funding for services for nonmedical assistance recipients.** (a) Funding for services under the alternative care program is available to persons who meet the following criteria:

(1) the person has been determined by a community assessment under section 256B.0911 to be a person who would require the level of care provided in a nursing facility, but for the provision of services under the alternative care program;

(2) the person is age 65 or older;

(3) the person would be eligible for medical assistance within 135 days of admission to a nursing facility;

(4) the person is not ineligible for the payment of long-term care services by the medical assistance program due to an asset transfer penalty under section 256B.0595 or equity interest in the home exceeding $500,000 as stated in section 256B.056;

(5) the person needs long-term care services that are not funded through other state or federal funding;

(6) the monthly cost of the alternative care services funded by the program for this person does not exceed 75 percent of the monthly limit described under section 256B.0915, subdivision 3a. This monthly limit does not prohibit the alternative care client from payment for additional services, but in no case may the cost of additional services purchased under this section exceed the difference between the client's monthly service limit defined under section 256B.0915, subdivision 3, and the alternative care program monthly service limit defined in this paragraph. If ~~medical~~ care-related supplies and equipment or environmental modifications and adaptations are or will be purchased for an alternative care services recipient, the costs may be prorated on a monthly basis for up to 12 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's other alternative care services exceeds the monthly limit established in this paragraph, the annual cost of the alternative care services shall be determined. In this event, the annual cost of alternative care services shall not exceed 12 times the monthly limit described in this paragraph; and

(7) the person is making timely payments of the assessed monthly fee.

A person is ineligible if payment of the fee is over 60 days past due, unless the person agrees to:

(i) the appointment of a representative payee;

(ii) automatic payment from a financial account;

(iii) the establishment of greater family involvement in the financial management of payments; or

(iv) another method acceptable to the ~~county~~ lead agency to ensure prompt fee payments.

The ~~county shall~~ lead agency may extend the client's eligibility as necessary while making arrangements to facilitate payment of past-due amounts and future premium

payments. Following disenrollment due to nonpayment of a monthly fee, eligibility shall not be reinstated for a period of 30 days.

(b) Alternative care funding under this subdivision is not available for a person who is a medical assistance recipient or who would be eligible for medical assistance without a spenddown or waiver obligation. A person whose initial application for medical assistance and the elderly waiver program is being processed may be served under the alternative care program for a period up to 60 days. If the individual is found to be eligible for medical assistance, medical assistance must be billed for services payable under the federally approved elderly waiver plan and delivered from the date the individual was found eligible for the federally approved elderly waiver plan. Notwithstanding this provision, alternative care funds may not be used to pay for any service the cost of which: (i) is payable by medical assistance; (ii) is used by a recipient to meet a waiver obligation; or (iii) is used to pay a medical assistance income spenddown for a person who is eligible to participate in the federally approved elderly waiver program under the special income standard provision.

(c) Alternative care funding is not available for a person who resides in a licensed nursing home, certified boarding care home, hospital, or intermediate care facility, except for case management services which are provided in support of the discharge planning process for a nursing home resident or certified boarding care home resident to assist with a relocation process to a community-based setting.

(d) Alternative care funding is not available for a person whose income is greater than the maintenance needs allowance under section 256B.0915, subdivision 1d, but equal to or less than 120 percent of the federal poverty guideline effective July 1 in the fiscal year for which alternative care eligibility is determined, who would be eligible for the elderly waiver with a waiver obligation.

Sec. 36. Minnesota Statutes 2006, section 256B.0913, subdivision 5, is amended to read:

Subd. 5. **Services covered under alternative care.** Alternative care funding may be used for payment of costs of:

(1) adult day care;

(2) home health aide;

(3) homemaker services;

(4) personal care;

(5) case management;

(6) respite care;

(7) care-related supplies and equipment;

(8) meals delivered to the home;

(9) nonmedical transportation;

(10) nursing services;

(11) chore services;

(12) companion services;

(13) nutrition services;

(14) training for direct informal caregivers;

(15) telehome care to provide services in their own homes in conjunction with in-home visits;

(16) ~~discretionary services, for which counties may make payment from their alternative care program allocation or services not otherwise defined in this section or section 256B.0625, following approval by the commissioner~~ consumer-directed community services under the alternative care programs which are available statewide and limited to the average monthly expenditures representative of all alternative care program participants for the same case mix resident class assigned in the most recent fiscal year for which complete expenditure data is available;

(17) environmental modifications and adaptations; and

(18) ~~direct cash payments for which counties may make payment from their alternative care program allocation to clients for the purpose of purchasing services, following approval by the commissioner, and subject to the provisions of subdivision 5h, until approval and implementation of consumer-directed services through the federally approved elderly waiver plan. Upon implementation, consumer-directed services under the alternative care program are available statewide and limited to the average monthly expenditures representative of all alternative care program participants for the same case mix resident class assigned in the most recent fiscal year for which complete expenditure data is available~~ discretionary services, for which lead agencies may make payment from their alternative care program allocation for services not otherwise defined in this section or section 256B.0625, following approval by the commissioner.

Total annual payments for discretionary services ~~and direct cash payments, until the federally approved consumer-directed service option is implemented statewide,~~ for all clients ~~within a county may~~ served by a lead agency must not exceed 25 percent of that ~~county's~~ lead agency's annual alternative care program base allocation. ~~Thereafter, discretionary services are limited to 25 percent of the county's annual alternative care program base allocation.~~

Sec. 37. Minnesota Statutes 2006, section 256B.0913, subdivision 5a, is amended to read:

Subd. 5a. **Services; service definitions; service standards.** (a) Unless specified in statute, the services, service definitions, and standards for alternative care services shall be the same as the services, service definitions, and standards specified in the federally approved elderly waiver plan, except ~~for~~ alternative care does not cover transitional support services, assisted living services, adult foster care services, and residential care ~~services~~ and benefits defined under section 256B.0625 that meet primary and acute health care needs.

(b) The ~~county~~ lead agency must ensure that the funds are not used to supplant or supplement services available through other public assistance or services programs~~.~~, including supplementation of client co-pays, deductibles, premiums, or other cost-sharing arrangements for health-related benefits and services or entitlement programs and services that are available to the person, but in which they have elected not to enroll. For a provider of supplies and equipment when the monthly cost of the supplies and equipment is less than $250, persons or agencies must be employed by or under a contract with the ~~county~~ lead agency or the public health nursing agency of the local board of health in order to receive funding under the alternative care program. Supplies and equipment may be purchased from a vendor not certified to participate in the Medicaid program if the cost for the item is less than that of a Medicaid vendor.

(c) Personal care services must meet the service standards defined in the federally approved elderly waiver plan, except that a ~~county~~ lead agency may contract with a client's relative who meets the relative hardship waiver requirements or a relative who meets the criteria and is also the responsible party under an individual service plan that ensures the client's health and safety and supervision of the personal care services by a qualified professional as defined in section 256B.0625, subdivision 19c. Relative hardship is established by the ~~county~~ lead agency when the client's care causes a relative caregiver to do any of the following: resign from a paying job, reduce work hours resulting in lost wages, obtain a leave of absence resulting in lost wages, incur substantial client-related expenses, provide services to address authorized, unstaffed direct care time, or meet special needs of the client unmet in the formal service plan.

Sec. 38. Minnesota Statutes 2006, section 256B.0913, subdivision 8, is amended to read:

Subd. 8. **Requirements for individual care plan.** (a) The case manager shall implement the plan of care for each alternative care client and ensure that a client's

service needs and eligibility are reassessed at least every 12 months. The plan shall include any services prescribed by the individual's attending physician as necessary to allow the individual to remain in a community setting. In developing the individual's care plan, the case manager should include the use of volunteers from families and neighbors, religious organizations, social clubs, and civic and service organizations to support the formal home care services. The ~~county~~ lead agency shall be held harmless for damages or injuries sustained through the use of volunteers under this subdivision including workers' compensation liability. The ~~county of service~~ case manager shall provide documentation in each individual's plan of care and, if requested, to the commissioner that the most cost-effective alternatives available have been offered to the individual and that the individual was free to choose among available qualified providers, both public and private, including qualified case management or service coordination providers other than those employed by any county; however, the county or tribe maintains responsibility for prior authorizing services in accordance with statutory and administrative requirements. The case manager must give the individual a ten-day written notice of any denial, termination, or reduction of alternative care services.

(b) The county of service or tribe must provide access to and arrange for case management services, including assuring implementation of the plan. "County of service" has the meaning given it in Minnesota Rules, part 9505.0015, subpart 11. The county of service must notify the county of financial responsibility of the approved care plan and the amount of encumbered funds.

Sec. 39. Minnesota Statutes 2006, section 256B.0913, subdivision 9, is amended to read:

Subd. 9. **Contracting provisions for providers.** Alternative care funds paid to service providers are subject to audit by the commissioner for fiscal and utilization control.

The lead agency must select providers for contracts or agreements using the following criteria and other criteria established by the ~~county~~ lead agency:

(1) the need for the particular services offered by the provider;

(2) the population to be served, including the number of clients, the length of time services will be provided, and the medical condition of clients;

(3) the geographic area to be served;

(4) quality assurance methods, including appropriate licensure, certification, or standards, and supervision of employees when needed;

(5) rates for each service and unit of service exclusive of ~~county~~ lead agency administrative costs;

(6) evaluation of services previously delivered by the provider; and

(7) contract or agreement conditions, including billing requirements, cancellation, and indemnification.

The ~~county~~ lead agency must evaluate its own agency services under the criteria established for other providers.

Sec. 40. Minnesota Statutes 2006, section 256B.0913, subdivision 10, is amended to read:

Subd. 10. **Allocation formula.** (a) ~~The alternative care appropriation for fiscal years 1992 and beyond shall cover only alternative care eligible clients.~~ By July ~~1~~ 15 of each year, the commissioner shall allocate to county agencies the state funds available for alternative care for persons eligible under subdivision 2.

(b) The adjusted base for each ~~county~~ lead agency is the ~~county's~~ lead agency's current fiscal year base allocation plus any targeted funds approved during the current fiscal year. Calculations for paragraphs (c) and (d) are to be made as follows: for each ~~county~~ lead agency, the determination of alternative care program expenditures shall be based on payments for services rendered from April 1 through March 31 in the base year, to the extent that claims have been submitted and paid by June 1 of that year.

(c) If the alternative care program expenditures as defined in paragraph (b) are 95 percent or more of the ~~county's~~ lead agency's adjusted base allocation, the allocation for the next fiscal year is 100 percent of the adjusted base, plus inflation to the extent that inflation is included in the state budget.

(d) If the alternative care program expenditures as defined in paragraph (b) are less than 95 percent of the ~~county's~~ lead agency's adjusted base allocation, the allocation for the next fiscal year is the adjusted base allocation less the amount of unspent funds below the 95 percent level.

(e) If the annual legislative appropriation for the alternative care program is inadequate to fund the combined ~~county~~ lead agency allocations for a biennium, the commissioner shall distribute to each ~~county~~ lead agency the entire annual appropriation as that ~~county's~~ lead agency's percentage of the computed base as calculated in paragraphs (c) and (d).

(f) On agreement between the commissioner and the lead agency, the commissioner may have discretion to reallocate alternative care base allocations distributed to lead agencies in which the base amount exceeds program expenditures.

Sec. 41. Minnesota Statutes 2006, section 256B.0913, subdivision 11, is amended to read:

Subd. 11. **Targeted funding.** (a) The purpose of targeted funding is to make additional money available to ~~counties~~ lead agencies with the greatest need. Targeted funds are not intended to be distributed equitably among all ~~counties~~ lead agencies, but rather, allocated to those with long-term care strategies that meet state goals.

(b) The funds available for targeted funding shall be the total appropriation for each fiscal year minus ~~county~~ lead agency allocations determined under subdivision 10 as adjusted for any inflation increases provided in appropriations for the biennium.

(c) The commissioner shall allocate targeted funds to ~~counties~~ lead agencies that demonstrate to the satisfaction of the commissioner that they have developed feasible plans to increase alternative care spending. In making targeted funding allocations, the commissioner shall use the following priorities:

(1) ~~counties~~ lead agencies that received a lower allocation in fiscal year 1991 than in fiscal year 1990. Counties remain in this priority until they have been restored to their fiscal year 1990 level plus inflation;

(2) ~~counties~~ lead agencies that sustain a base allocation reduction for failure to spend 95 percent of the allocation if they demonstrate that the base reduction should be restored;

(3) ~~counties~~ lead agencies that propose projects to divert community residents from nursing home placement or convert nursing home residents to community living; and

(4) ~~counties~~ lead agencies that can otherwise justify program growth by demonstrating the existence of waiting lists, demographically justified needs, or other unmet needs.

(d) ~~Counties~~ Lead agencies that would receive targeted funds according to paragraph (c) must demonstrate to the commissioner's satisfaction that the funds would be appropriately spent by showing how the funds would be used to further the state's alternative care goals as described in subdivision 1, and that the county has the administrative and service delivery capability to use them.

(e) The commissioner shall ~~request applications~~ make applications available for targeted funds by November 1 of each year. The ~~counties~~ lead agencies selected for targeted funds shall be notified of the amount of their additional funding. Targeted funds allocated to a ~~county~~ lead agency in one year shall be treated as part of the ~~county's~~ lead agency's base allocation for that year in determining allocations for subsequent years. No reallocations between ~~counties~~ lead agencies shall be made.

Sec. 42. Minnesota Statutes 2006, section 256B.0913, subdivision 12, is amended to read:

Subd. 12. **Client fees.** (a) A fee is required for all alternative care eligible clients to help pay for the cost of participating in the program. The amount of the fee for the alternative care client shall be determined as follows:

(1) when the alternative care client's income less recurring and predictable medical expenses is less than 100 percent of the federal poverty guideline effective on July 1 of the state fiscal year in which the fee is being computed, and total assets are less than $10,000, the fee is zero;

(2) when the alternative care client's income less recurring and predictable medical expenses is equal to or greater than 100 percent but less than 150 percent of the federal poverty guideline effective on July 1 of the state fiscal year in which the fee is being computed, and total assets are less than $10,000, the fee is five percent of the cost of alternative care services;

(3) when the alternative care client's income less recurring and predictable medical expenses is equal to or greater than 150 percent but less than 200 percent of the federal poverty guidelines effective on July 1 of the state fiscal year in which the fee is being computed and assets are less than $10,000, the fee is 15 percent of the cost of alternative care services;

(4) when the alternative care client's income less recurring and predictable medical expenses is equal to or greater than 200 percent of the federal poverty guidelines effective on July 1 of the state fiscal year in which the fee is being computed and assets are less than $10,000, the fee is 30 percent of the cost of alternative care services; and

(5) when the alternative care client's assets are equal to or greater than $10,000, the fee is 30 percent of the cost of alternative care services.

For married persons, total assets are defined as the total marital assets less the estimated community spouse asset allowance, under section 256B.059, if applicable. For married persons, total income is defined as the client's income less the monthly spousal allotment, under section 256B.058.

All alternative care services shall be included in the estimated costs for the purpose of determining the fee.

Fees are due and payable each month alternative care services are received unless the actual cost of the services is less than the fee, in which case the fee is the lesser amount.

(b) The fee shall be waived by the commissioner when:

(1) a person ~~who~~ is residing in a nursing facility ~~is receiving case management only~~;

(2) a married couple is requesting an asset assessment under the spousal impoverishment provisions;

(3) a person is found eligible for alternative care, but is not yet receiving alternative care services including case management services; or

(4) a person has chosen to participate in a consumer-directed service plan for which the cost is no greater than the total cost of the person's alternative care service plan less the monthly fee amount that would otherwise be assessed.

(c) The ~~county agency must record in the state's receivable system the client's assessed fee amount or the reason the fee has been waived. The~~ commissioner will bill and collect the fee from the client. Money collected must be deposited in the general fund and is appropriated to the commissioner for the alternative care program. The client must supply the ~~county~~ lead agency with the client's Social Security number at the time of application. The ~~county~~ lead agency shall supply the commissioner with the client's Social Security number and other information the commissioner requires to collect the fee from the client. The commissioner shall collect unpaid fees using the Revenue Recapture Act in chapter 270A and other methods available to the commissioner. The commissioner may require ~~counties~~ lead agencies to inform clients of the collection procedures that may be used by the state if a fee is not paid. This paragraph does not apply to alternative care pilot projects authorized in Laws 1993, First Special Session chapter 1, article 5, section 133, if a county operating under the pilot project reports the following dollar amounts to the commissioner quarterly:

(1) total fees billed to clients;

(2) total collections of fees billed; and

(3) balance of fees owed by clients.

If a ~~county~~ lead agency does not adhere to these reporting requirements, the commissioner may terminate the billing, collecting, and remitting portions of the pilot project and require the ~~county~~ lead agency involved to operate under the procedures set forth in this paragraph.

Sec. 43. Minnesota Statutes 2006, section 256B.0913, subdivision 13, is amended to read:

Subd. 13. **~~County~~ Lead agency biennial plan.** The ~~county~~ lead agency biennial plan for long-term care consultation services under section 256B.0911, the alternative care program under this section, and waivers for the elderly under section 256B.0915, shall be submitted by the lead agency as the home and community-based services quality assurance plan on a form provided by the commissioner.

Sec. 44. Minnesota Statutes 2006, section 256B.0913, subdivision 14, is amended to read:

Subd. 14. **Provider requirements, payment, and rate adjustments.** (a) Unless otherwise specified in statute, providers must be enrolled as Minnesota health care program providers and abide by the requirements for provider participation according to Minnesota Rules, part 9505.0195.

(b) Payment for provided alternative care services as approved by the client's case manager shall occur through the invoice processing procedures of the department's Medicaid Management Information System (MMIS). To receive payment, the ~~county~~ lead agency or vendor must submit invoices within 12 months following the date of service. The ~~county~~ lead agency and its vendors under contract shall not be reimbursed for services which exceed the county allocation.

(c) The ~~county~~ lead agency shall negotiate individual rates with vendors and may authorize service payment for actual costs up to the county's current approved rate. Notwithstanding any other rule or statutory provision to the contrary, the commissioner shall not be authorized to increase rates by an annual inflation factor, unless so authorized by the legislature. To improve access to community services and eliminate payment disparities between the alternative care program and the elderly waiver program, the commissioner shall establish statewide maximum service rate limits and eliminate county-specific service rate limits.

(1) Effective July 1, 2001, for service rate limits, except those in subdivision 5, paragraphs (d) and (i), the rate limit for each service shall be the greater of the alternative care statewide maximum rate or the elderly waiver statewide maximum rate.

(2) ~~Counties~~ Lead agencies may negotiate individual service rates with vendors for actual costs up to the statewide maximum service rate limit.

Sec. 45. Minnesota Statutes 2006, section 256B.0915, is amended to read:

256B.0915 MEDICAID WAIVER FOR ELDERLY SERVICES.

Subdivision 1. **Authority.** The commissioner is authorized to apply for a home and community-based services waiver for the elderly, authorized under section 1915(c) of the Social Security Act, in order to obtain federal financial participation to expand the availability of services for persons who are eligible for medical assistance. The commissioner may apply for additional waivers or pursue other federal financial participation which is advantageous to the state for funding home care services for the frail elderly who are eligible for medical assistance. The provision of waivered services

to elderly and disabled medical assistance recipients must comply with the criteria for service definitions and provider standards approved in the waiver.

Subd. 1a. **Elderly waiver case management services.** (a) Elderly case management services under the home and community-based services waiver for elderly individuals are available from providers meeting qualification requirements and the standards specified in subdivision 1b. Eligible recipients may choose any qualified provider of elderly case management services.

Case management services assist individuals who receive waiver services in gaining access to needed waiver and other state plan services, as well as needed medical, social, educational, and other services regardless of the funding source for the services to which access is gained.

A case aide shall provide assistance to the case manager in carrying out administrative activities of the case management function. The case aide may not assume responsibilities that require professional judgment including assessments, reassessments, and care plan development. The case manager is responsible for providing oversight of the case aide.

Case managers shall be responsible for ongoing monitoring of the provision of services included in the individual's plan of care. Case managers shall initiate and oversee the process of assessment and reassessment of the individual's care and review plan of care at intervals specified in the federally approved waiver plan.

(b) The county of service or tribe must provide access to and arrange for case management services. County of service has the meaning given it in Minnesota Rules, part 9505.0015, subpart 11.

Subd. 1b. **Provider qualifications and standards.** The commissioner must enroll qualified providers of elderly case management services under the home and community-based waiver for the elderly under section 1915(c) of the Social Security Act. The enrollment process shall ensure the provider's ability to meet the qualification requirements and standards in this subdivision and other federal and state requirements of this service. An elderly case management provider is an enrolled medical assistance provider who is determined by the commissioner to have all of the following characteristics:

(1) the demonstrated capacity and experience to provide the components of case management to coordinate and link community resources needed by the eligible population;

(2) administrative capacity and experience in serving the target population for whom it will provide services and in ensuring quality of services under state and federal requirements;

(3) a financial management system that provides accurate documentation of services and costs under state and federal requirements;

(4) the capacity to document and maintain individual case records under state and federal requirements; and

(5) the ~~county~~ lead agency may allow a case manager employed by the ~~county~~ lead agency to delegate certain aspects of the case management activity to another individual employed by the ~~county~~ lead agency provided there is oversight of the individual by the case manager. The case manager may not delegate those aspects which require professional judgment including assessments, reassessments, and care plan development. Lead agencies include counties, health plans, and federally recognized tribes who authorize services under this section.

~~Subd. 1c. **Case management activities under the state plan.** The commissioner shall seek an amendment to the home and community-based services waiver for the elderly to implement the provisions of subdivisions 1a and 1b. If the commissioner is unable to secure the approval of the secretary of health and human services for the requested waiver amendment by December 31, 1993, the commissioner shall amend the medical assistance state plan to provide that case management provided under the home and community-based services waiver for the elderly is performed by counties as an administrative function for the proper and effective administration of the state medical assistance plan. The state shall reimburse counties for the nonfederal share of costs for case management performed as an administrative function under the home and community-based services waiver for the elderly.~~

Subd. 1d. **Posteligibility treatment of income and resources for elderly waiver.** Notwithstanding the provisions of section 256B.056, the commissioner shall make the following amendment to the medical assistance elderly waiver program effective July 1, 1999, or upon federal approval, whichever is later.

A recipient's maintenance needs will be an amount equal to the Minnesota supplemental aid equivalent rate as defined in section 256I.03, subdivision 5, plus the medical assistance personal needs allowance as defined in section 256B.35, subdivision 1, paragraph (a), when applying posteligibility treatment of income rules to the gross income of elderly waiver recipients, except for individuals whose income is in excess of the special income standard according to Code of Federal Regulations, title 42, section 435.236. Recipient maintenance needs shall be adjusted under this provision each July 1.

Subd. 2. **Spousal impoverishment policies.** The commissioner shall ~~seek to amend the federal waiver and the medical assistance state plan to allow~~ apply:

(1) the spousal impoverishment criteria as authorized under United States Code, title 42, section 1396r-5, and as implemented in sections 256B.0575, 256B.058, and 256B.059~~;~~ ~~except that the amendment shall seek to add to~~;

(2) the personal needs allowance permitted in section 256B.0575~~;~~; and

(3) an amount equivalent to the group residential housing rate as set by section 256I.03, subdivision 5, and according to the approved federal waiver and medical assistance state plan.

Subd. 3. **Limits of cases.** The number of medical assistance waiver recipients that a ~~county~~ lead agency may serve must be allocated according to the number of medical assistance waiver cases open on July 1 of each fiscal year. Additional recipients may be served with the approval of the commissioner.

Subd. 3a. **Elderly waiver cost limits.** (a) The monthly limit for the cost of waivered services to an individual elderly waiver client shall be the weighted average monthly nursing facility rate of the case mix resident class to which the elderly waiver client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, less the recipient's maintenance needs allowance as described in subdivision 1d, paragraph (a), until the first day of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented. Effective on the first day of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented and the first day of each subsequent state fiscal year, the monthly limit for the cost of waivered services to an individual elderly waiver client shall be the rate of the case mix resident class to which the waiver client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, in effect on the last day of the previous state fiscal year, adjusted by the greater of any legislatively adopted home and community-based services percentage rate increase or the average statewide percentage increase in nursing facility payment rates.

(b) If extended medical supplies and equipment or environmental modifications are or will be purchased for an elderly waiver client, the costs may be prorated for up to 12 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's waivered services exceeds the monthly limit established in paragraph (a), the annual cost of all waivered services shall be determined. In this event, the annual cost of all waivered services shall not exceed 12 times the monthly limit of waivered services as described in paragraph (a).

Subd. 3b. **Cost limits for elderly waiver applicants who reside in a nursing facility.** (a) For a person who is a nursing facility resident at the time of requesting a determination of eligibility for elderly waivered services, a monthly conversion limit for the cost of elderly waivered services may be requested. The monthly conversion limit for the cost of elderly waiver services shall be the resident class assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, for that resident in the nursing facility where the resident currently resides until July 1 of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented. Effective on July 1 of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented, the monthly conversion limit for the cost of elderly waiver services shall be the per diem nursing facility rate as determined by the resident assessment system as described in section 256B.437 for that resident in the nursing facility where the resident currently resides multiplied by 365 and divided by 12, less the recipient's maintenance needs allowance as described in subdivision 1d. The initially approved conversion rate may be adjusted by the greater of any subsequent legislatively adopted home and community-based services percentage rate increase or the average statewide percentage increase in nursing facility payment rates. The limit under this subdivision only applies to persons discharged from a nursing facility after a minimum 30-day stay and found eligible for waivered services on or after July 1, 1997. For conversions from the nursing home to the elderly waiver with consumer directed community support services, the conversion rate limit is equal to the nursing facility rate reduced by a percentage equal to the percentage difference between the consumer directed services budget limit that would be assigned according to the federally approved waiver plan and the corresponding community case mix cap, but not to exceed 50 percent.

(b) The following costs must be included in determining the total monthly costs for the waiver client:

(1) cost of all waivered services, including extended medical supplies and equipment and environmental modifications and adaptations; and

(2) cost of skilled nursing, home health aide, and personal care services reimbursable by medical assistance.

Subd. 3c. **Service approval and contracting provisions.** (a) Medical assistance funding for skilled nursing services, private duty nursing, home health aide, and personal care services for waiver recipients must be approved by the case manager and included in the individual care plan.

(b) A ~~county~~ lead agency is not required to contract with a provider of supplies and equipment if the monthly cost of the supplies and equipment is less than $250.

Subd. 3d. **Adult foster care rate.** The adult foster care rate shall be considered a difficulty of care payment and shall not include room and board. The adult foster care service rate shall be negotiated between the ~~county~~ lead agency and the foster care provider. The elderly waiver payment for the foster care service in combination with the payment for all other elderly waiver services, including case management, must not exceed the limit specified in subdivision 3a, paragraph (a).

Subd. 3e. ~~**Assisted living**~~ **Customized living service rate.** (a) Payment for ~~assisted living service~~ customize living services shall be a monthly rate negotiated and authorized by the ~~county agency based on an individualized service plan for each resident and may not cover direct rent or food costs.~~ lead agency within the parameters established by the commissioner. The payment agreement must delineate the services that have been customized for each recipient and specify the amount of each service to be provided. The lead agency shall ensure that there is a documented need for all services authorized. Customized living services must not include rent or raw food costs. The negotiated payment rate must be based on services to be provided. Negotiated rates must not exceed payment rates for comparable elderly waiver or medical assistance services and must reflect economies of scale.

(b) The individualized monthly negotiated payment for ~~assisted living~~ customized living services ~~as described in section 256B.0913, subdivisions 5d to 5f, and residential care services as described in section 256B.0913, subdivision 5c,~~ shall not exceed the nonfederal share, in effect on July 1 of the state fiscal year for which the rate limit is being calculated, of the greater of either the statewide or any of the geographic groups' weighted average monthly nursing facility rate of the case mix resident class to which the elderly waiver eligible client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, less the maintenance needs allowance as described in subdivision 1d, paragraph (a), until the July 1 of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented. Effective on July 1 of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented and July 1 of each subsequent state fiscal year, the individualized monthly negotiated payment for the services described in this clause shall not exceed the limit described in this clause which was in effect on June 30 of the previous state fiscal year and which has been adjusted by the greater of any legislatively adopted home and

community-based services cost-of-living percentage increase or any legislatively adopted statewide percent rate increase for nursing facilities.

(c) ~~The individualized monthly negotiated payment for assisted~~ Customized living services ~~described in section 144A.4605 and~~ are delivered by a provider licensed by the Department of Health as a class A or class F home care provider ~~or an assisted living home care provider~~ and provided in a building that is registered as a housing with services establishment under chapter 144D ~~and that provides 24-hour supervision in combination with the payment for other elderly waiver services, including case management, must not exceed the limit specified in subdivision 3a~~.

Subd. 3f. **Individual service rates; expenditure forecasts.** (a) The ~~county~~ lead agency shall negotiate individual service rates with vendors and may authorize payment for actual costs up to the ~~county's~~ lead agency's current approved rate. Persons or agencies must be employed by or under a contract with the ~~county~~ lead agency or the public health nursing agency of the local board of health in order to receive funding under the elderly waiver program, except as a provider of supplies and equipment when the monthly cost of the supplies and equipment is less than $250.

(b) Reimbursement for the medical assistance recipients under the approved waiver shall be made from the medical assistance account through the invoice processing procedures of the department's Medicaid Management Information System (MMIS), only with the approval of the client's case manager. The budget for the state share of the Medicaid expenditures shall be forecasted with the medical assistance budget, and shall be consistent with the approved waiver.

Subd. 3g. **Service rate limits; state assumption of costs.** (a) To improve access to community services and eliminate payment disparities between the alternative care program and the elderly waiver, the commissioner shall establish statewide maximum service rate limits and eliminate ~~county-specific~~ lead agency-specific service rate limits.

(b) Effective July 1, 2001, for service rate limits, except those described or defined in subdivisions 3d and 3e, the rate limit for each service shall be the greater of the alternative care statewide maximum rate or the elderly waiver statewide maximum rate.

(c) ~~Counties~~ Lead agencies may negotiate individual service rates with vendors for actual costs up to the statewide maximum service rate limit.

Subd. 3h. **Service rate limits; 24-hour customized living services.** The payment rates for 24-hour customized living services is a monthly rate negotiated and authorized by the lead agency within the parameters established by the commissioner of human services. The payment agreement must delineate the services that have been customized for each recipient and specify the amount of each service to be provided. The lead agency shall

ensure that there is a documented need for all services authorized. The lead agency shall not authorize 24-hour customized living services unless there is a documented need for 24-hour supervision. For purposes of this section, "24-hour supervision" means that the recipient requires assistance due to needs related to one or more of the following:

(1) intermittent assistance with toileting or transferring;

(2) cognitive or behavioral issues;

(3) a medical condition that requires clinical monitoring; or

(4) other conditions or needs as defined by the commissioner of human services.

The lead agency shall ensure that the frequency and mode of supervision of the recipient and the qualifications of staff providing supervision are described and meet the needs of the recipient. Customized living services must not include rent or raw food costs. The negotiated payment rate for 24-hour customized living services must be based on services to be provided. Negotiated rates must not exceed payment rates for comparable elderly waiver or medical assistance services and must reflect economies of scale. The individually negotiated 24-hour customized living payments, in combination with the payment for other elderly waiver services, including case management, must not exceed the recipient's community budget cap specified in subdivision 3a.

Subd. 4. **Termination notice.** The case manager must give the individual a ten-day written notice of any denial, reduction, or termination of waivered services.

Subd. 5. **Assessments and reassessments for waiver clients.** Each client shall receive an initial assessment of strengths, informal supports, and need for services in accordance with section 256B.0911, subdivisions 3, 3a, and 3b. A reassessment of a client served under the elderly waiver must be conducted at least every 12 months and at other times when the case manager determines that there has been significant change in the client's functioning. This may include instances where the client is discharged from the hospital.

Subd. 6. **Implementation of care plan.** Each elderly waiver client shall be provided a copy of a written care plan that meets the requirements outlined in section 256B.0913, subdivision 8. The care plan must be implemented by the county ~~administering waivered services~~ of service when it is different than the county of financial responsibility. The county of service administering waivered services must notify the county of financial responsibility of the approved care plan.

Subd. 7. **Prepaid elderly waiver services.** An individual for whom a prepaid health plan is liable for nursing home services or elderly waiver services according to section 256B.69, subdivision 6a, is not eligible to also receive county-administered elderly waiver services ~~under this section~~.

Subd. 8. **Services and supports.** (a) Services and supports shall meet the requirements set out in United States Code, title 42, section 1396n.

(b) Services and supports shall promote consumer choice and be arranged and provided consistent with individualized, written care plans.

(c) The state of Minnesota, county, managed care organization, or tribal government under contract to administer the elderly waiver shall not be liable for damages, injuries, or liabilities sustained through the purchase of direct supports or goods by the person, the person's family, or the authorized representatives with funds received through consumer-directed community support services under the federally approved waiver plan. Liabilities include, but are not limited to, workers' compensation liability, the Federal Insurance Contributions Act (FICA), or the Federal Unemployment Tax Act (FUTA).

Subd. 9. **Tribal management of elderly waiver.** Notwithstanding contrary provisions of this section, or those in other state laws or rules, the commissioner may develop a model for tribal management of the elderly waiver program and implement this model through a contract between the state and any of the state's federally recognized tribal governments. The model shall include the provision of tribal waiver case management, assessment for personal care assistance, and administrative requirements otherwise carried out by ~~counties~~ lead agencies but shall not include tribal financial eligibility determination for medical assistance.

EFFECTIVE DATE. Subdivision 3h is effective the day following final enactment.

Sec. 46. Minnesota Statutes 2006, section 256B.0917, subdivision 8, is amended to read:

Subd. 8. **Living-at-home/block nurse program grant.** (a) The organization awarded the contract under subdivision 7, shall develop and administer a grant program to establish or expand up to ~~33~~ 51 community-based organizations that will implement living-at-home/block nurse programs that are designed to enable senior citizens to live as independently as possible in their homes and in their communities. At least one-half of the programs must be in counties outside the seven-county metropolitan area. Nonprofit organizations and units of local government are eligible to apply for grants to establish the community organizations that will implement living-at-home/block nurse programs. In awarding grants, the organization awarded the contract under subdivision 7 shall give preference to nonprofit organizations and units of local government from communities that:

(1) have high nursing home occupancy rates;

(2) have a shortage of health care professionals;

(3) are located in counties adjacent to, or are located in, counties with existing living-at-home/block nurse programs; and

(4) meet other criteria established by LAH/BN, Inc., in consultation with the commissioner.

(b) Grant applicants must also meet the following criteria:

(1) the local community demonstrates a readiness to establish a community model of care, including the formation of a board of directors, advisory committee, or similar group, of which at least two-thirds is comprised of community citizens interested in community-based care for older persons;

(2) the program has sponsorship by a credible, representative organization within the community;

(3) the program has defined specific geographic boundaries and defined its organization, staffing and coordination/delivery of services;

(4) the program demonstrates a team approach to coordination and care, ensuring that the older adult participants, their families, the formal and informal providers are all part of the effort to plan and provide services; and

(5) the program provides assurances that all community resources and funding will be coordinated and that other funding sources will be maximized, including a person's own resources.

(c) Grant applicants must provide a minimum of five percent of total estimated development costs from local community funding. Grants shall be awarded for four-year periods, and the base amount shall not exceed ~~$80,000~~ $100,000 per applicant for the grant period. The organization under contract may increase the grant amount for applicants from communities that have socioeconomic characteristics that indicate a higher level of need for assistance. Subject to the availability of funding, grants and grant renewals awarded or entered into on or after July 1, 1997, shall be renewed by LAH/BN, Inc. every four years, unless LAH/BN, Inc. determines that the grant recipient has not satisfactorily operated the living-at-home/block nurse program in compliance with the requirements of paragraphs (b) and (d). Grants provided to living-at-home/block nurse programs under this paragraph may be used for both program development and the delivery of services.

(d) Each living-at-home/block nurse program shall be designed by representatives of the communities being served to ensure that the program addresses the specific needs of the community residents. The programs must be designed to:

(1) incorporate the basic community, organizational, and service delivery principles of the living-at-home/block nurse program model;

(2) provide senior citizens with registered nurse directed assessment, provision and coordination of health and personal care services on a sliding fee basis as an alternative to expensive nursing home care;

(3) provide information, support services, homemaking services, counseling, and training for the client and family caregivers;

(4) encourage the development and use of respite care, caregiver support, and in-home support programs, such as adult foster care and in-home adult day care;

(5) encourage neighborhood residents and local organizations to collaborate in meeting the needs of senior citizens in their communities;

(6) recruit, train, and direct the use of volunteers to provide informal services and other appropriate support to senior citizens and their caregivers; and

(7) provide coordination and management of formal and informal services to senior citizens and their families using less expensive alternatives.

Sec. 47. Minnesota Statutes 2006, section 256B.0919, subdivision 3, is amended to read:

Subd. 3. **County certification of persons providing adult foster care to related persons.** A person exempt from licensure under section 245A.03, subdivision 2, who provides adult foster care to a related individual age 65 and older, and who meets the requirements in Minnesota Rules, parts 9555.5105 to 9555.6265, may be certified by the county to provide adult foster care. A person certified by the county to provide adult foster care may be reimbursed for services provided and eligible for funding under ~~sections 256B.0913 and~~ section 256B.0915, if the relative would suffer a financial hardship as a result of providing care. For purposes of this subdivision, financial hardship refers to a situation in which a relative incurs a substantial reduction in income as a result of resigning from a full-time job or taking a leave of absence without pay from a full-time job to care for the client.

Sec. 48. Minnesota Statutes 2006, section 256B.095, is amended to read:

256B.095 QUALITY ASSURANCE SYSTEM ESTABLISHED.

(a) Effective July 1, 1998, a quality assurance system for persons with developmental disabilities, which includes an alternative quality assurance licensing system for programs, is established in Dodge, Fillmore, Freeborn, Goodhue, Houston, Mower, Olmsted, Rice, Steele, Wabasha, and Winona Counties for the purpose of improving the quality of services provided to persons with developmental disabilities. A county, at its option, may choose to have all programs for persons with developmental disabilities located within

the county licensed under chapter 245A using standards determined under the alternative quality assurance licensing system or may continue regulation of these programs under the licensing system operated by the commissioner. The project expires on June 30, ~~2009~~ 2014.

(b) Effective July 1, 2003, a county not listed in paragraph (a) may apply to participate in the quality assurance system established under paragraph (a). The commission established under section 256B.0951 may, at its option, allow additional counties to participate in the system.

(c) Effective July 1, 2003, any county or group of counties not listed in paragraph (a) may establish a quality assurance system under this section. A new system established under this section shall have the same rights and duties as the system established under paragraph (a). A new system shall be governed by a commission under section 256B.0951. The commissioner shall appoint the initial commission members based on recommendations from advocates, families, service providers, and counties in the geographic area included in the new system. Counties that choose to participate in a new system shall have the duties assigned under section 256B.0952. The new system shall establish a quality assurance process under section 256B.0953. The provisions of section 256B.0954 shall apply to a new system established under this paragraph. The commissioner shall delegate authority to a new system established under this paragraph according to section 256B.0955.

(d) Effective July 1, 2007, the quality assurance system may be expanded to include programs for persons with disabilities and older adults.

Sec. 49. Minnesota Statutes 2006, section 256B.0951, subdivision 1, is amended to read:

Subdivision 1. **Membership.** The Quality Assurance Commission is established. The commission consists of at least 14 but not more than 21 members as follows: at least three but not more than five members representing advocacy organizations; at least three but not more than five members representing consumers, families, and their legal representatives; at least three but not more than five members representing service providers; at least three but not more than five members representing counties; and the commissioner of human services or the commissioner's designee. The first commission shall establish membership guidelines for the transition and recruitment of membership for the commission's ongoing existence. Members of the commission who do not receive a salary or wages from an employer for time spent on commission duties may receive a per diem payment when performing commission duties and functions. All members may be

reimbursed for expenses related to commission activities. Notwithstanding the provisions of section 15.059, subdivision 5, the commission expires on June 30, ~~2009~~ 2014.

Sec. 50. **[256B.096] QUALITY MANAGEMENT; ASSURANCE; AND IMPROVEMENT SYSTEM FOR MINNESOTANS RECEIVING DISABILITY SERVICES.**

Subdivision 1. **Scope.** In order to improve the quality of services provided to Minnesotans with disabilities and to meet the requirements of the federally approved home and community-based waivers under section 1915c of the Social Security Act, a statewide quality assurance and improvement system for Minnesotans receiving disability services shall be developed. The disability services included are the home and community-based services waiver programs for persons with developmental disabilities under section 256B.092, subdivision 4, and persons with disabilities under section 256B.49.

Subd. 2. **Stakeholder advisory group.** The commissioner shall consult with a stakeholder advisory group on the development and implementation of the state quality management, assurance, and improvement system, including representatives from: disability service recipients, disability service providers, disability advocacy groups, county human service agencies, and state agency staff from the Departments of Human Services and Health and ombudsman for mental health and developmental disabilities on the development of a statewide quality assurance and improvement system.

Subd. 3. **Annual survey of service recipients.** The commissioner, in consultation with the stakeholder advisory group, shall develop and conduct an annual independent random statewide survey of between five and ten percent of service recipients to determine the effectiveness and quality of disability services. The survey shall be consistent with the system performance expectations of the Centers for Medicare and Medicaid Services quality management requirements and framework. The survey shall analyze whether desired outcomes have been achieved for persons with different demographic, diagnostic, health, and functional needs and receiving different types of services, in different settings, with different costs. The survey shall be field tested during 2008 and implemented by February 1, 2009. Annual statewide and regional reports of the results shall be published for use by regions, counties, and providers to plan and measure the impact of quality improvement activities.

Subd. 4. **Improvements for incident reporting, investigation, analysis, and follow-up.** In consultation with the stakeholder group, the commissioner shall identify the information, data sources, and technology needed to improve the system of incident reporting, including:

(1) reports made under the Maltreatment of Minors and Vulnerable Adults Acts; and

(2) investigation, analysis, and follow-up for disability services.

The commissioner must ensure that the federal home and community-based waiver requirements are met and that incidents that may have jeopardized safety; health; or violated service-related assurances, civil and human rights, and other protections designed to prevent abuse, neglect, and exploitation are reviewed, investigated, and acted upon in a timely manner.

Subd. 5. **Biennial report.** The commissioner shall provide a biennial report to the chairs of the legislative committees with jurisdiction over health and human services policy and funding beginning January 15, 2009, on the development and activities of the quality management, assurance, and improvement system designed to meet the federal requirements under the home and community-based services waiver programs for persons with disabilities. By January 15, 2008, the commissioner shall provide a preliminary report on the priorities for meeting the federal requirements, progress on the annual survey, recommendations for improvements in the incident reporting system, and a plan for incorporating the quality assurance efforts under section 256B.095 and other regional efforts into the statewide system.

Sec. 51. Minnesota Statutes 2006, section 256B.431, subdivision 1, is amended to read:

Subdivision 1. **In general.** The commissioner shall determine prospective payment rates for resident care costs. For rates established on or after July 1, 1985, the commissioner shall develop procedures for determining operating cost payment rates that take into account the mix of resident needs, geographic location, and other factors as determined by the commissioner. The commissioner shall consider whether the fact that a facility is attached to a hospital or has an average length of stay of 180 days or less should be taken into account in determining rates. The commissioner shall consider the use of the standard metropolitan statistical areas when developing groups by geographic location. The commissioner shall provide notice to each nursing facility on or before ~~May 1~~ August 15 of the rates effective for the following rate year except that if legislation is pending on ~~May 1~~ August 15 that may affect rates for nursing facilities, the commissioner shall set the rates after the legislation is enacted and provide notice to each facility as soon as possible.

Compensation for top management personnel shall continue to be categorized as a general and administrative cost and is subject to any limits imposed on that cost category.

Sec. 52. Minnesota Statutes 2006, section 256B.431, subdivision 2e, is amended to read:

Subd. 2e. **Contracts for services for ventilator-dependent persons.** (a) The commissioner may negotiate with a nursing facility eligible to receive medical assistance payments to provide services to a ventilator-dependent person identified by the commissioner according to criteria developed by the commissioner, including:

(1) nursing facility care has been recommended for the person by a preadmission screening team;

(2) the person has been hospitalized and no longer requires inpatient acute care hospital services; and

(3) the commissioner has determined that necessary services for the person cannot be provided under existing nursing facility rates.

The commissioner may negotiate an adjustment to the operating cost payment rate for a nursing facility with a resident who is ventilator-dependent, for that resident. The negotiated adjustment must reflect only the actual additional cost of meeting the specialized care needs of a ventilator-dependent person identified by the commissioner for whom necessary services cannot be provided under existing nursing facility rates and which are not otherwise covered under Minnesota Rules, parts 9549.0010 to 9549.0080 or 9505.0170 to 9505.0475. For persons who are initially admitted to a nursing facility before July 1, 2001, and have their payment rate under this subdivision negotiated after July 1, 2001, the negotiated payment rate must not exceed 200 percent of the highest multiple bedroom payment rate for the facility, as initially established by the commissioner for the rate year for case mix classification K; or, upon implementation of the RUG's-based case mix system, 200 percent of the highest RUG's rate. For persons initially admitted to a nursing facility on or after July 1, 2001, the negotiated payment rate must not exceed 300 percent of the facility's multiple bedroom payment rate for case mix classification K; or, upon implementation of the RUG's-based case mix system, 300 percent of the highest RUG's rate. The negotiated adjustment shall not affect the payment rate charged to private paying residents under the provisions of section 256B.48, subdivision 1.

(b) Effective July 1, 2007, or upon opening a unit of at least ten beds dedicated to care of ventilator-dependent persons in partnership with Mayo Health Systems, whichever is later, the operating payment rates for residents determined eligible under paragraph (a) of a nursing facility in Waseca County that on February 1, 2007, was licensed for 70 beds and reimbursed under this section, section 256B.434, or section 256B.441, shall be 300 percent of the facility's highest RUG rate.

Sec. 53. Minnesota Statutes 2006, section 256B.431, subdivision 3f, is amended to read:

Subd. 3f. **Property costs after July 1, 1988.** (a) **Investment per bed limit.** For the rate year beginning July 1, 1988, the replacement-cost-new per bed limit must be $32,571 per licensed bed in multiple bedrooms and $48,857 per licensed bed in a single bedroom. For the rate year beginning July 1, 1989, the replacement-cost-new per bed limit for a single bedroom must be $49,907 adjusted according to Minnesota Rules, part 9549.0060, subpart 4, item A, subitem (1). Beginning January 1, 1990, the replacement-cost-new per bed limits must be adjusted annually as specified in Minnesota Rules, part 9549.0060, subpart 4, item A, subitem (1). Beginning January 1, 1991, the replacement-cost-new per bed limits will be adjusted annually as specified in Minnesota Rules, part 9549.0060, subpart 4, item A, subitem (1), except that the index utilized will be the Bureau of ~~the Census: Composite fixed-weighted price index as published in the C30 Report, Value of New Construction Put in Place~~ Economic Analysis: Price Indexes for Private Fixed Investments in Structures; Special Care.

(b) **Rental factor.** For the rate year beginning July 1, 1988, the commissioner shall increase the rental factor as established in Minnesota Rules, part 9549.0060, subpart 8, item A, by 6.2 percent rounded to the nearest 100th percent for the purpose of reimbursing nursing facilities for soft costs and entrepreneurial profits not included in the cost valuation services used by the state's contracted appraisers. For rate years beginning on or after July 1, 1989, the rental factor is the amount determined under this paragraph for the rate year beginning July 1, 1988.

(c) **Occupancy factor.** For rate years beginning on or after July 1, 1988, in order to determine property-related payment rates under Minnesota Rules, part 9549.0060, for all nursing facilities except those whose average length of stay in a skilled level of care within a nursing facility is 180 days or less, the commissioner shall use 95 percent of capacity days. For a nursing facility whose average length of stay in a skilled level of care within a nursing facility is 180 days or less, the commissioner shall use the greater of resident days or 80 percent of capacity days but in no event shall the divisor exceed 95 percent of capacity days.

(d) **Equipment allowance.** For rate years beginning on July 1, 1988, and July 1, 1989, the commissioner shall add ten cents per resident per day to each nursing facility's property-related payment rate. The ten-cent property-related payment rate increase is not cumulative from rate year to rate year. For the rate year beginning July 1, 1990, the commissioner shall increase each nursing facility's equipment allowance as established in Minnesota Rules, part 9549.0060, subpart 10, by ten cents per resident per day. For rate years beginning on or after July 1, 1991, the adjusted equipment allowance must be adjusted annually for inflation as in Minnesota Rules, part 9549.0060, subpart 10, item E.

For the rate period beginning October 1, 1992, the equipment allowance for each nursing facility shall be increased by 28 percent. For rate years beginning after June 30, 1993, the allowance must be adjusted annually for inflation.

(e) **Post chapter 199 related-organization debts and interest expense.** For rate years beginning on or after July 1, 1990, Minnesota Rules, part 9549.0060, subpart 5, item E, shall not apply to outstanding related organization debt incurred prior to May 23, 1983, provided that the debt was an allowable debt under Minnesota Rules, parts 9510.0010 to 9510.0480, the debt is subject to repayment through annual principal payments, and the nursing facility demonstrates to the commissioner's satisfaction that the interest rate on the debt was less than market interest rates for similar arm's-length transactions at the time the debt was incurred. If the debt was incurred due to a sale between family members, the nursing facility must also demonstrate that the seller no longer participates in the management or operation of the nursing facility. Debts meeting the conditions of this paragraph are subject to all other provisions of Minnesota Rules, parts 9549.0010 to 9549.0080.

(f) **Building capital allowance for nursing facilities with operating leases.** For rate years beginning on or after July 1, 1990, a nursing facility with operating lease costs incurred for the nursing facility's buildings shall receive its building capital allowance computed in accordance with Minnesota Rules, part 9549.0060, subpart 8. If an operating lease provides that the lessee's rent is adjusted to recognize improvements made by the lessor and related debt, the costs for capital improvements and related debt shall be allowed in the computation of the lessee's building capital allowance, provided that reimbursement for these costs under an operating lease shall not exceed the rate otherwise paid.

Sec. 54. Minnesota Statutes 2006, section 256B.431, subdivision 17e, is amended to read:

Subd. 17e. **Replacement-costs-new per bed limit effective July 1, 2001.** Notwithstanding Minnesota Rules, part 9549.0060, subpart 11, item C, subitem (2), for a total replacement, as defined in ~~paragraph (f)~~ subdivision 17d, authorized under section 144A.071 or 144A.073 after July 1, 1999, or any building project that is a relocation, renovation, upgrading, or conversion completed on or after July 1, 2001, the replacement-costs-new per bed limit shall be $74,280 per licensed bed in multiple-bed rooms, $92,850 per licensed bed in semiprivate rooms with a fixed partition separating the resident beds, and $111,420 per licensed bed in single rooms. Minnesota Rules, part 9549.0060, subpart 11, item C, subitem (2), does not apply. These amounts must be adjusted annually as specified in subdivision 3f, paragraph (a), beginning January 1, 2000.

Sec. 55. Minnesota Statutes 2006, section 256B.434, subdivision 4, is amended to read:

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

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

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

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

the specified outcomes and related criteria, the commissioner shall consider the following state policy objectives:

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

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

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

(4) reduced acute care costs; and

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

(e) Notwithstanding the threshold in section 256B.431, subdivision 16, facilities that take action to come into compliance with existing or pending requirements of the life safety code provisions or other federal regulations governing sprinkler systems shall receive reimbursement for the costs associated with compliance if all of the following conditions are met:

(1) the expenses associated with compliance occurred on or after January 1, 2005, and before December 31, 2008;

(2) the costs were not otherwise reimbursed under section 144A.071, 144A.073, or 256B.434, subdivision 4f; and

(3) the total allowable costs reported under this paragraph are less than the minimum threshold established under section 256B.431, subdivisions 15, paragraph (e), and 16.

The commissioner shall use funds appropriated for this purpose to provide to qualifying nursing facilities a rate adjustment beginning October 1, 2007, and ending September 30, 2008. Nursing facilities that have expended funds or anticipate the need to expend funds to satisfy the most recent life safety code requirements by (1) installing a sprinkler system or (2) replacing all or portions of an existing sprinkler system may submit to the commissioner by June 30, 2007, on a form provided by the commissioner the actual costs of a completed project or the estimated costs, based on a project bid, of a planned project. The commissioner shall calculate a rate adjustment equal to the allowable costs of the project divided by the resident days reported for the report year ending September 30, 2006. If the costs from all projects exceed the appropriation for this purpose, the commissioner shall allocate the funds appropriated on a pro rata basis to the qualifying facilities by reducing the rate adjustment determined for each facility by an equal percentage. If the commissioner determines that there are any unexpended funds for the purposes of this paragraph, the commissioner may allocate the remainder of the funds to the qualifying facilities on a pro rata basis for other physical plant changes required by the nursing facility in order to meet the most recent life safety code compliance standards.

Facilities that used estimated costs when requesting the rate adjustment shall report to the commissioner by January 31, 2009, on the use of these funds on a form provided by the commissioner. If the nursing facility fails to provide the report, the commissioner shall recoup the funds appropriated to the facility for this purpose. If the facility reports expenditures allowable under this subdivision that are less than the amount received in the facility's annualized rate adjustment, the commissioner shall recoup the difference.

Sec. 56. Minnesota Statutes 2006, section 256B.434, is amended by adding a subdivision to read:

Subd. 4i. **Nursing facility rate increase effective October 1, 2007; Hennepin County.** For the rate year beginning October 1, 2007, the commissioner shall provide to a nursing facility in Hennepin County licensed for 268 beds as of February 1, 2007, an increase in the property payment rate of $6.52 per resident per day. The increase under this subdivision must be added following the determination under this chapter of the payment rate for the rate year beginning October 1, 2007, and must be included in the facility's total payment rate for purposes of determining future rates under this section or any other section.

Sec. 57. Minnesota Statutes 2006, section 256B.434, is amended by adding a subdivision to read:

Subd. 4j. **Rate increase for facilities in Chisago County.** Effective October 1, 2007, operating payment rates of all nursing facilities in Chisago County that are reimbursed under this section or section 256B.441 shall be increased to be equal, for a RUG's rate with a weight of 1.00, to the geographic group III median rate for the same RUG's weight. The percentage of the operating payment rate for each facility to be case-mix adjusted shall be equal to the percentage that is case-mix adjusted in that facility's September 30, 2007, operating payment rate. This subdivision applies only if it results in a rate increase. Increases provided by this subdivision shall be added to the rate determined under any new reimbursement system established under section 256B.441.

Sec. 58. Minnesota Statutes 2006, section 256B.434, is amended by adding a subdivision to read:

Subd. 4k. **Nursing facility rate increase effective January 1, 2008; Hennepin County.** Effective January 1, 2008, a nursing facility in Hennepin County licensed for 137 beds as of February 1, 2007, shall receive an increase of $2.81 in each case mix payment rate to offset property tax payments due as a result of the facility's conversion

from nonprofit to for-profit status. The increase under this subdivision must be added following the determination under this chapter of the payment rate for the rate year beginning October 1, 2007, and must be included in the facility's total payment rate for the purposes of determining future rates under this section or any other section.

Sec. 59. Minnesota Statutes 2006, section 256B.434, is amended by adding a subdivision to read:

Subd. 4l. **Property rate adjustment; Kanabec County.** The commissioner shall allow a property rate adjustment for a facility located in Kanabec County that was approved for a moratorium exception project in 2001, but experienced a delay and additional costs associated with the project, and completed the project in 2005. The property payment rate for the rate years beginning October 1, 2007, and ending September 30, 2009, must be $22.73 per resident day. For subsequent years, the property rate of $22.73 per resident day shall be adjusted as provided in subdivision 4, paragraph (c), as long as the facility has a contract under this section.

Sec. 60. Minnesota Statutes 2006, section 256B.434, is amended by adding a subdivision to read:

Subd. 4m. **Rate increase for facilities in Rice County.** Effective July 1, 2007, operating payment rates of nursing facilities in Rice County located within two miles of Scott County or Dakota County that are reimbursed under this section or section 256B.441 must be increased to be equal, for a RUG's rate with a weight of 1.00, to the geographic group III median rate for the same RUG's weight. The percentage of the operating payment rate for each facility to be case-mix adjusted must be equal to the percentage that is case-mix adjusted in that facility's June 30, 2006, operating payment rate. This subdivision applies only if it results in a rate increase.

Sec. 61. Minnesota Statutes 2006, section 256B.434, is amended by adding a subdivision to read:

Subd. 4n. **Facility rate increase.** For the rate year beginning July 1, 2007, and for the rate year beginning October 1, 2007, a nursing facility in Faribault County licensed for 50 beds as of April 19, 2006, shall receive a rate increase of $2.64 in each case mix payment rate to offset property tax payments due as a result of the facility's conversion from nonprofit to for-profit status. The increase under this subdivision shall be added to the payment rates in effect for the facility on June 30, 2007, and shall be included in

the facility's total payment rates for the purposes of determining future rates under this section or any other section.

Sec. 62. Minnesota Statutes 2006, section 256B.434, is amended by adding a subdivision to read:

Subd. 19. **Rate increases for October 1, 2007, and October 1, 2008.** (a) For the rate years beginning October 1, 2007, and October 1, 2008, the commissioner shall make available to each nursing facility reimbursed under this section an adjustment equal to three percent of the total operating payment rate.

(b) Seventy-five percent of the money resulting from the rate adjustment under paragraph (a) must be used to increase wages and benefits and pay associated costs for all employees, except management fees, the administrator, and central office staff. Seventy-five percent of the money received by a facility as a result of the rate adjustment provided in paragraph (a) must be used only for wage and benefit increases and payment of associated costs, implemented on or after the effective date of the rate increase each year, and must not be used for increases implemented prior to that date.

(c) Nursing facilities may apply for the portion of the rate adjustment under paragraph (a) for employee wages and benefits and associated costs. The application must be made to the commissioner and contain a plan by which the nursing facility will distribute the funds according to paragraph (b). For nursing facilities in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative constitutes the plan. The commissioner shall not review and shall not require changes to the portion or portions of the plan covered by collective bargaining agreements. A negotiated agreement may constitute the plan only if the agreement is finalized after the date of enactment of all increases for the rate year and signed by both parties prior to submission to the commissioner. The commissioner shall review the plan to ensure that the rate adjustments are used as provided in paragraph (b). To be eligible, a facility must submit its distribution plan by March 31, 2008, and March 31, 2009, respectively. The commissioner may approve distribution plans on or before June 30, 2008, and June 30, 2009, respectively. If a facility's distribution plan is effective after the first day of the applicable rate period that the funds are available, the rate adjustments are effective the same date as the facility's plan.

(d) A copy of the approved distribution plan must be made available to all employees by giving each employee a copy or by posting a copy in an area of the nursing facility to which all employees have access. If an employee does not receive the wage and

benefit adjustment described in the facility's approved plan and is unable to resolve the problem with the facility's management or through the employee's union representative, the employee may contact the commissioner at an address or telephone number provided by the commissioner and included in the approved plan.

Sec. 63. Minnesota Statutes 2006, section 256B.434, is amended by adding a subdivision to read:

Subd. 20. **Payment of Public Employees Retirement Association costs.** Nursing facilities that participate in the Public Employees Retirement Association (PERA) shall have the component of their payment rate associated with the costs of PERA determined for each rate year. Effective for rate years beginning on and after October 1, 2007, the commissioner shall determine the portion of the payment rate in effect on September 30 each year and shall subtract that amount from the payment rate to be effective on the following October 1. The portion that shall be deemed to be included in the September 30, 2007, rate that is associated with PERA costs shall be the allowed costs in the facility's base for determining rates under this section, divided by the resident days reported for that year. The commissioner shall add to the payment rate to be effective on October 1 each year an amount equal to the reported costs associated with PERA, for the year ended on the most recent September 30 for which data is available, divided by total resident days for that year, as reported by the facility and audited under section 256B.441.

Sec. 64. Minnesota Statutes 2006, section 256B.437, is amended by adding a subdivision to read:

Subd. 11. **Big Stone County rate adjustment.** Notwithstanding the time period specified in subdivision 3, the commissioner may approve a planned closure rate adjustment in Big Stone County for an eight-bed facility in Clinton for reassignment to a 50-bed facility in Graceville. The adjustment shall be calculated according to subdivision 6.

Sec. 65. Minnesota Statutes 2006, section 256B.438, subdivision 3, is amended to read:

Subd. 3. **Case mix indices.** (a) The commissioner of human services shall assign a case mix index to each resident class based on the Centers for Medicare and Medicaid Services staff time measurement study and adjusted for Minnesota-specific wage indices. The case mix indices assigned to each resident class shall be published in the Minnesota State Register at least 120 days prior to the implementation of the 34 group, RUG-III resident classification system.

(b) An index maximization approach shall be used to classify residents.

~~(c) After implementation of the revised case mix system, the commissioner of human services may annually rebase case mix indices and base rates using more current data on average wage rates and staff time measurement studies. This rebasing shall be calculated under subdivision 7, paragraph (b). The commissioner shall publish in the Minnesota State Register adjusted case mix indices at least 45 days prior to the effective date of the adjusted case mix indices.~~

Sec. 66. Minnesota Statutes 2006, section 256B.439, subdivision 1, is amended to read:

Subdivision 1. **Development and implementation of quality profiles.** (a) The commissioner of human services, in cooperation with the commissioner of health, shall develop and implement a quality profile system for nursing facilities and, beginning not later than July 1, 2004, other providers of long-term care services, except when the quality profile system would duplicate requirements under section 256B.5011, 256B.5012, or 256B.5013. Beginning July 1, 2008, the commissioners shall include quality profiles of nursing homes that are not medical assistance certified in the Minnesota Nursing Home Report Card. The nonmedical assistance certified nursing homes may provide to the commissioners information necessary to conduct consumer satisfaction surveys and to determine other quality measures. The system must be developed and implemented to the extent possible without the collection of significant amounts of new data. To the extent possible, the system must incorporate or be coordinated with information on quality maintained by area agencies on aging, long-term care trade associations, and other entities. The system must be designed to provide information on quality to:

(1) consumers and their families to facilitate informed choices of service providers;

(2) providers to enable them to measure the results of their quality improvement efforts and compare quality achievements with other service providers; and

(3) public and private purchasers of long-term care services to enable them to purchase high-quality care.

(b) The system must be developed in consultation with the long-term care task force, area agencies on aging, and representatives of consumers, providers, and labor unions. Within the limits of available appropriations, the commissioners may employ consultants to assist with this project.

Sec. 67. Minnesota Statutes 2006, section 256B.49, subdivision 11, is amended to read:

Subd. 11. **Authority.** (a) The commissioner is authorized to apply for home and community-based service waivers, as authorized under section 1915(c) of the Social

Security Act to serve persons under the age of 65 who are determined to require the level of care provided in a nursing home and persons who require the level of care provided in a hospital. The commissioner shall apply for the home and community-based waivers in order to:

(i) promote the support of persons with disabilities in the most integrated settings;

(ii) expand the availability of services for persons who are eligible for medical assistance;

(iii) promote cost-effective options to institutional care; and

(iv) obtain federal financial participation.

(b) The provision of waivered services to medical assistance recipients with disabilities shall comply with the requirements outlined in the federally approved applications for home and community-based services and subsequent amendments, including provision of services according to a service plan designed to meet the needs of the individual. For purposes of this section, the approved home and community-based application is considered the necessary federal requirement.

(c) The commissioner shall provide interested persons serving on agency advisory committees ~~and~~, task forces, the Centers for Independent Living, and others ~~upon~~ who request~~, with~~ to be on a list to receive, notice of, and an opportunity to comment on, at least 30 days before any effective dates, (1) any substantive changes to the state's disability services provider manual, or (2) changes or amendments to the federally approved applications for home and community-based waivers, prior to their submission to the federal Centers for Medicare and Medicaid Services.

(d) The commissioner shall seek approval, as authorized under section 1915(c) of the Social Security Act, to allow medical assistance eligibility under this section for children under age 21 without deeming of parental income or assets.

(e) The commissioner shall seek approval, as authorized under section 1915(c) of the Social Act, to allow medical assistance eligibility under this section for individuals under age 65 without deeming the spouse's income or assets.

Sec. 68. Minnesota Statutes 2006, section 256B.49, is amended by adding a subdivision to read:

Subd. 16a. **Medical assistance reimbursement.** (a) The commissioner shall seek federal approval for medical assistance reimbursement of independent living skills services, foster care waiver service, supported employment, prevocational service, structured day service, and adult day care under the home and community-based waiver

for persons with a traumatic brain injury, the community alternatives for disabled individuals waivers, and the community alternative care waivers.

(b) Medical reimbursement shall be made only when the provider demonstrates evidence of its capacity to meet basic health, safety, and protection standards through one of the methods in paragraphs (c) to (e).

(c) The provider is licensed to provide services under chapter 245B and agrees to apply these standards to services funded through the traumatic brain injury, community alternatives for disabled, or community alternative care home and community-based waivers.

(d) The local agency contracting for the services certifies on a form provided by the commissioner that the provider has the capacity to meet the individual needs as identified in each person's individual service plan. When certifying that the service provider meets the necessary provider qualifications, the local agency shall verify that the provider has policies and procedures governing the following:

(1) protection of the consumer's rights and privacy;

(2) risk assessment and planning;

(3) record keeping and reporting of incidents and emergencies with documentation of corrective action if needed;

(4) service outcomes, regular reviews of progress, and periodic reports;

(5) complaint and grievance procedures;

(6) service termination or suspension;

(7) necessary training and supervision of direct care staff that includes:

(i) documentation in personnel files of 20 hours of orientation training in providing training related to service provision;

(ii) training in recognizing the symptoms and effects of certain disabilities, health conditions, and positive behavioral supports and interventions; and

(iii) a minimum of five hours of related training annually; and

(8) when applicable, the local agency shall verify that the provider has policies and procedures in place governing the following:

(i) safe medication administration;

(ii) proper handling of consumer funds; and

(iii) behavioral interventions that are in compliance with prohibitions and standards developed by the commissioner to meet federal requirements regarding the use of restraints and restrictive interventions.

(e) For foster care waiver services or independent living skills services, the local agency contracting for the services certifies on a form provided by the commissioner that the provider meets the following:

(1) the provider of foster care waiver services is licensed to provide adult foster care under Minnesota Rules, parts 9555.5105 to 9555.6265, or child foster care under Minnesota Rules, parts 2960.3000 to 2960.3230;

(2) the provider of independent living skills services also provides licensed foster care services and agrees to apply the foster care standards under Minnesota Rules, parts 9555.5105; 9555.5705, subpart 2; 9555.6167; 9555.6185; 9555.6195; 9555.6225, subpart 8; 9555.6245; 9555.6255; and 9555.6265, or parts 2960.3010; 2960.3080, subparts 10 and 11; 2960.3210; 2960.3220, subparts 5 to 7; and 2960.3230, for the provision of those services; and

(3) the provider has policies and procedures applying to the provision of foster care waiver services or independent living skills services that govern (i) behavioral interventions that are in compliance with prohibitions and standards developed by the commissioner to meet federal requirements regarding the use of restraints and restrictive interventions and (ii) documentation of service needs and outcomes, regular reviews of progress, and periodic reports.

(f) The local agency shall review each provider's continued compliance with the basic health, safety, and protection standards on a regular basis. For the review of paragraph (e), the local agency shall coordinate the review with the county review of foster care licensure.

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

Sec. 69. Minnesota Statutes 2006, section 256B.5012, is amended by adding a subdivision to read:

Subd. 7. **ICF/MR rate increases October 1, 2007, and October 1, 2008.** (a) For the rate periods beginning October 1, 2007, and October 1, 2008, the commissioner shall make available to each facility reimbursed under this section an adjustment to the total operating payment rate of three percent.

(b) Seventy-five percent of the money resulting from the rate adjustment under paragraph (a) must be used to increase wages and benefits and pay associated costs for employees, except for administrative and central office employees. Seventy-five percent of the money received by a facility as a result of the rate adjustment provided in paragraph (a) must be used only for wage, benefit, and staff increases implemented on or after the effective date of the rate increase each year, and must not be used for increases

implemented prior to that date. The wage adjustment eligible employees may receive may vary based on merit, seniority, or other factors determined by the provider.

(c) For each facility, the commissioner shall make available an adjustment, based on occupied beds, using the percentage specified in paragraph (a) multiplied by the total payment rate, including variable rate but excluding the property-related payment rate, in effect on the preceding day. The total payment rate must include the adjustment provided in section 256B.501, subdivision 12.

(d) A facility whose payment rates are governed by closure agreements, receivership agreements, or Minnesota Rules, part 9553.0075, is not eligible for an adjustment otherwise granted under this subdivision.

(e) A facility may apply for the portion of the payment rate adjustment provided under paragraph (a) for employee wages and benefits and associated costs. The application must be made to the commissioner and contain a plan by which the facility will distribute the funds according to paragraph (b). For facilities in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative constitutes the plan. The commissioner shall not review, and shall not require changes, to the portion or portions of the plan covered by collective bargaining agreements. A negotiated agreement may constitute the plan only if the agreement is finalized after the date of enactment of all rate increases for the rate year. The commissioner shall review the plan to ensure that the payment rate adjustment per diem is used as provided in this subdivision. To be eligible, a facility must submit its plan by March 31, 2008, and December 31, 2008, respectively. If a facility's plan is effective for its employees after the first day of the applicable rate period that the funds are available, the payment rate adjustment per diem is effective the same date as its plan.

(f) A copy of the approved distribution plan must be made available to all employees by giving each employee a copy or by posting it in an area of the facility to which all employees have access. If an employee does not receive the wage and benefit adjustment described in the facility's approved plan and is unable to resolve the problem with the facility's management or through the employee's union representative, the employee may contact the commissioner at an address or telephone number provided by the commissioner and included in the approved plan.

Sec. 70. Minnesota Statutes 2006, section 256B.69, subdivision 23, is amended to read:

Subd. 23. **Alternative services; elderly and disabled persons.** (a) The commissioner may implement demonstration projects to create alternative integrated

delivery systems for acute and long-term care services to elderly persons and persons with disabilities as defined in section 256B.77, subdivision 7a, that provide increased coordination, improve access to quality services, and mitigate future cost increases. The commissioner may seek federal authority to combine Medicare and Medicaid capitation payments for the purpose of such demonstrations and may contract with Medicare-approved special needs plans to provide Medicaid services. Medicare funds and services shall be administered according to the terms and conditions of the federal contract and demonstration provisions. For the purpose of administering medical assistance funds, demonstrations under this subdivision are subject to subdivisions 1 to 22. The provisions of Minnesota Rules, parts 9500.1450 to 9500.1464, apply to these demonstrations, with the exceptions of parts 9500.1452, subpart 2, item B; and 9500.1457, subpart 1, items B and C, which do not apply to persons enrolling in demonstrations under this section. An initial open enrollment period may be provided. Persons who disenroll from demonstrations under this subdivision remain subject to Minnesota Rules, parts 9500.1450 to 9500.1464. When a person is enrolled in a health plan under these demonstrations and the health plan's participation is subsequently terminated for any reason, the person shall be provided an opportunity to select a new health plan and shall have the right to change health plans within the first 60 days of enrollment in the second health plan. Persons required to participate in health plans under this section who fail to make a choice of health plan shall not be randomly assigned to health plans under these demonstrations. Notwithstanding section 256L.12, subdivision 5, and Minnesota Rules, part 9505.5220, subpart 1, item A, if adopted, for the purpose of demonstrations under this subdivision, the commissioner may contract with managed care organizations, including counties, to serve only elderly persons eligible for medical assistance, elderly and disabled persons, or disabled persons only. For persons with a primary diagnosis of developmental disability, serious and persistent mental illness, or serious emotional disturbance, the commissioner must ensure that the county authority has approved the demonstration and contracting design. Enrollment in these projects for persons with disabilities shall be voluntary. The commissioner shall not implement any demonstration project under this subdivision for persons with a primary diagnosis of developmental disabilities, serious and persistent mental illness, or serious emotional disturbance, without approval of the county board of the county in which the demonstration is being implemented.

(b) Notwithstanding chapter 245B, sections 252.40 to 252.46, 256B.092, 256B.501 to 256B.5015, and Minnesota Rules, parts 9525.0004 to 9525.0036, 9525.1200 to 9525.1330, 9525.1580, and 9525.1800 to 9525.1930, the commissioner may implement under this section projects for persons with developmental disabilities. The commissioner

may capitate payments for ICF/MR services, waivered services for developmental disabilities, including case management services, day training and habilitation and alternative active treatment services, and other services as approved by the state and by the federal government. Case management and active treatment must be individualized and developed in accordance with a person-centered plan. Costs under these projects may not exceed costs that would have been incurred under fee-for-service. Beginning July 1, 2003, and until ~~two~~ four years after the pilot project implementation date, subcontractor participation in the long-term care developmental disability pilot is limited to a nonprofit long-term care system providing ICF/MR services, home and community-based waiver services, and in-home services to no more than 120 consumers with developmental disabilities in Carver, Hennepin, and Scott Counties. The commissioner shall report to the legislature prior to expansion of the developmental disability pilot project. This paragraph expires ~~two~~ four years after the implementation date of the pilot project.

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

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

(e) The commissioner, in consultation with the commissioners of commerce and health, may approve and implement programs for all-inclusive care for the elderly (PACE) according to federal laws and regulations governing that program and state laws or rules applicable to participating providers. The process for approval of these programs shall begin only after the commissioner receives grant money in an amount sufficient to cover the state share of the administrative and actuarial costs to implement the programs during state fiscal years 2006 and 2007. Grant amounts for this purpose shall be deposited in an account in the special revenue fund and are appropriated to the commissioner to be used solely for the purpose of PACE administrative and actuarial costs. A PACE provider is not required to be licensed or certified as a health plan company as defined in section 62Q.01, subdivision 4. Persons age 55 and older who have been screened by the county and found to be eligible for services under the elderly waiver or community alternatives for disabled individuals or who are already eligible for Medicaid but meet level of care criteria for receipt of waiver services may choose to enroll in the PACE program. Medicare and Medicaid services will be provided according to this subdivision and

federal Medicare and Medicaid requirements governing PACE providers and programs. PACE enrollees will receive Medicaid home and community-based services through the PACE provider as an alternative to services for which they would otherwise be eligible through home and community-based waiver programs and Medicaid State Plan Services. The commissioner shall establish Medicaid rates for PACE providers that do not exceed costs that would have been incurred under fee-for-service or other relevant managed care programs operated by the state.

(f) The commissioner shall seek federal approval to expand the Minnesota disability health options (MnDHO) program established under this subdivision in stages, first to regional population centers outside the seven-county metro area and then to all areas of the state. Until ~~January 1, 2008~~ July 1, 2009, expansion for MnDHO projects that include home and community-based services is limited to the two projects and service areas in effect on March 1, 2006. Enrollment in integrated MnDHO programs that include home and community-based services shall remain voluntary. Costs for home and community-based services included under MnDHO must not exceed costs that would have been incurred under the fee-for-service program. In developing program specifications for expansion of integrated programs, the commissioner shall involve and consult the state-level stakeholder group established in subdivision 28, paragraph (d), including consultation on whether and how to include home and community-based waiver programs. Plans for further expansion of MnDHO projects shall be presented to the chairs of the house and senate committees with jurisdiction over health and human services policy and finance by February 1, 2007.

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

Sec. 71. **[256C.261] SERVICES FOR DEAF-BLIND PERSONS.**

(a) The commissioner of human services shall combine the existing biennial base level funding for deaf-blind services into a single grant program. At least 35 percent of the total funding is awarded for services and other supports to deaf-blind children and their families and at least 25 percent is awarded for services and other supports to deaf-blind adults.

The commissioner shall award grants for the purposes of:

(1) providing services and supports to individuals who are deaf-blind; and

(2) developing and providing training to counties and the network of senior citizen service providers. The purpose of the training grants is to teach counties how to use existing programs that capture federal financial participation to meet the needs of eligible deaf-blind persons and to build capacity of senior service programs to meet the needs of seniors with a dual sensory hearing and vision loss.

(b) The commissioner may make grants:

(1) for services and training provided by organizations; and

(2) to develop and administer consumer-directed services.

(c) Any entity that is able to satisfy the grant criteria is eligible to receive a grant under paragraph (a).

(d) Deaf-blind service providers are not required to, but may, provide intervenor services as part of the service package provided with grant funds under this section.

Sec. 72. Minnesota Statutes 2006, section 256D.44, subdivision 2, is amended to read:

Subd. 2. **Standard of assistance for persons eligible for medical assistance waivers or at risk of placement in a group residential housing facility.** The state standard of assistance for a person (1) who is eligible for a medical assistance home and community-based services waiver ~~or a person~~, (2) who has been determined by the local agency to meet the plan requirements for placement in a group residential housing facility under section 256I.04, subdivision 1a, or (3) who is eligible for a shelter needy payment under subdivision 5, paragraph (f), is the standard established in subdivision 3, paragraph (a) or (b).

Sec. 73. Minnesota Statutes 2006, section 256D.44, subdivision 5, is amended to read:

Subd. 5. **Special needs.** In addition to the state standards of assistance established in subdivisions 1 to 4, payments are allowed for the following special needs of recipients of Minnesota supplemental aid who are not residents of a nursing home, a regional treatment center, or a group residential housing facility.

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

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

(2) controlled protein diet, 40 to 60 grams and requires special products, 100 percent of thrifty food plan;

(3) controlled protein diet, less than 40 grams and requires special products, 125 percent of thrifty food plan;

(4) low cholesterol diet, 25 percent of thrifty food plan;

(5) high residue diet, 20 percent of thrifty food plan;

(6) pregnancy and lactation diet, 35 percent of thrifty food plan;

(7) gluten-free diet, 25 percent of thrifty food plan;

(8) lactose-free diet, 25 percent of thrifty food plan;

(9) antidumping diet, 15 percent of thrifty food plan;

(10) hypoglycemic diet, 15 percent of thrifty food plan; or

(11) ketogenic diet, 25 percent of thrifty food plan.

(b) Payment for nonrecurring special needs must be allowed for necessary home repairs or necessary repairs or replacement of household furniture and appliances using the payment standard of the AFDC program in effect on July 16, 1996, for these expenses, as long as other funding sources are not available.

(c) A fee for guardian or conservator service is allowed at a reasonable rate negotiated by the county or approved by the court. This rate shall not exceed five percent of the assistance unit's gross monthly income up to a maximum of $100 per month. If the guardian or conservator is a member of the county agency staff, no fee is allowed.

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

(e) A fee of ten percent of the recipient's gross income or $25, whichever is less, is allowed for representative payee services provided by an agency that meets the requirements under SSI regulations to charge a fee for representative payee services. This special need is available to all recipients of Minnesota supplemental aid regardless of their living arrangement.

(f) Notwithstanding the language in this subdivision, an amount equal to the maximum allotment authorized by the federal Food Stamp Program for a single individual which is in effect on the first day of ~~January~~ July of ~~the previous~~ each year will be added to the standards of assistance established in subdivisions 1 to 4 for ~~individuals~~ adults under the age of 65 who qualify as shelter needy and are: (1) relocating from an institution, or

an adult mental health residential treatment program under section 256B.0622~~, and who are shelter needy~~; (2) self-directed supports option participants defined under section 256B.0657 if enacted in the 2007 legislative session; or (3) home and community-based waiver recipients living in their own rented, leased, or owned apartment or home not owned, operated, or controlled by a provider of service not related by blood or marriage. Notwithstanding subdivision 3, paragraph (c), an individual eligible for the shelter needy benefit under subdivision 5, paragraph (f), is considered a household of one. An eligible individual who receives this benefit prior to age 65 may continue to receive the benefit after the age of 65.

(g)(1) Persons eligible for shelter needy funding under paragraph (f), who are not receiving medial assistance home and community-based waiver services, are eligible for a state-funded transitional supports allowance under section 256B.49, subdivision 16, paragraph (e), to establish their own residence not owned, operated, or controlled by a provider of service not related by blood or marriage.

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

Sec. 74. Minnesota Statutes 2006, section 256I.04, subdivision 3, is amended to read:

Subd. 3. **Moratorium on the development of group residential housing beds.** (a) County agencies shall not enter into agreements for new group residential housing beds with total rates in excess of the MSA equivalent rate except: (1) for group residential housing establishments licensed under Minnesota Rules, parts 9525.0215 to 9525.0355, provided the facility is needed to meet the census reduction targets for persons with developmental disabilities at regional treatment centers; (2) to ensure compliance with the federal Omnibus Budget Reconciliation Act alternative disposition plan requirements for inappropriately placed persons with developmental disabilities or mental illness; (3) up to 80 beds in a single, specialized facility located in Hennepin County that will provide housing for chronic inebriates who are repetitive users of detoxification centers and are refused placement in emergency shelters because of their state of intoxication, and planning for the specialized facility must have been initiated before July 1, 1991, in anticipation of receiving a grant from the Housing Finance Agency under section 462A.05,

subdivision 20a, paragraph (b); (4) notwithstanding the provisions of subdivision 2a, for up to 190 supportive housing units in Anoka, Dakota, Hennepin, or Ramsey County for homeless adults with a mental illness, a history of substance abuse, or human immunodeficiency virus or acquired immunodeficiency syndrome. For purposes of this section, "homeless adult" means a person who is living on the street or in a shelter or discharged from a regional treatment center, community hospital, or residential treatment program and has no appropriate housing available and lacks the resources and support necessary to access appropriate housing. At least 70 percent of the supportive housing units must serve homeless adults with mental illness, substance abuse problems, or human immunodeficiency virus or acquired immunodeficiency syndrome who are about to be or, within the previous six months, has been discharged from a regional treatment center, or a state-contracted psychiatric bed in a community hospital, or a residential mental health or chemical dependency treatment program. If a person meets the requirements of subdivision 1, paragraph (a), and receives a federal or state housing subsidy, the group residential housing rate for that person is limited to the supplementary rate under section 256I.05, subdivision 1a, and is determined by subtracting the amount of the person's countable income that exceeds the MSA equivalent rate from the group residential housing supplementary rate. A resident in a demonstration project site who no longer participates in the demonstration program shall retain eligibility for a group residential housing payment in an amount determined under section 256I.06, subdivision 8, using the MSA equivalent rate. Service funding under section 256I.05, subdivision 1a, will end June 30, 1997, if federal matching funds are available and the services can be provided through a managed care entity. If federal matching funds are not available, then service funding will continue under section 256I.05, subdivision 1a; ~~or (6)~~ (5) for group residential housing beds in settings meeting the requirements of subdivision 2a, clauses (1) and (3), which are used exclusively for recipients receiving home and community-based waiver services under sections 256B.0915, 256B.092, subdivision 5, 256B.093, and 256B.49, and who resided in a nursing facility for the six months immediately prior to the month of entry into the group residential housing setting. The group residential housing rate for these beds must be set so that the monthly group residential housing payment for an individual occupying the bed when combined with the nonfederal share of services delivered under the waiver for that person does not exceed the nonfederal share of the monthly medical assistance payment made for the person to the nursing facility in which the person resided prior to entry into the group residential housing establishment. The rate may not exceed the MSA equivalent rate plus $426.37 for any case~~.~~; or (6) for an additional two beds, resulting in a total of 32 beds, for a facility located in Hennepin County providing services

for recovering and chemically dependent men that has had a group residential housing contract with the county and has been licensed as a board and lodge facility with special services since 1980; (7) for a group residential housing provider located in Stearns County that operates a 40-bed facility, that received financing through the Minnesota Housing Finance Agency Ending Long-Term Homelessness Initiative and serves chemically dependent clientele, providing 24-hour-a-day supervision; (8) for a group residential housing provider located in Crow Wing County that serves a chemically dependent clientele, providing 24-hour-a-day supervision and limiting a resident's maximum length of stay to 13 months out of a consecutive 24-month period; (9) for a 60-bed facility in St. Louis County which opened in January 2006 that will serve chemically dependent persons operated by a group residential housing provider that currently operates a 304-bed facility in Minneapolis; and (10) for a group residential housing provider that operates two ten-bed facilities, one located in Hennepin County and one located in Ramsey County, which provide community support and serve the mental health needs of individuals who have chronically lived unsheltered, providing 24-hour-a-day supervision.

(b) A county agency may enter into a group residential housing agreement for beds with rates in excess of the MSA equivalent rate in addition to those currently covered under a group residential housing agreement if the additional beds are only a replacement of beds with rates in excess of the MSA equivalent rate which have been made available due to closure of a setting, a change of licensure or certification which removes the beds from group residential housing payment, or as a result of the downsizing of a group residential housing setting. The transfer of available beds from one county to another can only occur by the agreement of both counties.

Sec. 75. Minnesota Statutes 2006, section 256I.05, is amended by adding a subdivision to read:

Subd. 1h. **Supplementary rate for certain facilities serving chemically dependent males.** Notwithstanding subdivisions 1a and 1c, beginning July 1, 2007, a county agency shall negotiate a supplementary rate in addition to the rate specified in subdivision 1, not to exceed $737.87 per month, including any legislatively authorized inflationary adjustments, for a group residential housing provider that:

(1) is located in Ramsey County and has had a group residential housing contract with the county since 1982 and has been licensed as a board and lodge facility with special services since 1979; and

(2) serves recovering and chemically dependent males, providing 24-hour-a-day supervision.

Sec. 76. Minnesota Statutes 2006, section 256I.05, is amended by adding a subdivision to read:

Subd. 1i. **Supplementary rate for certain facilities; Hennepin County.** Notwithstanding the provisions of subdivisions 1a and 1c, a county agency shall negotiate a supplementary rate in addition to the rate specified in subdivision 1, not to exceed $700 per month, including any legislatively authorized inflationary adjustments, for a facility located in Hennepin County with a capacity of up to 48 beds that has been licensed since 1978 as a board and lodging facility and that until August 1, 2007, operated as a licensed chemical dependency treatment program.

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

Sec. 77. Minnesota Statutes 2006, section 256I.05, is amended by adding a subdivision to read:

Subd. 1j. **Supplementary rate for certain facilities; St. Louis County.** (a) Notwithstanding the provisions of subdivisions 1a and 1c, beginning July 1, 2007, a county agency shall negotiate a supplementary rate in addition to the rate specified in subdivision 1, not to exceed $700 per month, including any legislatively authorized inflationary adjustments, for a 60-bed facility in St. Louis County which opened in January 2006 that will serve chemically dependent persons operated by a group residential housing provider that currently operates a 304-bed facility in Minneapolis.

(b) The supplementary rate in paragraph (a) applies to the 48 beds which do not already receive a supplementary rate.

Sec. 78. Minnesota Statutes 2006, section 256I.05, is amended by adding a subdivision to read:

Subd. 1k. **Supplementary rate for certain facilities; Crow Wing County.** Notwithstanding the provisions of subdivisions 1a and 1c, beginning July 1, 2007, a county agency shall negotiate a supplementary rate in addition to the rate specified in subdivision 1, not to exceed $700 per month, including any legislatively authorized inflationary adjustments, for a new 65-bed facility in Crow Wing County that will serve chemically dependent persons operated by a group residential housing provider that currently operates a 304-bed facility in Minneapolis and a 44-bed facility in Duluth which opened in January of 2006.

Sec. 79. Minnesota Statutes 2006, section 256I.05, is amended by adding a subdivision to read:

Subd. 1l. **Supplementary rate for certain facilities; Stearns County.** Notwithstanding the provisions of this section, beginning July 1, 2007, a county agency shall negotiate a supplementary service rate in addition to the rate specified in subdivision 1, not to exceed $700 per month, including any legislatively authorized inflationary adjustments, for a group residential housing provider located in Stearns County that operates a 40-bed facility, that received financing through the Minnesota Housing Finance Agency Ending Long-Term Homelessness Initiative and serves chemically dependent clientele, providing 24-hour-a-day supervision.

Sec. 80. Minnesota Statutes 2006, section 256I.05, is amended by adding a subdivision to read:

Subd. 1m. **Supplementary rate for certain facilities; St. Louis County.** Notwithstanding the provisions of this section, beginning July 1, 2007, a county agency shall negotiate a supplementary service rate in addition to the rate specified in subdivision 1, not to exceed $700 per month, including any legislatively authorized inflationary adjustments, for a group residential housing provider located in St. Louis County that operates a 30-bed facility, that received financing through the Minnesota Housing Finance Agency Ending Long-Term Homelessness Initiative and serves chemically dependent clientele, providing 24-hour-a-day supervision.

Sec. 81. Minnesota Statutes 2006, section 256I.05, is amended by adding a subdivision to read:

Subd. 1n. **Supplemental rate for certain facilities; Hennepin and Ramsey Counties.** Notwithstanding the provisions of this section, beginning July 1, 2007, a county agency shall negotiate a supplemental service rate in addition to the rate specified in subdivision 1, not to exceed $715.78 per month, including any legislatively authorized inflationary adjustments, for a group residential housing provider that operates two ten-bed facilities, one located in Hennepin County and one located in Ramsey County, which provide community support and serve the mental health needs of individuals who have chronically lived unsheltered, providing 24-hour-a-day supervision.

Sec. 82. Laws 2000, chapter 340, section 19, is amended to read:

Sec. 19. **ALTERNATIVE CARE PILOT PROJECTS.**

(a) Expenditures for housing with services and adult foster care shall be excluded when determining average monthly expenditures per client for alternative care pilot projects authorized in Laws 1993, First Special Session chapter 1, article 5, section 133.

(b) Alternative care pilot projects shall not expire on June 30, 2001, but shall continue until June 30, ~~2005~~ 2007.

EFFECTIVE DATE. This section is effective retroactively from June 29, 2005, for activities related to discontinuing pilot projects under this section.

Sec. 83. Laws 2006, chapter 282, article 20, section 37, is amended to read:

Sec. 37. **REPAYMENT DELAY.**

A county that overspent its allowed amounts in calendar year 2004 or 2005 under the waivered services program for persons with developmental disabilities shall not be required to pay back the amount of overspending ~~until May 31, 2007~~.

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

Sec. 84. **LICENSURE; SERVICES FOR YOUTH WITH DISABILITIES.**

(a) Notwithstanding the requirements of Minnesota Statutes, chapter 245A, upon the recommendation of a county agency, the commissioner of human services shall grant a license with any necessary variances to a nonresidential program for youth which provides services to youth with disabilities under age 21 during nonschool hours established to ensure health and safety, prevent out-of-home placement, and increase community inclusion of youth with disabilities. The nonresidential youth program is subject to the conditions of any variances granted and with consumer rights under Minnesota Statutes, section 245B.04, consumer protection standards under Minnesota Statutes, section 245B.05, service standards under Minnesota Statutes, section 245B.06, management standards under Minnesota Statutes, section 245B.07, and fire marshal inspections under Minnesota Statutes, section 245A.151, until the commissioner develops other licensure requirements for this type of program.

(b) By February 1, 2008, the commissioner shall recommend amendments to licensure requirements in Minnesota Statutes, chapter 245A, to allow licensure of appropriate services for school-age youth with disabilities under age 21 who need supervision and services to develop skills necessary to maintain personal safety and increase their independence, productivity, and participation in their communities during nonschool hours. As part of developing the recommendations, the commissioner shall survey county agencies to determine how the needs of youth with disabilities under age 21 who require supervision and support services are being met and the funding sources used. The recommendations must be provided to the house and senate chairs of the committees with jurisdiction over licensing of programs for youth with disabilities.

Sec. 85. **INDEPENDENT LIVING.**

An individual who has lived in one of the facilities under Minnesota Statutes, section 256I.05, subdivision 1n, who is being transitioned to independent living as part of the program plan continues to be eligible for group residential housing and the supplemental service rate negotiated with the county under Minnesota Statutes, section 256I.05, subdivision 1n.

Sec. 86. **ASSISTIVE TECHNOLOGY STUDY AND REPORT.**

Subdivision 1. **Study.** (a) During the biennium ending June 30, 2009, the Council on Disability shall facilitate a statewide study of the assistive technology needs of people with disabling conditions, and seniors. As part of the study, the council shall identify community-based service providers, state agencies, and other entities involved in providing assistive technology supports. The study shall also examine the creation of an assistive technology pretax savings account to allow disabled persons to set aside pretax and unearned income to purchase assistive technology devices, equipment, and services.

(b) The council shall provide oversight and direction to the Minnesota Regions Assistive Technology Collaborative during the biennium ending June 30, 2009.

Subd. 2. **Report.** The council shall present to the chairs of the house and senate committees having jurisdiction over human services, by January 1, 2009, a report of the findings of the study, including proposed legislation creating a statewide comprehensive plan to meet the assistive technology needs of people with disabling conditions and seniors. The statewide plan must include steps to coordinate and streamline assistive technology services and the creation of an assistive technology pretax savings account.

Sec. 87. **HOUSING WITH SERVICES AND HOME CARE PROVIDERS STUDY; REPORT.**

The commissioner of human services shall conduct a study of housing with services establishments and their arranged home care providers to assess the impact that residents' spending down to eligibility for public programs has on public expenditures. The preliminary results of this study shall be reported to the house and senate committees with jurisdiction over health and human services policy and finance issues by February 15, 2008, with a final report completed by December 15, 2008. Housing with services establishments and home care providers shall provide information upon request of the commissioner in order to achieve study outcomes, including:

(1) length of stay of residents in the housing with services establishment;

(2) housing and services provided and related charges, payments, and payment sources;

(3) housing and services included in base rates charged to all residents;

(4) reasons for termination of services;

(5) reasons for termination of leases;

(6) copies of contracts, agreements, and leases;

(7) resident demographics; and

(8) other information as requested by the commissioner.

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

Sec. 88. **COMMUNITY SERVICES PROVIDER RATE INCREASES.**

(a) The commissioner of human services shall increase reimbursement rates or rate limits, as applicable, by three percent for the rate period beginning October 1, 2007, and the rate period beginning October 1, 2008, effective for services rendered on or after those dates.

(b) The three percent annual rate increase described in this section must be provided to:

(1) home and community-based waivered services for persons with developmental disabilities or related conditions under Minnesota Statutes, section 256B.501;

(2) home and community-based waivered services for the elderly under Minnesota Statutes, section 256B.0915;

(3) waivered services under community alternatives for disabled individuals under Minnesota Statutes, section 256B.49;

(4) community alternative care waivered services under Minnesota Statutes, section 256B.49;

(5) traumatic brain injury waivered services under Minnesota Statutes, section 256B.49;

(6) nursing services and home health services under Minnesota Statutes, section 256B.0625, subdivision 6a;

(7) personal care services and nursing supervision of personal care services under Minnesota Statutes, section 256B.0625, subdivision 19a;

(8) private duty nursing services under Minnesota Statutes, section 256B.0625, subdivision 7;

(9) day training and habilitation services for adults with developmental disabilities or related conditions under Minnesota Statutes, sections 252.40 to 252.46, including the

additional cost of rate adjustments on day training and habilitation service, provided as a social service under Minnesota Statutes, section 256M.60;

(10) alternative care services under Minnesota Statutes, section 256B.0913;

(11) adult residential program grants under Minnesota Statutes, section 245.73;

(12) adult and children's mental health grants under Minnesota Rules, parts 9535.1700 to 9535.1760;

(13) the group residential housing supplementary service rate under Minnesota Statutes, section 256I.05, subdivision 1a;

(14) adult mental health integrated fund grants under Minnesota Statutes, section 245.4661;

(15) semi-independent living services (SILS) under Minnesota Statutes, section 252.275, including SILS funding under county social services grants formerly funded under Minnesota Statutes, chapter 256I;

(16) community support services for deaf and hard-of-hearing adults with mental illness who use or wish to use sign language as their primary means of communication under Minnesota Statutes, section 256.01, subdivision 2;

(17) living skills training programs for persons with intractable epilepsy who need assistance in the transition to independent living under Laws 1988, chapter 689;

(18) physical therapy services under Minnesota Statutes, sections 256B.0625, subdivision 8, and 256D.03, subdivision 4;

(19) occupational therapy services under Minnesota Statutes, sections 256B.0625, subdivision 8a, and 256D.03, subdivision 4;

(20) speech-language therapy services under Minnesota Statutes, section 256D.03, subdivision 4, and Minnesota Rules, part 9505.0390;

(21) respiratory therapy services under Minnesota Statutes, section 256D.03, subdivision 4, and Minnesota Rules, part 9505.0295;

(22) aging grants under Minnesota Statutes, sections 256.975 to 256.977, 256B.0917, and 256B.0928;

(23) deaf and hard-of-hearing grants under Minnesota Statutes, sections 256C.233; 256C.25; Laws 1985, chapter 9, article 1; and Laws 1997, First Special Session chapter 5, section 20;

(24) children's therapeutic services and supports under Minnesota Statutes, section 256B.0943;

(25) tier I chemical health services under Minnesota Statutes, chapter 254B;

(26) consumer support grants under Minnesota Statutes, section 256.476;

(27) family support grants under Minnesota Statutes, section 252.32;

(28) case management services to persons with HIV or AIDS under Minnesota Statutes, section 256.01, subdivision 19; and

(29) adult rehabilitative mental health services under Minnesota Statutes, section 256B.0623.

(c) Providers that receive a rate increase under this section shall use 75 percent of the additional revenue to increase wages and benefits and pay associated costs for all employees, except for management fees, the administrator, and central office staff.

(d) For public employees, the increase for wages and benefits for certain staff is available and pay rates must be increased only to the extent that they comply with laws governing public employees' collective bargaining. Money received by a provider for pay increases under this section may be used only for increases implemented on or after the first day of the rate period in which the increase is available and must not be used for increases implemented prior to that date.

(e) A copy of the provider's plan for complying with paragraph (c) must be made available to all employees by giving each employee a copy or by posting a copy in an area of the provider's operation to which all employees have access. If an employee does not receive the adjustment, if any, described in the plan and is unable to resolve the problem with the provider, the employee may contact the employee's union representative. If the employee is not covered by a collective bargaining agreement, the employee may contact the commissioner at a telephone number provided by the commissioner and included in the provider's plan.

(f) The commissioner and each county agency shall take steps necessary to implement the increases required by this section on the dates specified, and the increases must be effective on the dates specified, regardless of the client's service authorization date and notwithstanding the terms of any provider contract, service agreement, or schedule that limits when a county may increase payment rates.

Sec. 89. **DENTAL ACCESS FOR PERSONS WITH DISABILITIES.**

The commissioner of human services shall study access to dental services for persons with disabilities, and shall present recommendations for improving access to dental services to the legislature by January 15, 2008. The study must examine physical and geographic access, the willingness of dentists to serve persons with disabilities enrolled in state health care programs, reimbursement rates for dental service providers, and other factors identified by the commissioner.

Sec. 90. **COMMISSIONER REQUIRED TO SEEK FEDERAL APPROVAL.**

By October 1, 2007, the commissioner shall seek federal approval to allow persons who have been eligible for medical assistance for employed persons with disabilities (MA-EPD) under Minnesota Statutes, section 256B.057, subdivision 9, for each of the 24 consecutive months prior to becoming age 65 to continue using the MA-EPD eligibility rules as long as they qualify.

Sec. 91. **MINNESOTA RULES.**

The Department of Administration shall publish adopted rules in the State Register making the terminology changes specified in section 92 in Minnesota Rules. Upon publication in the State Register, the terminology changes for Minnesota Rules are adopted without further administrative action.

Sec. 92. **REVISOR'S INSTRUCTION.**

The revisor of statutes shall change the terms in column A to the terms in column B wherever they appear in Minnesota Statutes:

Column A	Column B
"Office of Ombudsman for Older Minnesotans" and "Office of the Ombudsman for Older Minnesotans"	"Office of Ombudsman for Long-Term Care"
"ombudsman for older Minnesotans"	"ombudsman for long-term care"

Sec. 93. **REPEALER.**

(a) Minnesota Statutes 2006, sections 252.21; 252.22; 252.23; 252.24; 252.25; 252.261; 252.275, subdivision 5; 256.9743; and 256B.0913, subdivisions 5b, 5c, 5d, 5e, 5f, 5g, and 5h, are repealed.

(b) Minnesota Rules, part 9505.0335, is repealed.

ARTICLE 5
MENTAL HEALTH

Section 1. Minnesota Statutes 2006, section 245.462, subdivision 20, is amended to read:

Subd. 20. **Mental illness.** (a) "Mental illness" means an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that is listed in the clinical manual of the International Classification of Diseases (ICD-9-CM), current edition, code range 290.0 to 302.99 or 306.0 to 316.0

or the corresponding code in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-MD), current edition, Axes I, II, or III, and that seriously limits a person's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, and recreation.

(b) An "adult with acute mental illness" means an adult who has a mental illness that is serious enough to require prompt intervention.

(c) For purposes of case management and community support services, a "person with serious and persistent mental illness" means an adult who has a mental illness and meets at least one of the following criteria:

(1) the adult has undergone two or more episodes of inpatient care for a mental illness within the preceding 24 months;

(2) the adult has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months' duration within the preceding 12 months;

(3) the adult has been treated by a crisis team two or more times within the preceding 24 months;

(4) the adult:

(i) has a diagnosis of schizophrenia, bipolar disorder, major depression, or borderline personality disorder;

(ii) indicates a significant impairment in functioning; and

(iii) has a written opinion from a mental health professional, in the last three years, stating that the adult is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in clause (1) or (2), unless ongoing case management or community support services are provided;

~~(4)~~ (5) the adult has, in the last three years, been committed by a court as a person who is mentally ill under chapter 253B, or the adult's commitment has been stayed or continued; or

~~(5)~~ (6) the adult (i) was eligible under clauses (1) to ~~(4)~~ (5), but the specified time period has expired or the adult was eligible as a child under section 245.4871, subdivision 6; and (ii) has a written opinion from a mental health professional, in the last three years, stating that the adult is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in clause (1) or (2), unless ongoing case management or community support services are provided.

Sec. 2. Minnesota Statutes 2006, section 245.50, subdivision 5, is amended to read:

Subd. 5. **Special contracts; bordering states.** (a) An individual who is detained, committed, or placed on an involuntary basis under chapter 253B may be confined or

treated in a bordering state pursuant to a contract under this section. An individual who is detained, committed, or placed on an involuntary basis under the civil law of a bordering state may be confined or treated in Minnesota pursuant to a contract under this section. A peace or health officer who is acting under the authority of the sending state may transport an individual to a receiving agency that provides services pursuant to a contract under this section and may transport the individual back to the sending state under the laws of the sending state. Court orders valid under the law of the sending state are granted recognition and reciprocity in the receiving state for individuals covered by a contract under this section to the extent that the court orders relate to confinement for treatment or care of mental illness or chemical dependency. Such treatment or care may address other conditions that may be co-occurring with the mental illness or chemical dependency. These court orders are not subject to legal challenge in the courts of the receiving state. Individuals who are detained, committed, or placed under the law of a sending state and who are transferred to a receiving state under this section continue to be in the legal custody of the authority responsible for them under the law of the sending state. Except in emergencies, those individuals may not be transferred, removed, or furloughed from a receiving agency without the specific approval of the authority responsible for them under the law of the sending state.

(b) While in the receiving state pursuant to a contract under this section, an individual shall be subject to the sending state's laws and rules relating to length of confinement, reexaminations, and extensions of confinement. No individual may be sent to another state pursuant to a contract under this section until the receiving state has enacted a law recognizing the validity and applicability of this section.

(c) If an individual receiving services pursuant to a contract under this section leaves the receiving agency without permission and the individual is subject to involuntary confinement under the law of the sending state, the receiving agency shall use all reasonable means to return the individual to the receiving agency. The receiving agency shall immediately report the absence to the sending agency. The receiving state has the primary responsibility for, and the authority to direct, the return of these individuals within its borders and is liable for the cost of the action to the extent that it would be liable for costs of its own resident.

(d) Responsibility for payment for the cost of care remains with the sending agency.

(e) This subdivision also applies to county contracts under subdivision 2 which include emergency care and treatment provided to a county resident in a bordering state.

(f) If a Minnesota resident is admitted to a facility in a bordering state under this chapter, a physician, licensed psychologist who has a doctoral degree in psychology, or

an advance practice registered nurse certified in mental health, who is licensed in the bordering state, may act as an examiner under sections 253B.07, 253B.08, 253B.092, 253B.12, and 253B.17 subject to the same requirements and limitations in section 253B.02, subdivision 7.

Sec. 3. Minnesota Statutes 2006, section 245.98, subdivision 2, is amended to read:

Subd. 2. **Program.** The commissioner of human services shall establish a program for the treatment of compulsive gamblers. The commissioner may contract with an entity with expertise regarding the treatment of compulsive gambling to operate the program. The program may include the establishment of a statewide toll-free number, resource library, public education programs; regional in-service training programs and conferences for health care professionals, educators, treatment providers, employee assistance programs, and criminal justice representatives; and the establishment of certification standards for programs and service providers. The commissioner may enter into agreements with other entities and may employ or contract with consultants to facilitate the provision of these services or the training of individuals to qualify them to provide these services. The program may also include inpatient and outpatient treatment and rehabilitation services ~~and~~ for residents in a temporary or permanent residential setting for mental health or chemical dependency, and individuals in jails or correctional facilities. The program may also include research studies. The research studies must include baseline and prevalence studies for adolescents and adults to identify those at the highest risk. The program must be approved by the commissioner before it is established.

Sec. 4. Minnesota Statutes 2006, section 245.98, subdivision 5, is amended to read:

Subd. 5. **Standards.** The commissioner shall create standards for treatment and provider qualifications for the treatment component of the compulsive gambling program. The commissioner, in coordination with the commissioner of corrections, shall create standards for the assessment and treatment of compulsive gamblers in programs operated by the commissioner of corrections.

Sec. 5. **[245A.175] MENTAL HEALTH TRAINING REQUIREMENT.**

Prior to placement of a child in a foster care home, the child foster care provider, if required to be licensed, must complete two hours of training that addresses the causes, symptoms, and key warning signs of mental health disorders; cultural considerations; and effective approaches for dealing with a child's behaviors. At least one hour of the annual 12-hour training requirement for foster parents must be on children's mental health issues

and treatment. Training curriculum shall be approved by the commissioner of human services.

Sec. 6. Minnesota Statutes 2006, section 246.54, subdivision 1, is amended to read:

Subdivision 1. **County portion for cost of care.** Except for chemical dependency services provided under sections 254B.01 to 254B.09, the client's county shall pay to the state of Minnesota a portion of the cost of care provided in a regional treatment center or a state nursing facility to a client legally settled in that county. A county's payment shall be made from the county's own sources of revenue and payments shall be ~~paid as follows: payments to the state from the county shall equal 20 percent~~ a percentage of the cost of care, as determined by the commissioner, for each day, or the portion thereof, that the client spends at a regional treatment center or a state nursing facility~~.~~ according to the following schedule for each admission:

(1) for the first 30 days: 20 percent until January 1, 2008, ten percent from January 1, 2008, to June 30, 2009, and zero percent thereafter;

(2) 20 percent for days 31 to 60; and

(3) for any days over 60: 20 percent until January 1, 2008, 30 percent from January 1, 2008, to June 30, 2009, 40 percent from July 1, 2009, to June 30, 2010, and 50 percent thereafter.

If payments received by the state under sections 246.50 to 246.53 exceed ~~80 percent~~ the noncounty portion of the cost of care, the county shall be responsible for paying the state only the remaining amount. The county shall not be entitled to reimbursement from the client, the client's estate, or from the client's relatives, except as provided in section 246.53. ~~No such payments shall be made for any client who was last committed prior to July 1, 1947.~~

Sec. 7. Minnesota Statutes 2006, section 256B.0623, subdivision 8, is amended to read:

Subd. 8. **Diagnostic assessment.** Providers of adult rehabilitative mental health services must complete a diagnostic assessment as defined in section 245.462, subdivision 9, within five days after the recipient's second visit or within 30 days after intake, whichever occurs first. A diagnostic assessment must be reimbursed at the same rate as an assessment under section 256B.0655, subdivision 8. In cases where a diagnostic assessment is available that reflects the recipient's current status, and has been completed within 180 days preceding admission, an update must be completed. An update shall include a written summary by a mental health professional of the recipient's current mental health status and service needs. If the recipient's mental health status

has changed significantly since the adult's most recent diagnostic assessment, a new diagnostic assessment is required. For initial implementation of adult rehabilitative mental health services, until June 30, 2005, a diagnostic assessment that reflects the recipient's current status and has been completed within the past three years preceding admission is acceptable.

Sec. 8. Minnesota Statutes 2006, section 256B.0625, subdivision 20, is amended to read:

Subd. 20. **Mental health case management.** (a) To the extent authorized by rule of the state agency, medical assistance covers case management services to persons with serious and persistent mental illness and children with severe emotional disturbance. Services provided under this section must meet the relevant standards in sections 245.461 to 245.4887, the Comprehensive Adult and Children's Mental Health Acts, Minnesota Rules, parts 9520.0900 to 9520.0926, and 9505.0322, excluding subpart 10.

(b) Entities meeting program standards set out in rules governing family community support services as defined in section 245.4871, subdivision 17, are eligible for medical assistance reimbursement for case management services for children with severe emotional disturbance when these services meet the program standards in Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

(c) Medical assistance and MinnesotaCare payment for mental health case management shall be made on a monthly basis. In order to receive payment for an eligible child, the provider must document at least a face-to-face contact with the child, the child's parents, or the child's legal representative. To receive payment for an eligible adult, the provider must document:

(1) at least a face-to-face contact with the adult or the adult's legal representative; or

(2) at least a telephone contact with the adult or the adult's legal representative and document a face-to-face contact with the adult or the adult's legal representative within the preceding two months.

(d) Payment for mental health case management provided by county or state staff shall be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph (b), with separate rates calculated for child welfare and mental health, and within mental health, separate rates for children and adults.

(e) Payment for mental health case management provided by Indian health services or by agencies operated by Indian tribes may be made according to this section or other relevant federally approved rate setting methodology.

(f) Payment for mental health case management provided by vendors who contract with a county or Indian tribe shall be based on a monthly rate negotiated by the host county or tribe. The negotiated rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the county or tribe may negotiate a team rate with a vendor who is a member of the team. The team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county or tribe, except to reimburse the county or tribe for advance funding provided by the county or tribe to the vendor.

(g) If the service is provided by a team which includes contracted vendors, tribal staff, and county or state staff, the costs for county or state staff participation in the team shall be included in the rate for county-provided services. In this case, the contracted vendor, the tribal agency, and the county may each receive separate payment for services provided by each entity in the same month. In order to prevent duplication of services, each entity must document, in the recipient's file, the need for team case management and a description of the roles of the team members.

(h) The commissioner shall calculate the nonfederal share of actual medical assistance and general assistance medical care payments for each county, based on the higher of calendar year 1995 or 1996, by service date, project that amount forward to 1999, and transfer one-half of the result from medical assistance and general assistance medical care to each county's mental health grants under section 256E.12 for calendar year 1999. The annualized minimum amount added to each county's mental health grant shall be $3,000 per year for children and $5,000 per year for adults. The commissioner may reduce the statewide growth factor in order to fund these minimums. The annualized total amount transferred shall become part of the base for future mental health grants for each county.

(i) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for mental health case management shall be provided by the recipient's county of responsibility, as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds used to match other federal funds. If the service is provided by a tribal agency, the nonfederal share, if any, shall be provided by the recipient's tribe. When this service is paid by the state without a federal share through fee-for-service, 50 percent of the cost shall be provided by the recipient's county of responsibility.

(j) Notwithstanding any administrative rule to the contrary, MinnesotaCare includes mental health case management. When the service is provided through prepaid capitation, the nonfederal share is paid by the state and the county pays no share.

~~(j)~~ (k) The commissioner may suspend, reduce, or terminate the reimbursement to a provider that does not meet the reporting or other requirements of this section. The county

of responsibility, as defined in sections 256G.01 to 256G.12, or, if applicable, the tribal agency, is responsible for any federal disallowances. The county or tribe may share this responsibility with its contracted vendors.

~~(k)~~ (l) The commissioner shall set aside a portion of the federal funds earned under this section to repay the special revenue maximization account under section 256.01, subdivision 2, clause (15). The repayment is limited to:

(1) the costs of developing and implementing this section; and

(2) programming the information systems.

~~(l)~~ (m) Payments to counties and tribal agencies for case management expenditures under this section shall only be made from federal earnings from services provided under this section. Payments to county-contracted vendors shall include ~~both~~ the federal earnings, the state share, and the county share.

~~(m)~~ (n) Notwithstanding section 256B.041, county payments for the cost of mental health case management services provided by county or state staff shall not be made to the commissioner of finance. For the purposes of mental health case management services provided by county or state staff under this section, the centralized disbursement of payments to counties under section 256B.041 consists only of federal earnings from services provided under this section.

~~(n)~~ (o) Case management services under this subdivision do not include therapy, treatment, legal, or outreach services.

~~(o)~~ (p) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital, and the recipient's institutional care is paid by medical assistance, payment for case management services under this subdivision is limited to the last 180 days of the recipient's residency in that facility and may not exceed more than six months in a calendar year.

~~(p)~~ (q) Payment for case management services under this subdivision shall not duplicate payments made under other program authorities for the same purpose.

~~(q)~~ (r) By July 1, 2000, the commissioner shall evaluate the effectiveness of the changes required by this section, including changes in number of persons receiving mental health case management, changes in hours of service per person, and changes in caseload size.

~~(r)~~ (s) For each calendar year beginning with the calendar year 2001, the annualized amount of state funds for each county determined under paragraph (h) shall be adjusted by the county's percentage change in the average number of clients per month who received case management under this section during the fiscal year that ended six months prior to the calendar year in question, in comparison to the prior fiscal year.

~~(s)~~ (t) For counties receiving the minimum allocation of $3,000 or $5,000 described in paragraph (h), the adjustment in paragraph (s) shall be determined so that the county receives the higher of the following amounts:

(1) a continuation of the minimum allocation in paragraph (h); or

(2) an amount based on that county's average number of clients per month who received case management under this section during the fiscal year that ended six months prior to the calendar year in question, times the average statewide grant per person per month for counties not receiving the minimum allocation.

~~(t)~~ (u) The adjustments in paragraphs (s) and (t) shall be calculated separately for children and adults.

Sec. 9. Minnesota Statutes 2006, section 256B.0625, subdivision 47, is amended to read:

Subd. 47. **Treatment foster care services.** Effective July 1, ~~2006~~ 2009, and subject to federal approval, medical assistance covers treatment foster care services according to section 256B.0946.

Sec. 10. Minnesota Statutes 2006, section 256B.69, subdivision 5g, is amended to read:

Subd. 5g. **Payment for covered services.** For services rendered on or after January 1, 2003, the total payment made to managed care plans for providing covered services under the medical assistance and general assistance medical care programs is reduced by .5 percent from their current statutory rates. This provision excludes payments for nursing home services, home and community-based waivers, ~~and~~ payments to demonstration projects for persons with disabilities, and mental health services added as covered benefits after December 31, 2007.

Sec. 11. Minnesota Statutes 2006, section 256B.69, subdivision 5h, is amended to read:

Subd. 5h. **Payment reduction.** In addition to the reduction in subdivision 5g, the total payment made to managed care plans under the medical assistance program is reduced 1.0 percent for services provided on or after October 1, 2003, and an additional 1.0 percent for services provided on or after January 1, 2004. This provision excludes payments for nursing home services, home and community-based waivers, ~~and~~ payments to demonstration projects for persons with disabilities, and mental health services added as covered benefits after December 1, 2007.

Sec. 12. Minnesota Statutes 2006, section 256B.763, is amended to read:

256B.763 CRITICAL ACCESS MENTAL HEALTH RATE INCREASE.

(a) For services defined in paragraph (b) and rendered on or after July 1, 2007, payment rates shall be increased by 23.7 percent over the rates in effect on January 1, 2006, for:

(1) psychiatrists and advanced practice registered nurses with a psychiatric specialty;

(2) community mental health centers under section 256B.0625, subdivision 5; and

(3) mental health clinics and centers certified under Minnesota Rules, parts 9520.0750 to 9520.0870, or hospital outpatient psychiatric departments that are designated as essential community providers under section 62Q.19.

(b) This increase applies to group skills training when provided as a component of children's therapeutic services and support, psychotherapy, medication management, evaluation and management, diagnostic assessment, explanation of findings, psychological testing, neuropsychological services, direction of behavioral aides, and inpatient consultation.

(c) This increase does not apply to rates that are governed by section 256B.0625, subdivision 30, or 256B.761, paragraph (b), other cost-based rates, rates that are negotiated with the county, rates that are established by the federal government, or rates that increased between January 1, 2004, and January 1, 2005.

(d) The commissioner shall adjust rates paid to prepaid health plans under contract with the commissioner to reflect the rate increases provided in paragraph (a). The prepaid health plan must pass this rate increase to the providers identified in ~~paragraph (a)~~ paragraphs (a), (e), and (f). The prepaid plan must pass this rate increase to the providers identified in paragraphs (a), (e), and (f).

(e) For MinnesotaCare only, payment rates shall be increased by 23.7 percent over the rates in effect on December 31, 2007, for:

(1) medication education services provided on or after January 1, 2008, by adult rehabilitative mental health services providers certified under section 256B.0623; and

(2) mental health behavioral aide services provided on or after January 1, 2008, by children's therapeutic services and support providers certified under section 256B.0943.

(f) For services defined in paragraph (b) and rendered on or after January 1, 2008, by children's therapeutic services and support providers certified under section 256B.0943 and not already included in paragraph (a), payment rates for MinnesotaCare shall be increased by 23.7 percent over the rates in effect on December 31, 2007.

Sec. 13. Minnesota Statutes 2006, section 256L.03, subdivision 1, is amended to read:

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

"Covered health services" also includes intensive mental health outpatient treatment for dialectical behavioral therapy for adults.

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

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

EFFECTIVE DATE. This section is effective January 1, 2008, except coverage for mental health case management is effective January 1, 2009.

Sec. 14. Minnesota Statutes 2006, section 256L.03, subdivision 5, is amended to read:

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

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

(2) $3 per prescription for adult enrollees;

(3) $25 for eyeglasses for adult enrollees;

(4) $3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or

physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist; and

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

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

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

(d) Paragraph (a), clause (4), does not apply to mental health services.

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

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

Sec. 15. Minnesota Statutes 2006, section 256L.035, is amended to read:

256L.035 LIMITED BENEFITS COVERAGE FOR CERTAIN SINGLE ADULTS AND HOUSEHOLDS WITHOUT CHILDREN.

(a) "Covered health services" for individuals under section 256L.04, subdivision 7, with income above 75 percent, but not exceeding 175 percent, of the federal poverty guideline means:

(1) inpatient hospitalization benefits with a ten percent co-payment up to $1,000 and subject to an annual limitation of $10,000;

(2) physician services provided during an inpatient stay; and

(3) physician services not provided during an inpatient stay; outpatient hospital services; freestanding ambulatory surgical center services; chiropractic services; lab and diagnostic services; diabetic supplies and equipment; mental health services as covered under chapter 256B; and prescription drugs; subject to the following co-payments:

(i) $50 co-pay per emergency room visit;

(ii) $3 co-pay per prescription drug; and

(iii) $5 co-pay per nonpreventive visit; except this co-pay does not apply to mental health services or community mental health services.

The services covered under this section may be provided by a physician, physician ancillary, chiropractor, psychologist, ~~or~~ licensed independent clinical social worker, or other mental health providers covered under chapter 256B if the services are within the scope of practice of that health care professional.

For purposes of this section, "a visit" means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by any health care provider identified in this paragraph.

Enrollees are responsible for all co-payments in this section.

(b) Reimbursement to the providers shall be reduced by the amount of the co-payment, except that reimbursement for prescription drugs shall not be reduced once a recipient has reached the $20 per month maximum for prescription drug co-payments. The provider collects the co-payment from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment, except as provided in paragraph (c).

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

Sec. 16. Minnesota Statutes 2006, section 256L.12, subdivision 9a, is amended to read:

Subd. 9a. **Rate setting; ratable reduction.** For services rendered on or after October 1, 2003, the total payment made to managed care plans under the MinnesotaCare program is reduced 1.0 percent. This provision excludes payments for mental health services added as covered benefits after December 31, 2007.

Sec. 17. Minnesota Statutes 2006, section 609.115, subdivision 9, is amended to read:

Subd. 9. **Compulsive gambling assessment required.** (a) If a person is convicted of theft under section 609.52, embezzlement of public funds under section 609.54, or forgery under section 609.625, 609.63, or 609.631, the probation officer shall determine in the report prepared under subdivision 1 whether or not compulsive gambling contributed to the commission of the offense. If so, the report shall contain the results of a compulsive gambling assessment conducted in accordance with this subdivision. The probation officer shall make an appointment for the offender to undergo the assessment if so indicated.

(b) The compulsive gambling assessment report must include a recommended level of treatment for the offender if the assessor concludes that the offender is in need of compulsive gambling treatment. The assessment must be conducted by an assessor qualified under section 245.98, subdivision 2a, to perform these assessments or to provide compulsive gambling treatment. An assessor providing a compulsive gambling assessment may not have any direct or shared financial interest or referral relationship resulting in shared financial gain with a treatment provider. If an independent assessor is not available, the probation officer may use the services of an assessor with a financial interest or referral relationship as authorized under rules adopted by the commissioner of human services under section 245.98, subdivision 2a.

(c) The commissioner of human services shall reimburse the assessor for the costs associated with a compulsive gambling assessment at a rate established by the commissioner up to a maximum of $100 for each assessment. To the extent practicable, the commissioner shall standardize reimbursement rates for assessments. The commissioner shall reimburse these costs after receiving written verification from the probation officer that the assessment was performed and found acceptable.

(d) The commissioner shall make a report to the legislature by January 15, 2008, regarding the transfer of funds to counties for state registered nurses employed in community mental health pilot projects as part of the assertive community treatment teams under section 245.4661. The report shall address the impact of the nursing shortage on replacing these positions, continuity of patient care if these positions cannot be filled, and ways to maintain state registered nurses in these positions until the nurse retires or leaves employment. No funds for state registered nurse positions may be transferred before the report date.

Sec. 18. **CASE MANAGEMENT; BEST PRACTICES.**

The commissioner of human services, in consultation with consumers, families, counties, and other interested stakeholders, will develop recommendations for changes in the adult mental health act related to case management, consistent with evidence-based and best practices.

Sec. 19. **REGIONAL CHILDREN'S MENTAL HEALTH INITIATIVE.**

Subdivision 1. **Pilot project authorized; purpose.** A two-year Regional Children's Mental Health Initiative pilot project is established to improve children's mental health service coordination, communication, and processes in Blue Earth, Brown, Faribault, Freeborn, Le Sueur, Martin, Nicollet, Rice, Sibley, Waseca, and Watonwan Counties. The

purpose of the Regional Children's Mental Health Initiative will be to plan and develop new programs and services related to children's mental health in south central Minnesota.

Subd. 2. **Goals.** To accomplish its purpose, the Regional Children's Mental Health Initiative shall have the following goals:

(1) work to streamline delivery and regional access to services;

(2) share strategies and resources for the management of out-of-home placements;

(3) establish standard protocols and operating procedures for functions that are performed across all counties;

(4) share information to improve resource allocation and service delivery across counties;

(5) evaluate outcomes of various treatment alternatives;

(6) create a network for and provide support to service delivery groups;

(7) establish a regional process to match children in need of out-of-home placement with foster homes that can meet their needs; and

(8) recruit and retain foster homes.

Subd. 3. **Director's Council.** The Director's Council shall govern the operations of the Regional Children's Mental Health Initiative. Members of the Director's Council shall represent each of the 11 counties participating in the pilot project.

Subd. 4. **Regional Children's Mental Health Initiative Team.** The members of the Regional Children's Mental Health Initiative Team shall conduct planning and development of new and modified children's mental health programs and services in the region. Members of the team shall reflect the cultural, demographic, and geographic diversity of the region and shall be composed of representatives from each of the following:

(1) the medical community;

(2) human services;

(3) corrections;

(4) education;

(5) mental health providers and vendors;

(6) advocacy organizations;

(7) parents; and

(8) children and youth.

Subd. 5. **Authority.** The regional children's mental health initiative shall have the authority to develop and implement the following programs:

(1) Flexible funding payments. This program will make funds available to respond to the unique and unpredictable needs of children with mental health issues such as the need for prescription drugs, transportation, clothing, and assessments not otherwise available.

(2) Transition to self-sufficiency. This program will help youths between the ages of 14 and 21 establish professional relationships, find jobs, build financial foundations, and learn to fulfill their roles as productive citizens.

(3) Crisis response. This program will establish public and private partnerships to offer a range of options to meet the needs of children in crisis. Methods to meet these needs may include accessible local services, holistic assessments, urgent care and stabilization services, and telehealth for specialized diagnosis and therapeutic sessions.

(4) Integrated services for complex conditions. This program will design, develop, and implement packages of integrated services to meet the needs of children with specific, complex conditions.

Subd. 6. **Evaluation and report.** The regional children's mental health initiative shall develop a method for evaluating the effectiveness of this pilot project focusing on identifiable goals and outcomes. An interim report on the pilot project's effectiveness shall be submitted to the house and senate finance committees having jurisdiction over mental health, the commissioner of human services, and the Minnesota Association of County Social Service Administrators no later than December 31, 2008. A final report is due no later than December 31, 2009.

Sec. 20. **TRAUMA-FOCUSED EVIDENCE-BASED PRACTICES TO CHILDREN.**

Organizations that are certified to provide children's therapeutic services and supports under Minnesota Statutes, section 256B.0943, are eligible to apply for a grant. Grants are to be used to provide trauma-focused evidence-based practices to children who are living in a battered women's shelter, homeless shelter, transitional housing, or supported housing. Children served must have been exposed to or witnessed domestic violence, have been exposed to or witnessed community violence, or be a refugee. Priority shall be given to organizations that demonstrate collaboration with battered women's shelters, homeless shelters, or providers of transitional housing or supported housing. The commissioner shall specify which constitutes evidence-based practice. Organizations shall use all available funding streams.

Sec. 21. **DUAL DIAGNOSIS; DEMONSTRATION PROJECT.**

(a) The commissioner of human services shall fund demonstration projects for high risk adults with serious mental illness and co-occurring substance abuse problems. The projects must include, but not be limited to, the following:

(1) housing services, including rent or housing subsidies, housing with clinical staff, or housing support;

(2) assertive outreach services; and

(3) intensive direct therapeutic, rehabilitative, and care management services oriented to harm reduction.

(b) The commissioner shall work with providers to ensure proper licensure or certification to meet medical assistance or third-party payor reimbursement requirements.

Sec. 22. **MINNESOTA FAMILY INVESTMENT PROGRAM AND CHILDREN'S MENTAL HEALTH PILOT PROJECT.**

Subdivision 1. **Pilot project authorized.** The commissioner of human services shall fund a three-year pilot project to measure the effect of children's identified mental health needs, including social and emotional needs, on Minnesota family investment program (MFIP) participants' ability to obtain and retain employment. The project shall also measure the effect on work activity of MFIP participants' needs to address their children's identified mental health needs.

Subd. 2. **Provider and agency proposals.** (a) Interested MFIP providers and agencies shall:

(1) submit proposals defining how they will identify participants whose children have mental health needs that hinder the employment process;

(2) connect families with appropriate developmental, social, and emotional screenings and services; and

(3) incorporate those services into the participant's employment plan.

Each proposal under this paragraph must include an evaluation component.

(b) Interested MFIP providers and agencies shall develop a protocol to inform MFIP participants of the following:

(1) the availability of developmental, social, and emotional screening tools for children and youth;

(2) the purpose of the screenings;

(3) how the information will be used to assist the participants in identifying and addressing potential barriers to employment; and

(4) that their employment plan may be modified based on the screening results.

Subd. 3. **Program components.** (a) MFIP providers shall obtain the participant's written consent for participation in the pilot project, including consent for developmental, social, and emotional screening.

(b) MFIP providers shall coordinate with county social service agencies and health plans to assist recipients in arranging referrals indicated by the screening results.

(c) Tools used for developmental, social, and emotional screenings shall be approved by the commissioner of human services.

Subd. 4. **Program evaluation.** The commissioner of human services shall conduct an evaluation of the pilot project to determine:

(1) the number of participants who took part in the screening;

(2) the number of children who were screened and what screening tools were used;

(3) the number of children who were identified in the screening who needed referral or follow-up services;

(4) the number of children who received services, what agency provided the services, and what type of services were provided;

(5) the number of employment plans that were adjusted to include the activities recommended in the screenings;

(6) the changes in work participation rates;

(7) the changes in earned income;

(8) the changes in sanction rates; and

(9) the participants' report of program effectiveness.

Subd. 5. **Work activity.** Participant involvement in screenings and subsequent referral and follow-up services shall count as work activity under Minnesota Statutes, section 256J.49, subdivision 13.

Sec. 23. **SOCIAL AND ECONOMIC COSTS OF GAMBLING.**

Subdivision 1. **Report.** The commissioner of human services, in consultation with the state affiliate of the National Council on Problem Gambling, stakeholders, and licensed vendors, shall prepare a report that provides a process and funding mechanism to study the issues in subdivisions 2 and 3. The commissioner, in consultation with the state affiliate of the National Council on Problem Gambling, stakeholders, and licensed vendors, shall include in the report potential financial commitments made by stakeholders and others in order to fund the study. The report is due to the legislative committees having jurisdiction over compulsive gambling issues by December 1, 2007.

Subd. 2. **Issues to be addressed.** The study must address:

(1) state, local, and tribal government policies and practices in Minnesota to legalize or prohibit gambling;

(2) the relationship between gambling and crime in Minnesota, including: (i) the relationship between gambling and overall crime rates; (ii) the relationship between gambling and crimes rates for specific crimes, such as forgery, domestic abuse, child neglect and abuse, alcohol and drug offenses, and youth crime; and (iii) enforcement and regulation practices that are intended to address the relationship between gambling and levels of crime;

(3) the relationship between expanded gambling and increased rates of problem gambling in Minnesota, including the impact of pathological or problem gambling on individuals, families, businesses, social institutions, and the economy;

(4) the social impact of gambling on individuals, families, businesses, and social institutions in Minnesota, including an analysis of the relationship between gambling and depression, abuse, divorce, homelessness, suicide, and bankruptcy;

(5) the economic impact of gambling on state, local, and tribal economies in Minnesota; and

(6) any other issues deemed necessary in assessing the social and economic impact of gambling in Minnesota.

Subd. 3. **Quantification of social and economic impact.** The study shall quantify the social and economic impact on both (1) state, local, and tribal governments in Minnesota, and (2) Minnesota's communities and social institutions, including individuals, families, and businesses within those communities and institutions.

Sec. 24. **REPEALER.**

Minnesota Rules, part 9585.0030, is repealed.

ARTICLE 6
DEPARTMENT OF HEALTH

Section 1. Minnesota Statutes 2006, section 62J.17, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For purposes of this section, the terms defined in this subdivision have the meanings given.

~~(a) "Access" means the financial, temporal, and geographic availability of health care to individuals who need it.~~

~~(b)~~ (a) "Capital expenditure" means an expenditure which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance.

~~(c) "Cost" means the amount paid by consumers or third party payers for health care services or products.~~

~~(d) "Date of the major spending commitment" means the date the provider formally obligated itself to the major spending commitment. The obligation may be incurred by entering into a contract, making a down payment, issuing bonds or entering a loan agreement to provide financing for the major spending commitment, or taking some other formal, tangible action evidencing the provider's intention to make the major spending commitment.~~

~~(e)~~ (b) "Health care service" means:

(1) a service or item that would be covered by the medical assistance program under chapter 256B if provided in accordance with medical assistance requirements to an eligible medical assistance recipient; and

(2) a service or item that would be covered by medical assistance except that it is characterized as experimental, cosmetic, or voluntary.

"Health care service" does not include retail, over-the-counter sales of nonprescription drugs and other retail sales of health-related products that are not generally paid for by medical assistance and other third-party coverage.

~~(f)~~ (c) "Major spending commitment" means an expenditure in excess of $1,000,000 for:

(1) acquisition of a unit of medical equipment;

(2) a capital expenditure for a single project for the purposes of providing health care services, other than for the acquisition of medical equipment;

(3) offering a new specialized service not offered before;

(4) planning for an activity that would qualify as a major spending commitment under this paragraph; or

(5) a project involving a combination of two or more of the activities in clauses (1) to (4).

The cost of acquisition of medical equipment, and the amount of a capital expenditure, is the total cost to the provider regardless of whether the cost is distributed over time through a lease arrangement or other financing or payment mechanism.

~~(g)~~ (d) "Medical equipment" means fixed and movable equipment that is used by a provider in the provision of a health care service. "Medical equipment" includes, but is not limited to, the following:

(1) an extracorporeal shock wave lithotripter;

(2) a computerized axial tomography (CAT) scanner;

(3) a magnetic resonance imaging (MRI) unit;

(4) a positron emission tomography (PET) scanner; and

(5) emergency and nonemergency medical transportation equipment and vehicles.

~~(h)~~ (e) "New specialized service" means a specialized health care procedure or treatment regimen offered by a provider that was not previously offered by the provider, including, but not limited to:

(1) cardiac catheterization services involving high-risk patients as defined in the Guidelines for Coronary Angiography established by the American Heart Association and the American College of Cardiology;

(2) heart, heart-lung, liver, kidney, bowel, or pancreas transplantation service, or any other service for transplantation of any other organ;

(3) megavoltage radiation therapy;

(4) open heart surgery;

(5) neonatal intensive care services; and

(6) any new medical technology for which premarket approval has been granted by the United States Food and Drug Administration, excluding implantable and wearable devices.

(f) "Specialty care" includes but is not limited to cardiac, neurology, orthopedic, obstetrics, mental health, chemical dependency, and emergency services.

Sec. 2. Minnesota Statutes 2006, section 62J.17, subdivision 4a, is amended to read:

Subd. 4a. **Expenditure reporting.** ~~(a) A provider making a major spending commitment after April 1, 1992, shall submit notification of the expenditure to the commissioner and provide the commissioner with any relevant background information.~~

~~(b) Notification must include a report, submitted within 60 days after the date of the major spending commitment, using terms conforming to the definitions in section 62J.03 and this section. Each report is subject to retrospective review and must contain:~~

~~(1) a detailed description of the major spending commitment, including the specific dollar amount of each expenditure, and its purpose;~~

~~(2) the date of the major spending commitment;~~

~~(3) a statement of the expected impact that the major spending commitment will have on charges by the provider to patients and third party payers;~~

~~(4) a statement of the expected impact on the clinical effectiveness or quality of care received by the patients that the provider expects to serve;~~

~~(5) a statement of the extent to which equivalent services or technology are already available to the provider's actual and potential patient population;~~

~~(6) a statement of the distance from which the nearest equivalent services or technology are already available to the provider's actual and potential population;~~

~~(7) a statement describing the pursuit of any lawful collaborative arrangements; and~~

~~(8) a statement of assurance that the provider will not use, purchase, or perform health care technologies and procedures that are not clinically effective and cost-effective, unless the technology is used for experimental or research purposes to determine whether a technology or procedure is clinically effective and cost-effective.~~

~~The provider may submit any additional information that it deems relevant.~~

~~(c) The commissioner may request additional information from a provider for the purpose of review of a report submitted by that provider, and may consider relevant information from other sources. A provider shall provide any information requested by the commissioner within the time period stated in the request, or within 30 days after the date of the request if the request does not state a time.~~

~~(d) If the provider fails to submit a complete and timely expenditure report, including any additional information requested by the commissioner, the commissioner may make the provider's subsequent major spending commitments subject to the procedures of prospective review and approval under subdivision 6a.~~

Each hospital, outpatient surgical center, diagnostic imaging center, and physician clinic shall report annually to the commissioner on all major spending commitments, in the form and manner specified by the commissioner. The report shall include the following information:

(a) a description of major spending commitments made during the previous year, including the total dollar amount of major spending commitments and purpose of the expenditures;

(b) the cost of land acquisition, construction of new facilities, and renovation of existing facilities;

(c) the cost of purchased or leased medical equipment, by type of equipment;

(d) expenditures by type for specialty care and new specialized services;

(e) information on the amount and types of added capacity for diagnostic imaging services, outpatient surgical services, and new specialized services; and

(f) information on investments in electronic medical records systems.

For hospitals and outpatient surgical centers, this information shall be included in reports to the commissioner that are required under section 144.698. For diagnostic imaging centers, this information shall be included in reports to the commissioner that are required under section 144.565. For physician clinics, this information shall be included in reports to the commissioner that are required under section 62J.41. For all other health care

providers that are subject to this reporting requirement, reports must be submitted to the commissioner by March 1 each year for the preceding calendar year.

Sec. 3. Minnesota Statutes 2006, section 62J.17, subdivision 7, is amended to read:

Subd. 7. **Exceptions.** (a) The ~~retrospective review process as described in subdivision 5a and the prospective review and approval process as described in subdivision 6a~~ reporting requirement in subdivision 4a ~~do~~ does not apply to:

~~(1) a major spending commitment to replace existing equipment with comparable equipment used for direct patient care, upgrades of equipment beyond the current model, or comparable model must be reported;~~

~~(2)~~ (1) a major spending commitment made by a research and teaching institution for purposes of conducting medical education, medical research supported or sponsored by a medical school, or by a federal or foundation grant or clinical trials;

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

~~(4)~~ (2) a major spending commitment for building maintenance including heating, water, electricity, and other maintenance-related expenditures; and

~~(5)~~ (3) a major spending commitment for activities, not directly related to the delivery of patient care services, including food service, laundry, housekeeping, and other service-related activities~~; and~~.

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

(b) In addition to the exceptions listed in paragraph (a), the ~~prospective review and approval process described in subdivision 6a~~ reporting requirement in subdivision 4a does not apply to mergers, acquisitions, and other changes in ownership or control that, in the judgment of the commissioner, do not involve a substantial expansion of service capacity or a substantial change in the nature of health care services provided.

Sec. 4. Minnesota Statutes 2006, section 62J.41, subdivision 1, is amended to read:

Subdivision 1. **Cost containment data to be collected from providers.** The commissioner shall require health care providers to collect and provide both patient specific information and descriptive and financial aggregate data on:

(1) the total number of patients served;

(2) the total number of patients served by state of residence and Minnesota county;

(3) the site or sites where the health care provider provides services;

(4) the number of individuals employed, by type of employee, by the health care provider;

(5) the services and their costs for which no payment was received;

(6) total revenue by type of payer or by groups of payers, including but not limited to, revenue from Medicare, medical assistance, MinnesotaCare, nonprofit health service plan corporations, commercial insurers, health maintenance organizations, and individual patients;

(7) revenue from research activities;

(8) revenue from educational activities;

(9) revenue from out-of-pocket payments by patients;

(10) revenue from donations; ~~and~~

(11) a report on health care capital expenditures during the previous year, as required by section 62J.17; and

~~(11)~~ (12) any other data required by the commissioner, including data in unaggregated form, for the purposes of developing spending estimates, setting spending limits, monitoring actual spending, and monitoring costs.

The commissioner may, by rule, modify the data submission categories listed above if the commissioner determines that this will reduce the reporting burden on providers without having a significant negative effect on necessary data collection efforts.

Sec. 5. Minnesota Statutes 2006, section 62J.52, subdivision 1, is amended to read:

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

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

(c) Services to be billed using the uniform billing form CMS 1450 include: institutional inpatient hospital services and distinct units in the hospital such as psychiatric

unit services, physical therapy unit services, swing bed (SNF) services, inpatient state psychiatric hospital services, inpatient skilled nursing facility services, home health services (Medicare part A), and hospice services; ancillary services, where benefits are exhausted or patient has no Medicare part A, from hospitals, state psychiatric hospitals, skilled nursing facilities, and home health (Medicare part B); institutional owned or operated outpatient services such as waivered services, hospital outpatient services, including ambulatory surgical center services, hospital referred laboratory services, hospital-based ambulance services, and other hospital outpatient services, skilled nursing facilities, home health, freestanding renal dialysis centers, comprehensive outpatient rehabilitation facilities (CORF), outpatient rehabilitation facilities (ORF), rural health clinics, and community mental health centers; home health services such as home health intravenous therapy providers, waivered services, personal care attendants, and hospice; and any other health care provider certified by the Medicare program to use this form.

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

(e) Services provided by Medicare Critical Access Hospitals electing Method II billing will be allowed an exception to this provision to allow the inclusion of the professional fees on the CMS 1450.

Sec. 6. Minnesota Statutes 2006, section 62J.52, subdivision 2, is amended to read:

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

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

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

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

(d) Services provided by Medicare Critical Access Hospitals electing Method II billing will be allowed an exception to this provision to allow the inclusion of the professional fees on the CMS 1450.

Sec. 7. Minnesota Statutes 2006, section 62J.60, subdivision 2, is amended to read:

Subd. 2. **General characteristics.** (a) The Minnesota uniform health care identification card must be a preprinted card constructed of plastic, paper, or any other medium that conforms with ANSI and ISO 7810 physical characteristics standards. The card dimensions must also conform to ANSI and ISO 7810 physical characteristics standard. The use of a signature panel is optional. The uniform prescription drug information contained on the card must conform with the format adopted by the NCPDP and, except as provided in subdivision 3, paragraph (a), clause (2), must include all of the fields required to submit a claim in conformance with the most recent pharmacy identification card implementation guide produced by the NCPDP. All information required to submit a prescription drug claim, exclusive of information provided on a prescription that is required by law, must be included on the card in a clear, readable, and understandable manner. If a health benefit plan requires a conditional or situational field, as defined by the NCPDP, the conditional or situational field must conform to the most recent pharmacy information card implementation guide produced by the NCPDP.

(b) The Minnesota uniform health care identification card must have an essential information window on the front side with the following data elements: card issuer name, electronic transaction routing information, card issuer identification number, cardholder (insured) identification number, and cardholder (insured) identification name. No optional data may be interspersed between these data elements.

(c) Standardized labels are required next to human readable data elements and must come before the human data elements.

Sec. 8. Minnesota Statutes 2006, section 62J.60, subdivision 3, is amended to read:

Subd. 3. **Human readable data elements.** (a) The following are the minimum human readable data elements that must be present on the front side of the Minnesota uniform health care identification card:

(1) card issuer name or logo, which is the name or logo that identifies the card issuer. The card issuer name or logo may be located at the top of the card. No standard label is required for this data element;

(2) complete electronic transaction routing information including, at a minimum, the international identification number. The standardized label of this data element is "RxBIN." Processor control numbers and group numbers are required if needed to electronically process a prescription drug claim. The standardized label for the process control numbers data element is "RxPCN" and the standardized label for the group numbers data element is "RxGrp," except that if the group number data element is a universal element to be used by all health care providers, the standardized label may be "Grp." To conserve vertical space on the card, the international identification number and the processor control number may be printed on the same line;

(3) cardholder (insured) identification number, which is the unique identification number of the individual card holder established and defined under this section. The standardized label for the data element is "ID";

(4) cardholder (insured) identification name, which is the name of the individual card holder. The identification name must be formatted as follows: first name, space, optional middle initial, space, last name, optional space and name suffix. The standardized label for this data element is "Name";

(5) care type, which is the description of the group purchaser's plan product under which the beneficiary is covered. The description shall include the health plan company name and the plan or product name. The standardized label for this data element is "Care Type";

(6) service type, which is the description of coverage provided such as hospital, dental, vision, prescription, or mental health. The standard label for this data element is "Svc Type"; and

(7) provider/clinic name, which is the name of the primary care clinic the card holder is assigned to by the health plan company. The standard label for this field is "PCP." This information is mandatory only if the health plan company assigns a specific primary care provider to the card holder.

(b) The following human readable data elements shall be present on the back side of the Minnesota uniform health care identification card. These elements must be left justified, and no optional data elements may be interspersed between them:

(1) claims submission names and addresses, which are the names and addresses of the entity or entities to which claims should be submitted. If different destinations are required for different types of claims, this must be labeled;

(2) telephone numbers and names that pharmacies and other health care providers may call for assistance. These telephone numbers and names are required on the back side of the card only if one of the contacts listed in clause (3) cannot provide pharmacies

or other providers with assistance or with the telephone numbers and names of contacts for assistance; and

(3) telephone numbers and names; which are the telephone numbers and names of the following contacts with a standardized label describing the service function as applicable:

(i) eligibility and benefit information;

(ii) utilization review;

(iii) precertification; or

(iv) customer services.

(c) The following human readable data elements are mandatory on the back side of the Minnesota uniform health care identification card for health maintenance organizations:

(1) emergency care authorization telephone number or instruction on how to receive authorization for emergency care. There is no standard label required for this information; and

(2) one of the following:

(i) telephone number to call to appeal to or file a complaint with the commissioner of health; or

(ii) for persons enrolled under section 256B.69, 256D.03, or 256L.12, the telephone number to call to file a complaint with the ombudsperson designated by the commissioner of human services under section 256B.69 and the address to appeal to the commissioner of human services. There is no standard label required for this information.

(d) All human readable data elements not required under paragraphs (a) to (c) are optional and may be used at the issuer's discretion.

Sec. 9. Minnesota Statutes 2006, section 62Q.80, is amended by adding a subdivision to read:

Subd. 1a. **Demonstration project.** The commissioner of health shall award a demonstration project grant to a community-based health care initiative to develop and operate a community-based health care coverage program to operate within Carlton, Cook, Lake, and St. Louis Counties. The demonstration project shall extend for five years and must comply with all the requirements of this section.

Sec. 10. Minnesota Statutes 2006, section 62Q.80, subdivision 3, is amended to read:

Subd. 3. **Approval.** (a) Prior to the operation of a community-based health care coverage program, a community-based health initiative shall submit to the commissioner of health for approval the community-based health care coverage program developed by

the initiative. ~~The commissioner shall only approve a program that has been awarded a community access program grant from the United States Department of Health and Human Services.~~ The commissioner shall ensure that the program meets the federal grant requirements and any requirements described in this section and is actuarially sound based on a review of appropriate records and methods utilized by the community-based health initiative in establishing premium rates for the community-based health care coverage program.

(b) Prior to approval, the commissioner shall also ensure that:

(1) the benefits offered comply with subdivision 8 and that there are adequate numbers of health care providers participating in the community-based health network to deliver the benefits offered under the program;

(2) the activities of the program are limited to activities that are exempt under this section or otherwise from regulation by the commissioner of commerce;

(3) the complaint resolution process meets the requirements of subdivision 10; and

(4) the data privacy policies and procedures comply with state and federal law.

Sec. 11. Minnesota Statutes 2006, section 62Q.80, subdivision 4, is amended to read:

Subd. 4. **Establishment.** ~~(a)~~ The initiative shall establish and operate upon approval by the commissioner of health a community-based health care coverage program. The operational structure established by the initiative shall include, but is not limited to:

(1) establishing a process for enrolling eligible individuals and their dependents;

(2) collecting and coordinating premiums from enrollees and employers of enrollees;

(3) providing payment to participating providers;

(4) establishing a benefit set according to subdivision 8 and establishing premium rates and cost-sharing requirements;

(5) creating incentives to encourage primary care and wellness services; and

(6) initiating disease management services, as appropriate.

~~(b) The payments collected under paragraph (a), clause (2), may be used to capture available federal funds.~~

Sec. 12. Minnesota Statutes 2006, section 62Q.80, subdivision 13, is amended to read:

Subd. 13. **Report.** (a) The initiative shall submit quarterly status reports to the commissioner of health on January 15, April 15, July 15, and October 15 of each year, with the first report due January 15, ~~2007~~ 2008. The status report shall include:

(1) the financial status of the program, including the premium rates, cost per member per month, claims paid out, premiums received, and administrative expenses;

(2) a description of the health care benefits offered and the services utilized;

(3) the number of employers participating, the number of employees and dependents covered under the program, and the number of health care providers participating;

(4) a description of the health outcomes to be achieved by the program and a status report on the performance measurements to be used and collected; and

(5) any other information requested by the commissioner of health or commerce or the legislature.

(b) The initiative shall contract with an independent entity to conduct an evaluation of the program to be submitted to the commissioners of health and commerce and the legislature by January 15, ~~2009~~ 2010. The evaluation shall include:

(1) an analysis of the health outcomes established by the initiative and the performance measurements to determine whether the outcomes are being achieved;

(2) an analysis of the financial status of the program, including the claims to premiums loss ratio and utilization and cost experience;

(3) the demographics of the enrollees, including their age, gender, family income, and the number of dependents;

(4) the number of employers and employees who have been denied access to the program and the basis for the denial;

(5) specific analysis on enrollees who have aggregate medical claims totaling over $5,000 per year, including data on the enrollee's main diagnosis and whether all the medical claims were covered by the program;

(6) number of enrollees referred to state public assistance programs;

(7) a comparison of employer-subsidized health coverage provided in a comparable geographic area to the designated community-based geographic area served by the program, including, to the extent available:

(i) the difference in the number of employers with 50 or fewer employees offering employer-subsidized health coverage;

(ii) the difference in uncompensated care being provided in each area; and

(iii) a comparison of health care outcomes and measurements established by the initiative; and

(8) any other information requested by the commissioner of health or commerce.

Sec. 13. Minnesota Statutes 2006, section 62Q.80, subdivision 14, is amended to read:

Subd. 14. **Sunset.** This section expires December 31, ~~2011~~ 2012.

Sec. 14. **[144.291] MINNESOTA HEALTH RECORDS ACT.**

Subdivision 1. **Short title.** Sections 144.291 to 144.298 may be cited as the Minnesota Health Records Act.

Subd. 2. **Definitions.** For the purposes of sections 144.291 to 144.298, the following terms have the meanings given.

(a) **Affiliate.** "Affiliate" has the meaning given in section 144.6521, subdivision 3, paragraph (b).

(b) **Group purchaser.** "Group purchaser" has the meaning given in section 62J.03, subdivision 6.

(c) **Health record.** "Health record" means any information, whether oral or recorded in any form or medium, that relates to the past, present, or future physical or mental health or condition of a patient; the provision of health care to a patient; or the past, present, or future payment for the provision of health care to a patient.

(d) **Identifying information.** "Identifying information" means the patient's name, address, date of birth, gender, parent's or guardian's name regardless of the age of the patient, and other nonclinical data which can be used to uniquely identify a patient.

(e) **Individually identifiable form.** "Individually identifiable form" means a form in which the patient is or can be identified as the subject of the health records.

(f) **Medical emergency.** "Medical emergency" means medically necessary care which is immediately needed to preserve life, prevent serious impairment to bodily functions, organs, or parts, or prevent placing the physical or mental health of the patient in serious jeopardy.

(g) **Patient.** "Patient" means a natural person who has received health care services from a provider for treatment or examination of a medical, psychiatric, or mental condition, the surviving spouse and parents of a deceased patient, or a person the patient appoints in writing as a representative, including a health care agent acting according to chapter 145C, unless the authority of the agent has been limited by the principal in the principal's health care directive. Except for minors who have received health care services under sections 144.341 to 144.347, in the case of a minor, patient includes a parent or guardian, or a person acting as a parent or guardian in the absence of a parent or guardian.

(h) **Provider.** "Provider" means:

(1) any person who furnishes health care services and is regulated to furnish the services under chapter 147, 147A, 147B, 147C, 147D, 148, 148B, 148C, 148D, 150A, 151, 153, or 153A;

(2) a home care provider licensed under section 144A.46;

(3) a health care facility licensed under this chapter or chapter 144A;

(4) a physician assistant registered under chapter 147A; and

(5) an unlicensed mental health practitioner regulated under sections 148B.60 to 148B.71.

(i) **Record locator service.** "Record locator service" means an electronic index of patient identifying information that directs providers in a health information exchange to the location of patient health records held by providers and group purchasers.

(j) **Related health care entity.** "Related health care entity" means an affiliate of the provider releasing the health records.

Sec. 15. **[144.292] PATIENT RIGHTS.**

Subdivision 1. **Scope.** Patients have the rights specified in this section regarding the treatment the patient receives and the patient's health record.

Subd. 2. **Patient access.** Upon request, a provider shall supply to a patient complete and current information possessed by that provider concerning any diagnosis, treatment, and prognosis of the patient in terms and language the patient can reasonably be expected to understand.

Subd. 3. **Additional patient rights.** A patient's right specified in this section and sections 144.293 to 144.298 are in addition to the rights specified in sections 144.651 and 144.652 and any other provision of law relating to the access of a patient to the patient's health records.

Subd. 4. **Notice of rights; information on release.** A provider shall provide to patients, in a clear and conspicuous manner, a written notice concerning practices and rights with respect to access to health records. The notice must include an explanation of:

(1) disclosures of health records that may be made without the written consent of the patient, including the type of records and to whom the records may be disclosed; and

(2) the right of the patient to have access to and obtain copies of the patient's health records and other information about the patient that is maintained by the provider.

The notice requirements of this subdivision are satisfied if the notice is included with the notice and copy of the patient and resident bill of rights under section 144.652 or if it is displayed prominently in the provider's place of business. The commissioner of health shall develop the notice required in this subdivision and publish it in the State Register.

Subd. 5. **Copies of health records to patients.** Except as provided in section 144.296, upon a patient's written request, a provider, at a reasonable cost to the patient, shall promptly furnish to the patient:

(1) copies of the patient's health record, including but not limited to laboratory reports, x-rays, prescriptions, and other technical information used in assessing the patient's health conditions; or

(2) the pertinent portion of the record relating to a condition specified by the patient.

With the consent of the patient, the provider may instead furnish only a summary of the record. The provider may exclude from the health record written speculations about the patient's health condition, except that all information necessary for the patient's informed consent must be provided.

Subd. 6. **Cost.** (a) When a patient requests a copy of the patient's record for purposes of reviewing current medical care, the provider must not charge a fee.

(b) When a provider or its representative makes copies of patient records upon a patient's request under this section, the provider or its representative may charge the patient or the patient's representative no more than 75 cents per page, plus $10 for time spent retrieving and copying the records, unless other law or a rule or contract provide for a lower maximum charge. This limitation does not apply to x-rays. The provider may charge a patient no more than the actual cost of reproducing x-rays, plus no more than $10 for the time spent retrieving and copying the x-rays.

(c) The respective maximum charges of 75 cents per page and $10 for time provided in this subdivision are in effect for calendar year 1992 and may be adjusted annually each calendar year as provided in this subdivision. The permissible maximum charges shall change each year by an amount that reflects the change, as compared to the previous year, in the Consumer Price Index for all Urban Consumers, Minneapolis-St. Paul (CPI-U), published by the Department of Labor.

(d) A provider or its representative must not charge a fee to provide copies of records requested by a patient or the patient's authorized representative if the request for copies of records is for purposes of appealing a denial of Social Security disability income or Social Security disability benefits under title II or title XVI of the Social Security Act. For the purpose of further appeals, a patient may receive no more than two medical record updates without charge, but only for medical record information previously not provided. For purposes of this paragraph, a patient's authorized representative does not include units of state government engaged in the adjudication of Social Security disability claims.

Subd. 7. **Withholding health records from patient.** (a) If a provider reasonably determines that the information is detrimental to the physical or mental health of the patient, or is likely to cause the patient to inflict self harm, or to harm another, the provider may withhold the information from the patient and may supply the information to an appropriate third party or to another provider. The other provider or third party may release the information to the patient.

(b) A provider shall release information upon written request unless, prior to the request, a provider has designated and described a specific basis for withholding the information as authorized by paragraph (a).

Sec. 16. **[144.293] RELEASE OR DISCLOSURE OF HEALTH RECORDS.**

Subdivision 1. **Release or disclosure of health records.** Health records can be released or disclosed as specified in subdivisions 2 to 9 and sections 144.294 and 144.295.

Subd. 2. **Patient consent to release of records.** A provider, or a person who receives health records from a provider, may not release a patient's health records to a person without:

(1) a signed and dated consent from the patient or the patient's legally authorized representative authorizing the release;

(2) specific authorization in law; or

(3) a representation from a provider that the provider holds a consent from the patient.

Subd. 3. **Release from one provider to another.** A patient's health record, including, but not limited to, laboratory reports, x-rays, prescriptions, and other technical information used in assessing the patient's condition, or the pertinent portion of the record relating to a specific condition, or a summary of the record, shall promptly be furnished to another provider upon the written request of the patient. The written request shall specify the name of the provider to whom the health record is to be furnished. The provider who furnishes the health record or summary may retain a copy of the materials furnished. The patient shall be responsible for the reasonable costs of furnishing the information.

Subd. 4. **Duration of consent.** Except as provided in this section, a consent is valid for one year or for a lesser period specified in the consent or for a different period provided by law.

Subd. 5. **Exceptions to consent requirement.** This section does not prohibit the release of health records:

(1) for a medical emergency when the provider is unable to obtain the patient's consent due to the patient's condition or the nature of the medical emergency;

(2) to other providers within related health care entities when necessary for the current treatment of the patient; or

(3) to a health care facility licensed by this chapter, chapter 144A, or to the same types of health care facilities licensed by this chapter and chapter 144A that are licensed in another state when a patient:

(i) is returning to the health care facility and unable to provide consent; or

(ii) who resides in the health care facility, has services provided by an outside resource under Code of Federal Regulations, title 42, section 483.75(h), and is unable to provide consent.

Subd. 6. **Consent does not expire.** Notwithstanding subdivision 4, if a patient explicitly gives informed consent to the release of health records for the purposes and restrictions in clauses (1) and (2), the consent does not expire after one year for:

(1) the release of health records to a provider who is being advised or consulted with in connection with the releasing provider's current treatment of the patient;

(2) the release of health records to an accident and health insurer, health service plan corporation, health maintenance organization, or third-party administrator for purposes of payment of claims, fraud investigation, or quality of care review and studies, provided that:

(i) the use or release of the records complies with sections 72A.49 to 72A.505;

(ii) further use or release of the records in individually identifiable form to a person other than the patient without the patient's consent is prohibited; and

(iii) the recipient establishes adequate safeguards to protect the records from unauthorized disclosure, including a procedure for removal or destruction of information that identifies the patient.

Subd. 7. **Exception to consent.** Subdivision 2 does not apply to the release of health records to the commissioner of health or the Health Data Institute under chapter 62J, provided that the commissioner encrypts the patient identifier upon receipt of the data.

Subd. 8. **Record locator service.** (a) A provider or group purchaser may send patient identifying information and information about the location of the patient's health records to a record locator service without consent from the patient. Except in the case of a medical emergency, a provider participating in a health information exchange using a record locator service cannot access patient identifying information and information about the location of the patient's health records until the patient has provided consent. The Minnesota Department of Health may not access the record locator service or receive data from the record locator service. Only a provider may access patient identifying information in a record locator service. The consent does not expire and may be revoked by the patient at any time by providing written notice of the revocation to the provider.

(b) A health information exchange maintaining a record locator service or an entity maintaining a record locator service for a health information exchange must maintain an audit log of providers accessing information in a record locator service that minimally contains information on:

(1) the identity of the provider accessing the information;

(2) the identity of the patient whose information was accessed by the provider; and

(3) the date the information was accessed.

(c) No group purchaser may in any way require a provider to participate in any record locator service as a condition of payment or participation.

(d) A record locator service must provide a mechanism for patients to opt out of including their identifying information and information about the location of their health records in a record locator service. At a minimum, any consent form that permits a provider to access a record locator service must include a check-box option that allows a patient to completely opt out of the record locator service which shall be clearly displayed to the patient. A provider participating in a health information exchange with a record locator service who receives a patient's request to completely opt out of the record locator service or to not have a specific provider contact in the record locator service shall be responsible for removing the patient's information from the record locator service.

Subd. 9. **Documentation of release.** (a) In cases where a provider releases health records without patient consent as authorized by law, the release must be documented in the patient's health record. In the case of a release under section 144.294, subdivision 2, the documentation must include the date and circumstances under which the release was made, the person or agency to whom the release was made, and the records that were released.

(b) When a health record is released using a representation from a provider that holds a consent from the patient, the releasing provider shall document:

(1) the provider requesting the health records;

(2) the identity of the patient;

(3) the health records requested; and

(4) the date the health records were requested.

Sec. 17. **[144.294] RECORDS RELATING TO MENTAL HEALTH.**

Subdivision 1. **Provider inquiry.** Upon the written request of a spouse, parent, child, or sibling of a patient being evaluated for or diagnosed with mental illness, a provider shall inquire of a patient whether the patient wishes to authorize a specific individual to receive information regarding the patient's current and proposed course of treatment. If the patient so authorizes, the provider shall communicate to the designated individual the patient's current and proposed course of treatment. Section 144.293, subdivisions 2 and 4, apply to consents given under this subdivision.

Subd. 2. **Disclosure to law enforcement agency.** Notwithstanding section 144.293, subdivisions 2 and 4, a provider must disclose health records relating to a patient's mental health to a law enforcement agency if the law enforcement agency provides the name of the patient and communicates that the:

(1) patient is currently involved in an emergency interaction with the law enforcement agency; and

(2) disclosure of the records is necessary to protect the health or safety of the patient or of another person.

The scope of disclosure under this subdivision is limited to the minimum necessary for law enforcement to respond to the emergency. A law enforcement agency that obtains health records under this subdivision shall maintain a record of the requestor, the provider of the information, and the patient's name. Health records obtained by a law enforcement agency under this subdivision are private data on individuals as defined in section 13.02, subdivision 12, and must not be used by law enforcement for any other purpose.

Subd. 3. **Records release for family and caretaker; mental health care.** (a) Notwithstanding section 144.293, a provider providing mental health care and treatment may disclose health record information described in paragraph (b) about a patient to a family member of the patient or other person who requests the information if:

(1) the request for information is in writing;

(2) the family member or other person lives with, provides care for, or is directly involved in monitoring the treatment of the patient;

(3) the involvement under clause (2) is verified by the patient's mental health care provider, the patient's attending physician, or a person other than the person requesting the information, and is documented in the patient's medical record;

(4) before the disclosure, the patient is informed in writing of the request, the name of the person requesting the information, the reason for the request, and the specific information being requested;

(5) the patient agrees to the disclosure, does not object to the disclosure, or is unable to consent or object, and the patient's decision or inability to make a decision is documented in the patient's medical record; and

(6) the disclosure is necessary to assist in the provision of care or monitoring of the patient's treatment.

(b) The information disclosed under this paragraph is limited to diagnosis, admission to or discharge from treatment, the name and dosage of the medications prescribed, side effects of the medication, consequences of failure of the patient to take the prescribed medication, and a summary of the discharge plan.

(c) If a provider reasonably determines that providing information under this subdivision would be detrimental to the physical or mental health of the patient or is likely to cause the patient to inflict self harm or to harm another, the provider must not disclose the information.

(d) This subdivision does not apply to disclosures for a medical emergency or to family members as authorized or required under subdivision 1 or section 144.293, subdivision 5, clause (1).

Sec. 18. **[144.295] DISCLOSURE OF HEALTH RECORDS FOR EXTERNAL RESEARCH.**

Subdivision 1. **Methods of release.** (a) Notwithstanding section 144.293, subdivisions 2 and 4, health records may be released to an external researcher solely for purposes of medical or scientific research only as follows:

(1) health records generated before January 1, 1997, may be released if the patient has not objected or does not elect to object after that date;

(2) for health records generated on or after January 1, 1997, the provider must:

(i) disclose in writing to patients currently being treated by the provider that health records, regardless of when generated, may be released and that the patient may object, in which case the records will not be released; and

(ii) use reasonable efforts to obtain the patient's written general authorization that describes the release of records in item (i), which does not expire but may be revoked or limited in writing at any time by the patient or the patient's authorized representative;

(3) the provider must advise the patient of the rights specified in clause (4); and

(4) the provider must, at the request of the patient, provide information on how the patient may contact an external researcher to whom the health record was released and the date it was released.

(b) Authorization may be established if an authorization is mailed at least two times to the patient's last known address with a postage prepaid return envelope and a conspicuous notice that the patient's medical records may be released if the patient does not object, and at least 60 days have expired since the second notice was sent.

Subd. 2. **Duties of researcher.** In making a release for research purposes, the provider shall make a reasonable effort to determine that:

(1) the use or disclosure does not violate any limitations under which the record was collected;

(2) the use or disclosure in individually identifiable form is necessary to accomplish the research or statistical purpose for which the use or disclosure is to be made;

(3) the recipient has established and maintains adequate safeguards to protect the records from unauthorized disclosure, including a procedure for removal or destruction of information that identifies the patient; and

(4) further use or release of the records in individually identifiable form to a person other than the patient without the patient's consent is prohibited.

Sec. 19. **[144.296] COPIES OF VIDEOTAPES.**

A provider may not release a copy of a videotape of a child victim or alleged victim of physical or sexual abuse without a court order under section 13.03, subdivision 6, or as provided in section 611A.90. This section does not limit the right of a patient to view the videotape.

Sec. 20. **[144.297] INDEPENDENT MEDICAL EXAMINATION.**

This section applies to the subject and provider of an independent medical examination requested by or paid for by a third party. Notwithstanding section 144.293, a provider may release health records created as part of an independent medical examination to the third party who requested or paid for the examination.

Sec. 21. **[144.298] PENALTIES.**

Subdivision 1. **Licensing action.** A violation of sections 144.291 to 144.298 may be grounds for disciplinary action against a provider by the appropriate licensing board or agency.

Subd. 2. **Allocation of liability.** In adjudicating a dispute involving the disclosure of patient health records, a court shall use the criteria in this subdivision in determining how liability will be allocated.

(a) When requesting health records using consent, a person warrants that the consent:

(1) contains no information known to the person to be false; and

(2) accurately states the patient's desire to have health records disclosed or that there is specific authorization in law.

(b) When requesting health records using consent or the representation authorized in section 144.293, subdivision 2, a provider warrants that the request:

(1) contains no information known to the provider to be false;

(2) accurately states the patient's desire to have health records disclosed or that there is specific authorization in law; and

(3) does not exceed any limits imposed by the patient in the consent.

(c) When disclosing health records, a person releasing health records warrants that the person:

(1) has complied with the requirements of this section regarding disclosure of health records;

(2) knows of no information related to the request that is false; and

(3) has complied with the limits set by the patient in the consent or as described in the representation of consent.

(d) A court of this state presumes that:

(1) a request made by a person that complies with the provisions of this section is valid and represents the wishes of the patient;

(2) the information listed in a consent or representation of consent is accurate;

(3) the recipient of a consent or representation of consent has no knowledge or notice that the person making the request breached a duty to the patient or does not rightfully have a consent;

(4) the signature on the consent or representation of consent is not forged;

(5) the consent or representation of consent was not obtained under false pretenses; and

(6) the consent or representation of consent was not altered without the patient's permission.

(e) No person or provider may disclaim or contractually limit the application of this section, or obtain indemnity for its effects, if the disclaimer, limitation, or indemnity restricts liability for misrepresentation against persons reasonably relying on the consent, representation of consent, or disclosure.

(f) A court of this state shall give effect to liability allocations between the parties provided by contract that does not allocate liability to the detriment of the patient and the allocation is consistent with the requirements of sections 144.291 to 144.298.

(g) A patient is eligible to receive compensatory damages plus costs and reasonable attorney fees if there is a negligent or intentional violation of sections 144.293 to 144.295.

Subd. 3. **Liability for a record locator service.** A patient is eligible to receive compensatory damages plus costs and reasonable attorney fees if a health information exchange maintaining a record locator service, or an entity maintaining a record locator service for a health information exchange, negligently or intentionally violates the provisions of section 144.293, subdivision 8.

Sec. 22. Minnesota Statutes 2006, section 144.3345, is amended to read:

144.3345 INTERCONNECTED ELECTRONIC HEALTH RECORD GRANTS.

Subdivision 1. **Definitions.** The following definitions are used for the purposes of this section.

(a) "Eligible community e-health collaborative" means an existing or newly established collaborative to support the adoption and use of interoperable electronic health records. A collaborative must consist of at least ~~three~~ two or more eligible health care entities in at least two of the categories listed in paragraph (b) and have a focus on interconnecting the members of the collaborative for secure and interoperable exchange of health care information.

(b) "Eligible health care entity" means one of the following:

(1) community clinics, as defined under section 145.9268;

(2) hospitals eligible for rural hospital capital improvement grants, as defined in section 144.148;

(3) physician clinics located in a community with a population of less than 50,000 according to United States Census Bureau statistics and outside the seven-county metropolitan area;

(4) nursing facilities licensed under sections 144A.01 to 144A.27;

(5) community health boards or boards of health as established under chapter 145A;

(6) nonprofit entities with a purpose to provide health information exchange coordination governed by a representative, multi-stakeholder board of directors; and

(7) other providers of health or health care services approved by the commissioner for which interoperable electronic health record capability would improve quality of care, patient safety, or community health.

Subd. 2. **Grants authorized.** The commissioner of health shall award grants to:

(a) eligible community e-health collaborative projects to improve the implementation and use of interoperable electronic health records including but not limited to the following projects:

(1) collaborative efforts to host and support fully functional interoperable electronic health records in multiple care settings;

(2) electronic medication history and electronic patient ~~registration~~ medical history information;

(3) electronic personal health records for persons with chronic diseases and for prevention services;

(4) rural and underserved community models for electronic prescribing; ~~and~~

(5) ~~enabling~~ modernize local public health information systems to rapidly and electronically exchange information needed to participate in community e-health collaboratives or for public health emergency preparedness and response~~.~~; and

(6) implement regional or community-based health information exchange organizations;

(b) community clinics, as defined under section 145.9268, to implement and use interoperable electronic health records, including but not limited to the following projects:

(1) efforts to plan for and implement fully functional, standards-based interoperable electronic health records; and

(2) purchases and implementation of computer hardware, software, and technology to fully implement interoperable electronic health records;

(c) regional or community-based health information exchange organizations to connect and facilitate the exchange of health information between eligible health care entities, including but not limited to the development, testing, and implementation of:

(1) data exchange standards, including data, vocabulary, and messaging standards, for the exchange of health information, provided that such standards are consistent with state and national standards;

(2) security standards necessary to ensure the confidentiality and integrity of health records;

(3) computer interfaces and mechanisms for standardizing health information exchanged between eligible health care entities;

(4) a record locator service for identifying the location of patient health records; or

(5) interfaces and mechanisms for implementing patient consent requirements; and

(d) community health boards and boards of health as established under chapter 145A to modernize local public health information systems to be standards-based and interoperable with other electronic health records and information systems, or for enhanced public health emergency preparedness and response.

Grant funds may not be used for construction of health care or other buildings or facilities.

Subd. 3. **Allocation of grants.** (a) To receive a grant under this section, an eligible community e-health collaborative, community clinic, regional or community-based health information exchange, or community health boards and boards of health must submit an application to the commissioner of health by the deadline established by the commissioner. A grant may be awarded upon the signing of a grant contract. In awarding grants, the commissioner shall give preference to projects benefiting providers located in rural and underserved areas of Minnesota which the commissioner has determined have an unmet need for the development and funding of electronic health records. Applicants may apply for and the commissioner may award grants for one-year, two-year, or three-year periods.

(b) An application must be on a form and contain information as specified by the commissioner but at a minimum must contain:

(1) a description of the purpose or project for which grant funds will be used;

(2) a description of the problem or problems the grant funds will be used to address, including an assessment of the likelihood of the project occurring absent grant funding;

(3) a description of achievable objectives, a workplan, budget, budget narrative, a project communications plan, a timeline for implementation and completion of processes or projects enabled by the grant, and an assessment of privacy and security issues and a proposed approach to address these issues;

(4) a description of the health care entities and other groups participating in the project, including identification of the lead entity responsible for applying for and receiving grant funds;

(5) a plan for how patients and consumers will be involved in development of policies and procedures related to the access to and interchange of information;

(6) evidence of consensus and commitment among the health care entities and others who developed the proposal and are responsible for its implementation; ~~and~~

(7) a plan for documenting and evaluating results of the grant~~.~~ ; and

(8) a plan for use of data exchange standards, including data and vocabulary.

(c) The commissioner shall review each application to determine whether the application is complete and whether the applicant and the project are eligible for a grant. In evaluating applications, the commissioner shall take into consideration factors, including but not limited to, the following:

(1) the degree to which the proposal interconnects ~~the various providers of care~~ with other health care entities in the applicant's geographic community;

(2) the degree to which the project provides for the interoperability of electronic health records or related health information technology ~~between the members of the collaborative, and presence and scope of a description of how the project intends to interconnect with other providers not part of the project into the future~~;

(3) the degree to which the project addresses current unmet needs pertaining to interoperable electronic health records in a geographic area of Minnesota and the likelihood that the needs would not be met absent grant funds;

(4) the applicant's thoroughness and clarity in describing the project, how the project will improve patient safety, quality of care, and consumer empowerment, and the role of the various collaborative members;

(5) the recommendations of the Health Information and Technology Infrastructure Advisory Committee; and

(6) other factors that the commissioner deems relevant.

(d) Grant funds shall be awarded on a three-to-one match basis. Applicants shall be required to provide $1 in the form of cash or in-kind staff or services for each $3 provided under the grant program.

(e) Grants shall not exceed $900,000 per grant. The commissioner has discretion over the size and number of grants awarded.

Subd. 4. **Evaluation and report.** The commissioner of health shall evaluate the overall effectiveness of the grant program. The commissioner shall collect progress and expenditure reports to evaluate the grant program from the eligible community collaboratives receiving grants.

Sec. 23. Minnesota Statutes 2006, section 144.565, is amended to read:

144.565 DIAGNOSTIC IMAGING FACILITIES.

Subdivision 1. **Utilization and services data; economic and financial interests.** The commissioner shall require diagnostic imaging facilities and providers of diagnostic imaging services in Minnesota to ~~annually~~ report by March 1 each year for the preceding fiscal year to the commissioner, in the form and manner specified by the commissioner:

(1) utilization data for each health plan company and each public program, including workers' compensation, ~~as follows:~~ of diagnostic imaging services as defined in subdivision 4, paragraph (b);

~~(i) the number of computerized tomography (CT) procedures performed;~~

~~(ii) the number of magnetic resonance imaging (MRI) procedures performed; and~~

~~(iii) the number of positron emission tomography (PET) procedures performed; and~~

(2) the names of all physicians with any financial or economic interest and all other individuals with a ten percent or greater financial or economic interest in the facility~~.~~;

(3) the location where procedures were performed;

(4) the number of units of each type of fixed, portable, and mobile scanner used at each location;

(5) the average number of hours per month each mobile scanner was operated at each location;

(6) the number of hours per month each scanner was leased, if applicable;

(7) the total number of diagnostic imaging procedures billed for by the provider at each location, by type of diagnostic imaging service as defined in subdivision 4, paragraph (b); and

(8) a report on major health care capital expenditures during the previous year, as required by section 62J.17.

Subd. 2. **Commissioner's right to inspect records.** If the report is not filed or the commissioner of health has reason to believe the report is incomplete or false, the commissioner shall have the right to inspect diagnostic imaging facility books, audits, and records.

Subd. 3. **Separate reports.** ~~For a diagnostic imaging facility that is not attached or not contiguous to a hospital or a hospital affiliate, the commissioner shall require the information in subdivision 1 be reported separately for each detached diagnostic imaging facility as part of the report required under section 144.702.~~ If any entity owns more than one diagnostic imaging facility, that entity must report by individual facility. Reports must include only services that were billed by the provider of diagnostic imaging services submitting the report. If a diagnostic imaging facility leases capacity, technical services, or professional services to one or more other providers of diagnostic imaging services, each provider must submit a separate annual report to the commissioner for all diagnostic imaging services that it provided and billed. The owner of the leased capacity must provide a report listing the names and addresses of providers to whom the diagnostic imaging services and equipment were leased.

Subd. 4. **Definitions.** For purposes of this section, the following terms have the meanings given:

(a) "Diagnostic imaging facility" means a health care facility that ~~provides~~ is not a hospital or location licensed as a hospital which offers diagnostic imaging services ~~through the use of ionizing radiation or other imaging technique including, but not limited to magnetic resonance imaging (MRI) or computerized tomography (CT) scan on a freestanding or mobile basis~~ in Minnesota, regardless of whether the equipment used to provide the service is owned or leased. For the purposes of this section, diagnostic imaging facility includes, but is not limited to, facilities such as a physician's office, clinic, mobile transport vehicle, outpatient imaging center, or surgical center.

(b) "Diagnostic imaging service" means the use of ionizing radiation or other imaging technique on a human patient including, but not limited to, magnetic resonance imaging (MRI) or computerized tomography (CT), positron emission tomography (PET), or single photon emission computerized tomography (SPECT) scans using fixed, portable, or mobile equipment.

~~(b)~~ (c) "Financial or economic interest" means a direct or indirect:

(1) equity or debt security issued by an entity, including, but not limited to, shares of stock in a corporation, membership in a limited liability company, beneficial interest in a trust, units or other interests in a partnership, bonds, debentures, notes or other equity interests or debt instruments, or any contractual arrangements;

(2) membership, proprietary interest, or co-ownership with an individual, group, or organization to which patients, clients, or customers are referred to; or

(3) employer-employee or independent contractor relationship, including, but not limited to, those that may occur in a limited partnership, profit-sharing arrangement, or other similar arrangement with any facility to which patients are referred, including any compensation between a facility and a health care provider, the group practice of which the provider is a member or employee or a related party with respect to any of them.

~~(c)~~ (d) "~~Freestanding~~ Fixed equipment" means a stationary diagnostic imaging ~~facility that is not located within a:~~ machine installed in a permanent location.

~~(1) hospital;~~

~~(2) location licensed as a hospital; or~~

~~(3) physician's office or clinic where the professional practice of medicine by licensed physicians is the primary purpose and not the provision of ancillary services such as diagnostic imaging.~~

~~(d)~~ (e) "Mobile equipment" means a diagnostic imaging ~~facility that is transported to various sites not including movement within a hospital or a physician's office or clinic~~ machine in a self-contained transport vehicle designed to be brought to a temporary offsite location to perform diagnostic imaging services.

(f) "Portable equipment" means a diagnostic imaging machine designed to be temporarily transported within a permanent location to perform diagnostic imaging services.

(g) "Provider of diagnostic imaging services" means a diagnostic imaging facility or an entity that offers and bills for diagnostic imaging services at a facility owned or leased by the entity.

Subd. 5. **Reports open to public inspection.** All reports filed pursuant to this section shall be open to public inspection.

Sec. 24. Minnesota Statutes 2006, section 144.651, subdivision 26, is amended to read:

Subd. 26. **Right to associate.** (a) Residents may meet with and receive visitors and participate in activities of commercial, religious, political, as defined in section 203B.11 and community groups without interference at their discretion if the activities do not infringe on the right to privacy of other residents or are not programmatically contraindicated. This includes:

(1) the right to join with other individuals within and outside the facility to work for improvements in long-term care;

(2) the right to visitation by an individual the patient has appointed as the patient's health care agent under chapter 145C;

(3) the right to visitation and health care decision making by an individual designated by the patient under paragraph (c).

(b) Upon admission to a facility where federal law prohibits unauthorized disclosure of patient or resident identifying information to callers and visitors, the patient or resident, or the legal guardian or conservator of the patient or resident, shall be given the opportunity to authorize disclosure of the patient's or resident's presence in the facility to callers and visitors who may seek to communicate with the patient or resident. To the extent possible, the legal guardian or conservator of a patient or resident shall consider the opinions of the patient or resident regarding the disclosure of the patient's or resident's presence in the facility.

(c) Upon admission to a facility, the patient or resident, or the legal guardian or conservator of the patient or resident, must be given the opportunity to designate a person who is not related who will have the status of the patient's next of kin with respect to visitation and making a health care decision. A designation must be included in the patient's health record. With respect to making a health care decision, a health care directive or appointment of a health care agent under chapter 145C prevails over a designation made under this paragraph. The unrelated person may also be identified as such by the patient or by the patient's family.

Sec. 25. **[145.9269] FEDERALLY QUALIFIED HEALTH CENTERS.**

Subdivision 1. **Definitions.** For purposes of this section, "federally qualified health center" means an entity that is receiving a grant under United States Code, title 42, section 254b, or, based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the secretary to meet the requirements for receiving such a grant.

Subd. 2. **Allocation of subsidies.** The commissioner of health shall distribute subsidies to federally qualified health centers operating in Minnesota to continue, expand, and improve federally qualified health center services to low-income populations. The commissioner shall distribute the funds appropriated under this section to federally qualified health centers operating in Minnesota as of January 1, 2007. The amount of each subsidy shall be in proportion to each federally qualified health center's amount of discounts granted to patients during calendar year 2006 as reported on the federal Uniform Data System report in conformance with the Bureau of Primary Health Care Program Expectations Policy Information Notice 98-23, except that each eligible federally qualified

health center shall receive at least two percent but no more than 30 percent of the total amount of money available under this section.

Sec. 26. Minnesota Statutes 2006, section 145C.05, is amended to read:

145C.05 SUGGESTED FORM; PROVISIONS THAT MAY BE INCLUDED.

Subdivision 1. **Content.** A health care directive executed pursuant to this chapter may, but need not, be in the form contained in section 145C.16.

Subd. 2. **Provisions that may be included.** (a) A health care directive may include provisions consistent with this chapter, including, but not limited to:

(1) the designation of one or more alternate health care agents to act if the named health care agent is not reasonably available to serve;

(2) directions to joint health care agents regarding the process or standards by which the health care agents are to reach a health care decision for the principal, and a statement whether joint health care agents may act independently of one another;

(3) limitations, if any, on the right of the health care agent or any alternate health care agents to receive, review, obtain copies of, and consent to the disclosure of the principal's medical records or to visit the principal when the principal is a patient in a health care facility;

(4) limitations, if any, on the nomination of the health care agent as guardian for purposes of sections 524.5-202, 524.5-211, 524.5-302, and 524.5-303;

(5) a document of gift for the purpose of making an anatomical gift, as set forth in sections 525.921 to 525.9224, or an amendment to, revocation of, or refusal to make an anatomical gift;

(6) a declaration regarding intrusive mental health treatment under section 253B.03, subdivision 6d, or a statement that the health care agent is authorized to give consent for the principal under section 253B.04, subdivision 1a;

(7) a funeral directive as provided in section 149A.80, subdivision 2;

(8) limitations, if any, to the effect of dissolution or annulment of marriage or termination of domestic partnership on the appointment of a health care agent under section 145C.09, subdivision 2;

(9) specific reasons why a principal wants a health care provider or an employee of a health care provider attending the principal to be eligible to act as the principal's health care agent;

(10) health care instructions by a woman of child bearing age regarding how she would like her pregnancy, if any, to affect health care decisions made on her behalf; and

(11) health care instructions regarding artificially administered nutrition or hydration.

(b) A health care directive may include a statement of the circumstances under which the directive becomes effective other than upon the judgment of the principal's attending physician in the following situations:

(1) a principal who in good faith generally selects and depends upon spiritual means or prayer for the treatment or care of disease or remedial care and does not have an attending physician, may include a statement appointing an individual who may determine the principal's decision-making capacity; and

(2) a principal who in good faith does not generally select a physician or a health care facility for the principal's health care needs may include a statement appointing an individual who may determine the principal's decision-making capacity, provided that if the need to determine the principal's capacity arises when the principal is receiving care under the direction of an attending physician in a health care facility, the determination must be made by an attending physician after consultation with the appointed individual.

If a person appointed under clause (1) or (2) is not reasonably available and the principal is receiving care under the direction of an attending physician in a health care facility, an attending physician shall determine the principal's decision-making capacity.

(c) A health care directive may authorize a health care agent to make health care decisions for a principal even though the principal retains decision-making capacity.

Sec. 27. Minnesota Statutes 2006, section 145C.07, is amended by adding a subdivision to read:

Subd. 5. **Visitation.** A health care agent may visit the principal when the principal is a patient in a health care facility regardless of whether the principal retains decision-making capacity, unless:

(1) the principal has otherwise specified in the health care directive;

(2) a principal who retains decision-making capacity indicates otherwise; or

(3) a health care provider reasonably determines that the principal must be isolated from all visitors or that the presence of the health care agent would endanger the health or safety of the principal, other patients, or the facility in which the care is being provided.

Sec. 28. Minnesota Statutes 2006, section 157.16, subdivision 1, is amended to read:

Subdivision 1. **License required annually.** A license is required annually for every person, firm, or corporation engaged in the business of conducting a food and beverage service establishment, hotel, motel, lodging establishment, or resort. Any person wishing to operate a place of business licensed in this section shall first make application, pay the required fee specified in this section, and receive approval for operation, including plan

review approval. Seasonal and temporary food stands and special event food stands are not required to submit plans. Nonprofit organizations operating a special event food stand with multiple locations at an annual one-day event shall be issued only one license. Application shall be made on forms provided by the commissioner and shall require the applicant to state the full name and address of the owner of the building, structure, or enclosure, the lessee and manager of the food and beverage service establishment, hotel, motel, lodging establishment, or resort; the name under which the business is to be conducted; and any other information as may be required by the commissioner to complete the application for license.

Sec. 29. **HEALTH PROMOTION PROGRAM.**

The State Community Health Services Advisory Committee established in Minnesota Statutes, section 145A.10, subdivision 10, shall develop a plan to fund and implement an ongoing comprehensive health promotion program that can effect change more effectively and at lower cost at a community level rather than through individual counseling and change promotion. The program shall use proven public health strategies to promote healthy lifestyles and behaviors in order to establish a sustainable, long-term approach to reducing preventable disability, chronic health conditions, and disease. The focus shall be on community based initiatives that address childhood and adult obesity, tobacco and substance abuse, improved activity levels among senior citizens, and other lifestyle issues that impact health and healthcare costs. Because of its population health focus, funding shall be related to the size of the population to be served. The plan shall be completed by September 15, 2007, and shared with the Legislative Health Care Access Commission.

Sec. 30. **INJUNCTIVE RELIEF REPORT.**

The commissioner of health shall present to the 2008 legislature, by December 15, 2007, recommendations to fund the cost of bringing actions for injunctive relief under Minnesota Statutes, section 144G.02, subdivision 2, paragraph (b).

Sec. 31. **DIAGNOSTIC IMAGING SERVICES ADVISORY COMMITTEE; ESTABLISHMENT.**

(a) The commissioner of health shall establish a Diagnostic Imaging Services Advisory Committee to perform the following duties:

(1) gather and analyze data using minimally intrusive efforts to understand the factors driving utilization of diagnostic imaging services, including computed tomography

(CT), magnetic resonance imaging (MRI), positron emission tomography (PET), magnetic resonance angiography (MRA), and nuclear cardiology, in the state relative to evidence-based guidelines; and

(2) develop recommendations, based on the data collected, on how to improve the delivery of evidence-based diagnostic imaging services. In developing these recommendations, the advisory committee shall consider the impacts on patient care, premium costs, and administrative simplicity.

(b) The members of the Diagnostic Imaging Services Advisory Committee shall include the commissioners of health and human services or the commissioners' designees and the following:

(1) three physicians representing speciality and geographic diversity, appointed by the Minnesota Medical Association;

(2) two hospital representatives, one from a metropolitan hospital and one from a rural hospital, appointed by the Minnesota Hospital Association;

(3) three health plan company representatives appointed by the Minnesota Council of Health Plans;

(4) two representatives appointed by the Institute for Clinical System Improvement; and

(5) one clinic manager appointed by the Minnesota Medical Group Management Association.

(c) The Diagnostic Imaging Services Advisory Committee shall convene no later than September 1, 2007. The commissioner shall report back to the legislature no later than January 15, 2008. The advisory committee is governed under Minnesota Statutes, section 15.059, except that members shall not receive a per diem and may only be reimbursed for expenses.

(d) If an alternative strategy to improve the delivery of evidence-based diagnostic imaging services is developed, the commissioner of health shall report the agreement to the chairs of the senate and house health care committees immediately.

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

Sec. 32. **HEARING AID DISPENSER FEES.**

Fees relating to hearing aid dispensers, as provided in Minnesota Statutes, section 153A.17, may not be increased until after the Department of Health provides a report to the legislature regarding the need and reasons for fee increases.

Sec. 33. **REVISOR'S INSTRUCTION.**

In Minnesota Statutes and Minnesota Rules, the revisor shall change the references in column A with the references in column B.

Column A	Column B
section 144.335	sections 144.291 to 144.298
section 144.335, subdivision 1	section 144.291, subdivision 2
section 144.335, subdivision 1, paragraph (b)	section 144.291, subdivision 2, paragraph (h)
section 144.335, subdivision 2, paragraphs (a) and (b)	section 144.292, subdivisions 2 and 5
section 144.335, subdivision 2	section 144.292
section 144.335, subdivision 3a	section 144.294, subdivision 2
section 144.335, subdivision 3a, paragraph (d)	section 144.295
section 144.335, subdivision 3a, paragraph (f)	section 144.294
section 144.335, subdivision 3b	section 144.293, subdivision 7

Sec. 34. **REPEALER.**

(a) Minnesota Statutes 2006, section 144.335, is repealed.

(b) Minnesota Statutes 2006, section 62J.17, subdivisions 1, 5a, 6a, and 8, are repealed, effective the day following final enactment.

ARTICLE 7
MISCELLANEOUS

Section 1. Minnesota Statutes 2006, section 16A.10, is amended by adding a subdivision to read:

Subd. 2a. **Base budget detail.** Within one week of the release of the budget forecasts required in section 16A.102 in November of an even-numbered year and February of an odd-numbered year, the commissioner, after consulting with the commissioners of human services and health, must provide to the legislature information at the program, budget activity and management activity level for the base level budget of the Department of Human Services and the Department of Health for the next biennium. The information must be organized in a manner that explains how base level budget appropriations are projected to be spent. Within one week of the release of the budget forecasts required in section 16A.102 in November of an even-numbered year, the commissioner must also provide the legislature with the information submitted by the commissioners of human services and health under subdivision 2, clauses (3) and (4).

Sec. 2. Minnesota Statutes 2006, section 43A.316, is amended to read:

43A.316 PUBLIC EMPLOYEES INSURANCE PROGRAM.

Subdivision 1. **Intent.** The legislature finds that the creation of a statewide program to provide public employees and other eligible persons with life insurance and hospital, medical, and dental benefit coverage ~~through provider organizations~~ would result in a ~~greater utilization~~ more efficient use of government resources and would advance the health and welfare of the citizens of the state.

Subd. 2. **Definitions.** For the purpose of this section, the terms defined in this subdivision have the meaning given them.

(a) **Commissioner.** "Commissioner" means the commissioner of employee relations.

(b) **Employee.** "Employee" means:

(1) a person who is a public employee within the definition of section 179A.03, subdivision 14, who is insurance eligible and is employed by an eligible employer;

(2) an elected public official of an eligible employer who is insurance eligible;

(3) a person employed by a labor organization or employee association certified as an exclusive representative of employees of an eligible employer or by another public employer approved by the commissioner, so long as the plan meets the requirements of a governmental plan under United States Code, title 29, section 1002(32); or

(4) a person employed by a county or municipal hospital.

(c) **Eligible employer.** "Eligible employer" means:

(1) a public employer within the definition of section 179A.03, subdivision 15, that is a town, county, city, school district as defined in section 120A.05, service cooperative as defined in section 123A.21, intermediate district as defined in section 136D.01, Cooperative Center for Vocational Education as defined in section 123A.22, regional management information center as defined in section 123A.23, or an education unit organized under the joint powers action, section 471.59; or

(2) an exclusive representative of employees, as defined in paragraph (b);

(3) a county or municipal hospital; ~~or~~

(4) another public employer approved by the commissioner; or

(5) a nursing home as defined in section 144A.01, subdivision 5, located in this state.

(d) **Exclusive representative.** "Exclusive representative" means an exclusive representative as defined in section 179A.03, subdivision 8.

(e) **Labor-Management Committee.** "Labor-Management Committee" means the committee established by subdivision 4.

(f) **Program.** "Program" means the statewide public employees insurance program created by subdivision 3.

Subd. 3. **Public employee insurance program.** The commissioner shall be the administrator of the public employee insurance program and may determine its funding arrangements. The commissioner may contract with a qualified entity to perform the administrative functions. The commissioner shall model the program after the plan established in section 43A.18, subdivision 2, but may ~~modify~~ adopt variations from that plan, in consultation with the Labor-Management Committee. The variations may include different deductibles, coinsurance, co-pays, or other enrollee cost-sharing provisions.

Subd. 4. **Labor-Management Committee.** (a) The Labor-Management Committee consists of ten members appointed by the commissioner. The Labor-Management Committee must comprise five members who represent employees, including at least one retired employee, and five members who represent eligible employers. Committee members are eligible for expense reimbursement in the same manner and amount as authorized by the commissioner's plan adopted under section 43A.18, subdivision 2. The commissioner shall consult with the labor-management committee in major decisions that affect the program. The committee shall study issues and make recommendations relating to the insurance program including, but not limited to, flexible benefits, utilization review, quality assessment, and cost efficiency. The committee continues to exist while the program remains in operation.

(b) The five members of the Labor-Management Committee who represent employees must be chosen by the commissioner from among persons nominated as provided in this paragraph. Exclusive representatives of employees of counties, cities, school districts, and nursing homes are entitled to nominate two candidates for the Labor-Management Committee from each of those four categories, and the commissioner shall appoint one of those two nominees from each category. The commissioner shall choose the fifth employee to represent retired employees.

(c) The five members of the Labor-Management Committee who represent employers must be chosen by the commissioner from among persons nominated as provided in this paragraph. The Association of Minnesota Counties, Minnesota League of Cities, Minnesota School Boards Association, and the Minnesota Association of Nursing Homes are each entitled to nominate two candidates for the committee, and the commissioner shall appoint one of those from each group. The commissioner shall select the fifth employer member from an employer participating in the program and not represented by the other four employer members, if any, or if that is not reasonably possible, the commissioner may appoint any other person as the fifth employer representative.

Subd. 5. **Public employee participation.** (a) Participation in the program is subject to the conditions in this subdivision.

(b) Each exclusive representative for an eligible employer determines whether the employees it represents will participate in the program. The exclusive representative shall give the employer notice of intent to participate at least ~~30~~ 60 days before the expiration date of the collective bargaining agreement preceding the collective bargaining agreement that covers the date of entry into the program. Either all or none of the employees represented by an exclusive representative must participate. The exclusive representative and the eligible employer shall give notice to the commissioner of the determination to participate in the program at least ~~30~~ 60 days before entry into the program. Entry into the program is governed by a schedule established by the commissioner.

(c) Employees not represented by exclusive representatives may become members of the program upon a determination of an eligible employer to include these employees in the program. Either all or none of the employer's unrepresented employees must participate. The eligible employer shall give at least ~~30~~ 60 days' notice to the commissioner before entering the program. Entry into the program is governed by a schedule established by the commissioner.

(d) Participation in the program is for a ~~two-year~~ three-year term. Participation is automatically renewed for an additional ~~two-year~~ three-year term unless the exclusive representative, or the employer for unrepresented employees, gives the commissioner notice of withdrawal at least ~~30~~ 60 days before expiration of the participation period. A group that withdraws must wait two years before rejoining, except with the approval of the commissioner. An exclusive representative, or employer for unrepresented employees, may also withdraw if premiums increase ~~50 percent~~ by more than 20 percent in excess of the Consumer Price Index for all urban consumers or more from one insurance year to the next.

(e) The exclusive representative shall give the employer notice of intent to withdraw ~~to the commissioner~~ at least ~~30~~ 60 days before the expiration date of a collective bargaining agreement that includes the date on which the term of participation expires.

(f) Each participating eligible employer shall notify the commissioner of the names of individuals who will be participating within two weeks ~~of~~ after the commissioner ~~receiving~~ receives notice of the parties' intent to participate. The employer shall also submit other information as required by the commissioner for administration of the program.

(g) An employer that withdraws from the program under circumstances that do not permit withdrawal under this subdivision is liable to the board for premiums payable by the employer until the time that the employer is eligible to withdraw, and the employer shall pay those premiums voluntarily and no later than their due date. If the premiums are

not paid voluntarily, the board has authority to and shall collect these premiums under any method permitted by law for a governmental or nongovernmental creditor of the employer.

Subd. 6. **Coverage.** (a) ~~By January 1, 1989,~~ The commissioner shall announce the benefits of the program. The program shall include employee hospital, medical, dental, and life insurance for employees and hospital and medical benefits for dependents. Health maintenance organization options and other delivery system options may be provided if they are available, cost-effective, and capable of servicing the number of people covered in the program. Participation in optional coverages may be provided by collective bargaining agreements. For employees not represented by an exclusive representative, the employer may offer the optional coverages to eligible employees and their dependents provided in the program. Health coverage must include at least the benefits required of a health plan company regulated under chapter 62A, 62C, or 62D.

(b) The commissioner, with the assistance of the Labor-Management Committee, shall periodically assess whether it is financially feasible for the program to offer or to continue an individual retiree program that has competitive premium rates and benefits. If the commissioner determines it to be feasible to offer an individual retiree program, the commissioner shall announce the applicable benefits, premium rates, and terms of participation. Eligibility to participate in the individual retiree program is governed by subdivision 8, but applies to retirees of eligible employers that do not participate in the program and to those retirees' dependents and surviving spouses.

Subd. 6a. ~~**Chiropractic services**~~ **Choice of type of provider.** All benefits provided by the program ~~or a successor program~~ relating to expenses incurred for medical treatment or services of a ~~physician~~ health care provider must also include ~~chiropractic~~ treatment and services of ~~a chiropractor~~ any other type of licensed, certified, or registered health care provider to the extent that the ~~chiropractic~~ services and treatment are within the scope of ~~chiropractic licensure~~ the provider's licensure, certification, or registration.

~~This subdivision is intended to provide equal access to benefits for program members who choose to obtain treatment for illness or injury from a doctor of chiropractic, as long as the treatment falls within the chiropractor's scope of practice. This subdivision is not intended to change or add to the benefits provided for in the program.~~

Subd. 7. **Premiums.** (a) The proportion of premium paid by the employer and employee is subject to collective bargaining or personnel policies. If, at the beginning of the coverage period, no collective bargaining agreement has been finalized, the increased dollar costs, if any, from the previous year is the sole responsibility of the individual participant until a collective bargaining agreement states otherwise. Premiums, including an administration fee, shall be established by the commissioner. The commissioner may

decide to rate specific employers separately for premium purposes, if the commissioner determines that doing so is in the best interests of the program. Each employer shall pay monthly the amounts due for employee benefits including the amounts under subdivision 8 to the commissioner no later than the dates established by the commissioner. If an employer fails to make the payments as required, the commissioner ~~may~~ shall cancel program benefits and pursue other civil remedies, as provided in subdivision 5, paragraph (d).

(b) The premium charged for an employer's first month in the program must be three times the regular monthly premium charged to that employer, to help establish and maintain the program's financial resources. The extra two months premium must be refunded to the employer if the employer leaves the program, if the refund would not reduce the program's reserves below the level determined to be appropriate by the commissioner.

Subd. 8. **Continuation of coverage.** (a) A former employee of an employer participating in the program who is receiving a public pension disability benefit or an annuity or has met the age and service requirements necessary to receive an annuity under chapter 353, 353C, 354, 354A, 356, 422A, 423, 423A, or 424, and the former employee's dependents, are eligible to participate in the program. This participation is at the person's expense unless a collective bargaining agreement or personnel policy provides otherwise. Premiums for these participants must be established by the commissioner.

The commissioner may provide policy exclusions for preexisting conditions only when there is a break in coverage between a participant's coverage under the employment-based group insurance program and the participant's coverage under this section. An employer shall notify an employee of the option to participate under this paragraph no later than the effective date of retirement. The retired employee or the employer of a participating group on behalf of a current or retired employee shall notify the commissioner within 30 days of the effective date of retirement of intent to participate in the program according to the rules established by the commissioner.

(b) The spouse of a deceased employee or former employee may purchase the benefits provided at premiums established by the commissioner if the spouse was a dependent under the employee's or former employee's coverage under this section at the time of the death. The spouse remains eligible to participate in the program as long as the group that included the deceased employee or former employee participates in the program. Coverage under this clause must be coordinated with relevant insurance benefits provided through the federally sponsored Medicare program.

(c) The program benefits must continue in the event of strike permitted by section 179A.18, if the exclusive representative chooses to have coverage continue and the employee pays the total monthly premiums when due.

~~(d) A participant who discontinues coverage may not reenroll.~~

(d) Persons participating under ~~these paragraphs~~ this subdivision shall make appropriate premium payments in the time and manner established by the commissioner. They are not subject to the payment of the extra payments required under subdivision 7, paragraph (b).

Subd. 9. **Insurance trust fund.** The insurance trust fund in the state treasury consists of deposits of the premiums received from employers participating in the program and transfers before July 1, 1994, from the excess contributions holding account established by section 353.65, subdivision 7. All money in the fund is appropriated to the commissioner to pay insurance premiums, approved claims, refunds, administrative costs, and other related service costs. Premiums paid by employers to the fund are exempt from the taxes imposed by chapter 297I. The commissioner shall reserve an amount of money to cover the estimated costs of claims incurred but unpaid. The State Board of Investment shall invest the money according to section 11A.24. Investment income and losses attributable to the fund must be credited to the fund.

Subd. 10. **Exemption.** The public employee insurance program and, where applicable, the employers participating in it are exempt from chapters 60A, 62A, 62C, 62D, 62E, and 62H, section 471.617, subdivisions 2 and 3, and the bidding requirements of section 471.6161, except as otherwise provided in subdivision 6, paragraph (a).

Subd. 11. **Reinsurance.** The commissioner may, on behalf of the program, participate in an insured or self-insured reinsurance pool.

Sec. 3. **[62Q.40] LANGUAGE INTERPRETER SERVICES.**

(a) A health plan must cover sign language interpreter services provided to deaf and hard-of-hearing enrollees and language interpreter services provided to enrollees with limited English proficiency in order to facilitate the provision of health care services by a provider. For purposes of this section, "provider" has the meaning given in section 62J.03, subdivision 8, and includes a health care provider facility; and "health plan" includes coverage excluded under section 62A.011, subdivision 3, clauses (6), (7), (9), and (10). Interpreter services may be provided in person, by telephone, facsimile, video or audio streaming, or by video conference. In accordance with paragraphs (b) and (c), a health plan company shall reimburse either the party providing interpreter services directly for the costs of language interpreter services provided to the enrollee or the provider

arranging for the provision of interpreter services. Providers that employ or contract with interpreters may bill and shall be reimbursed directly by health plan companies for such services in accordance with paragraph (b). A health plan company shall provide to enrollees, upon request, the policies and procedures for addressing the needs of deaf and hard-of-hearing enrollees and enrollees with limited English proficiency. All parties providing interpreter services must disclose their methods for ensuring competency upon request of any health plan company, provider, or consumer.

(b) A health plan company shall pay for interpreter services as required in paragraph (a) by establishing a network of interpreter service providers and requiring use of its own network of interpreter services providers. The health plan company shall consider, as part of its interpreter service provider network, entering into an agreement with a provider for use of an interpreter service provider employed by or under contract with the provider if:

(1) the provider accepts as reimbursement for services rendered by the provider's employed or contracted interpreter service provider the lesser of either the health plan company's reimbursement rate for its in-network interpreter service providers or the provider's fee for services rendered by the provider's interpreter service provider; and

(2) the interpreter service provider meets the published quality standards of the health plan company.

(c) If a health plan company's or a provider's employed or contracted interpreter service provider is unavailable to provide interpreter services, the health plan company shall reimburse the interpreter service provider at the lesser of the health plan company's median reimbursement rate for its in-network interpreter service providers or the interpreter service provider's fee. An interpreter service provider not employed or under contract with a health plan company or provider who fails to meet the quality standards of a health plan company or as required by law, shall be ineligible for reimbursement under this section.

(d) If the health plan company pays the interpreter service provider directly, it has no obligation to pay the provider under this section.

(e) Nothing in this section requires a health plan company to establish a network of interpreter service providers.

EFFECTIVE DATE. This section is effective July 1, 2008, and applies to plans issued or renewed to provide coverage to Minnesota residents on or after that date unless the legislature enacts alternative funding sources based on the recommendations of the commissioner.

Sec. 4. Minnesota Statutes 2006, section 144.05, is amended by adding a subdivision to read:

Subd. 5. **Base budget detail.** The commissioner shall provide the commissioner of finance with the information necessary to provide base budget detail to the legislature under section 16A.10, subdivision 2a.

Sec. 5. Minnesota Statutes 2006, section 148.235, is amended by adding a subdivision to read:

Subd. 11. **Dispensing by protocol.** A registered nurse in a family planning agency as defined in Minnesota Rules, part 9505.0280, subpart 3, may dispense oral contraceptives prescribed by a licensed practitioner as defined in section 151.01, subdivision 23, pursuant to a dispensing protocol established by the agency's medical director or under the direction of a physician. The dispensing protocol must address the requirements of sections 151.01, subdivision 30, and 151.212, subdivision 1.

Sec. 6. Minnesota Statutes 2006, section 151.37, subdivision 2, is amended to read:

Subd. 2. **Prescribing and filing.** (a) A licensed practitioner in the course of professional practice only, may prescribe, administer, and dispense a legend drug, and may cause the same to be administered by a nurse, a physician assistant, or medical student or resident under the practitioner's direction and supervision, and may cause a person who is an appropriately certified, registered, or licensed health care professional to prescribe, dispense, and administer the same within the expressed legal scope of the person's practice as defined in Minnesota Statutes. A licensed practitioner may prescribe a legend drug, without reference to a specific patient, by directing a nurse, pursuant to section 148.235, subdivisions 8 and 9, physician assistant, or medical student or resident to adhere to a particular practice guideline or protocol when treating patients whose condition falls within such guideline or protocol, and when such guideline or protocol specifies the circumstances under which the legend drug is to be prescribed and administered. An individual who verbally, electronically, or otherwise transmits a written, oral, or electronic order, as an agent of a prescriber, shall not be deemed to have prescribed the legend drug. This paragraph applies to a physician assistant only if the physician assistant meets the requirements of section 147A.18.

(b) A licensed practitioner that dispenses for profit a legend drug that is to be administered orally, is ordinarily dispensed by a pharmacist, and is not a vaccine, must file with the practitioner's licensing board a statement indicating that the practitioner dispenses legend drugs for profit, the general circumstances under which the practitioner

dispenses for profit, and the types of legend drugs generally dispensed. It is unlawful to dispense legend drugs for profit after July 31, 1990, unless the statement has been filed with the appropriate licensing board. For purposes of this paragraph, "profit" means (1) any amount received by the practitioner in excess of the acquisition cost of a legend drug for legend drugs that are purchased in prepackaged form, or (2) any amount received by the practitioner in excess of the acquisition cost of a legend drug plus the cost of making the drug available if the legend drug requires compounding, packaging, or other treatment. The statement filed under this paragraph is public data under section 13.03. This paragraph does not apply to a licensed doctor of veterinary medicine or a registered pharmacist. Any person other than a licensed practitioner with the authority to prescribe, dispense, and administer a legend drug under paragraph (a) shall not dispense for profit. To dispense for profit does not include dispensing by a community health clinic when the profit from dispensing is used to meet operating expenses.

(c) A prescription or drug order for a legend drug is not valid unless it is issued for a legitimate medical purpose arising from a prescriber-patient relationship that includes a documented patient evaluation adequate to establish diagnoses and identify underlying conditions and contraindications to the treatment. Treatment, including issuing a prescription or drug order, based solely on an online questionnaire does not constitute a legitimate medical purpose.

Sec. 7. Minnesota Statutes 2006, section 152.11, is amended by adding a subdivision to read:

Subd. 2d. **Identification requirement for schedule II or III controlled substance.** No person may dispense a controlled substance included in schedule II or III without requiring the person purchasing the controlled substance, who need not be the person for whom the controlled substance prescription is written, to present valid photographic identification, unless the person purchasing the controlled substance, or if applicable the person for whom the controlled substance prescription is written, is known to the dispenser.

Sec. 8. **[152.126] SCHEDULE II AND III CONTROLLED SUBSTANCES PRESCRIPTION ELECTRONIC REPORTING SYSTEM.**

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

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

(b) "Controlled substances" means those substances listed in section 152.02, subdivisions 3 and 4, and those substances defined by the board pursuant to section 152.02, subdivisions 8 and 12.

(c) "Dispense" or "dispensing" has the meaning given in section 151.01, subdivision 30. Dispensing does not include the direct administering of a controlled substance to a patient by a licensed health care professional.

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

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

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

Subd. 2. **Prescription electronic reporting system.** (a) By January 1, 2009, or upon enactment of legislation that implements the recommendations of the Board of Pharmacy under subdivision 3, paragraph (c), whichever is later, the board shall establish an electronic system for reporting the information required under subdivision 4 for all controlled substances dispensed within the state. Data for controlled substance prescriptions that are dispensed in a quantity small enough to provide treatment to a patient for a period of 48 hours or less need not be reported.

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

(c) The board may issue a waiver to a dispenser that is unable to submit dispensing information by electronic means. The waiver may permit the dispenser to submit dispensing information by paper form or other means, provided all information required by subdivision 4 is submitted in this alternative format.

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

(1) the Department of Health;

(2) the Department of Human Services;

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

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

(5) a professional pharmacy association;

(6) a consumer privacy or security advocate; and

(7) a consumer or patient rights organization.

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

(1) technical standards for electronic prescription drug reporting;

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

(3) an evaluation process for the program.

(c) The Board of Pharmacy, after consultation with the advisory committee, shall present recommendations and draft legislation on the issues addressed by the advisory committee under paragraph (b), to the legislature by December 15, 2007.

Subd. 4. **Reporting requirements and notice.** (a) Each dispenser must submit the following data to the board or its designated vendor, subject to the notice required under paragraph (d):

(1) prescriber DEA number;

(2) dispenser DEA number;

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

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

(5) date the prescription was written;

(6) date the prescription was filled;

(7) NDC code for drug dispensed; and

(8) quantity of controlled substance dispensed.

(b) The dispenser must submit the required information according to the format and protocols specified in the "ASAP Telecommunications Format for Controlled Substances," May 1995 edition, published by the American Society for Automation in Pharmacy, which is hereby adopted by reference, by a procedure established by the board.

(c) A dispenser is not required to submit this data for those controlled substance prescriptions dispensed for:

(1) individuals residing in licensed skilled nursing or intermediate care facilities;

(2) individuals receiving assisted living services under chapter 144G or through a medical assistance home and community-based waiver;

(3) individuals receiving medication intravenously;

(4) individuals receiving hospice and other palliative or end-of-life care; and

(5) individuals receiving services from a home care provider regulated under chapter 144A.

(d) A dispenser must not submit data under this subdivision unless a conspicuous notice of the reporting requirements of this section is given to the patient for whom the prescription was written.

Subd. 5. **Use of data by board.** (a) The board shall develop and maintain a database of the data reported under subdivision 4. The board shall maintain data that could identify an individual prescriber or dispenser in encrypted form. The database may be used by permissible users identified under subdivision 6 for the identification of:

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

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

(b) No permissible user identified under subdivision 6 may access the database for the sole purpose of identifying prescribers of controlled substances for unusual or excessive prescribing patterns without a valid search warrant or court order.

(c) No personnel of a state or federal occupational licensing board or agency may access the database for the purpose of obtaining information to be used to initiate or substantiate a disciplinary action against a prescriber.

(d) Data reported under subdivision 4 shall be retained by the board in the database for a six-month period, and shall be removed from the database six months from the date the data was received.

Subd. 6. **Access to reporting system data.** (a) Except as indicated in this subdivision, the data submitted to the board under subdivision 4 is private data on individuals as defined in section 13.02, subdivision 12, and not subject to public disclosure.

(b) Except as specified in subdivision 5, the following persons shall be considered permissible users and may access the data submitted under subdivision 4 in the same or similar manner, and for the same or similar purposes, as those persons who are authorized to access similar private data on individuals under federal and state law:

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

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

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

(4) personnel of the board specifically assigned to conduct a bona fide investigation of a specific board licensee;

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

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

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

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

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

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

(e) The board shall not release the name of a prescriber without the written consent of the prescriber or a valid search warrant or court order. The board shall provide a mechanism for a prescriber to submit to the board a signed consent authorizing the release of the prescriber's name when data containing the prescriber's name is requested.

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

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

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

Subd. 8. **Evaluation and reporting.** (a) The board shall evaluate the prescription electronic reporting system to determine if the system is cost-effective and whether it is negatively impacting appropriate prescribing practices of controlled substances. The board may contract with a vendor to design and conduct the evaluation.

(b) The board shall submit the evaluation of the system to the legislature by January 15, 2010.

Subd. 9. **Immunity from liability; no requirement to obtain information.** (a) A pharmacist, prescriber, or other dispenser making a report to the program in good faith under this section is immune from any civil, criminal, or administrative liability, which might otherwise be incurred or imposed as a result of the report, or on the basis that the pharmacist or prescriber did or did not seek or obtain or use information from the program.

(b) Nothing in this section shall require a pharmacist, prescriber, or other dispenser to obtain information about a patient from the program, and the pharmacist, prescriber, or other dispenser, if acting in good faith, is immune from any civil, criminal, or administrative liability that might otherwise be incurred or imposed for requesting, receiving, or using information from the program.

EFFECTIVE DATE. This section is effective July 1, 2007, or upon receiving sufficient nonstate funds to implement the prescription electronic reporting program, whichever is later. In the event that nonstate funds are not secured by the Board of Pharmacy to adequately fund the implementation of the prescription electronic reporting program, the board is not required to implement this section without a subsequent appropriation from the legislature.

Sec. 9. Minnesota Statutes 2006, section 179A.03, subdivision 7, is amended to read:

Subd. 7. **Essential employee.** "Essential employee" means firefighters, peace officers subject to licensure under sections 626.84 to 626.863, 911 system and police and fire department public safety dispatchers, guards at correctional facilities, confidential employees, supervisory employees, assistant county attorneys, assistant city attorneys, principals, and assistant principals. However, for state employees, "essential employee"

means all employees, except for nonprofessional employees employed by the Department of Human Services in mental health facilities for the treatment of psychopathic personalities, sexual predators, and the criminally insane, in law enforcement, public safety radio communications operators, health care professionals, correctional guards, professional engineering, and supervisory collective bargaining units, irrespective of severance, and no other employees. For University of Minnesota employees, "essential employee" means all employees in law enforcement, nursing professional and supervisory units, irrespective of severance, and no other employees. "Firefighters" means salaried employees of a fire department whose duties include, directly or indirectly, controlling, extinguishing, preventing, detecting, or investigating fires. Employees for whom the state court administrator is the negotiating employer are not essential employees. For Hennepin Healthcare System, Inc. employees, "essential employees" means all employees.

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

Sec. 10. Minnesota Statutes 2006, section 245.4874, is amended to read:

245.4874 DUTIES OF COUNTY BOARD.

(a) The county board must:

(1) develop a system of affordable and locally available children's mental health services according to sections 245.487 to 245.4887;

(2) establish a mechanism providing for interagency coordination as specified in section 245.4875, subdivision 6;

(3) consider the assessment of unmet needs in the county as reported by the local children's mental health advisory council under section 245.4875, subdivision 5, paragraph (b), clause (3). The county shall provide, upon request of the local children's mental health advisory council, readily available data to assist in the determination of unmet needs;

(4) assure that parents and providers in the county receive information about how to gain access to services provided according to sections 245.487 to 245.4887;

(5) coordinate the delivery of children's mental health services with services provided by social services, education, corrections, health, and vocational agencies to improve the availability of mental health services to children and the cost-effectiveness of their delivery;

(6) assure that mental health services delivered according to sections 245.487 to 245.4887 are delivered expeditiously and are appropriate to the child's diagnostic assessment and individual treatment plan;

(7) provide the community with information about predictors and symptoms of emotional disturbances and how to access children's mental health services according to sections 245.4877 and 245.4878;

(8) provide for case management services to each child with severe emotional disturbance according to sections 245.486; 245.4871, subdivisions 3 and 4; and 245.4881, subdivisions 1, 3, and 5;

(9) provide for screening of each child under section 245.4885 upon admission to a residential treatment facility, acute care hospital inpatient treatment, or informal admission to a regional treatment center;

(10) prudently administer grants and purchase-of-service contracts that the county board determines are necessary to fulfill its responsibilities under sections 245.487 to 245.4887;

(11) assure that mental health professionals, mental health practitioners, and case managers employed by or under contract to the county to provide mental health services are qualified under section 245.4871;

(12) assure that children's mental health services are coordinated with adult mental health services specified in sections 245.461 to 245.486 so that a continuum of mental health services is available to serve persons with mental illness, regardless of the person's age;

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

(14) consistent with section 245.486, arrange for or provide a children's mental health screening to a child receiving child protective services or a child in out-of-home placement, a child for whom parental rights have been terminated, a child found to be delinquent, and a child found to have committed a juvenile petty offense for the third or subsequent time, unless a screening or diagnostic assessment has been performed within the previous 180 days, or the child is currently under the care of a mental health professional. The court or county agency must notify a parent or guardian whose parental rights have not been terminated of the potential mental health screening and the option to prevent the screening by notifying the court or county agency in writing. The screening shall be conducted with a screening instrument approved by the commissioner of human services according to criteria that are updated and issued annually to ensure that approved screening instruments are valid and useful for child welfare and juvenile justice populations, and shall be conducted by a mental health practitioner as defined in section 245.4871, subdivision 26, or a probation officer or local social services agency

staff person who is trained in the use of the screening instrument. Training in the use of the instrument shall include training in the administration of the instrument, the interpretation of its validity given the child's current circumstances, the state and federal data practices laws and confidentiality standards, the parental consent requirement, and providing respect for families and cultural values. If the screen indicates a need for assessment, the child's family, or if the family lacks mental health insurance, the local social services agency, in consultation with the child's family, shall have conducted a diagnostic assessment, including a functional assessment, as defined in section 245.4871. The administration of the screening shall safeguard the privacy of children receiving the screening and their families and shall comply with the Minnesota Government Data Practices Act, chapter 13, and the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191. Screening results shall be considered private data and the commissioner shall not collect individual screening results.

(b) When the county board refers clients to providers of children's therapeutic services and supports under section 256B.0943, the county board must clearly identify the desired services components not covered under section 256B.0943 and identify the reimbursement source for those requested services, the method of payment, and the payment rate to the provider.

Sec. 11. Minnesota Statutes 2006, section 253B.185, subdivision 2, is amended to read:

Subd. 2. **Transfer to correctional facility.** (a) If a person has been committed under this section and later is committed to the custody of the commissioner of corrections for any reason, including but not limited to, being sentenced for a crime or revocation of the person's supervised release or conditional release under section 244.05~~, 609.108, subdivision 6,~~ or 609.109, subdivision 7, the person shall be transferred to a facility designated by the commissioner of corrections without regard to the procedures provided in section 253B.18.

(b) If a person is committed under this section after a commitment to the commissioner of corrections, the person shall first serve the sentence in a facility designated by the commissioner of corrections. After the person has served the sentence, the person shall be transferred to a treatment program designated by the commissioner of human services.

Sec. 12. Minnesota Statutes 2006, section 254A.03, subdivision 3, is amended to read:

Subd. 3. **Rules for chemical dependency care.** The commissioner of human services shall establish by rule criteria to be used in determining the appropriate level

of chemical dependency care~~, whether outpatient, inpatient or short-term treatment programs,~~ for each recipient of public assistance seeking treatment for alcohol or other drug dependency and abuse problems. ~~The criteria shall address, at least, the family relationship, past treatment history, medical or physical problems, arrest record, and employment situation.~~

Sec. 13. Minnesota Statutes 2006, section 254A.16, subdivision 2, is amended to read:

Subd. 2. **Program and service guidelines.** (a) The commissioner shall provide program and service guidelines and technical assistance to the county boards in carrying out services authorized under ~~sections~~ section 254A.08~~, 254A.12, 254A.14, and their responsibilities under chapter 256E~~.

(b) The commissioner shall recommend to the governor means of improving the efficiency and effectiveness of comprehensive program services in the state and maximizing the use of nongovernmental funds for providing comprehensive programs.

Sec. 14. **[254A.20] CHEMICAL USE ASSESSMENTS; FINANCIAL CONFLICT OF INTEREST.**

(a) Except as provided in paragraph (b), an assessor conducting a chemical use assessment under Minnesota Rules, parts 9530.6600 to 9530.6655, may not have any direct or shared financial interest or referral relationship resulting in shared financial interest or referral relationship resulting in shared financial gain with a treatment provider.

(b) A county may contract with an assessor having a conflict described in paragraph (a) if the county documents that:

(1) the assessor is employed by a culturally specific service provider or a service provider with a program designed to treat individuals of a specific age, sex, or sexual preference;

(2) the county does not employ a sufficient number of qualified assessors and the only qualified assessors available in the county have a direct or shared financial interest or a referral relationship resulting in shared financial gain with a treatment provider; or

(3) the county social service agency has an existing relationship with an assessor or service provider and elects to enter into a contract with that assessor to provide both assessment and treatment under circumstances specified in the county's contract, provided the county retains responsibility for making placement decisions.

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

Sec. 15. Minnesota Statutes 2006, section 254B.02, subdivision 1, is amended to read:

Subdivision 1. **Chemical dependency treatment allocation.** The chemical dependency funds appropriated for allocation shall be placed in a special revenue account. The commissioner shall annually transfer funds from the chemical dependency fund to pay for operation of the drug and alcohol abuse normative evaluation system and to pay for all costs incurred by adding two positions for licensing of chemical dependency treatment and rehabilitation programs located in hospitals for which funds are not otherwise appropriated. ~~For each year of the biennium ending June 30, 1999, the commissioner shall allocate funds to the American Indian chemical dependency tribal account for treatment of American Indians by eligible vendors under section 254B.05, equal to the amount allocated in fiscal year 1997.~~ Six percent of the remaining money must be reserved for tribal allocation under section 254B.09, subdivisions 4 and 5. The commissioner shall annually divide the money available in the chemical dependency fund that is not held in reserve by counties from a previous allocation, or allocated to the American Indian chemical dependency tribal account. Six percent of the remaining money must be reserved for the nonreservation American Indian chemical dependency allocation for treatment of American Indians by eligible vendors under section 254B.05, subdivision 1. The remainder of the money must be allocated among the counties according to the following formula, using state demographer data and other data sources determined by the commissioner:

(a) For purposes of this formula, American Indians and children under age 14 are subtracted from the population of each county to determine the restricted population.

(b) The amount of chemical dependency fund expenditures for entitled persons for services not covered by prepaid plans governed by section 256B.69 in the previous year is divided by the amount of chemical dependency fund expenditures for entitled persons for all services to determine the proportion of exempt service expenditures for each county.

(c) The prepaid plan months of eligibility is multiplied by the proportion of exempt service expenditures to determine the adjusted prepaid plan months of eligibility for each county.

(d) The adjusted prepaid plan months of eligibility is added to the number of restricted population fee for service months of eligibility for the Minnesota family investment program, general assistance, and medical assistance and divided by the county restricted population to determine county per capita months of covered service eligibility.

(e) The number of adjusted prepaid plan months of eligibility for the state is added to the number of fee for service months of eligibility for the Minnesota family investment program, general assistance, and medical assistance for the state restricted population and

divided by the state restricted population to determine state per capita months of covered service eligibility.

(f) The county per capita months of covered service eligibility is divided by the state per capita months of covered service eligibility to determine the county welfare caseload factor.

(g) The median married couple income for the most recent three-year period available for the state is divided by the median married couple income for the same period for each county to determine the income factor for each county.

(h) The county restricted population is multiplied by the sum of the county welfare caseload factor and the county income factor to determine the adjusted population.

(i) $15,000 shall be allocated to each county.

(j) The remaining funds shall be allocated proportional to the county adjusted population.

Sec. 16. Minnesota Statutes 2006, section 254B.02, subdivision 5, is amended to read:

Subd. 5. **Administrative adjustment.** The commissioner may make payments to local agencies from money allocated under this section to support administrative activities under sections 254B.03 and 254B.04. The administrative payment must not exceed five percent of the first $50,000, four percent of the next $50,000, and three percent of the remaining payments for services from the allocation. ~~Twenty-five percent of the administrative allowance shall be advanced at the beginning of each quarter, based on the payments for services made in the most recent quarter for which data is available. Adjustment of any overestimate or underestimate based on actual expenditures shall be made by the state agency by adjusting the administrative allowance for any succeeding quarter.~~

Sec. 17. Minnesota Statutes 2006, section 254B.03, subdivision 1, is amended to read:

Subdivision 1. **Local agency duties.** (a) Every local agency shall provide chemical dependency services to persons residing within its jurisdiction who meet criteria established by the commissioner for placement in a chemical dependency residential or nonresidential treatment service. Chemical dependency money must be administered by the local agencies according to law and rules adopted by the commissioner under sections 14.001 to 14.69.

(b) In order to contain costs, the county board shall, with the approval of the commissioner of human services, select eligible vendors of chemical dependency services who can provide economical and appropriate treatment. Unless the local agency is a social

services department directly administered by a county or human services board, the local agency shall not be an eligible vendor under section 254B.05. The commissioner may approve proposals from county boards to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are provided. If a county implements a demonstration or experimental medical services funding plan, the commissioner shall transfer the money as appropriate. If a county selects a vendor located in another state, the county shall ensure that the vendor is in compliance with the rules governing licensure of programs located in the state.

~~(c) The calendar year 2002 rate for vendors may not increase more than three percent above the rate approved in effect on January 1, 2001. The calendar year 2003 rate for vendors may not increase more than three percent above the rate in effect on January 1, 2002. The calendar years 2004 and 2005 rates may not exceed the rate in effect on January 1, 2003.~~

~~(d)~~ (c) A culturally specific vendor that provides assessments under a variance under Minnesota Rules, part 9530.6610, shall be allowed to provide assessment services to persons not covered by the variance.

Sec. 18. Minnesota Statutes 2006, section 254B.03, subdivision 3, is amended to read:

Subd. 3. **Local agencies to pay state for county share.** ~~Local agencies shall submit invoices to the state on forms supplied by the commissioner and according to procedures established by the commissioner.~~ Local agencies shall pay the state for the county share of the ~~invoiced~~ services authorized by the local agency. ~~Payments shall be made at the beginning of each month for services provided in the previous month. The commissioner shall bill the county monthly for services, based on the most recent month for which expenditure information is available. Adjustment of any overestimate or underestimate based on actual expenditures shall be made by the state agency by adjusting the estimate for any succeeding month.~~

Sec. 19. Minnesota Statutes 2006, section 254B.06, subdivision 3, is amended to read:

Subd. 3. **Payment; denial.** The commissioner shall pay eligible vendors for placements made by local agencies under section 254B.03, subdivision 1, and placements by tribal designated agencies according to section 254B.09. The commissioner may reduce or deny payment of the state share when services are not provided according to the placement criteria established by the commissioner. The commissioner may pay for all or a portion of improper county chemical dependency placements and bill the county for the entire payment made when the placement did not comply with criteria established by the

commissioner. The commissioner may make payments to vendors and charge the county 100 percent of the payments if documentation of a county approved placement is received more than 30 working days, exclusive of weekends and holidays, after the date services began~~; or if the county approved invoice is received by the commissioner more than 120 days after the last date of service provided.~~ The commissioner shall not pay vendors until private insurance company claims have been settled.

Sec. 20. Minnesota Statutes 2006, section 256.01, is amended by adding a subdivision to read:

Subd. 25. **Base budget detail.** The commissioner shall provide the commissioner of finance with the information necessary to provide base budget detail to the legislature under section 16A.10, subdivision 2a.

Sec. 21. Minnesota Statutes 2006, section 256B.0625, subdivision 13c, is amended to read:

Subd. 13c. **Formulary committee.** The commissioner, after receiving recommendations from professional medical associations and professional pharmacy associations, and consumer groups shall designate a Formulary Committee to carry out duties as described in subdivisions 13 to 13g. The Formulary Committee shall be comprised of four licensed physicians actively engaged in the practice of medicine in Minnesota one of whom must be actively engaged in the treatment of persons with mental illness; at least three licensed pharmacists actively engaged in the practice of pharmacy in Minnesota; and one consumer representative; the remainder to be made up of health care professionals who are licensed in their field and have recognized knowledge in the clinically appropriate prescribing, dispensing, and monitoring of covered outpatient drugs. Members of the Formulary Committee shall not be employed by the Department of Human Services, but the committee shall be staffed by an employee of the department who shall serve as an ex officio, nonvoting member of the ~~board~~ committee. The department's medical director shall also serve as an ex officio, nonvoting member for the committee. Committee members shall serve three-year terms and may be reappointed by the commissioner. The Formulary Committee shall meet at least quarterly. The commissioner may require more frequent Formulary Committee meetings as needed. An honorarium of $100 per meeting and reimbursement for mileage shall be paid to each committee member in attendance.

Sec. 22. Minnesota Statutes 2006, section 256B.0625, subdivision 23, is amended to read:

Subd. 23. **Day treatment services.** Medical assistance covers day treatment services as specified in sections 245.462, subdivision 8, and 245.4871, subdivision 10, that are provided under contract with the county board. Notwithstanding Minnesota Rules, part 9505.0323, subpart 15, the commissioner may set authorization thresholds for day treatment for adults according to section 256B.0625, subdivision 25. Notwithstanding Minnesota Rules, part 9505.0323, subpart 15, effective July 1, 2004, medical assistance covers day treatment services for children as specified under section 256B.0943.

Sec. 23. **[256B.0636] PRESCRIBING OF CONTROLLED SUBSTANCES; ABUSE PREVENTION.**

The commissioner shall develop and implement a plan to:

(1) monitor the prescribing of controlled substances listed in section 152.02, subdivisions 3 and 4, and those substances defined by the Board of Pharmacy under section 152.02, subdivisions 8 and 12, by enrolled providers and providers under contract with participating managed care plans;

(2) require enrolled providers and providers under contract with participating managed care plans to report information related to potential patient abuse of the controlled substances to the commissioner, and the Board of Pharmacy; and

(3) provide education to Minnesota health care program enrollees on the proper use of controlled substances.

Sec. 24. Minnesota Statutes 2006, section 256B.0943, subdivision 6, is amended to read:

Subd. 6. **Provider entity clinical infrastructure requirements.** (a) To be an eligible provider entity under this section, a provider entity must have a clinical infrastructure that utilizes diagnostic assessment, an individualized treatment plan, service delivery, and individual treatment plan review that are culturally competent, child-centered, and family-driven to achieve maximum benefit for the client. The provider entity must review and update the clinical policies and procedures every three years and must distribute the policies and procedures to staff initially and upon each subsequent update.

(b) The clinical infrastructure written policies and procedures must include policies and procedures for:

(1) providing or obtaining a client's diagnostic assessment that identifies acute and chronic clinical disorders, co-occurring medical conditions, sources of psychological and environmental problems, and a functional assessment. The functional assessment must clearly summarize the client's individual strengths and needs;

(2) developing an individual treatment plan that is:

(i) based on the information in the client's diagnostic assessment;

(ii) developed no later than the end of the first psychotherapy session after the completion of the client's diagnostic assessment by the mental health professional who provides the client's psychotherapy;

(iii) developed through a child-centered, family-driven planning process that identifies service needs and individualized, planned, and culturally appropriate interventions that contain specific treatment goals and objectives for the client and the client's family or foster family;

(iv) reviewed at least once every 90 days and revised, if necessary; and

(v) signed by the client or, if appropriate, by the client's parent or other person authorized by statute to consent to mental health services for the client;

(3) developing an individual behavior plan that documents services to be provided by the mental health behavioral aide. The individual behavior plan must include:

(i) detailed instructions on the service to be provided;

(ii) time allocated to each service;

(iii) methods of documenting the child's behavior;

(iv) methods of monitoring the child's progress in reaching objectives; and

(v) goals to increase or decrease targeted behavior as identified in the individual treatment plan;

(4) clinical supervision of the mental health practitioner and mental health behavioral aide. A mental health professional must document the clinical supervision the professional provides by cosigning individual treatment plans and making entries in the client's record on supervisory activities. Clinical supervision does not include the authority to make or terminate court-ordered placements of the child. A clinical supervisor must be available for urgent consultation as required by the individual client's needs or the situation. Clinical supervision may occur individually or in a small group to discuss treatment and review progress toward goals. The focus of clinical supervision must be the client's treatment needs and progress and the mental health practitioner's or behavioral aide's ability to provide services;

(4a) CTSS certified provider entities providing day treatment programs must meet the conditions in items (i) to (iii):

(i) the ~~provider~~ supervisor must be present and available on the premises more than 50 percent of the time in a five-working-day period during which the supervisee is providing a mental health service;

(ii) the diagnosis and the client's individual treatment plan or a change in the diagnosis or individual treatment plan must be made by or reviewed, approved, and signed by the ~~provider~~ supervisor; and

(iii) every 30 days, the supervisor must review and sign the record of the client's care for all activities in the preceding 30-day period;

(4b) for all other services provided under CTSS, clinical supervision standards provided in items (i) to (iii) must be used:

(i) medical assistance shall reimburse a mental health practitioner who maintains a consulting relationship with a mental health professional who accepts full professional responsibility and is present on site for at least one observation during the first 12 hours in which the mental health practitioner provides the individual, family, or group skills training to the child or the child's family;

(ii) thereafter, the mental health professional is required to be present on site for observation as clinically appropriate when the mental health practitioner is providing individual, family, or group skills training to the child or the child's family; and

(iii) the observation must be a minimum of one clinical unit. The on-site presence of the mental health professional must be documented in the child's record and signed by the mental health professional who accepts full professional responsibility;

(5) providing direction to a mental health behavioral aide. For entities that employ mental health behavioral aides, the clinical supervisor must be employed by the provider entity or other certified children's therapeutic supports and services provider entity to ensure necessary and appropriate oversight for the client's treatment and continuity of care. The mental health professional or mental health practitioner giving direction must begin with the goals on the individualized treatment plan, and instruct the mental health behavioral aide on how to construct therapeutic activities and interventions that will lead to goal attainment. The professional or practitioner giving direction must also instruct the mental health behavioral aide about the client's diagnosis, functional status, and other characteristics that are likely to affect service delivery. Direction must also include determining that the mental health behavioral aide has the skills to interact with the client and the client's family in ways that convey personal and cultural respect and that the aide actively solicits information relevant to treatment from the family. The aide must be able to clearly explain the activities the aide is doing with the client and the activities' relationship to treatment goals. Direction is more didactic than is supervision

and requires the professional or practitioner providing it to continuously evaluate the mental health behavioral aide's ability to carry out the activities of the individualized treatment plan and the individualized behavior plan. When providing direction, the professional or practitioner must:

(i) review progress notes prepared by the mental health behavioral aide for accuracy and consistency with diagnostic assessment, treatment plan, and behavior goals and the professional or practitioner must approve and sign the progress notes;

(ii) identify changes in treatment strategies, revise the individual behavior plan, and communicate treatment instructions and methodologies as appropriate to ensure that treatment is implemented correctly;

(iii) demonstrate family-friendly behaviors that support healthy collaboration among the child, the child's family, and providers as treatment is planned and implemented;

(iv) ensure that the mental health behavioral aide is able to effectively communicate with the child, the child's family, and the provider; and

(v) record the results of any evaluation and corrective actions taken to modify the work of the mental health behavioral aide;

(6) providing service delivery that implements the individual treatment plan and meets the requirements under subdivision 9; and

(7) individual treatment plan review. The review must determine the extent to which the services have met the goals and objectives in the previous treatment plan. The review must assess the client's progress and ensure that services and treatment goals continue to be necessary and appropriate to the client and the client's family or foster family. Revision of the individual treatment plan does not require a new diagnostic assessment unless the client's mental health status has changed markedly. The updated treatment plan must be signed by the client, if appropriate, and by the client's parent or other person authorized by statute to give consent to the mental health services for the child.

Sec. 25. Minnesota Statutes 2006, section 256B.0943, subdivision 9, is amended to read:

Subd. 9. **Service delivery criteria.** (a) In delivering services under this section, a certified provider entity must ensure that:

(1) each individual provider's caseload size permits the provider to deliver services to both clients with severe, complex needs and clients with less intensive needs. The provider's caseload size should reasonably enable the provider to play an active role in service planning, monitoring, and delivering services to meet the client's and client's family's needs, as specified in each client's individual treatment plan;

(2) site-based programs, including day treatment and preschool programs, provide staffing and facilities to ensure the client's health, safety, and protection of rights, and that the programs are able to implement each client's individual treatment plan;

(3) a day treatment program is provided to a group of clients by a multidisciplinary team under the clinical supervision of a mental health professional. The day treatment program must be provided in and by: (i) an outpatient hospital accredited by the Joint Commission on Accreditation of Health Organizations and licensed under sections 144.50 to 144.55; (ii) a community mental health center under section 245.62; and (iii) an entity that is under contract with the county board to operate a program that meets the requirements of sections 245.4712, subdivision 2, and 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475. The day treatment program must stabilize the client's mental health status while developing and improving the client's independent living and socialization skills. The goal of the day treatment program must be to reduce or relieve the effects of mental illness and provide training to enable the client to live in the community. The program must be available at least one day a week for a ~~minimum~~ three-hour time block. The three-hour time block must include at least one hour, but no more than two hours, of individual or group psychotherapy. The remainder of the three-hour time block may include recreation therapy, socialization therapy, or independent living skills therapy, but only if the therapies are included in the client's individual treatment plan. Day treatment programs are not part of inpatient or residential treatment services; and

(4) a preschool program is a structured treatment program offered to a child who is at least 33 months old, but who has not yet reached the first day of kindergarten, by a preschool multidisciplinary team in a day program licensed under Minnesota Rules, parts 9503.0005 to 9503.0175. The program must be available at least one day a week for a minimum two-hour time block. The structured treatment program may include individual or group psychotherapy and recreation therapy, socialization therapy, or independent living skills therapy, if included in the client's individual treatment plan.

(b) A provider entity must deliver the service components of children's therapeutic services and supports in compliance with the following requirements:

(1) individual, family, and group psychotherapy must be delivered as specified in Minnesota Rules, part 9505.0323;

(2) individual, family, or group skills training must be provided by a mental health professional or a mental health practitioner who has a consulting relationship with a mental health professional who accepts full professional responsibility for the training;

(3) crisis assistance must be time-limited and designed to resolve or stabilize crisis through arrangements for direct intervention and support services to the child and the child's family. Crisis assistance must utilize resources designed to address abrupt or substantial changes in the functioning of the child or the child's family as evidenced by a sudden change in behavior with negative consequences for well being, a loss of usual coping mechanisms, or the presentation of danger to self or others;

(4) medically necessary services that are provided by a mental health behavioral aide must be designed to improve the functioning of the child and support the family in activities of daily and community living. A mental health behavioral aide must document the delivery of services in written progress notes. The mental health behavioral aide must implement goals in the treatment plan for the child's emotional disturbance that allow the child to acquire developmentally and therapeutically appropriate daily living skills, social skills, and leisure and recreational skills through targeted activities. These activities may include:

(i) assisting a child as needed with skills development in dressing, eating, and toileting;

(ii) assisting, monitoring, and guiding the child to complete tasks, including facilitating the child's participation in medical appointments;

(iii) observing the child and intervening to redirect the child's inappropriate behavior;

(iv) assisting the child in using age-appropriate self-management skills as related to the child's emotional disorder or mental illness, including problem solving, decision making, communication, conflict resolution, anger management, social skills, and recreational skills;

(v) implementing deescalation techniques as recommended by the mental health professional;

(vi) implementing any other mental health service that the mental health professional has approved as being within the scope of the behavioral aide's duties; or

(vii) assisting the parents to develop and use parenting skills that help the child achieve the goals outlined in the child's individual treatment plan or individual behavioral plan. Parenting skills must be directed exclusively to the child's treatment; and

(5) direction of a mental health behavioral aide must include the following:

(i) a total of one hour of on-site observation by a mental health professional during the first 12 hours of service provided to a child;

(ii) ongoing on-site observation by a mental health professional or mental health practitioner for at least a total of one hour during every 40 hours of service provided to a child; and

(iii) immediate accessibility of the mental health professional or mental health practitioner to the mental health behavioral aide during service provision.

Sec. 26. Minnesota Statutes 2006, section 256B.0943, subdivision 11, is amended to read:

Subd. 11. **Documentation and billing.** (a) A provider entity must document the services it provides under this section. The provider entity must ensure that the entity's documentation standards meet the requirements of federal and state laws. Services billed under this section that are not documented according to this subdivision shall be subject to monetary recovery by the commissioner. The provider entity may not bill for anything other than direct service time.

(b) An individual mental health provider must promptly document the following in a client's record after providing services to the client:

(1) each occurrence of the client's mental health service, including the date, type, length, and scope of the service;

(2) the name of the person who gave the service;

(3) contact made with other persons interested in the client, including representatives of the courts, corrections systems, or schools. The provider must document the name and date of each contact;

(4) any contact made with the client's other mental health providers, case manager, family members, primary caregiver, legal representative, or the reason the provider did not contact the client's family members, primary caregiver, or legal representative, if applicable; and

(5) required clinical supervision, as appropriate.

Sec. 27. Minnesota Statutes 2006, section 256B.0943, subdivision 12, is amended to read:

Subd. 12. **Excluded services.** The following services are not eligible for medical assistance payment as children's therapeutic services and supports:

(1) service components of children's therapeutic services and supports simultaneously provided by more than one provider entity unless prior authorization is obtained;

(2) children's therapeutic services and supports provided in violation of medical assistance policy in Minnesota Rules, part 9505.0220;

(3) mental health behavioral aide services provided by a personal care assistant who is not qualified as a mental health behavioral aide and employed by a certified children's therapeutic services and supports provider entity;

(4) service components of CTSS that are the responsibility of a residential or program license holder, including foster care providers under the terms of a service agreement or administrative rules governing licensure; ~~and~~

(5) adjunctive activities that may be offered by a provider entity but are not otherwise covered by medical assistance, including:

(i) a service that is primarily recreation oriented or that is provided in a setting that is not medically supervised. This includes sports activities, exercise groups, activities such as craft hours, leisure time, social hours, meal or snack time, trips to community activities, and tours;

(ii) a social or educational service that does not have or cannot reasonably be expected to have a therapeutic outcome related to the client's emotional disturbance;

(iii) consultation with other providers or service agency staff about the care or progress of a client;

(iv) prevention or education programs provided to the community; and

(v) treatment for clients with primary diagnoses of alcohol or other drug abuse~~.~~; and

(6) activities that are not direct service time.

Sec. 28. **[256B.764] REIMBURSEMENT FOR FAMILY PLANNING SERVICES.**

Effective for services rendered on or after July 1, 2007, payment rates for family planning services shall be increased by 25 percent over the rates in effect July 30, 2007, when these services are provided by a community clinic as defined in section 145.9268, subdivision 1.

Sec. 29. Minnesota Statutes 2006, section 256E.35, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Family asset account" means a savings account opened by a household participating in the Minnesota family assets for independence initiative.

(c) "Fiduciary organization" means:

(1) a community action agency that has obtained recognition under section ~~268.53~~ 256E.31;

(2) a federal community development credit union serving the seven-county metropolitan area; or

(3) a women-oriented economic development agency serving the seven-county metropolitan area.

(d) "Financial institution" means a bank, bank and trust, savings bank, savings association, or credit union, the deposits of which are insured by the Federal Deposit Insurance Corporation or the National Credit Union Administration.

(e) "Permissible use" means:

(1) postsecondary educational expenses at an accredited public postsecondary institution including books, supplies, and equipment required for courses of instruction;

(2) acquisition costs of acquiring, constructing, or reconstructing a residence, including any usual or reasonable settlement, financing, or other closing costs;

(3) business capitalization expenses for expenditures on capital, plant, equipment, working capital, and inventory expenses of a legitimate business pursuant to a business plan approved by the fiduciary organization; and

(4) acquisition costs of a principal residence within the meaning of section 1034 of the Internal Revenue Code of 1986 which do not exceed 100 percent of the average area purchase price applicable to the residence determined according to section 143(e)(2) and (3) of the Internal Revenue Code of 1986.

(f) "Household" means all individuals who share use of a dwelling unit as primary quarters for living and eating separate from other individuals.

Sec. 30. Minnesota Statutes 2006, section 256L.03, subdivision 5, is amended to read:

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

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

(2) $3 per prescription for adult enrollees;

(3) $25 for eyeglasses for adult enrollees;

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

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

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

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

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

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

Sec. 31. Minnesota Statutes 2006, section 256L.04, subdivision 1, is amended to read:

Subdivision 1. **Families with children.** (a) Families with children with family income equal to or less than 275 percent of the federal poverty guidelines for the applicable family size shall be eligible for MinnesotaCare according to this section. All other provisions of sections 256L.01 to 256L.18, including the insurance-related barriers to enrollment under section 256L.07, shall apply unless otherwise specified.

(b) Parents who enroll in the MinnesotaCare program must also enroll their children, if the children are eligible. Children may be enrolled separately without enrollment by parents. However, if one parent in the household enrolls, both parents must enroll, unless other insurance is available. If one child from a family is enrolled, all children must be enrolled, unless other insurance is available. If one spouse in a household enrolls, the other spouse in the household must also enroll, unless other insurance is available. Families cannot choose to enroll only certain uninsured members.

(c) Beginning October 1, 2003, the dependent sibling definition no longer applies to the MinnesotaCare program. These persons are no longer counted in the parental household and may apply as a separate household.

(d) Beginning July 1, 2003, or upon federal approval, whichever is later, parents are not eligible for MinnesotaCare if their gross income exceeds ~~$50,000~~ $25,000 for the six-month period of eligibility.

Sec. 32. Minnesota Statutes 2006, section 256L.04, subdivision 12, is amended to read:

Subd. 12. **Persons in detention.** Beginning January 1, 1999, an applicant residing in a correctional or detention facility is not eligible for MinnesotaCare. An enrollee residing in a correctional or detention facility is not eligible at renewal of eligibility under section 256L.05, subdivision ~~3b~~ 3a.

Sec. 33. **[525A.01] SHORT TITLE.**

This chapter may be cited as the "Darlene Luther Revised Uniform Anatomical Gift Act."

Sec. 34. **[525A.02] DEFINITIONS.**

Subdivision 1. **Scope.** The definitions in this section apply to this chapter.

Subd. 2. **Adult.** "Adult" means an individual who is at least 18 years of age.

Subd. 3. **Agent.** "Agent" means an individual who is:

(1) authorized to make health care decisions on the principal's behalf by a power of attorney for health care; or

(2) expressly authorized to make an anatomical gift on the principal's behalf by any other record signed by the principal.

Subd. 4. **Anatomical gift.** "Anatomical gift" means a donation of all or part of a human body to take effect after the donor's death for the purpose of transplantation, therapy, research, or education.

Subd. 5. **Decedent.** "Decedent" means a deceased individual and includes a stillborn infant or an embryo or fetus that has died of natural causes in utero.

Subd. 6. **Disinterested witness.** "Disinterested witness" means a witness other than the spouse, child, parent, sibling, grandchild, grandparent, or guardian of the individual who makes, amends, revokes, or refuses to make an anatomical gift, or another adult who exhibited special care and concern for the individual. The term does not include a person to which an anatomical gift could pass under section 525A.11.

Subd. 7. **Document of gift.** "Document of gift" means a donor card or other record used to make an anatomical gift. The term includes a statement or symbol on a driver's license, identification card, or donor registry.

Subd. 8. **Donor.** "Donor" means an individual whose body or part is the subject of an anatomical gift.

Subd. 9. **Donor registry.** "Donor registry" means a database that contains records of anatomical gifts and amendments to or revocations of anatomical gifts.

Subd. 10. **Driver's license.** "Driver's license" means a license or permit issued under chapter 171 to operate a vehicle, whether or not conditions are attached to the license or permit.

Subd. 11. **Eye bank.** "Eye bank" means a person that is licensed, accredited, or regulated under federal or state law to engage in the recovery, screening, testing, processing, storage, or distribution of human eyes or portions of human eyes.

Subd. 12. **Guardian.** "Guardian" means a person appointed by a court to make decisions regarding the support, care, education, health, or welfare of an individual. The term does not include a guardian ad litem.

Subd. 13. **Hospital.** "Hospital" means a facility licensed as a hospital under the law of any state or a facility operated as a hospital by the United States, a state, or a subdivision of a state.

Subd. 14. **Identification card.** "Identification card" means a Minnesota identification card issued under chapter 171.

Subd. 15. **Know.** "Know" means to have actual knowledge.

Subd. 16. **Medical examiner.** "Medical examiner" includes coroner.

Subd. 17. **Minor.** "Minor" means an individual who is under 18 years of age.

Subd. 18. **Organ procurement organization.** "Organ procurement organization" means a person designated by the secretary of the United States Department of Health and Human Services as an organ procurement organization.

Subd. 19. **Parent.** "Parent" means a parent whose parental rights have not been terminated.

Subd. 20. **Part.** "Part" means an organ, an eye, or tissue of a human being. The term does not include the whole body.

Subd. 21. **Person.** "Person" means an individual, corporation, business trust, estate, trust, partnership, limited liability company, association, joint venture, public corporation, government or governmental subdivision, agency, or instrumentality, or any other legal or commercial entity.

Subd. 22. **Physician.** "Physician" means an individual authorized to practice medicine or osteopathy under the law of any state.

Subd. 23. **Procurement organization.** "Procurement organization" means an eye bank, organ procurement organization, or tissue bank.

Subd. 24. **Prospective donor.** "Prospective donor" means an individual who is dead or near death and has been determined by a procurement organization to have a part that could be medically suitable for transplantation, therapy, research, or education. The term does not include an individual who has made a refusal.

Subd. 25. **Reasonably available.** "Reasonably available" means able to be contacted by a procurement organization without undue effort and willing and able to act in a timely manner consistent with existing medical criteria necessary for the making of an anatomical gift.

Subd. 26. **Recipient.** "Recipient" means an individual into whose body a decedent's part has been or is intended to be transplanted.

Subd. 27. **Record.** "Record" means information that is inscribed on a tangible medium or that is stored in an electronic or other medium and is retrievable in perceivable form.

Subd. 28. **Refusal.** "Refusal" means a record created under section 525A.07 that expressly states an intent to bar other persons from making an anatomical gift of an individual's body or part.

Subd. 29. **Sign.** "Sign" means, with the present intent to authenticate or adopt a record:

(1) to execute or adopt a tangible symbol; or

(2) to attach to or logically associate with the record an electronic symbol, sound, or process.

Subd. 30. **State.** "State" means a state of the United States, the District of Columbia, Puerto Rico, the United States Virgin Islands, or any territory or insular possession subject to the jurisdiction of the United States.

Subd. 31. **Technician.** "Technician" means an individual determined to be qualified to remove or process parts by an appropriate organization that is licensed, accredited, or regulated under federal or state law. The term includes an enucleator.

Subd. 32. **Tissue.** "Tissue" means a portion of the human body other than an organ or an eye. The term does not include blood unless the blood is donated for the purpose of research or education.

Subd. 33. **Tissue bank.** "Tissue bank" means a person that is licensed, accredited, or regulated under federal or state law to engage in the recovery, screening, testing, processing, storage, or distribution of tissue.

Subd. 34. **Transplant hospital.** "Transplant hospital" means a hospital that furnishes organ transplants and other medical and surgical specialty services required for the care of transplant patients.

Sec. 35. **[525A.03] APPLICABILITY.**

This chapter applies to an anatomical gift or amendment to, revocation of, or refusal to make an anatomical gift, whenever made.

Sec. 36. **[525A.04] WHO MAY MAKE ANATOMICAL GIFT BEFORE DONOR'S DEATH.**

Subject to section 525A.08, an anatomical gift of a donor's body or part may be made during the life of the donor for the purpose of transplantation, therapy, research, or education in the manner provided in section 525A.05 by:

(1) the donor, if the donor is an adult or if the donor is a minor and is:

(i) emancipated; or

(ii) authorized under state law to apply for a driver's license because the donor is at least 16 years of age;

(2) an agent of the donor, unless the power of attorney for health care or other record prohibits the agent from making an anatomical gift;

(3) a parent of the donor, if the donor is an unemancipated minor; or

(4) the donor's guardian.

Sec. 37. **[525A.05] MANNER OF MAKING ANATOMICAL GIFT BEFORE DONOR'S DEATH.**

(a) A donor may make an anatomical gift:

(1) by authorizing a statement or symbol indicating that the donor has made an anatomical gift to be imprinted on the donor's driver's license or identification card;

(2) in a will;

(3) during a terminal illness or injury of the donor, by any form of communication addressed to at least two adults, at least one of whom is a disinterested witness; or

(4) as provided in paragraph (b).

(b) A donor or other person authorized to make an anatomical gift under section 525A.04 may make a gift by a donor card or other record signed by the donor or other person making the gift or by authorizing that a statement or symbol indicating that the donor has made an anatomical gift be included on a donor registry. If the donor or other person is physically unable to sign a record, the record may be signed by another individual at the direction of the donor or other person and must:

(1) be witnessed by at least two adults, at least one of whom is a disinterested witness, who have signed at the request of the donor or the other person; and

(2) state that it has been signed and witnessed as provided in clause (1).

(c) Revocation, suspension, expiration, or cancellation of a driver's license or identification card upon which an anatomical gift is indicated does not invalidate the gift.

(d) An anatomical gift made by will takes effect upon the donor's death whether or not the will is probated. Invalidation of the will after the donor's death does not invalidate the gift.

(e) The making of an anatomical gift shall not itself authorize or direct the denial of health care.

Sec. 38. **[525A.06] AMENDING OR REVOKING ANATOMICAL GIFT BEFORE DONOR'S DEATH.**

(a) Subject to section 525A.08, a donor or other person authorized to make an anatomical gift under section 525A.04 may amend or revoke an anatomical gift by:

(1) a record signed by:

(i) the donor;

(ii) the other person; or

(iii) subject to paragraph (b), another individual acting at the direction of the donor or the other person if the donor or other person is physically unable to sign; or

(2) a later-executed document of gift that amends or revokes a previous anatomical gift or portion of an anatomical gift, either expressly or by inconsistency.

(b) A record signed pursuant to paragraph (a), clause (1), item (iii), must:

(1) be witnessed by at least two adults, at least one of whom is a disinterested witness, who have signed at the request of the donor or the other person; and

(2) state that it has been signed and witnessed as provided in clause (1).

(c) Subject to section 525A.08, a donor or other person authorized to make an anatomical gift under section 525A.04 may revoke an anatomical gift by the destruction or cancellation of the document of gift, or the portion of the document of gift used to make the gift, with the intent to revoke the gift.

(d) A donor may amend or revoke an anatomical gift that was not made in a will by any form of communication during a terminal illness or injury addressed to at least two adults, at least one of whom is a disinterested witness.

(e) A donor who makes an anatomical gift in a will may amend or revoke the gift in the manner provided for amendment or revocation of wills or as provided in paragraph (a).

Sec. 39. **[525A.07] REFUSAL TO MAKE ANATOMICAL GIFT; EFFECT OF REFUSAL.**

(a) An individual may refuse to make an anatomical gift of the individual's body or part by:

(1) a record signed by:

(i) the individual; or

(ii) subject to paragraph (b), another individual acting at the direction of the individual if the individual is physically unable to sign;

(2) the individual's will, whether or not the will is admitted to probate or invalidated after the individual's death; or

(3) any form of communication made by the individual during the individual's terminal illness or injury addressed to at least two adults, at least one of whom is a disinterested witness.

(b) A record signed pursuant to paragraph (a), clause (1), item (ii), must:

(1) be witnessed by at least two adults, at least one of whom is a disinterested witness, who have signed at the request of the individual; and

(2) state that it has been signed and witnessed as provided in clause (1).

(c) An individual who has made a refusal may amend or revoke the refusal:

(1) in the manner provided in paragraph (a) for making a refusal;

(2) by subsequently making an anatomical gift pursuant to section 525A.05 that is inconsistent with the refusal; or

(3) by destroying or canceling the record evidencing the refusal, or the portion of the record used to make the refusal, with the intent to revoke the refusal.

(d) Except as otherwise provided in section 525A.08, paragraph (h), in the absence of an express, contrary indication by the individual set forth in the refusal, an individual's unrevoked refusal to make an anatomical gift of the individual's body or part bars all other persons from making an anatomical gift of the individual's body or part.

Sec. 40. **[525A.08] PRECLUSIVE EFFECT OF ANATOMICAL GIFT, AMENDMENT, OR REVOCATION.**

(a) Except as otherwise provided in paragraph (g) and subject to paragraph (f), in the absence of an express, contrary indication by the donor, a person other than the donor is barred from making, amending, or revoking an anatomical gift of a donor's body or part if the donor made an anatomical gift of the donor's body or part under section 525A.05 or an amendment to an anatomical gift of the donor's body or part under section 525A.06. An anatomical gift made in a will, a designation on a driver's license or identification card, or a health care directive under chapter 145C, and not revoked, establishes the intent of the person making the designation and may not be overridden by any other person.

(b) A donor's revocation of an anatomical gift of the donor's body or part under section 525A.06 is not a refusal and does not bar another person specified in section 525A.04 or 525A.09 from making an anatomical gift of the donor's body or part under section 525A.05 or 525A.10.

(c) If a person other than the donor makes an unrevoked anatomical gift of the donor's body or part under section 525A.05 or an amendment to an anatomical gift of the donor's body or part under section 525A.06, another person may not make, amend, or revoke the gift of the donor's body or part under section 525A.10.

(d) A revocation of an anatomical gift of a donor's body or part under section 525A.06 by a person other than the donor does not bar another person from making an anatomical gift of the body or part under section 525A.05 or 525A.10.

(e) In the absence of an express, contrary indication by the donor or other person authorized to make an anatomical gift under section 525A.04, an anatomical gift of a part is neither a refusal to give another part nor a limitation on the making of an anatomical gift of another part at a later time by the donor or another person.

(f) In the absence of an express, contrary indication by the donor or other person authorized to make an anatomical gift under section 525A.04, an anatomical gift of a part for one or more of the purposes set forth in section 525A.04 is not a limitation on the making of an anatomical gift of the part for any of the other purposes by the donor or any other person under section 525A.05 or 525A.10.

(g) If a donor who is an unemancipated minor dies, a parent of the donor who is reasonably available may revoke or amend an anatomical gift of the donor's body or part.

(h) If an unemancipated minor who signed a refusal dies, a parent of the minor who is reasonably available may revoke the minor's refusal.

Sec. 41. **[525A.09] WHO MAY MAKE ANATOMICAL GIFT OF DECEDENT'S BODY OR PART.**

(a) Subject to paragraphs (b) and (c) and unless barred by section 525A.07 or 525A.08, an anatomical gift of a decedent's body or part for the purpose of transplantation, therapy, research, or education may be made by any member of the following classes of persons who is reasonably available, in the order of priority listed:

(1) an agent of the decedent at the time of death who could have made an anatomical gift under section 525A.04, clause (2), immediately before the decedent's death;

(2) the spouse of the decedent;

(3) adult children of the decedent;

(4) parents of the decedent;

(5) adult siblings of the decedent;

(6) adult grandchildren of the decedent;

(7) grandparents of the decedent;

(8) an adult who exhibited special care and concern for the decedent;

(9) the persons who were acting as the guardians of the person of the decedent at the time of death; and

(10) any other person having the authority to dispose of the decedent's body.

(b) If there is more than one member of a class listed in paragraph (a), clause (1), (3), (4), (5), (6), (7), or (9), entitled to make an anatomical gift, an anatomical gift may be made by a member of the class unless that member or a person to which the gift may pass under section 525A.11 knows of an objection by another member of the class. If an objection is known, the gift may be made only by a majority of the members of the class who are reasonably available.

(c) A person may not make an anatomical gift if, at the time of the decedent's death, a person in a prior class under paragraph (a) is reasonably available to make or to object to the making of an anatomical gift.

Sec. 42. **[525A.10] MANNER OF MAKING, AMENDING, OR REVOKING ANATOMICAL GIFT OF DECEDENT'S BODY OR PART.**

(a) A person authorized to make an anatomical gift under section 525A.09 may make an anatomical gift by a document of gift signed by the person making the gift or by that person's oral communication that is electronically recorded or is contemporaneously reduced to a record and signed by the individual receiving the oral communication.

(b) Subject to paragraph (c), an anatomical gift by a person authorized under section 525A.09 may be amended or revoked orally or in a record by any member of a prior class who is reasonably available. If more than one member of the prior class is reasonably available, the gift made by a person authorized under section 525A.09 may be:

(1) amended only if a majority of the reasonably available members agree to the amending of the gift; or

(2) revoked only if a majority of the reasonably available members agree to the revoking of the gift or if they are equally divided as to whether to revoke the gift.

(c) A revocation under paragraph (b) is effective only if, before an incision has been made to remove a part from the donor's body or before invasive procedures have begun to prepare the recipient, the procurement organization, transplant hospital, or physician or technician knows of the revocation.

Sec. 43. **[525A.11] PERSONS THAT MAY RECEIVE ANATOMICAL GIFT; PURPOSE OF ANATOMICAL GIFT.**

(a) An anatomical gift may be made to the following persons named in the document of gift:

(1) a hospital; accredited medical school, dental school, college, or university; organ procurement organization; or nonprofit organization in medical education or research, for research or education;

(2) subject to paragraph (b), an individual designated by the person making the anatomical gift if the individual is the recipient of the part; and

(3) an eye bank or tissue bank.

(b) If an anatomical gift to an individual under paragraph (a), clause (2), cannot be transplanted into the individual, the part passes in accordance with paragraph (g) in the absence of an express, contrary indication by the person making the anatomical gift.

(c) If an anatomical gift of one or more specific parts or of all parts is made in a document of gift that does not name a person described in paragraph (a) but identifies the purpose for which an anatomical gift may be used, the following rules apply:

(1) if the part is an eye and the gift is for the purpose of transplantation or therapy, the gift passes to the appropriate eye bank;

(2) if the part is tissue and the gift is for the purpose of transplantation or therapy, the gift passes to the appropriate tissue bank;

(3) if the part is an organ and the gift is for the purpose of transplantation or therapy, the gift passes to the appropriate organ procurement organization as custodian of the organ; and

(4) if the part is an organ, an eye, or tissue and the gift is for the purpose of research or education, the gift passes to the appropriate procurement organization.

(d) For the purpose of paragraph (c), if there is more than one purpose of an anatomical gift set forth in the document of gift but the purposes are not set forth in any priority, the gift must be used for transplantation or therapy, if suitable. If the gift cannot be used for transplantation or therapy, the gift may be used for research or education.

(e) If an anatomical gift of one or more specific parts is made in a document of gift that does not name a person described in paragraph (a) and does not identify the purpose of the gift, the gift may be used only for transplantation or therapy, and the gift passes in accordance with paragraph (g).

(f) If a document of gift specifies only a general intent to make an anatomical gift by words such as "donor," "organ donor," or "body donor," or by a symbol or statement

of similar import, the gift may be used only for transplantation or therapy, and the gift passes in accordance with paragraph (g).

(g) For purposes of paragraphs (b), (e), and (f), the following rules apply:

(1) if the part is an eye, the gift passes to the appropriate eye bank;

(2) if the part is tissue, the gift passes to the appropriate tissue bank; and

(3) if the part is an organ, the gift passes to the appropriate organ procurement organization as custodian of the organ.

(h) An anatomical gift of an organ for transplantation or therapy, other than an anatomical gift under paragraph (a), clause (2), passes to the organ procurement organization as custodian of the organ.

(i) If an anatomical gift does not pass pursuant to paragraphs (a) to (h) or the decedent's body or part is not used for transplantation, therapy, research, or education, custody of the body or part passes to the person under obligation to dispose of the body or part.

(j) A person may not accept an anatomical gift if the person knows that the gift was not effectively made under section 525A.05 or 525A.10 or if the person knows that the decedent made a refusal under section 525A.07 that was not revoked. For purposes of this paragraph, if a person knows that an anatomical gift was made on a document of gift, the person is deemed to know of any amendment or revocation of the gift or any refusal to make an anatomical gift on the same document of gift.

(k) Except as otherwise provided in paragraph (a), clause (2), nothing in this chapter affects the allocation of organs for transplantation or therapy.

Sec. 44. **[525A.12] SEARCH AND NOTIFICATION.**

(a) The following persons shall make a reasonable search of an individual who the person reasonably believes is dead or near death for a document of gift or other information identifying the individual as a donor or as an individual who made a refusal:

(1) a law enforcement officer, firefighter, paramedic, or other emergency rescuer finding the individual; and

(2) if no other source of the information is immediately available, a hospital, as soon as practical after the individual's arrival at the hospital.

(b) If a document of gift or a refusal to make an anatomical gift is located by the search required by paragraph (a), clause (1), and the individual or deceased individual to whom it relates is taken to a hospital, the person responsible for conducting the search shall send the document of gift or refusal to the hospital. If a body is transferred to the custody of the medical examiner, the person who discovered the body must notify

the person's dispatcher. A dispatcher notified under this section must notify the state's federally designated organ procurement organization and inform the organization of the deceased's name, donor status, and location.

(c) A person is not subject to criminal or civil liability for failing to discharge the duties imposed by this section but may be subject to administrative sanctions.

Sec. 45. **[525A.13] DELIVERY OF DOCUMENT OF GIFT NOT REQUIRED; RIGHT TO EXAMINE.**

(a) A document of gift need not be delivered during the donor's lifetime to be effective.

(b) Upon or after an individual's death, a person in possession of a document of gift or a refusal to make an anatomical gift with respect to the individual shall allow examination and copying of the document of gift or refusal by a person authorized to make or object to the making of an anatomical gift with respect to the individual or by a person to which the gift could pass under section 525A.11.

Sec. 46. **[525A.14] RIGHTS AND DUTIES OF PROCUREMENT ORGANIZATION AND OTHERS.**

(a) When a hospital refers an individual at or near death to a procurement organization, the organization shall make a reasonable search of the records of the Department of Public Safety and any donor registry that it knows exists for the geographical area in which the individual resides to ascertain whether the individual has made an anatomical gift.

(b) A procurement organization must be allowed reasonable access to information in the records of the Department of Public Safety to ascertain whether an individual at or near death is a donor.

(c) When a hospital refers an individual at or near death to a procurement organization, the organization may conduct any reasonable examination necessary to ensure the medical suitability of a part that is or could be the subject of an anatomical gift for transplantation, therapy, research, or education from a donor or a prospective donor. During the examination period, measures necessary to ensure the medical suitability of the part may not be withdrawn unless the hospital or procurement organization knows that the individual expressed a contrary intent.

(d) Unless prohibited by law other than this chapter, at any time after a donor's death, the person to which a part passes under section 525A.11 may conduct any reasonable

examination necessary to ensure the medical suitability of the body or part for its intended purpose.

(e) Unless prohibited by law other than this chapter, an examination under paragraph (c) or (d) may include an examination of all medical and dental records of the donor or prospective donor.

(f) Upon the death of a minor who was a donor or had signed a refusal, unless a procurement organization knows the minor is emancipated, the procurement organization shall conduct a reasonable search for the parents of the minor and provide the parents with an opportunity to revoke or amend the anatomical gift or revoke the refusal.

(g) Upon referral by a hospital under paragraph (a), a procurement organization shall make a reasonable search for any person listed in section 525A.09 having priority to make an anatomical gift on behalf of a prospective donor. If a procurement organization receives information that an anatomical gift to any other person was made, amended, or revoked, it shall promptly advise the other person of all relevant information.

(h) Subject to sections 525A.11, paragraph (i), and 525A.23, the rights of the person to which a part passes under section 525A.11 are superior to the rights of all others with respect to the part. The person may accept or reject an anatomical gift in whole or in part. Subject to the terms of the document of gift and this chapter, a person that accepts an anatomical gift of an entire body may allow embalming, burial, or cremation, and use of remains in a funeral service. If the gift is of a part, the person to which the part passes under section 525A.11, upon the death of the donor and before embalming, burial, or cremation, shall cause the part to be removed without unnecessary mutilation.

(i) Neither the physician who attends the decedent at death nor the physician who determines the time of the decedent's death may participate in the procedures for removing or transplanting a part from the decedent.

(j) A physician or technician may remove a donated part from the body of a donor that the physician or technician is qualified to remove.

Sec. 47. **[525A.15] COORDINATION OF PROCUREMENT AND USE.**

Each hospital in this state shall enter into agreements or affiliations with procurement organizations for coordination of procurement and use of anatomical gifts.

Sec. 48. **[525A.16] SALE OR PURCHASE OF PARTS PROHIBITED; FELONY.**

(a) Except as otherwise provided in paragraph (b), a person that, for valuable consideration, knowingly purchases or sells a part for transplantation or therapy if removal of a part from an individual is intended to occur after the individual's death, commits a

felony and upon conviction is subject to a fine not exceeding $10,000 or imprisonment not exceeding five years, or both.

(b) A person may charge a reasonable amount for the removal, processing, preservation, quality control, storage, transportation, implantation, or disposal of a part.

Sec. 49. **[525A.17] PROHIBITED ACTS; FELONY.**

A person that, in order to obtain a financial gain, intentionally falsifies, forges, conceals, defaces, or obliterates a document of gift, an amendment or revocation of a document of gift, or a refusal commits a felony and upon conviction is subject to a fine not exceeding $10,000 or imprisonment not exceeding five years, or both.

Sec. 50. **[525A.18] IMMUNITY.**

(a) A person that acts in accordance with this chapter or with the applicable anatomical gift law of another state, or attempts in good faith to do so, is not liable for the act in a civil action, criminal prosecution, or administrative proceeding.

(b) Neither the person making an anatomical gift nor the donor's estate is liable for any injury or damage that results from the making or use of the gift.

(c) In determining whether an anatomical gift has been made, amended, or revoked under this chapter, a person may rely upon representations of an individual listed in section 525A.09, paragraph (a), clause (2), (3), (4), (5), (6), (7), or (8), relating to the individual's relationship to the donor or prospective donor unless the person knows that the representation is untrue.

(d) An anatomical gift under this chapter is not a sale of goods as that term is defined in section 336.2-105, paragraph (1), or the sale of a product.

Sec. 51. **[525A.19] LAW GOVERNING VALIDITY; CHOICE OF LAW AS TO EXECUTION OF DOCUMENT OF GIFT; PRESUMPTION OF VALIDITY.**

(a) A document of gift is valid if executed in accordance with:

(1) this chapter;

(2) the laws of the state or country where it was executed; or

(3) the laws of the state or country where the person making the anatomical gift was domiciled, has a place of residence, or was a national at the time the document of gift was executed.

(b) If a document of gift is valid under this section, the law of this state governs the interpretation of the document of gift.

(c) A person may presume that a document of gift or amendment of an anatomical gift is valid unless that person knows that it was not validly executed or was revoked.

Sec. 52. **[525A.20] DONOR REGISTRY.**

(a) The Department of Health may establish or contract for the establishment of a donor registry.

(b) The Department of Public Safety shall cooperate with a person that administers any donor registry that this state establishes, contracts for, or recognizes for the purpose of transferring to the donor registry all relevant information regarding a donor's making, amendment to, or revocation of an anatomical gift.

(c) A donor registry must:

(1) allow a donor or other person authorized under section 525A.04 to include on the donor registry a statement or symbol that the donor has made, amended, or revoked an anatomical gift;

(2) be accessible to a procurement organization to allow it to obtain relevant information on the donor registry to determine, at or near death of the donor or a prospective donor, whether the donor or prospective donor has made, amended, or revoked an anatomical gift; and

(3) be accessible, for purposes of clauses (1) and (2), seven days a week on a 24-hour basis.

(d) Personally identifiable information on a donor registry about a donor or prospective donor may not be used or disclosed without the express consent of the donor, prospective donor, or person that made the anatomical gift for any purpose other than to determine, at or near death of the donor or prospective donor, whether the donor or prospective donor has made, amended, or revoked an anatomical gift.

(e) This section does not prohibit any person from creating or maintaining a donor registry that is not established by or under contract with the state. Any such registry must comply with paragraphs (c) and (d).

Sec. 53. **[525A.21] EFFECT OF ANATOMICAL GIFT ON ADVANCE HEALTH CARE DIRECTIVE.**

(a) In this section:

(1) "advance health care directive" means a power of attorney for health care or a record signed by a prospective donor containing the prospective donor's direction concerning a health care decision for the prospective donor;

(2) "declaration" means a record signed by a prospective donor specifying the circumstances under which a life support system may be withheld or withdrawn from the prospective donor; and

(3) "health care decision" means any decision made regarding the health care of the prospective donor.

(b) If a prospective donor has a declaration or advance health care directive, measures necessary to ensure the medical suitability of an organ for transplantation or therapy may not be withheld or withdrawn from the prospective donor, unless the declaration expressly provides to the contrary.

Sec. 54. **[525A.22] COOPERATION BETWEEN MEDICAL EXAMINER AND PROCUREMENT ORGANIZATION.**

(a) A medical examiner shall cooperate with procurement organizations to maximize the opportunity to recover anatomical gifts for the purpose of transplantation, therapy, research, or education.

(b) If a medical examiner receives notice from a procurement organization that an anatomical gift might be available or was made with respect to a decedent whose body is under the jurisdiction of the medical examiner and a postmortem examination is going to be performed, unless the medical examiner denies recovery in accordance with section 525A.23, the medical examiner or designee shall conduct a postmortem examination of the body or the part in a manner and within a period compatible with its preservation for the purposes of the gift.

(c) A part may not be removed from the body of a decedent under the jurisdiction of a medical examiner for transplantation, therapy, research, or education unless the part is the subject of an anatomical gift. The body of a decedent under the jurisdiction of the medical examiner may not be delivered to a person for research or education unless the body is the subject of an anatomical gift. This paragraph does not preclude a medical examiner from performing the medicolegal investigation upon the body or parts of a decedent under the jurisdiction of the medical examiner.

Sec. 55. **[525A.23] FACILITATION OF ANATOMICAL GIFT FROM DECEDENT WHOSE BODY IS UNDER JURISDICTION OF MEDICAL EXAMINER.**

(a) Upon request of a procurement organization, a medical examiner shall release to the procurement organization the name, contact information, and available medical and social history of a decedent whose body is under the jurisdiction of the medical examiner.

If the decedent's body or part is medically suitable for transplantation, therapy, research, or education, the medical examiner shall release postmortem examination results to the procurement organization. The procurement organization may make a subsequent disclosure of the postmortem examination results or other information received from the medical examiner only if relevant to transplantation or therapy.

(b) The medical examiner may conduct a medicolegal examination by reviewing all medical records, laboratory test results, x-rays, other diagnostic results, and other information that any person possesses about a donor or prospective donor whose body is under the jurisdiction of the medical examiner which the medical examiner determines may be relevant to the investigation.

(c) A person that has any information requested by a medical examiner pursuant to paragraph (b) shall provide that information as expeditiously as possible to allow the medical examiner to conduct the medicolegal investigation within a period compatible with the preservation of parts for the purpose of transplantation, therapy, research, or education.

(d) If an anatomical gift has been or might be made of a part of a decedent whose body is under the jurisdiction of the medical examiner and a postmortem examination is not required, or the medical examiner determines that a postmortem examination is required but that the recovery of the part that is the subject of an anatomical gift will not interfere with the examination, the medical examiner and procurement organization shall cooperate in the timely removal of the part from the decedent for the purpose of transplantation, therapy, research, or education.

(e) If an anatomical gift of a part from the decedent under the jurisdiction of the medical examiner has been or might be made, but the medical examiner initially believes that the recovery of the part could interfere with the postmortem investigation into the decedent's cause or manner of death, the medical examiner shall consult with the procurement organization or physician or technician designated by the procurement organization about the proposed recovery. After consultation, the medical examiner may allow the recovery.

(f) Following the consultation under paragraph (e), in the absence of mutually agreed-upon protocols to resolve conflict between the medical examiner and the procurement organization, if the medical examiner intends to deny recovery of an organ for transplantation, the medical examiner or designee, at the request of the procurement organization, shall attend the removal procedure for the part before making a final determination not to allow the procurement organization to recover the part. During the removal procedure, the medical examiner or designee may allow recovery by the

procurement organization to proceed, or, if the medical examiner or designee reasonably believes that the part may be involved in determining the decedent's cause or manner of death, deny recovery by the procurement organization.

(g) If the medical examiner or designee denies recovery under paragraph (f), the medical examiner or designee shall:

(1) explain in a record the specific reasons for not allowing recovery of the part;

(2) include the specific reasons in the records of the medical examiner; and

(3) provide a record with the specific reasons to the procurement organization.

(h) If the medical examiner or designee allows recovery of a part under paragraph (d), (e), or (f), the procurement organization, upon request, shall cause the physician or technician who removes the part to provide the medical examiner with a record describing the condition of the part, a biopsy, a photograph, and any other information and observations that would assist in the postmortem examination.

(i) If a medical examiner or designee is required to be present at a removal procedure under paragraph (f), upon request the procurement organization requesting the recovery of the part shall reimburse the medical examiner or designee for the additional costs incurred in complying with paragraph (f).

Sec. 56. **[525A.24] RELATION TO ELECTRONIC SIGNATURES IN GLOBAL AND NATIONAL COMMERCE ACT.**

This chapter modifies, limits, and supersedes the Electronic Signatures in Global and National Commerce Act, United States Code, title 15, section 7001 et seq., but does not modify, limit, or supersede section 101(a) of that act, United States Code, title 15, section 7001, or authorize electronic delivery of any of the notices described in section 103(b) of that act, United States Code, title 15, section 7003(b).

Sec. 57. Laws 2005, chapter 98, article 3, section 25, is amended to read:

Sec. 25. **REPEALER.**

Minnesota Statutes 2004, sections 245.713, ~~subdivisions 2 and~~ subdivision 4; 245.716; and 626.5551, subdivision 4, are repealed.

EFFECTIVE DATE. This section is effective retroactively from August 1, 2005.

Sec. 58. **SOBER HOUSES.**

Subdivision 1. **Sober house defined.** For purposes of this section, a "sober house" means a cooperative living residence that:

(1) provides temporary housing to persons with alcohol or other drug dependency and abuse problems in exchange for compensation;

(2) stipulates residents must abstain from using alcohol or drugs and meet other requirements as a condition of living in the residence; and

(3) does not provide counseling or treatment services to those residents within the meaning of Minnesota Statutes, chapter 148C or 254A.

Subd. 2. **Work group creation; membership.** The commissioner of human services shall convene a sober house work group which is comprised of the following members:

(1) sober house landlords;

(2) sober house residents;

(3) community members with knowledge of sober housing;

(4) representatives of cities and counties;

(5) a representative from the Department of Human Services, Chemical Health Division;

(6) a representative from the Department of Human Services, Licensing Division;

(7) a representative of chemical dependency treatment providers; and

(8) a representative from the Department of Health.

Subd. 3. **Report.** The work group created in subdivision 2 is directed to study the issue of sober houses in the state and determine whether state licensing or other regulation of sober houses is appropriate. Based on findings of the work group, the commissioner of human services shall submit a report of recommendations to the legislature by January 1, 2008.

Sec. 59. **INTERPRETER SERVICES WORK GROUP.**

(a) The commissioner of health shall, in consultation with the commissioners of commerce, human services, and employee relations, convene a work group to study the provision of interpreter services to patients in medical and dental care settings. The work group shall include one representative from each of the following groups:

(1) consumers;

(2) interpreters;

(3) interpreter service providers or agencies;

(4) health plan companies;

(5) self-insured purchasers;

(6) hospitals;

(7) health care providers;

(8) dental providers;

(9) clinic administrators;

(10) state agency staff from the Departments of Health, Human Services, and Employee Relations;

(11) Minnesota Registry of Interpreters for the Deaf;

(12) local county social services agencies;

(13) local public health agencies;

(14) interpreting stakeholders group;

(15) one interpreter trainer; and

(16) one interpreter certification examiner.

(b) The work group shall develop findings and recommendations on the following:

(1) assuring access to interpreter services;

(2) compliance with requirements of federal law and guidance;

(3) developing a quality assurance program to ensure the quality of health care interpreting services, including requirements for training and establishing a certification process; and

(4) identifying broad-based funding mechanisms for interpreter services.

(c) Based on the discussions of the work group, the commissioner shall make recommendations to the chairs of the health policy and finance committees in the house and senate by January 15, 2008, on how to ensure high quality interpreter services for patients in medical and dental settings, and for a broad-based funding mechanism for delivering these services.

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

Sec. 60. **FEDERAL GRANTS.**

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

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

Sec. 61. **BOARD OF PHARMACY.**

The Board of Pharmacy shall not increase the license fees of pharmacists or pharmacies in order to adequately fund the prescription electronic reporting system under Minnesota Statutes, section 152.126, without specific authority from the legislature.

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

Sec. 62. **BOARD OF MEDICAL PRACTICE.**

The Board of Medical Practice shall convene a work group to discuss the appropriate prescribing of controlled substances listed in Minnesota Statutes, section 152.02, subdivisions 3 and 4, and those substances defined by the Board of Pharmacy under Minnesota Statutes, section 152.02, subdivisions 7, 8, and 12, for pain management, and shall report to the legislature by December 15, 2007.

Sec. 63. **HEALTH PLAN PURCHASING POOL STUDY GROUP.**

Subdivision 1. **Creation; membership.** (a) A health plan purchasing pool study group is created to study and make recommendations regarding the creation of a voluntary, statewide health plan purchasing pool that would contract directly with providers to provide affordable health coverage to eligible Minnesota residents. The study group is composed of:

(1) three members of the senate appointed by the Subcommittee on Committees of the Committee on Rules and Administration, including one member of the minority;

(2) three members of the house of representatives, two from the majority party appointed by the speaker of the house and one from the minority party appointed by the minority leader of the house;

(3) the attorney general or the attorney general's designated representative;

(4) three representatives of health care providers appointed as follows:

(i) one member appointed by the governor;

(ii) one member appointed by the speaker of the house; and

(iii) one member appointed by the Subcommittee on Committees of the senate Committee on Rules and Administration;

(5) one member selected by the American Federation of State, County, and Municipal employees;

(6) one member selected by the Minnesota Association of Professional Employees;

(7) one member selected by Education Minnesota;

(8) one member selected by the Minnesota Business Partnership;

(9) one member selected by the Metropolitan Independent Business Alliance;

(10) one member selected by the Minnesota Chapter of the National Federation of Independent Business;

(11) one member selected by the Farmers Union; and

(12) one member selected by the Minnesota Farm Bureau.

All appointments to be made under this subdivision must be made within 30 days of the effective date of this act.

(b) The attorney general or the attorney general's designee shall convene the first meeting of the study group. The study group shall select its chair at the first meeting.

Subd. 2. **Study; report.** The study group shall study and make recommendations on the following issues related to the creation, maintenance, and funding of a voluntary, statewide health plan purchasing pool to provide comprehensive, cost-effective, and medically appropriate health coverage to all public and private employees in Minnesota and all Minnesota residents:

(1) the creation of an independent public entity to administer the pool;

(2) eligibility and participation requirements for existing public and private health care purchasing pools, public and private employers, and residents of this state;

(3) how to contract directly with providers to provide comprehensive coverage for preventive, mental health, dental and other medical services, and comprehensive drug benefits to enrollees and maximize the cost savings and other efficiencies that a large purchasing pool would be expected to generate without the need for a public subsidy;

(4) provisions that allow the pool to contract directly with health care providers to provide coverage to enrollees;

(5) incentives designed to attract and retain the maximum number of enrollees;

(6) recommendations for the administration of the pool and the plans that will be available to enrollees including, but not limited to, recommendations to keep the pool solvent and profitable so that public subsidies are not necessary; and

(7) other elements the study group concludes are necessary or desirable for the pool to possess.

The study group shall submit its report and the draft legislation necessary to implement its recommendations to the chairs of the legislative committees and divisions with jurisdiction over health care policy and finance, the Health Care Access Commission, and the governor by February 1, 2008.

Subd. 3. **Staffing.** State agencies shall assist the study group with any requests for information the study group considers necessary to complete the study and report under subdivision 2.

Subd. 4. **Removal; vacancies; expenses.** Removal of members, vacancies, and expenses for members shall be as provided in Minnesota Statutes, section 15.059.

Subd. 5. **Expiration.** This section expires after the submission of the report as required in subdivision 2.

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

Sec. 64. **REPEALER.**

(a) Minnesota Statutes 2006, sections 254A.02, subdivisions 7, 9, 12, 14, 15, and 16; 254A.085; 254A.086; 254A.12; 254A.14; 254A.15; 254A.16, subdivision 5; 254A.175; 254A.18; 256J.561, subdivision 1; 256J.62, subdivision 9; and 256J.65, are repealed.

(b) Minnesota Rules, part 9503.0035, subpart 2, is repealed.

(c) Minnesota Statutes 2006, sections 525.921; 525.9211; 525.9212; 525.9213; 525.9214; 525.9215; 525.9216; 525.9217; 525.9218; 525.9219; 525.9221; 525.9222; 525.9223; and 525.9224, are repealed.

ARTICLE 8
CHILDREN'S HEALTH SECURITY PROGRAM

Section 1. **[16A.726] CHILDREN'S HEALTH SECURITY ACCOUNT.**

A children's health security account is created in a special revenue fund in the state treasury. The commissioner shall deposit to the credit of the account money made available to the account. Notwithstanding section 11A.20, any investment income attributable to the investment of the children's health security account not currently needed shall be credited to the children's health security account.

Sec. 2. Minnesota Statutes 2006, section 256B.057, subdivision 8, is amended to read:

Subd. 8. **Children under age two.** Medical assistance may be paid for a child under two years of age whose countable family income is above ~~275~~ 300 percent of the federal poverty guidelines for the same size family but less than or equal to ~~280~~ 305 percent of the federal poverty guidelines for the same size family.

EFFECTIVE DATE. This section is effective January 1, 2011, or upon federal approval, whichever is later.

Sec. 3. **[256N.01] CITATION.**

This chapter may be cited as the "Children's Health Security Act."

Sec. 4. **[256N.02] DEFINITIONS.**

Subdivision 1. **Applicability.** The terms used in this chapter have the following meanings unless otherwise provided for by text.

Subd. 2. **Child.** "Child" means an individual under age 21.

Subd. 3. **Commissioner.** "Commissioner" means the commissioner of human services.

Subd. 4. **Dependent child.** "Dependent child" means an unmarried child under age 25 who is claimed as a dependent for federal income tax purposes by a parent, grandparent, foster parent, relative caretaker, or legal guardian.

Sec. 5. **[256N.03] ESTABLISHMENT.**

The commissioner shall establish the children's health security program. The commissioner shall begin implementation of the program on October 1, 2008, or upon federal approval, whichever is later. The children's health security program must comply with title XIX of the federal Social Security Act, and waivers granted under title XIX.

Sec. 6. **[256N.05] ELIGIBILITY.**

Subdivision 1. **General requirements.** Children meeting the eligibility requirements of this section are eligible for the children's health security program.

Subd. 2. **Income limit.** (a) Effective October 1, 2008, children in families with gross household incomes equal to or less than 225 percent of the federal poverty guidelines are eligible for the children's health security program. In determining gross income, the commissioner shall use the income methodology applied to children under the MinnesotaCare program.

(b) Effective October 1, 2008, a dependent child is eligible for state-funded benefits under this section.

(c) Effective January 1, 2011, or upon federal approval, whichever is later, children in families with household incomes equal to or less than 300 percent of the federal poverty guidelines must be included in the children's health security program.

(d) The Legislative Task Force On Children's Health Care Coverage established under section 19 shall develop recommendations on options for extending health insurance coverage to children in families with household incomes in excess of 300 percent of the federal poverty guidelines.

Subd. 3. **Residency.** Program participants must meet the residency requirements of section 256B.056, subdivision 1.

Subd. 4. **Enrollment voluntary.** Enrollment in the children's health security program is voluntary. Parents or guardians may retain private sector or Medicare coverage for a child as the sole source of coverage. Parents or guardians who have private sector or Medicare coverage for children may also enroll children in the children's health security program. If private sector or Medicare coverage is available, coverage under the children's health security program is secondary to the private sector or Medicare coverage.

Subd. 5. **Emergency services.** Payment must be made for care and services that are furnished to noncitizens, regardless of immigration status, who otherwise meet the eligibility requirements of this chapter, if the care and services are necessary for the treatment of an emergency medical condition, except for organ transplants and related care and services and routine prenatal care. For purposes of this subdivision, "emergency medical condition" means a medical condition that meets the requirements of United States Code, title 42, section 1396b(v).

Subd. 6. **Medical assistance standards and procedures.** (a) Unless otherwise specified in this chapter, the commissioner shall use medical assistance procedures and methodology when determining initial eligibility and redetermining eligibility for the children's health security program.

(b) The procedures and income standard specified in section 256B.056, subdivisions 5 and 5c, paragraph (a), apply to children who would be eligible for the children's health security program, except for excess income.

(c) Retroactive coverage for the children's health security program must be provided as specified in section 256B.056, subdivision 7.

Sec. 7. **[256N.07] COVERED SERVICES.**

Covered services under the children's health security program must consist of all covered services under chapter 256B.

Sec. 8. **[256N.09] NO ENROLLEE PREMIUMS OR COST SHARING.**

In order to ensure broad access to coverage, the children's health security program has no enrollee premium or cost-sharing requirements.

Sec. 9. **[256N.11] APPLICATION PROCEDURES; ELIGIBILITY DETERMINATION.**

Subdivision 1. **Application procedure.** The application form for the program must be easily understandable and must not exceed two pages in length. Applications for the program must be made available to provider offices, local human services agencies, school districts, schools, community health offices, and other sites willing to cooperate in program outreach. These sites may accept applications and forward applications to the commissioner, and counties where applicable. Applications may also be made directly to the commissioner and to counties that determine eligibility.

Subd. 2. **Eligibility determination.** Counties that determine eligibility for MinnesotaCare as of March 1, 2007, shall determine eligibility for the children's health

security program. The commissioner, and counties where applicable, shall determine an applicant's eligibility for the program within 30 days of the date the application is received, according to the procedures in Code of Federal Regulations, title 42, section 435.911.

Subd. 3. **Presumptive eligibility.** Coverage under the program is available during a presumptive eligibility period for children under age 19 whose family income does not exceed the applicable income standard. The presumptive eligibility period begins on the date on which a health care provider enrolled in the program, or other entity designated by the commissioner, determines, based on preliminary information, that the child's family income does not exceed the applicable income standard. The presumptive eligibility period ends the earlier of the day on which a determination is made of eligibility under this section or the last day of the month following the month presumptive eligibility was determined.

Subd. 4. **Renewal of eligibility.** The commissioner shall require enrollees to renew eligibility every 12 months.

Subd. 5. **Continuous eligibility.** Children under the age of 19 who are eligible under this section shall be continuously eligible until the earlier of the next renewal period, or the time that a child exceeds age 19.

Sec. 10. **[256N.12] COUNTY ROLE.**

Counties not required to determine eligibility under section 256N.11, subdivision 2, may choose to determine eligibility under that section. Counties may also choose to provide assistance to applicants under section 256N.17, subdivision 1, and provide ombudsperson services under section 256N.17, subdivision 2. This must not limit the ability of the commissioner to establish reasonable staffing standards that relate to the number of persons served, and that provide a county option to hire part-time staff or pursue multicounty implementation models. If a county chooses not to deliver these services, they must be delivered by the commissioner. State and federal funding to support these services must be the same, whether delivered by the state or by a county or group of counties.

Sec. 11. **[256N.13] SERVICE DELIVERY.**

Subdivision 1. **Contracts for service delivery.** The commissioner, within each county, may contract with managed care organizations, including health maintenance organizations licensed under chapter 62D, community integrated service networks licensed under chapter 62N, accountable provider networks licensed under chapter 62T, and county-based purchasing plans established under section 256B.692, to provide covered health care services to program enrollees under a managed care system, and may contract with health care and social service providers to provide services on a fee-for-service basis.

Section 256B.69, subdivision 26, applies to contracts with managed care organizations. In determining the method for service delivery, the commissioner shall consider the cost and quality of health care services; the breadth of services offered, including medical, dental and mental health services; the breadth of choice of medical providers for enrollees; the ease of access to quality medical care for enrollees; the efficiency and cost-effectiveness of service delivery; and the integration of best medical practice standards into the children's health security program.

Subd. 2. **Managed care organization requirements.** (a) Managed care organizations under contract are responsible for coordinating covered health care services provided to eligible individuals. Managed care organizations under contract:

(1) shall authorize and arrange for the provision of all needed covered health services under chapter 256B, with the exception of services available only under a medical assistance home and community-based waiver, in order to ensure appropriate health care is delivered to enrollees;

(2) shall comply with the requirements of section 256B.69, subdivision 26;

(3) shall accept the prospective, per capita payment from the commissioner in return for the provision of comprehensive and coordinated health care services for enrollees;

(4) may contract with health care and social service providers to provide covered services to enrollees; and

(5) shall institute enrollee grievance procedures according to the method established by the commissioner, utilizing applicable requirements of chapter 62D and Code of Federal Regulations, title 42, section 438, subpart F. Disputes may also be appealed to the commissioner using the procedures in section 256.045.

(b) Upon implementation of the children's health security program, the commissioner shall withhold five percent of managed care organization payments pending completion of performance targets, including lead screening, well child services, immunizations, vision screening, and customer service performance targets. Effective January 1, 2011, the commissioner shall add treatment of asthma and screening for mental health as new performance targets. Each performance target must apply uniformly to all managed care organizations, and be qualitative, objective, measurable, and reasonably attainable, except in the case of a performance target based on federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. The withhold funds must be returned no sooner than July of the following year if performance targets in the contract are achieved. The success of each managed care organization in reaching performance targets must be reported to the legislature annually.

Subd. 3. **Fee-for-service delivery.** Disputes related to services provided under the fee-for-service system may be appealed to the commissioner using the procedures in section 256.045.

Subd. 4. **Contracts for waiver services.** The commissioner, when services are delivered through managed care, may contract with health care and social service providers on a fee-for-service basis to provide program enrollees with covered services available only under a medical assistance home and community-based waiver. The commissioner shall determine eligibility for home and community-based waiver services using the criteria and procedures in chapter 256B. Disputes related to services provided on a fee-for-service basis may be appealed to the commissioner using the procedures in section 256.045.

Subd. 5. **Service delivery for Minnesota disabilities health option recipient.** Individuals who voluntarily enroll in the Minnesota Disability Health Option (MnDHO), established under section 256B.69, subdivision 23, shall continue to receive their home and community-based waiver services through MnDHO.

Subd. 6. **Disabled or blind children.** Children eligible for medical assistance due to blindness or disability as determined by the Social Security Administration or the state medical review team are exempt from enrolling in a managed care organization and shall be provided health benefits on a fee-for-service basis.

Sec. 12. **[256N.15] PAYMENT RATES.**

Subdivision 1. **Establishment.** The commissioner, in consultation with a health care actuary, shall establish the method and amount of payments for services. The commissioner shall annually contract with eligible entities to provide services to program enrollees. The commissioner, in consultation with the Risk Adjustment Association established under section 62Q.03, subdivision 6, shall develop and implement a risk adjustment system for the program.

Subd. 2. **Provider rates.** In establishing the payment amount under subdivision 1, the commissioner shall ensure that fee-for-service payment rates for preventative care services provided on or after October 1, 2008, are at least five percent above the medical assistance rates for preventative services in effect on September 30, 2008, and shall ensure that fee-for-service payment rates for all other services provided on or after October 1, 2008, are at least three percent above the medical assistance rates for those services in effect on September 30, 2008. The commissioner shall adjust managed care capitation rates to reflect these increases, and shall require managed care organizations, as a condition of contract, to pass these increases on to providers under contract.

Sec. 13. **[256N.17] CONSUMER ASSISTANCE.**

Subdivision 1. **Assistance to applicants.** The commissioner shall assist applicants in choosing a managed care organization or fee-for-service provider by:

(1) establishing a Web site to provide information about managed care organizations and fee-for-service providers and to allow online enrollment;

(2) make information on managed care organizations and fee-for-service providers available at the sites specified in section 256N.11, subdivision 1;

(3) make applications and information on managed care organizations and fee-for-service providers available to applicants and enrollees according to Title VI of the Civil Rights Act and federal regulations adopted under that law or any guidance from the United States Department of Health and Human Services; and

(4) make benefit educators available to assist applicants in choosing a managed care organization or fee-for-service provider.

Subd. 2. **Ombudsperson.** The commissioner shall designate an ombudsperson to advocate for children enrolled in the children's health security program. The ombudsperson shall assist enrollees in understanding and making use of complaint and appeal procedures and ensure that necessary medical services are provided to enrollees. At the time of enrollment, the commissioner shall inform enrollees about the ombudsperson program, the right to a resolution of the enrollee's complaint by the managed care organization if the enrollee experiences a problem with the managed care organization or its providers, and appeal rights under section 256.045.

Sec. 14. **[256N.19] MONITORING AND EVALUATION OF QUALITY AND COSTS.**

(a) The commissioner, as a condition of contract, shall require each participating managed care organization and participating provider to submit, in the form and manner specified by the commissioner, data required for assessing enrollee satisfaction, quality of care, cost, and utilization of services. The commissioner shall evaluate this data, in order to:

(1) make summary information on the quality of care across managed care organizations, medical clinics, and providers available to consumers;

(2) require managed care organizations and providers, as a condition of contract, to implement quality improvement plans; and

(3) compare the cost and quality of services under the program to the cost and quality of services provided to private sector enrollees.

(b) The commissioner shall implement this section to the extent allowed by federal and state laws on data privacy.

Sec. 15. **[256N.21] FEDERAL APPROVAL.**

The commissioner shall seek all federal waivers and approvals necessary to implement this chapter including, but not limited to, waivers and approvals necessary to:

(1) coordinate medical assistance and MinnesotaCare coverage for children with the children's health security program;

(2) use federal medical assistance and MinnesotaCare dollars to pay for health care services under the children's health security program;

(3) maximize receipt of the federal medical assistance match for covered children, by increasing income standards through the use of more liberal income methodologies as provided under United States Code, title 42, sections 1396a and 1396u-1;

(4) extend presumptive eligibility and continuous eligibility to children under age 21; and

(5) use federal medical assistance and MinnesotaCare dollars to provide benefits to dependent children.

Sec. 16. **[256N.23] RULEMAKING.**

The commissioner shall adopt rules to implement this chapter.

Sec. 17. **[256N.25] CHILDREN'S HEALTH SECURITY PROGRAM OUTREACH.**

Subdivision 1. **Grant awards.** The commissioner shall award grants to public or private organizations to:

(1) provide information, in areas of the state with high uninsured populations, on the importance of maintaining insurance coverage and on how to obtain coverage through the children's health security program; and

(2) monitor and provide ongoing support to ensure enrolled children remain covered.

Subd. 2. **Criteria.** In awarding the grants, the commissioner shall consider the following:

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

(2) the ability to raise matching funds;

(3) the ability to contact, effectively communicate with, or serve eligible populations; and

(4) the applicant's plan to monitor and provide support to ensure enrolled children remain covered.

Subd. 3. **Monitoring and termination.** The commissioner shall monitor the grants and may terminate a grant if the outreach effort does not increase enrollment in the children's health security program.

Sec. 18. **IMPLEMENTATION PLAN.**

The commissioner of human services shall develop an implementation plan for the children's health security program, which includes a health delivery plan based on the criteria specified in Minnesota Statutes, section 256N.13, subdivision 1. The commissioner shall present this plan, any necessary draft legislation, and a draft of proposed rules to the legislature by December 15, 2007. The plan must include recommendations for any additional legislative changes necessary to coordinate medical assistance and MinnesotaCare coverage for children with the children's health security program. The commissioner shall evaluate the provision of services under the program to children with disabilities and shall present recommendations to the legislature by December 15, 2009, for any program changes necessary to ensure the quality and continuity of care.

Sec. 19. **LEGISLATIVE TASK FORCE ON CHILDREN'S HEALTH CARE COVERAGE.**

Subdivision 1. **Establishment; membership.** (a) The Legislative Task Force on Children's Health Care Coverage is established. The task force is made up of 12 voting members and six nonvoting members.

(b) The voting members are:

(1) six members of the house of representatives, with three members from the majority party appointed by the speaker of the house of representatives and three members from the minority party appointed by the minority leader of the house of representatives; and

(2) six members of the senate, with three members from the majority party appointed by the majority leader of the senate and three members from the minority party appointed by the minority leader of the senate.

(c) The nonvoting members are one representative selected by each of the following organizations:

(1) the American Academy of Pediatrics, Minnesota chapter;

(2) the Minnesota Nurses Association;

(3) the Minnesota Council of Health Plans;

(4) the Minnesota Children's Platform Coalition;

(5) the Minnesota Universal Health Care Coalition; and

(6) the Minnesota Business Partnership.

(d) The task force members must be appointed by September 1, 2007. The majority leader of the senate and the speaker of the house of representatives must each designate a chair from their appointments. The chair appointed by the speaker of the house of representatives shall convene and chair the first meeting of the task force. The chair appointed by the majority leader of the senate shall chair the next meeting of the task force. The chairs shall then alternate for the duration of the task force.

Subd. 2. **Study; staff support.** (a) The task force shall study viable options to extend coverage to all children as provided in Minnesota Statutes, section 256N.05, subdivision 2, paragraph (d), and provide recommendations to the legislature. The study must:

(1) evaluate methods to achieve universal coverage for children, including, but not limited to, changes to the employer-based coverage system and an expansion of eligibility for the children's health security program established under Minnesota Statutes, chapter 256N;

(2) examine health care reform and cost containment methods that will contain costs and increase access and improve health outcomes;

(3) examine how to increase access to preventive care and health care services; and

(4) examine how to reduce health disparities among minority populations.

(b) The task force, through the Legislative Coordinating Commission, may hire staff or contract for staff support for the study.

(c) The task force, in developing recommendations, shall hold meetings to hear public testimony at locations throughout the state, including locations outside of the seven-county metropolitan area.

Subd. 3. **Recommendations.** The task force shall report its recommendations to the legislature by December 15, 2009. Recommendations must be consistent with the following criteria:

(1) health care coverage must include preventive care and all other medically necessary services;

(2) health care coverage must be affordable for families, with the family share of premium costs and cost-sharing in total not exceeding five percent of family income;

(3) the system of coverage must give priority to ensuring access to and the quality and continuity of care; and

(4) enrollment must be simple and seamless for families.

Subd. 4. **Expiration.** This section expires December 16, 2009.

ARTICLE 9
HEALTH CARE REFORM

Section 1. Minnesota Statutes 2006, section 62A.65, subdivision 3, is amended to read:

Subd. 3. **Premium rate restrictions.** No individual health plan may be offered, sold, issued, or renewed to a Minnesota resident unless the premium rate charged is determined in accordance with the following requirements:

(a) Premium rates must be no more than 25 percent above and no more than 25 percent below the index rate charged to individuals for the same or similar coverage, adjusted pro rata for rating periods of less than one year. The premium variations permitted by this paragraph must be based only upon health status, claims experience, and occupation. For purposes of this paragraph, health status includes refraining from tobacco use or other actuarially valid lifestyle factors associated with good health, provided that the lifestyle factor and its effect upon premium rates have been determined by the commissioner to be actuarially valid and have been approved by the commissioner. Variations permitted under this paragraph must not be based upon age or applied differently at different ages. This paragraph does not prohibit use of a constant percentage adjustment for factors permitted to be used under this paragraph.

(b) Premium rates may vary based upon the ages of covered persons only as provided in this paragraph. In addition to the variation permitted under paragraph (a), each health carrier may use an additional premium variation based upon age <u>for adults aged 19 and above</u> of up to plus or minus 50 percent of the index rate. <u>Premium rates for children under the age of 19 may not vary based on age, regardless of whether the child is covered as a dependent or as a primary insured.</u>

(c) A health carrier may request approval by the commissioner to establish separate geographic regions determined by the health carrier and to establish separate index rates for each such region. The commissioner shall grant approval if the following conditions are met:

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

(2) each geographic region must be composed of no fewer than seven counties that create a contiguous region; and

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

(d) Health carriers may use rate cells and must file with the commissioner the rate cells they use. Rate cells must be based upon the number of adults or children covered

under the policy and may reflect the availability of Medicare coverage. The rates for different rate cells must not in any way reflect generalized differences in expected costs between principal insureds and their spouses.

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

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

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

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

(g) The loss ratio must comply with the section 62A.021 requirements for individual health plans.

(h) The rates must not be approved, unless the commissioner has determined that the rates are reasonable. In determining reasonableness, the commissioner shall consider the growth rates applied under section 62J.04, subdivision 1, paragraph (b), to the calendar year or years that the proposed premium rate would be in effect, actuarially valid changes in risks associated with the enrollee populations, and actuarially valid changes as a result of statutory changes in Laws 1992, chapter 549.

(i) An insurer may, as part of a minimum lifetime loss ratio guarantee filing under section 62A.02, subdivision 3a, include a rating practices guarantee as provided in this paragraph. The rating practices guarantee must be in writing and must guarantee that the policy form will be offered, sold, issued, and renewed only with premium rates and premium rating practices that comply with subdivisions 2, 3, 4, and 5. The rating practices guarantee must be accompanied by an actuarial memorandum that demonstrates that the premium rates and premium rating system used in connection with the policy form will satisfy the guarantee. The guarantee must guarantee refunds of any excess premiums to policyholders charged premiums that exceed those permitted under subdivision 2, 3, 4, or 5. An insurer that complies with this paragraph in connection with a policy form is exempt from the requirement of prior approval by the commissioner under paragraphs (c), (f), and (h).

Sec. 2. **[62A.67] MINNESOTA HEALTH INSURANCE EXCHANGE.**

Subdivision 1. **Title; citation.** This section may be cited as the "Minnesota Health Insurance Exchange."

Subd. 2. **Creation; tax exemption.** The Minnesota Health Insurance Exchange is created for the limited purpose of providing individuals with greater access, choice, portability, and affordability of health insurance products. The Minnesota Health Insurance Exchange is a not-for-profit corporation under chapter 317A and section 501(c) of the Internal Revenue Code.

Subd. 3. **Definitions.** The following terms have the meanings given them unless otherwise provided in text.

(a) "Board" means the board of directors of the Minnesota Health Insurance Exchange under subdivision 13.

(b) "Commissioner" means:

(1) the commissioner of commerce for health insurers subject to the jurisdiction of the Department of Commerce;

(2) the commissioner of health for health insurers subject to the jurisdiction of the Department of Health; or

(3) either commissioner's designated representative.

(c) "Exchange" means the Minnesota Health Insurance Exchange.

(d) "HIPAA" means the Health Insurance Portability and Accountability Act of 1996.

(e) "Individual market health plans," unless otherwise specified, means individual market health plans defined in section 62A.011.

(f) "Section 125 Plan" means a cafeteria or Premium Only Plan under section 125 of the Internal Revenue Code that allows employees to pay for health insurance premiums with pretax dollars.

Subd. 4. **Insurer and health plan participation.** All health plans as defined in section 62A.011, subdivision 3, issued or renewed in the individual market shall participate in the exchange. No health plans in the individual market may be issued or renewed outside of the exchange. Group health plans as defined in section 62A.10 shall not be offered through the exchange. Health plans offered through the Minnesota Comprehensive Health Association as defined in section 62E.10 are offered through the exchange to eligible enrollees as determined by the Minnesota Comprehensive Health Association. Health plans offered through MinnesotaCare under chapter 256L are offered through the exchange to eligible enrollees as determined by the commissioner of human services.

Subd. 5. **Approval of health plans.** No health plan may be offered through the exchange unless the commissioner has first certified that:

(1) the insurer seeking to offer the health plan is licensed to issue health insurance in the state; and

(2) the health plan meets the requirements of this section, and the health plan and the insurer are in compliance with all other applicable health insurance laws.

Subd. 6. **Individual market health plans.** Individual market health plans offered through the exchange continue to be regulated by the commissioner as specified in chapters 62A, 62C, 62D, 62E, 62Q, and 72A, and must include the following provisions that apply to all health plans issued or renewed through the exchange:

(1) premiums for children under the age of 19 shall not vary by age in the exchange; and

(2) premiums for children under the age of 19 must be excluded from rating factors under section 62A.65, subdivision 3, paragraph (b).

Subd. 7. **Individual participation and eligibility.** Individuals are eligible to purchase health plans directly through the exchange or through an employer Section 125 Plan under section 62A.68. Nothing in this section requires guaranteed issue of individual market health plans offered through the exchange. Individuals are eligible to purchase individual market health plans through the exchange by meeting one or more of the following qualifications:

(1) the individual is a Minnesota resident, meaning the individual is physically residing on a permanent basis in a place that is the person's principal residence and from which the person is absent only for temporary purposes;

(2) the individual is a student attending an institution outside of Minnesota and maintains Minnesota residency;

(3) the individual is not a Minnesota resident but is employed by an employer physically located within the state and the individual's employer is required to offer a Section 125 Plan under section 62A.68;

(4) the individual is not a Minnesota resident but is self-employed and the individual's principal place of business is in the state; or

(5) the individual is a dependent as defined in section 62L.02, of another individual who is eligible to participate in the exchange.

Subd. 8. **Continuation of coverage.** Enrollment in a health plan may be canceled for nonpayment of premiums, fraud, or changes in eligibility for MinnesotaCare under chapter 256L. Enrollment in an individual market health plan may not be canceled or nonrenewed because of any change in employer or employment status, marital status, health status, age, residence, or any other change that does not affect eligibility as defined in this section.

Subd. 9. **Responsibilities of the exchange.** The exchange shall serve as the sole entity for enrollment and collection and transfer of premium payments for health plans

sold to individuals through the exchange. The exchange shall be responsible for the following functions:

(1) publicize the exchange, including but not limited to its functions, eligibility rules, and enrollment procedures;

(2) provide assistance to employers to establish Section 125 Plans under section 62A.68;

(3) provide education and assistance to employers to help them understand the requirements of Section 125 Plans and compliance with applicable regulations;

(4) create a system to allow individuals to compare and enroll in health plans offered through the exchange;

(5) create a system to collect and transmit to the applicable plans all premium payments made by individuals, including developing mechanisms to receive and process automatic payroll deductions for individuals who purchase coverage through employer Section 125 Plans. The exchange shall not accept premium payments for individual market health plans from an employer Section 125 Plan if the employer offers a group health plan as defined in section 62A.10 or if the employer is a self-insurer as defined in section 62E.02;

(6) refer individuals interested in MinnesotaCare under chapter 256L to the Department of Human Services to determine eligibility;

(7) establish a mechanism with the Department of Human Services to transfer premiums and subsidies for MinnesotaCare to qualify for federal matching payments;

(8) upon request, issue certificates of previous coverage according to the provisions of HIPAA and as referenced in section 62Q.181 to all such individuals who cease to be covered by a participating health plan through the exchange;

(9) establish procedures to account for all funds received and disbursed by the exchange for individual participants of the exchange; and

(10) make available to the public, at the end of each calendar year, a report of an independent audit of the exchange's accounts. The exchange shall not accept premium payments for individual market health plans from an employer Section 125 Plan if the employer offers a group health plan as defined in section 62A.10 or if the employer is a self-insurer as defined in section 62E.02.

Subd. 10. **Powers of the exchange.** The exchange shall have the power to:

(1) contract with insurance producers licensed in accident and health insurance under chapter 60K and vendors to perform one or more of the functions specified in subdivision 10;

(2) contract with employers to collect premiums through a Section 125 Plan for eligible individuals who purchase an individual market health plan through the exchange;

(3) establish and assess fees on health plan premiums of health plans purchased through the exchange to fund the cost of administering the exchange;

(4) seek and directly receive grant funding from government agencies or private philanthropic organizations to defray the costs of operating the exchange;

(5) establish and administer rules and procedures governing the operations of the exchange;

(6) establish one or more service centers within Minnesota;

(7) sue or be sued or otherwise take any necessary or proper legal action;

(8) establish bank accounts and borrow money; and

(9) enter into agreements with the commissioners of commerce, health, human services, revenue, employment and economic development, and other state agencies as necessary for the exchange to implement the provisions of this section.

Subd. 11. **Dispute resolution.** The exchange shall establish procedures for resolving disputes with respect to the eligibility of an individual to participate in the exchange. The exchange does not have the authority or responsibility to intervene in or resolve disputes between an individual and a health plan or health insurer. The exchange shall refer complaints from individuals participating in the exchange to the commissioner to be resolved according to sections 62Q.68 to 62Q.73.

Subd. 12. **Governance.** The exchange shall be governed by a board of directors with 11 members. The board shall convene on or before July 1, 2007, after the initial board members have been selected. The initial board membership consists of the following:

(1) the commissioner of commerce;

(2) the commissioner of human services;

(3) the commissioner of health;

(4) four members appointed by a joint committee of the Minnesota senate and the Minnesota house of representatives to serve three-year terms; and

(5) four members appointed by the governor to serve three-year terms.

Subd. 13. **Subsequent board membership.** Ongoing membership of the exchange consists of the following effective July 1, 2010:

(1) the commissioner of commerce;

(2) the commissioner of human services;

(3) the commissioner of health;

(4) four members appointed by the governor with the approval of a joint committee of the senate and house of representatives to serve two- or three-year terms. Appointed members may serve more than one term; and

(5) four members elected by the membership of the exchange of which two are elected to serve a two-year term and two are elected to serve a three-year term. Elected members may serve more than one term.

Subd. 14. **Operations of the board.** Officers of the board of directors are elected by members of the board and serve one-year terms. Six members of the board constitutes a quorum, and the affirmative vote of six members of the board is necessary and sufficient for any action taken by the board. Board members serve without pay, but are reimbursed for actual expenses incurred in the performance of their duties.

Subd. 15. **Operations of the exchange.** The board of directors shall appoint an exchange director who shall:

(1) be a full-time employee of the exchange;

(2) administer all of the activities and contracts of the exchange; and

(3) hire and supervise the staff of the exchange.

Subd. 16. **Insurance producers.** When a producer licensed in accident and health insurance under chapter 60K enrolls an eligible individual in the exchange, the health plan chosen by an individual may pay the producer a commission.

Subd. 17. **Implementation.** Health plan coverage through the exchange begins on January 1, 2009. The exchange must be operational to assist employers and individuals by September 1, 2008, and be prepared for enrollment by December 1, 2008. Enrollees of individual market health plans, MinnesotaCare, and the Minnesota Comprehensive Health Association as of December 2, 2008, are automatically enrolled in the exchange on January 1, 2009, in the same health plan and at the same premium that they were enrolled as of December 2, 2008, subject to the provisions of this section. As of January 1, 2009, all enrollees of individual market health plans, MinnesotaCare, and the Minnesota Comprehensive Health Association shall make premium payments to the exchange.

Sec. 3. **[62A.68] SECTION 125 PLANS.**

Subdivision 1. **Definitions.** The following terms have the meanings given unless otherwise provided in text:

(a) "Current employee" means an employee currently on an employer's payroll other than a retiree or disabled former employee.

(b) "Employer" means a person, firm, corporation, partnership, association, business trust, or other entity employing one or more persons, including a political subdivision of the state, filing payroll tax information on such employed person or persons.

(c) "Section 125 Plan" means a cafeteria or Premium Only Plan under section 125 of the Internal Revenue Code that allows employees to purchase health insurance with pretax dollars.

(d) "Exchange" means the Minnesota Health Insurance Exchange under section 62A.67.

(e) "Exchange director" means the appointed director under section 62A.67, subdivision 16.

Subd. 2. **Section 125 Plan requirement.** (a) Effective January 1, 2009, all employers with 11 or more current employees shall establish a Section 125 Plan to allow their employees to purchase individual market health plan coverage with pretax dollars. The following employers are exempt from the Section 125 Plan requirement:

(1) employers that offer a group health insurance plan as defined in 62A.10;

(2) employers that are self-insurers as defined in section 62E.02; and

(3) employers with fewer than 11 current employees, except that employers under this clause may voluntarily offer a Section 125 Plan.

(b) Employers that offer a Section 125 Plan may enter into an agreement with the exchange to administer the employer's Section 125 Plan.

Subd. 3. **Tracking compliance.** By July 1, 2008, the exchange, in consultation with the commissioners of commerce, health, employment and economic development, and revenue shall establish a method for tracking employer compliance with the Section 125 Plan requirement.

Subd. 4. **Employer requirements.** Employers that are required to offer or choose to offer a Section 125 Plan shall:

(1) allow employees to purchase an individual market health plan for themselves and their dependents through the exchange;

(2) upon an employee's request, deduct premium amounts on a pretax basis in an amount not to exceed an employee's wages, and remit these employee payments to the exchange; and

(3) provide notice to employees that individual market health plans purchased through the exchange are not employer-sponsored.

Subd. 5. **Section 125 eligible health plans.** Individuals who are eligible to use an employer Section 125 Plan to pay for health insurance coverage purchased through the exchange may enroll in any health plan offered through the exchange for which the

individual is eligible including individual market health plans, MinnesotaCare, and the Minnesota Comprehensive Health Association.

Sec. 4. Minnesota Statutes 2006, section 62E.141, is amended to read:

62E.141 INCLUSION IN EMPLOYER-SPONSORED PLAN.

No employee of an employer that offers a group health plan, under which the employee is eligible for coverage, is eligible to enroll, or continue to be enrolled, in the comprehensive health association, except for enrollment or continued enrollment necessary to cover conditions that are subject to an unexpired preexisting condition limitation, preexisting condition exclusion, or exclusionary rider under the employer's health plan. This section does not apply to persons enrolled in the Comprehensive Health Association as of June 30, 1993. With respect to persons eligible to enroll in the health plan of an employer that has more than 29 current employees, as defined in section 62L.02, this section does not apply to persons enrolled in the Comprehensive Health Association as of December 31, 1994.

Sec. 5. Minnesota Statutes 2006, section 62J.04, subdivision 3, is amended to read:

Subd. 3. **Cost containment duties.** The commissioner shall:

(1) establish statewide and regional cost containment goals for total health care spending under this section ~~and~~, collect data as described in sections 62J.38 to 62J.41 to monitor statewide achievement of the cost containment goals, and annually report to the legislature on whether the goals were achieved and, if not, what action should be taken to ensure that goals are achieved in the future;

(2) divide the state into no fewer than four regions, with one of those regions being the Minneapolis/St. Paul metropolitan statistical area but excluding Chisago, Isanti, Wright, and Sherburne Counties, for purposes of fostering the development of regional health planning and coordination of health care delivery among regional health care systems and working to achieve the cost containment goals;

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

(4) issue recommendations regarding uniform billing forms, uniform electronic billing procedures and data interchanges, patient identification cards, and other uniform claims and administrative procedures for health care providers and private and public sector payers. In developing the recommendations, the commissioner shall review the work of the work group on electronic data interchange (WEDI) and the American National Standards Institute (ANSI) at the national level, and the work being done at the state and

local level. The commissioner may adopt rules requiring the use of the Uniform Bill 82/92 form, the National Council of Prescription Drug Providers (NCPDP) 3.2 electronic version, the Centers for Medicare and Medicaid Services 1500 form, or other standardized forms or procedures;

(5) undertake health planning responsibilities;

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

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

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

(9) make the cost containment goal data available to the public in a consumer-oriented manner.

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

Sec. 6. Minnesota Statutes 2006, section 62J.495, is amended to read:

62J.495 HEALTH INFORMATION TECHNOLOGY AND INFRASTRUCTURE ~~ADVISORY COMMITTEE~~.

Subdivision 1. ~~**Establishment; members; duties**~~ **Implementation.** By January 1, 2012, all hospitals and health care providers must have in place an interoperable electronic health records system within their hospital system or clinical practice setting. The commissioner of health, in consultation with the Health Information Technology and Infrastructure Advisory Committee, shall develop a statewide plan to meet this goal, including the adoption of uniform standards to be used for the interoperable system for sharing and synchronizing patient data across systems. The standards must be compatible with federal efforts. The uniform standards must be refined and adopted for use when a standard development organization accredited by the American National Standards Institute completes the development of a standard for sharing and synchronizing patient data across systems.

Subd. 2. **Health Information Technology and Infrastructure Advisory Committee.** (a) The commissioner shall establish a Health Information Technology and Infrastructure Advisory Committee governed by section 15.059 to advise the commissioner on the following matters:

(1) assessment of the use of health information technology by the state, licensed health care providers and facilities, and local public health agencies;

(2) recommendations for implementing a statewide interoperable health information infrastructure, to include estimates of necessary resources, and for determining standards for administrative data exchange, clinical support programs, patient privacy requirements, and maintenance of the security and confidentiality of individual patient data; and

(3) other related issues as requested by the commissioner.

(b) The members of the Health Information Technology and Infrastructure Advisory Committee shall include the commissioners, or commissioners' designees, of health, human services, administration, and commerce and additional members to be appointed by the commissioner to include persons representing Minnesota's local public health agencies, licensed hospitals and other licensed facilities and providers, private purchasers, the medical and nursing professions, health insurers and health plans, the state quality improvement organization, academic and research institutions, consumer advisory organizations with an interest and expertise in health information technology, and other stakeholders as identified by the Health Information Technology and Infrastructure Advisory Committee.

~~Subd. 2. Annual report.~~ (c) The commissioner shall prepare and issue an annual report not later than January 30 of each year outlining progress to date in implementing a statewide health information infrastructure and recommending future projects.

~~Subd. 3. Expiration.~~ (d) Notwithstanding section 15.059, this ~~section~~ subdivision expires June 30, ~~2009~~ 2012.

Sec. 7. **[62J.496] ELECTRONIC HEALTH RECORD SYSTEM REVOLVING ACCOUNT AND LOAN PROGRAM.**

Subdivision 1. **Account establishment.** The commissioner of finance shall establish and implement a revolving account in the state government special revenue fund to provide loans to physicians or physician group practices to assist in financing the installation or support of an interoperable health record system. The system must provide for the interoperable exchange of health care information between the applicant and, at a minimum, a hospital system, pharmacy, and a health care clinic or other physician group.

Subd. 2. **Eligibility.** To be eligible for a loan under this section, the applicant must submit a loan application to the commissioner of health on forms prescribed by the commissioner. The application must include, at a minimum:

(1) the amount of the loan requested and a description of the purpose or project for which the loan proceeds will be used;

(2) a signed contract with a vendor;

(3) a description of the health care entities and other groups participating in the project;

(4) evidence of financial stability and a demonstrated ability to repay the loan; and

(5) a description of how the system to be financed interconnects or plans in the future to interconnect with other health care entities and provider groups located in the same geographical area.

Subd. 3. **Loans.** (a) The commissioner of health may make a no interest loan to a provider or provider group who is eligible under subdivision 2 on a first-come, first-served basis provided that the applicant is able to comply with this section. The total accumulative loan principal must not exceed $..... per loan. The commissioner of health has discretion over the size and number of loans made.

(b) The commissioner of health may prescribe forms and establish an application process and, notwithstanding section 16A.1283, may impose a reasonable nonrefundable application fee to cover the cost of administering the loan program.

(c) The borrower must begin repaying the principal no later than two years from the date of the loan. Loans must be amortized no later than 15 years from the date of the loan.

(d) Repayments must be credited to the account.

Sec. 8. **[62J.536] UNIFORM ELECTRONIC TRANSACTIONS AND IMPLEMENTATION GUIDE STANDARDS.**

Subdivision 1. **Electronic claims and eligibility transactions required.** (a) Beginning January 15, 2009, all group purchasers must accept from health care providers the eligibility for a health plan transaction described under Code of Federal Regulations, title 45, part 162, subpart L. Beginning July 15, 2009, all group purchasers must accept from health care providers the health care claims or equivalent encounter information transaction described under Code of Federal Regulations, title 45, part 162, subpart K.

(b) Beginning January 15, 2009, all group purchasers must transmit to providers the eligibility for a health plan transaction described under Code of Federal Regulations, title 45, part 162, subpart L. Beginning December 1, 2009, all group purchasers must transmit

to providers the health care payment and remittance advice transaction described under Code of Federal Regulations, title 45, part 162, subpart P.

(c) Beginning January 15, 2009, all health care providers must submit to group purchasers the eligibility for a health plan transaction described under Code of Federal Regulations, title 45, part 162, subpart L. Beginning July 15, 2009, all health care providers must submit to group purchasers the health care claims or equivalent encounter information transaction described under Code of Federal Regulations, title 45, part 162, subpart K.

(d) Beginning January 15, 2009, all health care providers must accept from group purchasers the eligibility for a health plan transaction described under Code of Federal Regulations, title 45, part 162, subpart L. Beginning December 15, 2009, all health care providers must accept from group purchasers the health care payment and remittance advice transaction described under Code of Federal Regulations, title 45, part 162, subpart P.

(e) Each of the transactions described in paragraphs (a) to (d) shall require the use of a single, uniform companion guide to the implementation guides described under Code of Federal Regulations, title 45, part 162. The companion guides will be developed pursuant to subdivision 2.

(f) Notwithstanding any other provisions in sections 62J.50 to 62J.61, all group purchasers and health care providers must exchange claims and eligibility information electronically using the transactions, companion guides, implementation guides, and timelines required under this subdivision. Group purchasers may not impose any fee on providers for the use of the transactions prescribed in this subdivision.

(g) Nothing in this subdivision shall prohibit group purchasers and health care providers from using a direct data entry, Web-based methodology for complying with the requirements of this subdivision. Any direct data entry method for conducting the transactions specified in this subdivision must be consistent with the data content component of the single, uniform companion guides required in paragraph (e) and the implementation guides described under Code of Federal Regulations, title 45, part 162.

Subd. 2. **Establishing uniform, standard companion guides.** (a) At least 12 months prior to the timelines required in subdivision 1, the commissioner of health shall promulgate rules pursuant to section 62J.61 establishing and requiring group purchasers and health care providers to use the transactions and the uniform, standard companion guides required under subdivision 1, paragraph (e).

(b) The commissioner of health must consult with the Minnesota Administrative Uniformity Committee on the development of the single, uniform companion guides

required under subdivision 1, paragraph (e), for each of the transactions in subdivision 1. The single uniform companion guides required under subdivision 1, paragraph (e), must specify uniform billing and coding standards. The commissioner of health shall base the companion guides required under subdivision 1, paragraph (e), billing and coding rules, and standards on the Medicare program, with modifications that the commissioner deems appropriate after consulting the Minnesota Administrative Uniformity Committee.

(c) No group purchaser or health care provider may add to or modify the single, uniform companion guides defined in subdivision 1, paragraph (e), through additional companion guides or other requirements.

(d) In promulgating the rules in paragraph (a), the commissioner shall not require data content that is not essential to accomplish the purpose of the transactions in subdivision 1.

Sec. 9. Minnesota Statutes 2006, section 62J.692, subdivision 4, is amended to read:

Subd. 4. **Distribution of funds.** (a) The commissioner shall annually distribute 90 percent of available medical education funds to all qualifying applicants based on a distribution formula that reflects a summation of two factors:

(1) an education factor, which is determined by the total number of eligible trainee FTEs and the total statewide average costs per trainee, by type of trainee, in each clinical medical education program; and

(2) a public program volume factor, which is determined by the total volume of public program ~~revenue received~~ charges submitted by each training site as a percentage of all public program ~~revenue received~~ charges submitted by all training sites in the fund pool.

In this formula, the education factor is weighted at 67 percent and the public program volume factor is weighted at 33 percent.

Public program ~~revenue~~ charges for the distribution formula ~~includes revenue from~~ include charges for medical assistance, prepaid medical assistance, general assistance medical care, and prepaid general assistance medical care submitted for payment to this state and to contiguous states. Training sites that ~~receive~~ have no public program ~~revenue~~ charges are ineligible for funds available under this paragraph. Total statewide average costs per trainee for medical residents is based on audited clinical training costs per trainee in primary care clinical medical education programs for medical residents. Total statewide average costs per trainee for dental residents is based on audited clinical training costs per trainee in clinical medical education programs for dental students. Total statewide average costs per trainee for pharmacy residents is based on audited clinical training costs per trainee in clinical medical education programs for pharmacy students.

(b) The commissioner shall annually distribute ten percent of total available medical education funds to all qualifying applicants based on the percentage received by each applicant under paragraph (a). These funds are to be used to offset clinical education costs at eligible clinical training sites based on criteria developed by the clinical medical education program. Applicants may choose to distribute funds allocated under this paragraph based on the distribution formula described in paragraph (a).

(c) Funds distributed shall not be used to displace current funding appropriations from federal or state sources.

(d) Funds shall be distributed to the sponsoring institutions indicating the amount to be distributed to each of the sponsor's clinical medical education programs based on the criteria in this subdivision and in accordance with the commissioner's approval letter. Each clinical medical education program must distribute funds allocated under paragraph (a) to the training sites as specified in the commissioner's approval letter. Sponsoring institutions, which are accredited through an organization recognized by the Department of Education or the Centers for Medicare and Medicaid Services, may contract directly with training sites to provide clinical training. To ensure the quality of clinical training, those accredited sponsoring institutions must:

(1) develop contracts specifying the terms, expectations, and outcomes of the clinical training conducted at sites; and

(2) take necessary action if the contract requirements are not met. Action may include the withholding of payments under this section or the removal of students from the site.

(e) Any funds not distributed in accordance with the commissioner's approval letter must be returned to the medical education and research fund within 30 days of receiving notice from the commissioner. The commissioner shall distribute returned funds to the appropriate training sites in accordance with the commissioner's approval letter.

(f) The commissioner shall distribute by June 30 of each year an amount equal to the funds transferred under subdivision 10, plus five percent interest to the University of Minnesota Board of Regents for the instructional costs of health professional programs at the Academic Health Center and for interdisciplinary academic initiatives within the Academic Health Center.

(g) A maximum of $150,000 of the funds dedicated to the commissioner under section 297F.10, subdivision 1, paragraph (b), clause (2), may be used by the commissioner for administrative expenses associated with implementing this section.

Sec. 10. Minnesota Statutes 2006, section 62J.81, subdivision 1, is amended to read:

Subdivision 1. **Required disclosure of estimated payment.** (a) A health care provider, as defined in section 62J.03, subdivision 8, or the provider's designee as agreed to by that designee, shall, at the request of a consumer, provide that consumer with a good faith estimate of the ~~reimbursement~~ allowable payment the provider ~~expects to receive from the health plan company in which the consumer is enrolled~~ has agreed to accept from the consumer's health plan company for the services specified by the consumer, specifying the amount of the allowable payment due from the health plan company. Health plan companies must allow contracted providers, or their designee, to release this information. ~~A good faith estimate must also be made available at the request of a consumer who is not enrolled in a health plan company.~~ If a consumer has no applicable public or private coverage, the health care provider must give the consumer a good faith estimate of the average allowable reimbursement the provider accepts as payment from private third-party payers for the services specified by the consumer and the estimated amount the noncovered consumer will be required to pay. Payment information provided by a provider, or by the provider's designee as agreed to by that designee, to a patient pursuant to this subdivision does not constitute a legally binding estimate of the allowable charge for or cost to the consumer of services.

(b) A health plan company, as defined in section 62J.03, subdivision 10, shall, at the request of an enrollee or the enrollee's designee, provide that enrollee with a good faith estimate of the ~~reimbursement~~ allowable amount the health plan company ~~would expect to pay to~~ has contracted for with a specified provider within the network as total payment for a health care service specified by the enrollee and the portion of the allowable amount due from the enrollee and the enrollee's out-of-pocket costs. ~~If requested by the enrollee, the health plan company shall also provide to the enrollee a good faith estimate of the enrollee's out-of-pocket cost for the health care service.~~ An estimate provided to an enrollee under this paragraph is not a legally binding estimate of the ~~reimbursement~~ allowable amount or enrollee's out-of-pocket cost.

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

Sec. 11. Minnesota Statutes 2006, section 62J.82, is amended to read:

62J.82 HOSPITAL ~~CHARGE~~ INFORMATION REPORTING DISCLOSURE.

Subdivision 1. **Required information.** The Minnesota Hospital Association shall develop a Web-based system, available to the public free of charge, for reporting ~~charge information~~ the following, for Minnesota residents~~;~~:

(1) hospital-specific performance on the measures of care developed under section 256B.072 for acute myocardial infarction, heart failure, and pneumonia;

(2) by January 1, 2009, hospital-specific performance on the public reporting measures for hospital-acquired infections as published by the National Quality Forum and collected by the Minnesota Hospital Association and Stratis Health in collaboration with infection control practitioners; and

(3) charge information, including, but not limited to, number of discharges, average length of stay, average charge, average charge per day, and median charge, for each of the 50 most common inpatient diagnosis-related groups and the 25 most common outpatient surgical procedures as specified by the Minnesota Hospital Association.

Subd. 2. **Web site.** The Web site must provide information that compares hospital-specific data to hospital statewide data. The Web site must be ~~established by October 1, 2006, and must be~~ updated annually. The commissioner shall provide a link to this reporting information on the department's Web site.

Subd. 3. **Enforcement.** The commissioner shall provide a link to this information on the department's Web site. If a hospital does not provide this information to the Minnesota Hospital Association, the commissioner of health may require the hospital to do so in accordance with section 144.55, subdivision 6. ~~The commissioner shall provide a link to this information on the department's Web site.~~

Sec. 12. **[62J.84] HEALTH CARE TRANSFORMATION TASK FORCE.**

Subdivision 1. **Task force.** The governor shall convene a health care transformation task force to advise and assist the governor and the Minnesota legislature. The task force shall consist of:

(1) four legislators from the house of representatives, two appointed by the speaker of the house of representatives and two by the minority leader, and four legislators from the senate, two appointed by the majority leader and two by the minority leader;

(2) four representatives of the governor and state agencies appointed by the governor;

(3) at least four persons appointed by the governor who have demonstrated leadership in health care organizations, health improvement initiatives, health care trade or professional associations, or other collaborative health system improvement activities; and

(4) at least two persons appointed by the governor who have demonstrated leadership in employer and group purchaser activities related to health system improvement, at least one of which must be from a labor organization.

Subd. 2. **Public input.** The commissioner of health shall review available research, and conduct statewide, regional, and local surveys, focus groups, and other activities as

needed to fill gaps in existing research, to determine Minnesotans' values, preferences, opinions, and perceptions related to health care and to the issues confronting the task force, and shall report the findings to the task force.

Subd. 3. **Inventory and assessment of existing activities; action plan.** The task force shall complete an inventory and assessment of all public and private organized activities, coalitions, and collaboratives working on tasks relating to health system improvement including, but not limited to, patient safety, quality measurement and reporting, evidence-based practice, adoption of health information technology, disease management and chronic care coordination, medical homes, access to health care, cultural competence, prevention and public health, consumer incentives, price and cost transparency, nonprofit organization community benefits, education, research, and health care workforce.

Subd. 4. **Action plan.** By December 15, 2007, the governor, with the advice and assistance of the task force, shall develop and present to the legislature a statewide action plan for transforming the health care system to improve affordability, quality, and access. The plan shall include draft legislation needed to implement the plan. The plan may consist of legislative actions, administrative actions of governmental entities, collaborative actions, and actions of individuals and individual organizations. Among other things, the action plan must include the following, with specific and measurable goals and deadlines for each:

(1) proposed actions that will slow the rate of increase in health care costs to a rate that does not exceed the increase in the Consumer Price Index for urban consumers for the preceding calendar year plus two percentage points, plus an additional percentage based on the added costs necessary to implement legislation enacted in 2007;

(2) actions that will increase the affordable health coverage options for uninsured and underinsured Minnesotans and other strategies that will ensure that all Minnesotans will have health coverage by January 2010;

(3) actions to improve the quality and safety of health care and reduce racial and ethnic disparities in access and quality;

(4) actions that will reduce the rate of preventable chronic illness through prevention and public health and wellness initiatives; and

(5) proposed changes to state health care purchasing and payment strategies used for state health care programs and state employees that will promote higher quality, lower cost health care through incentives that reward prevention and early intervention, use of cost-effective primary care, effective care coordination, and management of chronic disease;

(6) actions that will promote the appropriate and cost-effective investment in new facilities, technologies, and drugs;

(7) actions to reduce administrative costs; and

(8) the results of the inventory completed under subdivision 3 and recommendations for how these activities can be coordinated and improved.

Subd. 5. **Options for small employers.** The task force shall study and report back to the legislature by December 15, 2008, on options for serving small employers and their employees, and self-employed individuals.

Sec. 13. Minnesota Statutes 2006, section 62L.12, subdivision 2, is amended to read:

Subd. 2. **Exceptions.** (a) A health carrier may sell, issue, or renew individual conversion policies to eligible employees otherwise eligible for conversion coverage under section 62D.104 as a result of leaving a health maintenance organization's service area.

(b) A health carrier may sell, issue, or renew individual conversion policies to eligible employees otherwise eligible for conversion coverage as a result of the expiration of any continuation of group coverage required under sections 62A.146, 62A.17, 62A.21, 62C.142, 62D.101, and 62D.105.

(c) A health carrier may sell, issue, or renew conversion policies under section 62E.16 to eligible employees.

(d) A health carrier may sell, issue, or renew individual continuation policies to eligible employees as required.

(e) A health carrier may sell, issue, or renew individual health plans if the coverage is appropriate due to an unexpired preexisting condition limitation or exclusion applicable to the person under the employer's group health plan or due to the person's need for health care services not covered under the employer's group health plan.

(f) A health carrier may sell, issue, or renew an individual health plan, if the individual has elected to buy the individual health plan not as part of a general plan to substitute individual health plans for a group health plan nor as a result of any violation of subdivision 3 or 4.

(g) Nothing in this subdivision relieves a health carrier of any obligation to provide continuation or conversion coverage otherwise required under federal or state law.

(h) Nothing in this chapter restricts the offer, sale, issuance, or renewal of coverage issued as a supplement to Medicare under sections 62A.3099 to 62A.44, or policies or contracts that supplement Medicare issued by health maintenance organizations, or those contracts governed by sections 1833, 1851 to 1859, 1860D, or 1876 of the federal Social Security Act, United States Code, title 42, section 1395 et seq., as amended.

(i) Nothing in this chapter restricts the offer, sale, issuance, or renewal of individual health plans necessary to comply with a court order.

(j) A health carrier may offer, issue, sell, or renew an individual health plan to persons eligible for an employer group health plan, if the individual health plan is a high deductible health plan for use in connection with an existing health savings account, in compliance with the Internal Revenue Code, section 223. In that situation, the same or a different health carrier may offer, issue, sell, or renew a group health plan to cover the other eligible employees in the group.

(k) A health carrier may offer, sell, issue, or renew an individual health plan to one or more employees of a small employer if the individual health plan is marketed directly to all employees of the small employer and the small employer does not contribute directly or indirectly to the premiums or facilitate the administration of the individual health plan. The requirement to market an individual health plan to all employees does not require the health carrier to offer or issue an individual health plan to any employee. For purposes of this paragraph, an employer is not contributing to the premiums or facilitating the administration of the individual health plan if the employer does not contribute to the premium and merely collects the premiums from an employee's wages or salary through payroll deductions and submits payment for the premiums of one or more employees in a lump sum to the health carrier. Except for coverage under section 62A.65, subdivision 5, paragraph (b), or 62E.16, at the request of an employee, the health carrier may bill the employer for the premiums payable by the employee, provided that the employer is not liable for payment except from payroll deductions for that purpose. If an employer is submitting payments under this paragraph, the health carrier shall provide a cancellation notice directly to the primary insured at least ten days prior to termination of coverage for nonpayment of premium. Individual coverage under this paragraph may be offered only if the small employer has not provided coverage under section 62L.03 to the employees within the past 12 months.

The employer must provide a written and signed statement to the health carrier that the employer is not contributing directly or indirectly to the employee's premiums. The health carrier may rely on the employer's statement and is not required to guarantee-issue individual health plans to the employer's other current or future employees.

(l) Nothing in this chapter restricts the offer, sale, issuance, or renewal of individual health plans through the Minnesota Health Insurance Exchange under section 62A.67 or 62A.68.

Sec. 14. Minnesota Statutes 2006, section 62Q.165, subdivision 1, is amended to read:

Subdivision 1. **Definition.** It is the commitment of the state to achieve universal health coverage for all Minnesotans by the year 2010. Universal coverage is achieved when:

(1) every Minnesotan has access to a full range of quality health care services;

(2) every Minnesotan is able to obtain affordable health coverage which pays for the full range of services, including preventive and primary care; and

(3) every Minnesotan pays into the health care system according to that person's ability.

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

Sec. 15. Minnesota Statutes 2006, section 62Q.165, subdivision 2, is amended to read:

Subd. 2. **Goal.** It is the goal of the state to make continuous progress toward reducing the number of Minnesotans who do not have health coverage so that by January 1, ~~2000, fewer than four percent of the state's population will be without health coverage~~ 2010, all Minnesota residents have access to affordable health care. The goal will be achieved by improving access to private health coverage through insurance reforms and market reforms, by making health coverage more affordable for low-income Minnesotans through purchasing pools and state subsidies, and by reducing the cost of health coverage through cost containment programs and methods of ensuring that all Minnesotans are paying into the system according to their ability.

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

Sec. 16. Minnesota Statutes 2006, section 62Q.80, subdivision 3, is amended to read:

Subd. 3. **Approval.** (a) Prior to the operation of a community-based health care coverage program, a community-based health initiative shall submit to the commissioner of health for approval the community-based health care coverage program developed by the initiative. ~~The commissioner shall only approve a program that has been awarded a community access program grant from the United States Department of Health and Human Services.~~ The commissioner shall ensure that the program meets the federal grant requirements and any requirements described in this section and is actuarially sound based on a review of appropriate records and methods utilized by the community-based health initiative in establishing premium rates for the community-based health care coverage program.

(b) Prior to approval, the commissioner shall also ensure that:

(1) the benefits offered comply with subdivision 8 and that there are adequate numbers of health care providers participating in the community-based health network to deliver the benefits offered under the program;

(2) the activities of the program are limited to activities that are exempt under this section or otherwise from regulation by the commissioner of commerce;

(3) the complaint resolution process meets the requirements of subdivision 10; and

(4) the data privacy policies and procedures comply with state and federal law.

Sec. 17. Minnesota Statutes 2006, section 62Q.80, subdivision 4, is amended to read:

Subd. 4. **Establishment.** ~~(a)~~ The initiative shall establish and operate upon approval by the commissioner of health a community-based health care coverage program. The operational structure established by the initiative shall include, but is not limited to:

(1) establishing a process for enrolling eligible individuals and their dependents;

(2) collecting and coordinating premiums from enrollees and employers of enrollees;

(3) providing payment to participating providers;

(4) establishing a benefit set according to subdivision 8 and establishing premium rates and cost-sharing requirements;

(5) creating incentives to encourage primary care and wellness services; and

(6) initiating disease management services, as appropriate.

~~(b) The payments collected under paragraph (a), clause (2), may be used to capture available federal funds.~~

Sec. 18. Minnesota Statutes 2006, section 62Q.80, subdivision 13, is amended to read:

Subd. 13. **Report.** (a) The initiative shall submit quarterly status reports to the commissioner of health on January 15, April 15, July 15, and October 15 of each year, with the first report due January 15, ~~2007~~ 2008. The status report shall include:

(1) the financial status of the program, including the premium rates, cost per member per month, claims paid out, premiums received, and administrative expenses;

(2) a description of the health care benefits offered and the services utilized;

(3) the number of employers participating, the number of employees and dependents covered under the program, and the number of health care providers participating;

(4) a description of the health outcomes to be achieved by the program and a status report on the performance measurements to be used and collected; and

(5) any other information requested by the commissioner of health or commerce or the legislature.

(b) The initiative shall contract with an independent entity to conduct an evaluation of the program to be submitted to the commissioners of health and commerce and the legislature by January 15, ~~2009~~ 2010. The evaluation shall include:

(1) an analysis of the health outcomes established by the initiative and the performance measurements to determine whether the outcomes are being achieved;

(2) an analysis of the financial status of the program, including the claims to premiums loss ratio and utilization and cost experience;

(3) the demographics of the enrollees, including their age, gender, family income, and the number of dependents;

(4) the number of employers and employees who have been denied access to the program and the basis for the denial;

(5) specific analysis on enrollees who have aggregate medical claims totaling over $5,000 per year, including data on the enrollee's main diagnosis and whether all the medical claims were covered by the program;

(6) number of enrollees referred to state public assistance programs;

(7) a comparison of employer-subsidized health coverage provided in a comparable geographic area to the designated community-based geographic area served by the program, including, to the extent available:

(i) the difference in the number of employers with 50 or fewer employees offering employer-subsidized health coverage;

(ii) the difference in uncompensated care being provided in each area; and

(iii) a comparison of health care outcomes and measurements established by the initiative; and

(8) any other information requested by the commissioner of health or commerce.

Sec. 19. Minnesota Statutes 2006, section 62Q.80, subdivision 14, is amended to read:

Subd. 14. **Sunset.** This section expires December 31, ~~2011~~ 2012.

Sec. 20. Minnesota Statutes 2006, section 144.698, subdivision 1, is amended to read:

Subdivision 1. **Yearly reports.** (a) Each hospital and each outpatient surgical center, which has not filed the financial information required by this section with a voluntary, nonprofit reporting organization pursuant to section 144.702, shall file annually with the commissioner of health after the close of the fiscal year:

(1) a balance sheet detailing the assets, liabilities, and net worth of the hospital or outpatient surgical center;

(2) a detailed statement of income and expenses;

(3) a copy of its most recent cost report, if any, filed pursuant to requirements of Title XVIII of the United States Social Security Act;

(4) a copy of all changes to articles of incorporation or bylaws;

(5) information on services provided to benefit the community, including services provided at no cost or for a reduced fee to patients unable to pay, teaching and research activities, or other community or charitable activities;

(6) information required on the revenue and expense report form set in effect on July 1, 1989, or as amended by the commissioner in rule;

(7) information on changes in ownership or control; ~~and~~

(8) other information required by the commissioner in rule~~.~~;

(9) information on the number of available hospital beds that are dedicated to certain specialized services, as designated by the commissioner, and annual occupancy rates for those beds, separately for adult and pediatric care;

(10) from outpatient surgical centers, the total number of surgeries; and

(11) a report on health care capital expenditures during the previous year, as required by section 62J.17.

(b) Beginning with hospital fiscal year 2009, each nonprofit hospital shall report on community benefits under paragraph (a), clause (5). "Community benefit" means the costs of community care, underpayment for services provided under state health care programs, research costs, community health services costs, financial and in-kind contributions, costs of community building activities, costs of community benefit operations, education, and the cost of operating subsidized services. The cost of bad debts and underpayment for Medicare services are not included in the calculation of community benefit.

Sec. 21. Minnesota Statutes 2006, section 144.699, is amended by adding a subdivision to read:

Subd. 5. **Annual reports on community benefit, community care amounts, and state program underfunding.** (a) For each hospital reporting health care cost information under section 144.698 or 144.702, the commissioner shall report annually on the hospital's community benefit, community care, and underpayment for state public health care programs.

(b) For purposes of this subdivision, "community benefits" has the definition given in section 144.698, paragraph (b).

(c) For purposes of this subdivision, "community care" means the costs for medical care for which a hospital has determined is charity care, as defined under Minnesota Rules, part 4650.0115, or for which the hospital determines after billing for the services that there

is a demonstrated inability to pay. Any costs forgiven under a hospital's community care plan or under section 62J.83 may be counted in the hospital's calculation of community care. Bad debt expenses and discounted charges available to the uninsured shall not be included in the calculation of community care. The amount of community care is the value of costs incurred and not the charges made for services.

(d) For purposes of this subdivision, underpayment for services provided by state public health care programs is the difference between hospital costs and public program payments. The information shall be reported in terms of total dollars and as a percentage of total operating costs for each hospital.

Sec. 22. Minnesota Statutes 2006, section 256.01, subdivision 2b, is amended to read:

Subd. 2b. **Performance payments.** (a) The commissioner shall develop and implement a pay-for-performance system to provide performance payments to:

(1) eligible medical groups and clinics that demonstrate optimum care in serving individuals with chronic diseases who are enrolled in health care programs administered by the commissioner under chapters 256B, 256D, and 256L.;

(2) medical groups that implement effective medical home models of patient care that improve quality and reduce costs through effective primary and preventive care, care coordination, and management of chronic conditions; and

(3) eligible medical groups and clinics that evaluate medical provider usage patterns and provide feedback to individual medical providers on that provider's practice patterns relative to peer medical providers.

(b) The commissioner shall also develop and implement a patient incentive health program to provide incentives and rewards to patients who are enrolled in health care programs administered by the commissioner under chapters 256B, 256D, and 256L, and who have agreed to and meet personal health goals established with their primary care provider to manage a chronic disease or condition including, but not limited to, diabetes, high blood pressure, and coronary artery disease.

(c) The commissioner may receive any federal matching money that is made available through the medical assistance program for managed care oversight contracted through vendors including consumer surveys, studies, and external quality reviews as required by the Federal Balanced Budget Act of 1997, Code of Federal Regulations, title 42, part 438, subpart E. Any federal money received for managed care oversight is appropriated to the commissioner for this purpose. The commissioner may expend the federal money received in either year of the biennium.

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

Sec. 23. Minnesota Statutes 2006, section 256B.0625, is amended by adding a subdivision to read:

Subd. 49. **Provider-directed care coordination services.** The commissioner shall develop and implement a provider-directed care coordination program for medical assistance recipients who are not enrolled in the prepaid medical assistance program and who are receiving services on a fee-for-service basis. This program provides payment to primary care clinics for care coordination for people who have complex and chronic medical conditions. Clinics must meet certain criteria such as the capacity to develop care plans; have a dedicated care coordinator; and have an adequate number of fee-for-service clients, evaluation mechanisms, and quality improvement processes to qualify for reimbursement.

Sec. 24. Minnesota Statutes 2006, section 256L.01, subdivision 4, is amended to read:

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

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

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

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

Sec. 25. **HEALTH CARE PAYMENT SYSTEM REFORM.**

Subdivision 1. **Payment reform plan.** The commissioners of employee relations, human services, commerce, and health shall develop a plan for promoting and facilitating changes in payment rates and methods for paying for health care services, drugs, devices, supplies, and equipment in order to:

(1) reward the provision of cost-effective primary and preventive care;

(2) reward the use of evidence-based care;

(3) discourage underutilization, overuse, and misuse;

(4) reward the use of the most cost-effective settings, drugs, devices, providers, and treatments; and

(5) encourage consumers to maintain good health and use the health care system appropriately.

In developing the plan, the commissioners shall analyze existing data to determine specific services and health conditions for which changes in payment rates and methods would lead to significant improvements in quality of care.

Subd. 2. **Report.** The commissioners shall submit a report to the legislature by December 15, 2007, describing the payment reform plan. The report must include proposed legislation for implementing those components of the plan requiring legislative action or appropriations of money.

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

Sec. 26. **COMMUNITY COLLABORATIVE PILOT PROJECTS TO COVER THE UNINSURED.**

Subdivision 1. **Community collaboratives.** The commissioner of human services shall provide grants to and authorization for up to three community collaboratives that satisfy the requirements in this section. To be eligible to receive a grant and authorization under this section, a community collaborative must include:

(1) one or more counties;

(2) one or more local hospitals;

(3) one or more local employers who collectively provide at least 300 jobs in the community;

(4) one or more health care clinics or physician groups; and

(5) a third-party payer, which may be a county-based purchasing plan operating under Minnesota Statutes, section 256B.692, a self-insured employer, or a health plan company as defined in Minnesota Statutes, section 62Q.01, subdivision 4.

Subd. 2. **Pilot project requirements.** (a) Community collaborative pilot projects must:

(1) identify and enroll persons in the community who are uninsured, and who have, or are at risk of developing, one of the following chronic conditions: mental illness, diabetes, asthma, hypertension, or other chronic condition designated by the project;

(2) assist uninsured persons to obtain private-sector health insurance coverage if possible or to enroll in any public health care programs for which they are eligible. If the uninsured individual is unable to obtain health coverage, the community collaborative

must enroll the individual in a local health care assistance program that provides specified services to prevent or effectively manage the chronic condition;

(3) include components to help uninsured persons retain employment or to become employable, if currently unemployed;

(4) ensure that each uninsured person enrolled in the program has a medical home responsible for providing, or arranging for, health care services and assisting in the effective management of the chronic condition;

(5) coordinate services between all providers and agencies serving an enrolled individual; and

(6) be coordinated with the state's Q-Care initiative and improve the use of evidence-based treatments and effective disease management programs in the broader community, beyond those individuals enrolled in the project.

(b) Projects established under this section are not insurance and are not subject to state-mandated benefit requirements or insurance regulations.

Subd. 3. **Criteria.** Proposals must be evaluated by actuarial, financial, and clinical experts based on the likelihood that the project would produce a positive return on investment for the community. In awarding grants, the commissioner of human services shall give preference to proposals that:

(1) have broad community support from local businesses, provider counties, and other public and private organizations;

(2) would provide services to uninsured persons who have, or are at risk of developing, multiple, co-occurring chronic conditions;

(3) integrate or coordinate resources from multiple sources, such as employer contributions, county funds, social service programs, and provider financial or in-kind support;

(4) provide continuity of treatment and services when uninsured individuals in the program become eligible for public or private health insurance or when insured individuals lose their coverage;

(5) demonstrate how administrative costs for health plan companies and providers can be reduced through greater simplification, coordination, consolidation, standardization, reducing billing errors, or other methods; and

(6) involve local contributions to the cost of the pilot projects.

Subd. 4. **Grants.** The commissioner of human services shall provide implementation grants of up to one-half of the community collaborative's costs for planning, administration, and evaluation. The commissioner shall also provide grants to community collaboratives to develop a fund to pay up to 50 percent of the cost of the

services provided to uninsured individuals. The remaining costs must be paid for through other sources or by agreement of a health care provider to contribute the cost as charity care.

Subd. 5. **Evaluation.** The commissioner of human services shall evaluate the effectiveness of each community collaborative project awarded a grant, by comparing actual costs for serving the identified uninsured persons to the predicted costs that would have been incurred in the absence of early intervention and consistent treatment to manage the chronic condition, including the costs to medical assistance, MinnesotaCare, and general assistance medical care. The commissioner shall require community collaborative projects, as a condition of receipt of a grant award, to provide the commissioner with all information necessary for this evaluation.

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

Sec. 27. **HEALTH CARE PAYMENT REFORM PILOT PROJECTS.**

Subdivision 1. **Pilot projects.** (a) The commissioners of health, human services, and employee relations shall develop and administer payment reform pilot projects for state employees and persons enrolled in medical assistance, MinnesotaCare, or general assistance medical care, to the extent permitted by federal requirements. The purpose of the projects is to promote and facilitate changes in payment rates and methods for paying for health care services, drugs, devices, supplies, and equipment in order to:

(1) reward the provision of cost-effective primary and preventive care;

(2) reward the use of evidence-based care;

(3) reward coordination of care for patients with chronic conditions;

(4) discourage overuse and misuse;

(5) reward the use of the most cost-effective settings, drugs, devices, providers, and treatments;

(6) encourage consumers to maintain good health and use the health care system appropriately.

(b) The pilot projects must involve the use of designated care professionals or clinics to serve as a patient's medical home and be responsible for coordinating health care services across the continuum of care. The pilot projects must evaluate different payment reform models and must be coordinated with the Minnesota senior health options program and the Minnesota disability health options program. To the extent possible, the commissioners shall coordinate state purchasing activities with other public employers and with private purchasers, self-insured groups, and health plan companies to promote the use of pilot projects encompassing both public and private purchasers and markets.

Subd. 2. **Payment methods and incentives.** The commissioners shall modify existing payment methods and rates for those enrollees and health care providers participating in the pilot project in order to provide incentives for care management, team-based care, and practice redesign, and increase resources for primary care, chronic condition care, and care provided to complex patients. The commissioners may create financial incentives for patients to select a medical home under the pilot project by reducing, modifying, or eliminating deductibles and co-payments for certain services, or through other incentives. The commissioners may require patients to remain with their designated medical home for a specified period of time. Alternative payment methods may include complete or partial capitation, fee-for-service payments, or other payment methodologies. The payment methods may provide for the payment of bonuses to medical home providers or other providers, or to patients, for the achievement of performance goals. The payment methods may include allocating a portion of the payment that would otherwise be paid to health plans under state prepaid health care programs to the designated medical home for specified services.

Subd. 3. **Requirements.** In order to be designated a medical home under the pilot project, health care professionals or clinics must demonstrate their ability to:

(1) be the patient's first point of contact by telephone or other means, 24 hours a day, seven days a week;

(2) provide or arrange for patients' comprehensive health care needs, including the ability to structure planned chronic disease visits and to manage chronic disease through the use of disease registries;

(3) coordinate patients' care when care must be provided outside the medical home;

(4) provide longitudinal care, not just episodic care, including meeting long-term and unique personal needs;

(5) utilize an electronic health record and incorporate a plan to develop and make available to patients that choose a medical home an electronic personal health record that is prepopulated with the patient's data, consumer-directed, connected to the provider, 24-hour accessible, and owned and controlled by the patient;

(6) systematically improve quality of care using, among other inputs, patient feedback; and

(7) create a provider network that provides for increased reimbursement for a medical home in a cost-neutral manner.

Subd. 4. **Evaluation.** Pilot projects must be evaluated based on patient satisfaction, provider satisfaction, clinical process and outcome measures, program costs and savings,

and economic impact on health care providers. Pilot projects must be evaluated based on the extent to which the medical home:

(1) coordinated health care services across the continuum of care and thereby reduced duplication of services and enhanced communication across providers;

(2) provided safe and high-quality care by increasing utilization of effective treatments, reduced use of ineffective treatments, reduced barriers to essential care and services, and eliminated barriers to access;

(3) reduced unnecessary hospitalizations and emergency room visits and increased use of cost-effective care and settings;

(4) encouraged long-term patient and provider relationships by shifting from episodic care to consistent, coordinated communication and care with a specified team of providers or individual providers;

(5) engaged and educated consumers by encouraging shared patient and provider responsibility and accountability for disease prevention, health promotion, chronic disease management, acute care, and overall well-being, encouraging informed medical decision-making, ensuring the availability of accurate medical information, and facilitated the transfer of accurate medical information;

(6) encouraged innovation in payment methodologies by using patient and provider incentives to coordinate care and utilize medical home services and fostering the expansion of a technology infrastructure that supports collaboration; and

(7) reduced overall health care costs as compared to conventional payment methods for similar patient populations.

Subd. 5. **Rulemaking.** The commissioners are exempt from administrative rulemaking under chapter 14 for purposes of developing, administering, contracting for, and evaluating pilot projects under this section. The commissioner shall publish a proposed request for proposals in the State Register and allow 30 days for comment before issuing the final request for proposals.

Subd. 6. **Regulatory and payment barriers.** The commissioners shall study state and federal statutory and regulatory barriers to the creation of medical homes and provide a report and recommendations to the legislature by December 15, 2007.

Sec. 28. **HEALTH CARE SYSTEM CONSOLIDATION.**

(a) The commissioner of health shall study the effect of health care provider and health plan company consolidation in the four metropolitan statistical areas in Minnesota on: health care costs, including provider payment rates; quality of care; and access to care. The commissioner shall separately consider hospitals, specialty groups, and primary care

groups. The commissioner shall present findings and recommendations to the legislature by December 15, 2007.

(b) For purposes of this study, health carriers, provider networks, and other health care providers shall provide data on network participation, contracted payment rates, charges, costs, payments received, patient referrals, and other information requested by the commissioner, in the form and manner specified by the commissioner. Provider-level information on contracted payment rates and payments from health plans provided to the commissioner of health for the purposes of this study are (1) private data on individuals as defined in Minnesota Statutes, section 13.02, subdivision 12, and (2) nonpublic data as defined in Minnesota Statutes, section 13.02, subdivision 9. The commissioner may not collect patient-identified data for purposes of this study. Data collected for purposes of this study may not be used for any other purposes.

Sec. 29. **REPEALER.**

Minnesota Statutes 2006, section 62J.052, subdivision 1, is repealed effective August 1, 2007.

ARTICLE 10
HUMAN SERVICES APPROPRIATIONS

Section 1. **SUMMARY OF APPROPRIATIONS.**

The amounts shown in this section summarize direct appropriations, by fund, made in this article.

	2008	**2009**	**Total**
General	$ 4,564,390,000	$ 4,932,433,000	$ 10,996,343,000
State Government Special Revenue	13,854,000	13,864,000	27,718,000
Health Care Access	432,115,000	536,076,000	968,191,000
Federal TANF	244,362,000	253,978,000	498,340,000
Lottery Prize Fund	2,184,000	1,787,000	3,971,000
Total	**$ 5,256,905,000**	**$ 5,738,138,000**	**$ 10,995,043,000**

Sec. 2. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are appropriated to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2008" and "2009" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2008, or

June 30, 2009, respectively. "The first year" is fiscal year 2008. "The second year" is fiscal year 2009. "The biennium" is fiscal years 2008 and 2009. Appropriations for the fiscal year ending June 30, 2007, are effective the day following final enactment.

	APPROPRIATIONS Available for the Year Ending June 30	
	2008	**2009**

Sec. 3. **HUMAN SERVICES**

Subdivision 1. **Total Appropriation** **$ 5,205,998,000 $ 5,693,003,000**

Appropriations by Fund	2008	2009
General	4,549,005,000	4,916,220,000
State Government Special Revenue	545,000	555,000
Health Care Access	409,252,000	519,813,000
Federal TANF	244,362,000	253,978,000
Lottery Prize Fund	2,184,000	1,787,000

The amounts that may be spent for each purpose are specified in the following subdivisions.

Receipts for Systems Projects. Appropriations and federal receipts for information system projects for MAXIS, PRISM, MMIS, and SSIS must be deposited in the state system account authorized in Minnesota Statutes, section 256.014. Money appropriated for computer projects approved by the Minnesota Office of Enterprise Technology, funded by the legislature, and approved by the commissioner of finance, may be transferred from one project to another and from development to operations as the commissioner of human services considers necessary. Any unexpended balance in the appropriation for these

projects does not cancel but is available for ongoing development and operations.

Systems Continuity. In the event of disruption of technical systems or computer operations, the commissioner may use available grant appropriations to ensure continuity of payments for maintaining the health, safety, and well-being of clients served by programs administered by the Department of Human Services. Grant funds must be used in a manner consistent with the original intent of the appropriation.

Nonfederal Share Transfers. The nonfederal share of activities for which federal administrative reimbursement is appropriated to the commissioner may be transferred to the special revenue fund.

Gifts. Notwithstanding Minnesota Statutes, sections 16A.013 to 16A.016, the commissioner may accept, on behalf of the state, additional funding from sources other than state funds for the purpose of financing the cost of assistance program grants or nongrant administration. All additional funding is appropriated to the commissioner for use as designated by the grantor of funding.

TANF Funds Appropriated to Other Entities. Any expenditures from the TANF block grant shall be expended according to the requirements and limitations of part A of title IV of the Social Security Act, as amended, and any other applicable federal requirement or limitation. Prior to any expenditure of these funds, the commissioner

shall 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. It shall be the responsibility of any entity to which these 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. The commissioner shall receipt TANF funds appropriated to other state agencies and coordinate all related interagency accounting transactions necessary to implement these appropriations. Unexpended TANF funds appropriated to any state, local, or nonprofit entity cancel at the end of the state fiscal year unless appropriating or statutory language permits otherwise.

TANF Maintenance of Effort. (a) In order to meet the basic maintenance of effort (MOE) requirements of the TANF block grant specified under Code of Federal Regulations, title 45, section 263.1, the commissioner may only report nonfederal money expended for allowable activities listed in the following clauses as TANF/MOE expenditures:

(1) MFIP cash, diversionary work program, and food assistance benefits under Minnesota Statutes, chapter 256J;

(2) the child care assistance programs under Minnesota Statutes, sections 119B.03 and 119B.05, and county child care

administrative costs under Minnesota Statutes, section 119B.15;

(3) state and county MFIP administrative costs under Minnesota Statutes, chapters 256J and 256K;

(4) state, county, and tribal MFIP employment services under Minnesota Statutes, chapters 256J and 256K;

(5) expenditures made on behalf of noncitizen MFIP recipients who qualify for the medical assistance without federal financial participation program under Minnesota Statutes, section 256B.06, subdivision 4, paragraphs (d), (e), and (j); and

(6) qualifying working family credit expenditures under Minnesota Statutes, section 290.0671.

(b) The commissioner shall ensure that sufficient qualified nonfederal expenditures are made each year to meet the state's TANF/MOE requirements. For the activities listed in paragraph (a), clauses (2) to (6), the commissioner may only report expenditures that are excluded from the definition of assistance under Code of Federal Regulations, title 45, section 260.31.

(c) The commissioner shall ensure that the maintenance of effort used by the commissioner of finance for the February and November forecasts required under Minnesota Statutes, section 16A.103, contains expenditures under paragraph (a), clause (1), equal to at least 25 percent of

the total required under Code of Federal Regulations, title 45, section 263.1.

(d) Minnesota Statutes, section 256.011, subdivision 3, which requires that federal grants or aids secured or obtained under that subdivision be used to reduce any direct appropriations provided by law, does not apply if the grants or aids are federal TANF funds.

(e) Notwithstanding section 7, this rider expires June 30, 2011.

Working Family Credit Expenditures as TANF/MOE. The commissioner may claim as TANF maintenance of effort up to $6,707,000 per year for fiscal year 2008 through fiscal year 2011. Notwithstanding section 7, this rider expires June 30, 2011.

Additional Working Family Credit Expenditures to be Claimed for TANF/MOE. In addition to the amounts provided in this section, the commissioner may count the following amounts of working family credit expenditure as TANF/MOE:

(1) fiscal year 2008, $4,269,000; and

(2) fiscal year 2009, $4,889,000.

Notwithstanding section 7, this rider expires June 30, 2011.

Capitation Rate Increase. Of the health care access fund appropriations to the University of Minnesota in the higher education omnibus appropriation bill, $2,157,000 in fiscal year 2008 and $2,157,000 in fiscal year 2009 are to be used to increase the capitation

payments under Minnesota Statutes, section 256B.69.

Health Care Access Fund Transfer.

Notwithstanding Minnesota Statutes, section 295.581, in addition to the transfers in Minnesota Statutes, section 16A.724, subdivision 2, the commissioner of finance shall transfer up to the following amounts from the health care access fund to the general fund on June 30 of each fiscal year:

(1) fiscal year 2008, $6,416,000;

(2) fiscal year 2009, $5,643,000;

(3) fiscal year 2010, $6,677,000; and

(4) fiscal year 2011, $7,866,000.

Notwithstanding section 7, this rider expires June 30, 2011.

Subd. 2. **Agency Management** 57,495,000 57,696,000

Appropriations by Fund		
General	48,181,000	48,417,000
State Government Special Revenue	424,000	432,000
Health Care Access	8,018,000	7,975,000
Federal TANF	222,000	222,000

The amounts that may be spent from the appropriation for each purpose are as follows:

(a) **Financial Operations**

Appropriations by Fund		
General	7,102,000	7,523,000
Health Care Access	889,000	880,000
Federal TANF	122,000	122,000

(b) **Legal and Regulation Operations**

Appropriations by Fund		
General	12,805,000	12,673,000
State Government Special Revenue	424,000	432,000

Health Care Access	891,000	908,000	
Federal TANF	100,000	100,000	

(c) **Management Operations**

	Appropriations by Fund	
General	4,390,000	4,433,000
Health Care Access	234,000	238,000

(d) **Information Technology Operations**

	Appropriations by Fund	
General	23,884,000	23,788,000
Health Care Access	6,004,000	5,949,000

Subd. 3. **Revenue and Pass-Through Expenditures** 56,509,000 56,897,000

Federal TANF	56,509,000	56,897,000

Subd. 4. **Children and Economic Assistance Grants** 605,204,000 586,243,000

	Appropriations by Fund	
General	418,519,000	390,580,000
Federal TANF	186,435,000	195,663,000
Health Care Access	250,000	-0-

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) **MFIP/DWP Grants**

	Appropriations by Fund	
General	62,000,000	61,911,000
Federal TANF	82,431,000	91,082,000

(b) **Support Services Grants**

	Appropriations by Fund	
General	8,815,000	9,465,000
Federal TANF	103,382,000	103,382,000

TANF Prior Appropriation Cancellation.

Notwithstanding Laws 2001, First Special Session chapter 9, article 17, section 2, subdivision 11, paragraph (b), any unexpended TANF funds appropriated to the

commissioner to contract with the Board of Trustees of Minnesota State Colleges and Universities, to provide tuition waivers to employees of health care and human service providers that are members of qualifying consortia operating under Minnesota Statutes, sections 116L.10 to 116L.15, must cancel at the end of fiscal year 2007.

MFIP Pilot Program. Of the general fund appropriation, $100,000 in fiscal year 2008 and $750,000 in fiscal year 2009 are for a grant to the Stearns-Benton Employment and Training Council for the Workforce U pilot program.

Work Study. $750,000 in fiscal year 2008 and $750,000 in fiscal year 2009 are appropriated from the TANF reserve account to the Minnesota Office of Higher Education for work study grants under Minnesota Statutes, section 136A.233, specifically for low-income individuals who receive assistance under Minnesota Statutes, chapter 256J.

(c) **MFIP Child Care Assistance Grants**

General	337,000	553,000
Federal TANF	32,000	609,000

(d) **Child Support Enforcement Grants**

General	11,705,000	3,705,000

Child Support Enforcement. $8,000,000 for fiscal year 2008 is to make grants to counties for child support enforcement programs to make up for the loss under the 2006 federal Deficit Reduction Act of federal

matching funds for federal incentive funds passed on to the counties by the state.

(e) **Children's Services Grants**

	Appropriations by Fund	
General	64,745,000	76,383,000
Health Care Access	250,000	-0-

Base Adjustment. The general fund base is decreased by $673,000 in fiscal year 2010 and $670,000 in fiscal year 2011 for children's services grants.

Privatized Adoption Grants. Federal reimbursement for privatized adoption grant and foster care recruitment grant expenditures is appropriated to the commissioner for adoption grants and foster care and adoption administrative purposes.

Adoption Assistance Incentive Grants. Federal funds available during fiscal year 2008 and fiscal year 2009 for the adoption incentive grants are appropriated to the commissioner for these purposes.

Adoption Assistance and Relative Custody Assistance. The commissioner may transfer unencumbered appropriation balances for adoption assistance and relative custody assistance between fiscal years and between programs.

Adoption Assistance and Relative Custody Assistance Subsidy Payment Increase. Notwithstanding Minnesota Rules, part 9560.0083, subparts 5 and 6, the commissioner shall increase the payment schedules for basic and supplemental maintenance needs subsidies by 3.95 percent effective July 1, 2007. The commissioner

may make cost-neutral adjustments between schedules and between brackets within schedules to allow for whole-dollar bracket levels and account for differential cost increases in caring for children with special needs. Counties have until December 31, 2007, to implement the relative custody assistance payment increases and shall make payment adjustments retroactive to July 1, 2007.

Child Safety System. Of the general fund appropriation, $1,000,000 in fiscal year 2008 and $1,000,000 in fiscal year 2009 are to develop the child safety system.

Crisis Nurseries. $1,100,000 in fiscal year 2008 and $1,100,000 in fiscal year 2009 are appropriated from the general fund for the crisis nurseries program. Of this amount, $100,000 each year is to be made available for capacity development and technical support for crisis nurseries.

Respite Care. Of the general fund appropriation, $2,500,000 in fiscal year 2008 and $5,000,000 in fiscal year 2009 are to the commissioner of human services to fund respite care for children who have a diagnosis of emotional disturbance or severe emotional disturbance.

Childhood Trauma; Grants. Of the general fund appropriation, $125,000 in fiscal year 2008 and $250,000 in fiscal year 2009 are to the commissioner of human services to make grants for the purpose of maintaining and expanding evidence-based practices that

support children and youth who have been exposed to violence or who are refugees.

Collaborative Services for High-Risk Children. Of the general fund appropriation, $2,632,000 in fiscal year 2008 and $6,150,000 in fiscal year 2009 are to the commissioner of human services to fund early intervention collaborative programs.

Evidence-Based Practice. Of the general fund appropriation, $2,175,000 in fiscal year 2008 and $4,350,000 in fiscal year 2009 are to the commissioner of human services to develop and implement evidence-based practice in children's mental health care and treatment.

MFIP and Children's Mental Health Pilot Project. Of the general fund appropriation, $100,000 in fiscal year 2008 and $200,000 in fiscal year 2009 are to the commissioner of human services to fund the MFIP and children's mental health pilot project.

Regional Children's Mental Health Initiative. $700,000 in fiscal year 2008 and $700,000 in fiscal year 2009 are appropriated to the commissioner of human services to fund the Regional Children's Mental Health Initiative pilot project. This is a onetime appropriation.

Child Safety Efforts. $750,000 in fiscal year 2008 and $750,000 in fiscal year 2009 are appropriated to counties based on their population of residents under age 18. Funds are to be used to maintain and improve child safety services. By February 1, 2008, each county shall submit a report regarding current

child safety efforts, child safety funding, and unmet needs including investments needed. The report shall also include methods and community partners available to ensure early identification of at-risk families. The Association of Minnesota Counties and county agencies shall develop a uniform report structure so that statewide data can be easily summarized. This is a onetime appropriation.

Fetal Alcohol Syndrome. Of the general fund appropriation, $75,000 in fiscal year 2008 and $75,000 in fiscal year 2009 are for three programs that provide services to reduce fetal alcohol syndrome under Minnesota Statutes, section 145.9266. The three program grantees are the University of Minnesota, the Meeker-McLeod-Sibley Community, and the American Indian Family Center. This appropriation shall become part of the base appropriation.

Base Adjustment. The general fund base is increased by $366,000 in fiscal year 2010 and $368,000 in fiscal year 2011 for children's services grants.

(f) **Children and Community Services Grants**

General	110,802,000	69,567,000

Base Adjustment. The general fund base is increased by $99,000 in each of fiscal years 2010 and 2011 for children and community services grants.

Targeted Case Management Temporary Funding. Of the general fund appropriation, $40,000,000 in fiscal year 2008 is allocated to counties and tribes affected by reductions in

targeted case management federal Medicaid revenue as a result of the provisions in the federal Deficit Reduction Act of 2005, Public Law 109-171. The commissioner shall distribute the funds proportionate to each affected county or tribe's targeted case management federal earnings for calendar year 2005. Prior to distribution of funds, the commissioner shall estimate and certify the amount by which the federal regulations will reduce case management revenue over the 2008-2009 biennium. The commissioner may provide grants up to the amount of the estimated reduction, not to exceed $40,000,000 for the biennium. The commissioner may determine the timing and frequency of payments to counties. These funds are available in either year of the biennium. Counties shall use these funds to pay for social service-related costs, but the funds are not subject to provisions of the Children and Community Services Act grant under Minnesota Statutes, chapter 256M.

Child Welfare Project. Of the general fund appropriation, $2,000,000 for the biennium beginning July 1, 2007, is for expanding the American Indian chid welfare project under Minnesota Statutes, section 256.01, subdivision 14b, to include the Red Lake Band of Chippewa Indians Tribe, provided the tribe meets the criteria in Minnesota Statutes, section 256.01, subdivision 14b.

(g) **General Assistance Grants**

General	37,876,000	38,253,000

General Assistance Standard. The commissioner shall set the monthly standard of assistance for general assistance units consisting of an adult recipient who is childless and unmarried or living apart from parents or a legal guardian at $203. The commissioner may reduce this amount according to Laws 1997, chapter 85, article 3, section 54.

Emergency General Assistance. The amount appropriated for emergency general assistance funds is limited to no more than $7,889,812 in fiscal year 2008 and $7,889,812 in fiscal year 2009. Funds to counties must be allocated by the commissioner using the allocation method specified in Minnesota Statutes, section 256D.06.

(h) **Minnesota Supplemental Aid Grants**

General	30,798,000	31,439,000

Emergency Minnesota Supplemental Aid Funds. The amount appropriated for emergency Minnesota supplemental aid funds is limited to no more than $1,100,000 in fiscal year 2008 and $1,100,000 in fiscal year 2009. Funds to counties must be allocated by the commissioner using the allocation method specified in Minnesota Statutes, section 256D.46.

(i) **Group Residential Housing Grants**

General	91,441,000	99,304,000

Base Adjustment. The general fund base is increased by $6,665,000 in fiscal year 2010 and $13,419,000 in fiscal year 2011.

(j) **Other Children and Economic Assistance Grants**

Federal TANF	590,000	590,000

New Chance. $140,000 in fiscal year 2008 and $140,000 in fiscal year 2009 are appropriated from federal TANF funds to the Hennepin County new chance program.

Mothers First. Of the TANF appropriation, $450,000 in fiscal year 2008 and $450,000 in fiscal year 2009 are to fund the Ramsey County mothers first program. The appropriations are available until spent and are a onetime appropriation.

Subd. 5. **Children and Economic Assistance Management** 46,507,000 46,590,000

Appropriations by Fund		
General	44,964,000	45,040,000
Health Care Access	347,000	354,000
Federal TANF	1,196,000	1,196,000

The amounts that may be spent from the appropriation for each purpose are as follows:

(a) **Children and Economic Assistance Administration**

Appropriations by Fund		
General	9,321,000	9,318,000
Federal TANF	1,196,000	1,196,000

(b) **Children and Economic Assistance Operations**

Appropriations by Fund		
General	35,643,000	35,722,000
Health Care Access	347,000	354,000

Spending Authority for Food Stamps Bonus Awards. In the event that Minnesota qualifies for the United States Department of Agriculture Food and Nutrition Services

Food Stamp Program performance bonus awards, the funding is appropriated to the commissioner. The commissioner shall retain 25 percent of the funding, with the other 75 percent divided among the counties according to a formula that takes into account each county's impact on state performance in the applicable bonus categories.

Child Support Payment Center. Payments to the commissioner from other governmental units, private enterprises, and individuals for services performed by the child support payment center must be deposited in the state systems account authorized under Minnesota Statutes, section 256.014. These payments are appropriated to the commissioner for the operation of the child support payment center or system, according to Minnesota Statutes, section 256.014.

Financial Institution Data Match and Payment of Fees. The commissioner is authorized to allocate up to $310,000 each year in fiscal years 2008 and 2009 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 as authorized by Minnesota Statutes, section 13B.06, subdivision 7.

Subd. 6. **Basic Health Care Grants** 2,396,682,000 2,738,650,000

Appropriations by Fund		
General	2,020,207,000	2,256,041,000
Health Care Access	377,475,000	482,609,000

The amounts that may be spent from the appropriation for each purpose are as follows:

(a) **MinnesotaCare Grants**

Health Care Access	376,588,000	451,656,000

MinnesotaCare Federal Receipts. Receipts received as a result of federal participation in administering costs of the Minnesota health care reform waiver must be deposited as nondedicated revenue in the health care access fund. Receipts received as a result of federal participation in making grants must be deposited in the federal fund and must offset health care access funds for payments to providers.

MinnesotaCare Funding. The commissioner may expend money appropriated from the health care access fund for MinnesotaCare in either fiscal year of the biennium.

HealthMatch Delay. Of this appropriation, $2,560,000 in fiscal year 2008 and $21,735,000 in fiscal year 2009 are for MinnesotaCare program costs related to implementation of the HealthMatch program.

(b) **MA Basic Health Care - Families and Children**

	Appropriations by Fund	
General	761,537,000	860,106,000
Health Care Access	-0-	30,054,000

(c) **MA Basic Health Care - Elderly and Disabled**

General	1,017,377,000	1,144,341,000

Physician-Directed Care Coordination. In addition to medical assistance reimbursement

under Minnesota Statutes, sections 256B.0625 and 256B.76, clinics participating in physician-directed care coordination under Minnesota Statutes, section 256B.0625, also receive a monthly payment per client when the clinic serves an eligible client. The payments across the program must average $50 per month per client.

Services for Developmentally Disabled. Of the general fund appropriation, $4,715,000 in fiscal year 2009 is to serve: an additional 200 persons in the MR/RC waiver program; an additional 200 persons in the family support grant program under Minnesota Statutes, section 252.32; and an additional 200 persons in the semi-independent living services program under Minnesota Statutes, section 252.275.

(d) **General Assistance Medical Care Grants**

General	238,254,000	248,885,000

(e) **Other Health Care Grants**

General	3,039,000	2,709,000
Health Care Access	887,000	899,000

Care Coordination. Of the general fund appropriation, $500,000 in fiscal year 2008 and $1,000,000 in fiscal year 2009 are for the commissioner of human services for contracting for care coordination with the U special kids program under Minnesota Statutes, section 256B.0751.

Community-Based Health Care. Of the general fund appropriation, $1,050,000 for the biennium beginning July 1, 2007, is to the commissioner of human services

for the demonstration project grant described in Minnesota Statutes, section 62Q.80, subdivision 1a. This is a onetime appropriation and is available until June 30, 2012.

Community Collaboratives. Of the general fund appropriation, $330,000 in fiscal year 2008 and $850,000 in fiscal year 2009 are to provide grants to community collaboratives to cover the uninsured. These are onetime appropriations.

Health Care Payment Reform Pilot. Of the general fund appropriation, $1,018,000 in fiscal year 2008 and $1,027,000 in fiscal year 2009 are for the health care payment reform pilot project. These are onetime appropriations.

Patient Incentive Programs. Of the general fund appropriation, $500,000 in fiscal year 2008 and $500,000 in fiscal year 2009 are for patient incentive programs.

State Health Policies Grant. Of the general fund appropriation, $300,000 in fiscal year 2008 is to provide a grant to a research center associated with a safety net hospital and county-affiliated health system to develop the capabilities necessary for evaluating the effects of changes in state health policies on low-income and uninsured individuals, including the impact on state health care program costs, health outcomes, cost-shifting to different units and levels of government, and utilization patterns including use of emergency room care and hospitalization rates.

Neighborhood Health Care Network. Of the general fund appropriation, $150,000 in fiscal year 2008 and $150,000 in fiscal year 2009 are for a grant to the Neighborhood Health Care Network to maintain and staff a toll-free health care access telephone number.

Subd. 7. **Health Care Management** 54,536,000 58,714,000

Appropriations by Fund

General	36,416,000	30,589,000
Health Care Access	22,120,000	28,125,000

The amounts that may be spent from the appropriation for each purpose are as follows:

(a) **Health Care Policy Administration**

Appropriations by Fund

General	10,236,000	8,813,000
Health Care Access	2,323,000	10,074,000

Minnesota Senior Health Options Reimbursement. Federal administrative reimbursement resulting from the Minnesota senior health options project is appropriated to the commissioner for this activity.

Utilization Review. Federal administrative reimbursement resulting from prior authorization and inpatient admission certification by a professional review organization is dedicated to the commissioner for these purposes. A portion of these funds must be used for activities to decrease unnecessary pharmaceutical costs in medical assistance.

Dental Access for Persons with Disabilities. Of the general fund appropriation, $82,000 in fiscal year 2008 is for a study on access to dental services for persons with disabilities.

Base Adjustment. The health care access fund base is $10,716,000 in fiscal year 2010 and $8,870,000 in fiscal year 2011, for health care administration.

(b) **Health Care Operations**

	Appropriations by Fund	
General	22,180,000	21,776,000
Health Care Access	19,797,000	18,051,000

Base Adjustment. The general fund base is decreased by $214,000 in fiscal year 2010 for health care operations.

Subd. 8. **Continuing Care Grants** 1,701,172,000 1,861,095,000

	Appropriations by Fund	
General	1,698,689,000	1,858,712,000
Health Care Access	750,000	750,000
Lottery Prize	1,733,000	1,633,000

The amounts that may be spent from the appropriation for each purpose are as follows:

(a) **Aging and Adult Services Grants**

General	15,986,000	16,605,000

Information and Assistance Reimbursement. Federal administrative reimbursement obtained from information and assistance services provided by the Senior LinkAge Line to people who are identified as eligible for medical assistance are appropriated to the commissioner for this activity.

Senior Companion Program. Of the general fund appropriation, $191,000 in fiscal year 2008 and $191,000 in fiscal year 2009 are for the senior companion program under Minnesota Statutes, section 256.977.

Volunteer Senior Citizens. Of the general fund appropriation, $192,000 in fiscal year 2008 and $192,000 in fiscal year 2009 are for the volunteer programs for retired senior citizens under Minnesota Statutes, section 256.9753.

Foster Grandparent Program. Of the general fund appropriation, $192,000 in fiscal year 2008 and $192,000 in fiscal year 2009 are for the foster grandparent program in Minnesota Statutes, section 256.976.

Senior Nutrition. Of the general fund appropriation, $250,000 in fiscal year 2008 and $250,000 in fiscal year 2009 are for the senior nutrition programs under Minnesota Statutes, section 256.9752. The commissioner shall give priority to increase services to: (1) persons facing language or cultural barriers, (2) persons with special diets, (3) persons living in isolated rural areas, and (4) other hard-to-serve populations.

Living At Home/Block Nurse Program. Of the general fund appropriation, $580,000 in fiscal year 2008 and $655,000 in fiscal year 2009 are for the living at home/block nurse program. The purpose of the appropriation is to increase base funding levels to $25,000 per program year, provide base funding for nine programs currently operating without base funding, provide base funding for five new programs beginning July 1, 2007, and provide base funding for six additional programs beginning July 1, 2008.

$76,000 in fiscal year 2008 and $62,000 in fiscal year 2009 are for increased staff for the ombudsman for older Minnesotans and related costs.

$150,000 in fiscal year 2008 and $150,000 in fiscal year 2009 are to increase the base of the Senior LinkAge line program.

Minnesota Kinship Caregivers Association. (1) Of the general fund appropriation, $175,000 in fiscal year 2008 and $175,000 in fiscal year 2009 are transferred to a nonprofit organization experienced in kinship caregiver programs, with at least 50 percent of its board composed of kinship caregivers for purposes of providing support to grandparents or relatives who are raising kinship children.

(2) The demonstration grant sites must include the Minnesota Kinship Caregivers Association central site in the metropolitan area and another site in the Bemidji region. The support must provide a one-stop services program. The services that may be provided include but are not limited to legal services, education, information, family activities, support groups, mental health access, advocacy, mentors, and information related to foster care licensing. The funds may also be used for a media campaign to inform kinship families about available information and services, support sites, and other program development. The general fund base for the program shall be $160,000 in fiscal year 2010 and $160,000 in fiscal year 2011.

Base Adjustment. The general fund base is increased by $72,000 in fiscal year 2010 and $72,000 in fiscal year 2011 for aging and adult services grants.

(b) **Alternative Care Grants**

General	50,063,000	52,511,000

Alternative Care Transfer. Any money allocated to the alternative care program that is not spent for the purposes indicated does not cancel but is transferred to the medical assistance account.

Base Adjustment. The general fund base is increased by $547,000 in fiscal year 2010 and $784,000 in fiscal year 2011 for alternative care grants.

(c) **Medical Assistance Grants - Long-Term Care Facilities**

General	503,091,000	515,828,000

New Nursing Facility Reimbursement System Delay. Notwithstanding Minnesota Statutes, section 256B.441, subdivision 1, paragraph (c), the commissioner shall begin to phase in the new reimbursement system for nursing facilities on or after October 1, 2009.

Long-Term Care Consultation Funding Increase. For the rate year beginning October 1, 2008, the county long-term care consultation allocations in Minnesota Statutes, section 256B.0911, subdivision 6, must be increased based on the number of transitional long-term care consultation visits projected by the commissioner in each county. For the rate year beginning

October 1, 2009, final allocations must be determined based on the average between the actual number of transitional long-term care visits that were conducted in the prior 12-month period and the projected number of consultations that will be provided in the rate year beginning October 1, 2009. Notwithstanding section 7, this rider expires June 30, 2010.

Life Safety Code Compliance. Of the general fund appropriation, $2,000,000 in fiscal year 2008 is for payments to nursing facilities for life safety code compliance under Minnesota Statutes, section 256B.434, subdivision 4, paragraph (e). This is a onetime appropriation and available until spent.

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

General	966,623,000	1,099,540,000

(e) **Mental Health Grants**

	Appropriations by Fund	
General	57,522,000	60,678,000
Health Care Access	750,000	750,000
Lottery Prize	1,733,000	1,633,000

Dual Diagnosis; Demonstration Project. Of the general fund appropriation, $800,000 in fiscal year 2008 and $1,600,000 in fiscal year 2009 are to the commissioner of human services to fund the dual diagnosis demonstration project.

Mobile Mental Health Crisis Services. Of the general fund appropriation, $2,500,000 in fiscal year 2008 and $3,625,000 in fiscal year 2009 are to the commissioner of human

services for statewide funding of adult mobile mental health crisis services. Providers must utilize all available funding streams.

National Council on Problem Gambling. (1) $225,000 in fiscal year 2008 and $225,000 in fiscal year 2009 are appropriated from the lottery prize fund to the commissioner of human services for a grant to the state affiliate recognized by the National Council on Problem Gambling. The affiliate must provide services to increase public awareness of problem gambling, education, and training for individuals and organizations providing effective treatment services to problem gamblers and their families, and research relating to problem gambling. These services must be complementary to and not duplicative of the services provided through the problem gambling program administered by the commissioner of human services. This grant does not prevent the commissioner from regular monitoring and oversight of the grant or the ability to reallocate the funds to other services within the problem gambling program for nonperformance of duties by the grantee.

(2) Of this appropriation, $100,000 in fiscal year 2008 and $100,000 in fiscal year 2009 are contingent on the contribution of nonstate matching funds. Matching funds may be either cash or qualifying in-kind contributions. The commissioner of finance may disburse the state portion of the matching funds in increments of $25,000 upon receipt of a commitment for an equal amount of matching nonstate funds. The

general fund base shall be $100,000 in fiscal year 2010 and $100,000 in fiscal year 2011

(3) $100,000 in fiscal year 2008 is appropriated from the lottery prize fund to the commissioner of human services for a grant or grants to be awarded competitively to develop programs and services for problem gambling treatment, prevention, and education in immigrant communities. This appropriation is available until June 30, 2009, at which time the project must be completed and final products delivered, unless an earlier completion date is specified in the work program.

Compulsive Gambling. $300,000 in fiscal year 2008 and $100,000 in fiscal year 2009 are appropriated from the lottery prize fund to the commissioner of human services for purposes of compulsive gambling education, assessment, and treatment under Minnesota Statutes, section 245.98.

Compulsive Gambling Study. $100,000 in fiscal year 2008 is to continue the study currently being done on compulsive gambling treatment effectiveness and long-term effects of gambling.

Base Adjustment. The general fund base is increased by $266,000 in fiscal year 2010.

(f) **Deaf and Hard-of-Hearing Grants**

General	1,932,000	2,380,000

Hearing Loss Mentors. Of the general fund appropriation, $80,000 is to provide mentors who have a hearing loss to parents of newly

identified infants and children with hearing loss.

Base Adjustment. The general fund base is increased by $7,000 in fiscal year 2010 and $7,000 in fiscal year 2011 for deaf and hard-of-hearing grants.

(g) **Chemical Dependency Entitlement Grants**

General	78,749,000	89,946,000

(h) **Chemical Dependency Nonentitlement Grants**

General	1,055,000	1,055,000

(i) **Other Continuing Care Grants**

	Appropriations by Fund	
General	23,668,000	20,169,000

Native American Juvenile Treatment Center. Of the general fund appropriation, $50,000 is to conduct a feasibility study of and to predesign a Native American juvenile treatment center on or near the White Earth Reservation. The facility must house and treat Native American juveniles and provide culturally specific programming to juveniles placed in the treatment center. The commissioner of human services may contract with parties who have experience in the design and construction of juvenile treatment centers to assist in the feasibility study and predesign. On or before January 15, 2008, the commissioner shall present the results of the feasibility study and the predesign of the facility to the chairs of house of representatives and senate committees having jurisdiction over human services

finance, public safety finance, and capital investment.

Leech Lake Youth Treatment Center. Of the general fund appropriation, $75,000 in fiscal year 2008 and $75,000 in fiscal year 2009 are for a grant to the Leech Lake Youth Treatment Center project partners, in order to pay the salaries and other directly related costs associated with the development of this project.

Assistive Technology. Of the general fund appropriation, $300,000 in fiscal year 2008 is to the Minnesota State Council on Disability for the purposes of providing $100,000 in financial support to the Minnesota Regions Assistive Technology Collaborative and $200,000 in fiscal year 2008 is for a local match required to access the federal Technology-Related Assistance for Individuals with Disabilities Act, alternate finance project.

Remembering with Dignity Project. (1) $200,000 is appropriated from the general fund to the commissioner of human services to be available until September 30, 2008, to make a grant to Advocating Change Together for the purposes of the Remembering With Dignity project in clause (2).

(2) As part of the Remembering With Dignity project, the grant recipient shall:

(i) conduct necessary research on persons buried in state cemeteries who were residents of state hospitals or regional treatment centers and buried in numbered or unmarked graves;

(ii) purchase and install headstones that are properly inscribed with their names on the graves of those persons; and

(iii) collaborate with community groups and state and local government agencies to build community involvement and public awareness, ensure public access to the graves, and ensure appropriate perpetual maintenance of state cemeteries.

Base Adjustment. The general fund base is $20,276,000 in fiscal year 2010 and $20,332,000 in fiscal year 2011 for other continuing care grants.

Subd. 9. **Continuing Care Management** 20,248,000 19,400,000

Appropriations by Fund		
General	19,384,000	19,123,000
State Government Special Revenue	121,000	123,000
Health Care Access	292,000	-0-
Lottery Prize	451,000	154,000

Community Trainee and Consultation. Of the general fund appropriation, $125,000 in fiscal year 2008 is to the commissioner of human services to contract for training and consultation for clinical supervisors and staff of community mental health centers who provide services to children and adults. The purpose of the training and consultation is to improve clinical supervision of staff, strengthen compliance with federal and state rules and regulations, and to recommend strategies for standardization and simplification of administrative functions among community mental health centers.

Mental Health Tracking System. Of the general fund appropriation, $448,000 in fiscal year 2008 and $324,000 in fiscal year 2009 are to the commissioner of human services to fund implementation of the mental health services outcomes and tracking system.

Quality Management; Assurance; and Improvement System for Minnesotans Receiving Disability Services. Of the general fund appropriation, $300,000 for the biennium beginning July 1, 2007, is for the purposes of the quality management, assurance, and improvement system for Minnesotans receiving disability services. Federal Medicaid matching funds obtained for this purpose shall be dedicated to the commissioner for this purpose.

Base Adjustment. The health care access fund base is $0 in each of the fiscal years 2010 and 2011 for continuing care management.

Disability Linkage Line. Of the general fund appropriation, $650,000 in fiscal year 2008 and $626,000 in fiscal year 2009 are to establish and maintain the disability linkage line.

Subd. 10. **State-Operated Services**			266,645,000	267,718,000
General	266,645,000	267,718,000		

Transfer Authority Related to State-Operated Services. Money appropriated to finance state-operated services programs and administrative services may be transferred between fiscal years of the biennium with the approval of the commissioner of finance.

The amounts that may be spent from the appropriation for each purpose are as follows:

(a) **Mental Health Services**

General	116,270,000	120,095,000

Appropriation Limitation. No part of the appropriation in this article to the commissioner for mental health treatment services at the regional treatment centers shall be used for the Minnesota sex offender program.

(b) **Minnesota Sex Offender Services**

General	67,719,000	62,787,000

(c) **Minnesota Security Hospital and METO Services**

General	82,656,000	84,836,000

Minnesota Security Hospital. For the purposes of enhancing the safety of the public, improving supervision, and enhancing community-based mental health treatment, state-operated services may establish additional community capacity for providing treatment and supervision of clients who have been ordered into a less restrictive alternative care from the state-operated services transitional services program consistent with Minnesota Statutes, section 246.014.

Sec. 4. **COMMISSIONER OF HEALTH**

Subdivision 1. **Total Appropriation** **$ 51,557,000 $ 45,785,000**

Appropriations by Fund

	2008	2009
General	15,385,000	16,213,000

State Government				
Special Revenue	13,309,000	13,309,000		
Health Care Access	22,863,000	16,263,000		
Subd. 2. **Policy, Quality, and Compliance**			51,557,000	45,785,000
Appropriations by Fund				
General	15,385,000	16,213,000		
State Government				
Special Revenue	13,309,000	13,309,000		
Health Care Access	22,863,000	16,263,000		

Health Care Access Survey. Of the health care access fund appropriation, $600,000 in fiscal year 2008 is appropriated to the commissioner to conduct a health insurance survey of Minnesota households, in partnership with the State Health Access Data Assistance Center at the University of Minnesota. The commissioner shall contract with the State Health Access Data Assistance Center to conduct a survey that provides information on the characteristics of the uninsured in Minnesota and the reasons for changing patterns of insurance coverage and access to health care services. This appropriation shall become part of the agency's base budget for even-numbered fiscal years.

MERC. Of the general fund appropriation, $8,000,000 each fiscal year is for distribution of MERC grants as follows:

(1) $5,000,000 according to Minnesota Statutes, section 62J.692, subdivision 4, paragraph (c);

(2) $900,000 according to Minnesota Statutes, section 62J.692, subdivision 4, paragraph (d);

(3) $100,000 according to Minnesota Statutes, section 62J.692, subdivision 4, paragraph (e); and

(4) $2,000,000 according to Minnesota Statutes, section 62J.692, subdivision 7a, paragraph (b).

Health Information Technology. Of the health care access fund appropriation, $6,750,000 each fiscal year is to implement Minnesota Statutes, section 144.3345. Up to $350,000 each fiscal year is available for grant administration and health information technology technical assistance and $6,400,000 each year is to be transferred to the commissioner of finance to establish and implement a revolving account under Minnesota Statutes, section 62J.496. This appropriation shall not be included in the agency's base budget for the fiscal year beginning July 1, 2009.

Health Insurance Exchange. Of the health care access fund appropriation, $6,000,000 in fiscal year 2008 is appropriated to the commissioner to establish the health insurance exchange in Minnesota Statutes, section 62A.76. Up to $50,000 in fiscal year 2008 is available for administrative costs incurred by the Department of Health in establishing and providing grant funding to the legal entity responsible for implementing the health insurance exchange. This is a onetime appropriation.

Hearing Aid Loan Bank. Of the general fund appropriation, $70,000 in fiscal year 2008 and $70,000 in fiscal year 2009 are

for the purpose of providing a statewide hearing aid and instrument loan bank to families with children newly diagnosed with hearing loss from birth to the age of ten. This appropriation shall cover the administrative costs of the program.

Uncompensated Care Fund. Of the general fund appropriation, $65,000 in fiscal year 2008 is for the commissioner of health to study and present recommendations to the governor and the legislature by January 15, 2008, on the design, operation, and funding of an uncompensated care fund to be used to provide subsidies to hospitals, community clinics, federally qualified health centers, community mental health centers, and other health care providers that serve a disproportionately large percentage of uninsured patients. An organization must not provide or perform abortion services under this program.

Community Collaboratives. Of the general fund appropriation, $300,000 for the biennium beginning July 1, 2007, is to the commissioner of health to provide grants to community collaboratives to cover the uninsured. This is a onetime appropriation.

Uniform Electronic Transactions. Of the general fund appropriation, $146,000 in fiscal year 2008 is for development of uniform electronic transactions and implementation guide standards under Minnesota Statutes, section 62J.536.

Medical Home Learning Collaborative. Of the general fund appropriation, $500,000

in fiscal year 2008 and $500,000 in fiscal year 2009 are to expand the medical home learning collaborative initiative in collaboration with the commissioner of human services. Services provided under this funding must support a medical home model for children with special health care needs. The collaborative shall report back to the legislature on use of the funds by January 15, 2010.

Federally Qualified Health Centers. Of the general fund appropriation, $3,000,000 in fiscal year 2008 and $3,900,000 in fiscal year 2009 are for subsidies to federally qualified health centers under Minnesota Statutes, section 145.9269.

Sec. 5. **TRANSFERS.**

Subdivision 1. **Grants.** The commissioner of human services, with the approval of the commissioner of finance and after notifying the chairs of the senate and house committees with jurisdiction, may transfer unencumbered appropriation balances for the biennium ending June 30, 2009, within fiscal years among the MFIP; general assistance; general assistance medical care; medical assistance; MFIP child care assistance under Minnesota Statutes, section 119B.05; Minnesota supplemental aid and group residential housing programs; and the entitlement portion of the chemical dependency consolidated treatment fund and between fiscal years of the biennium.

Subd. 2. **Administration.** 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 as the commissioners and the board consider necessary, with the advance approval of the commissioner of finance. The commissioner or the board shall inform the chairs of the house and senate committees with jurisdiction quarterly about transfers made under this provision.

Sec. 6. **INDIRECT COSTS NOT TO FUND PROGRAMS.**

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.

Sec. 7. **SUNSET OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2009, unless a different expiration date is explicit.

Sec. 8. **EFFECTIVE DATE.**

The provisions in this article are effective July 1, 2007, unless a different effective date is specified.

APPENDIX
Repealed Minnesota Statutes: CEH0297-1

62J.052 PROVIDER COST DISCLOSURE.

Subdivision 1. **Health care providers.** (a) Each health care provider, as defined by section 62J.03, subdivision 8, except hospitals and outpatient surgical centers subject to the requirements of section 62J.823, shall provide the following information:

(1) the average allowable payment from private third-party payers for the 50 services or procedures most commonly performed;

(2) the average payment rates for those services and procedures for medical assistance;

(3) the average charge for those services and procedures for individuals who have no applicable private or public coverage; and

(4) the average charge for those services and procedures, including all patients.

(b) This information shall be updated annually and be readily available at no cost to the public on site.

62J.17 EXPENDITURE REPORTING.

Subdivision 1. **Purpose.** To ensure access to affordable health care services for all Minnesotans it is necessary to restrain the rate of growth in health care costs. An important factor believed to contribute to escalating costs may be the purchase of costly new medical equipment, major capital expenditures, and the addition of new specialized services. After spending limits are established under section 62J.04, providers, patients, and communities will have the opportunity to decide for themselves whether they can afford capital expenditures or new equipment or specialized services within the constraints of a spending limit. In this environment, the state's role in reviewing these spending commitments can be more limited. However, during the interim period until spending targets are established, it is important to prevent unrestrained major spending commitments that will contribute further to the escalation of health care costs and make future cost containment efforts more difficult. In addition, it is essential to protect against the possibility that the legislature's expression of its attempt to control health care costs may lead a provider to make major spending commitments before targets or other cost containment constraints are fully implemented because the provider recognizes that the spending commitment may not be considered appropriate, needed, or affordable within the context of a fixed budget for health care spending. Therefore, the legislature finds that a requirement for reporting health care expenditures is necessary.

Subd. 5a. **Retrospective review.** (a) The commissioner shall retrospectively review each major spending commitment and notify the provider of the results of the review. The commissioner shall determine whether the major spending commitment was appropriate. In making the determination, the commissioner may consider the following criteria: the major spending commitment's impact on the cost, access, and quality of health care; the clinical effectiveness and cost-effectiveness of the major spending commitment; and the alternatives available to the provider.

(b) The commissioner may not prevent or prohibit a major spending commitment subject to retrospective review. However, if the provider fails the retrospective review, any major spending commitments by that provider for the five-year period following the commissioner's decision are subject to prospective review under subdivision 6a.

Subd. 6a. **Prospective review and approval.** (a) No health care provider subject to prospective review under this subdivision shall make a major spending commitment unless:

(1) the provider has filed an application with the commissioner to proceed with the major spending commitment and has provided all supporting documentation and evidence requested by the commissioner; and

(2) the commissioner determines, based upon this documentation and evidence, that the major spending commitment is appropriate under the criteria provided in subdivision 5a in light of the alternatives available to the provider.

(b) A provider subject to prospective review and approval shall submit an application to the commissioner before proceeding with any major spending commitment. The application must address each item listed in subdivision 4a, paragraph (a), and must also include documentation to support the response to each item. The provider may submit information, with supporting documentation, regarding why the major spending commitment should be excepted from prospective review under subdivision 7. The submission may be made either in addition to or instead of the submission of information relating to the items listed in subdivision 4a, paragraph (a).

(c) The commissioner shall determine, based upon the information submitted, whether the major spending commitment is appropriate under the criteria provided in subdivision 5a, or whether it should be excepted from prospective review under subdivision 7. In making this determination, the commissioner may also consider relevant information from other sources. At the request of the commissioner, the health technology advisory committee shall convene an expert review panel made up of persons with knowledge and expertise regarding medical equipment, specialized services, health care expenditures, and capital expenditures to review applications and make recommendations to the commissioner. The commissioner shall make a decision on the application within 60 days after an application is received.

(d) The commissioner of health has the authority to issue fines, seek injunctions, and pursue other remedies as provided by law.

Subd. 8. **Radiation therapy facilities.** This subdivision shall apply only to those major spending commitments that are related to the purchase, construction, or leasing of a radiation therapy facility.

(a) The term "provider" shall mean:

(1) a provider as defined in section 62J.03, subdivision 8;

(2) a person or organization that, upon engaging in an activity related to a major spending commitment, will become a provider as defined in section 62J.03, subdivision 8;

(3) an organization under common control with an organization described in clause (1) or (2); or

(4) an organization that manages a person or organization described in clause (1), (2), or (3).

(b) In conducting the retrospective or prospective review, the commissioner shall consider the criteria described in subdivision 5a, paragraph (a), in determining whether the major spending commitment was appropriate. In addition, the commissioner shall consider the following criteria:

(1) the alternatives available to patients in terms of avoiding an unwarranted duplication based on whether additional capacity is needed of services, facilities, or equipment in and around the location of the major spending commitment; and

(2) the best interests of the patients, including conflicts of interest that may be present in influencing the utilization of the services, facility, or equipment relating to the major spending commitment.

(c) In addition to subdivision 6a, paragraph (c), the commissioner has the authority to pursue the following remedies:

(1) assessment of fines against providers violating subdivision 6a, paragraph (a), of up to triple the amount of the major spending commitment;

(2) securing a permanent injunction against providers violating subdivision 6a, paragraph (a), halting the purchase or construction of a facility, prohibiting the operation of a facility, or the providing of a service related to the major spending commitment; and

(3) obtaining a court order to invalidate any purchase agreement, management agreement, lease, or other contract relating to the major spending commitment or the conduct of any activity relating to the major spending commitment.

(d) If a provider fails the retrospective review of a major spending commitment that is identified under this subdivision, the prospective review and approval required under subdivision 6a shall be limited to major spending commitments that are identified under this subdivision.

(e) The provisions of this subdivision do not apply to radiation therapy facilities owned and operated or managed by a hospital licensed under chapter 144.

144.335 ACCESS TO HEALTH RECORDS.

Subdivision 1. **Definitions.** For the purposes of this section, the following terms have the meanings given them:

(a) "Patient" means a natural person who has received health care services from a provider for treatment or examination of a medical, psychiatric, or mental condition, the surviving spouse and parents of a deceased patient, or a person the patient appoints in writing as a representative, including a health care agent acting pursuant to chapter 145C, unless the authority of the agent has been limited by the principal in the principal's health care directive. Except for minors who have received health care services pursuant to sections 144.341 to 144.347, in the case of a minor, patient includes a parent or guardian, or a person acting as a parent or guardian in the absence of a parent or guardian.

(b) "Provider" means (1) any person who furnishes health care services and is regulated to furnish the services pursuant to chapter 147, 147A, 147B, 147C, 147D, 148, 148B, 148C, 148D, 150A, 151, 153, or 153A; (2) a home care provider licensed under section 144A.46; (3) a

health care facility licensed pursuant to this chapter or chapter 144A; (4) a physician assistant registered under chapter 147A; and (5) an unlicensed mental health practitioner regulated pursuant to sections 148B.60 to 148B.71.

(c) "Individually identifiable form" means a form in which the patient is or can be identified as the subject of the health records.

Subd. 2. **Patient access.** (a) Upon request, a provider shall supply to a patient complete and current information possessed by that provider concerning any diagnosis, treatment and prognosis of the patient in terms and language the patient can reasonably be expected to understand.

(b) Except as provided in paragraph (e), upon a patient's written request, a provider, at a reasonable cost to the patient, shall promptly furnish to the patient (1) copies of the patient's health record, including but not limited to laboratory reports, x-rays, prescriptions, and other technical information used in assessing the patient's health condition, or (2) the pertinent portion of the record relating to a condition specified by the patient. With the consent of the patient, the provider may instead furnish only a summary of the record. The provider may exclude from the health record written speculations about the patient's health condition, except that all information necessary for the patient's informed consent must be provided.

(c) If a provider, as defined in subdivision 1, clause (b)(1), reasonably determines that the information is detrimental to the physical or mental health of the patient, or is likely to cause the patient to inflict self harm, or to harm another, the provider may withhold the information from the patient and may supply the information to an appropriate third party or to another provider, as defined in subdivision 1, clause (b)(1). The other provider or third party may release the information to the patient.

(d) A provider as defined in subdivision 1, clause (b)(3), shall release information upon written request unless, prior to the request, a provider as defined in subdivision 1, clause (b)(1), has designated and described a specific basis for withholding the information as authorized by paragraph (c).

(e) A provider may not release a copy of a videotape of a child victim or alleged victim of physical or sexual abuse without a court order under section 13.03, subdivision 6, or as provided in section 611A.90. This paragraph does not limit the right of a patient to view the videotape.

Subd. 3. **Provider transfers and loans.** A patient's health record, including but not limited to, laboratory reports, x-rays, prescriptions, and other technical information used in assessing the patient's condition, or the pertinent portion of the record relating to a specific condition, or a summary of the record, shall promptly be furnished to another provider upon the written request of the patient. The written request shall specify the name of the provider to whom the health record is to be furnished. The provider who furnishes the health record or summary may retain a copy of the materials furnished. The patient shall be responsible for the reasonable costs of furnishing the information.

Subd. 3a. **Patient consent to release of records; liability.** (a) A provider, or a person who receives health records from a provider, may not release a patient's health records to a person without a signed and dated consent from the patient or the patient's legally authorized representative authorizing the release, unless the release is specifically authorized by law. Except as provided in paragraph (c) or (d), a consent is valid for one year or for a lesser period specified in the consent or for a different period provided by law.

(b) This subdivision does not prohibit the release of health records:

(1) for a medical emergency when the provider is unable to obtain the patient's consent due to the patient's condition or the nature of the medical emergency; or

(2) to other providers within related health care entities when necessary for the current treatment of the patient.

(c) Notwithstanding paragraph (a), if a patient explicitly gives informed consent to the release of health records for the purposes and pursuant to the restrictions in clauses (1) and (2), the consent does not expire after one year for:

(1) the release of health records to a provider who is being advised or consulted with in connection with the current treatment of the patient;

(2) the release of health records to an accident and health insurer, health service plan corporation, health maintenance organization, or third-party administrator for purposes of payment of claims, fraud investigation, or quality of care review and studies, provided that:

(i) the use or release of the records complies with sections 72A.49 to 72A.505;

(ii) further use or release of the records in individually identifiable form to a person other than the patient without the patient's consent is prohibited; and

(iii) the recipient establishes adequate safeguards to protect the records from unauthorized disclosure, including a procedure for removal or destruction of information that identifies the patient.

(d) Notwithstanding paragraph (a), health records may be released to an external researcher solely for purposes of medical or scientific research only as follows:

(1) health records generated before January 1, 1997, may be released if the patient has not objected or does not elect to object after that date;

(2) for health records generated on or after January 1, 1997, the provider must:

(i) disclose in writing to patients currently being treated by the provider that health records, regardless of when generated, may be released and that the patient may object, in which case the records will not be released; and

(ii) use reasonable efforts to obtain the patient's written general authorization that describes the release of records in item (i), which does not expire but may be revoked or limited in writing at any time by the patient or the patient's authorized representative;

(3) authorization may be established if an authorization is mailed at least two times to the patient's last known address with a postage prepaid return envelope and a conspicuous notice that the patient's medical records may be released if the patient does not object, and at least 60 days have expired since the second notice was sent; and the provider must advise the patient of the rights specified in clause (4); and

(4) the provider must, at the request of the patient, provide information on how the patient may contact an external researcher to whom the health record was released and the date it was released.

In making a release for research purposes the provider shall make a reasonable effort to determine that:

(i) the use or disclosure does not violate any limitations under which the record was collected;

(ii) the use or disclosure in individually identifiable form is necessary to accomplish the research or statistical purpose for which the use or disclosure is to be made;

(iii) the recipient has established and maintains adequate safeguards to protect the records from unauthorized disclosure, including a procedure for removal or destruction of information that identifies the patient; and

(iv) further use or release of the records in individually identifiable form to a person other than the patient without the patient's consent is prohibited.

(e) A person who negligently or intentionally releases a health record in violation of this subdivision, or who forges a signature on a consent form, or who obtains under false pretenses the consent form or health records of another person, or who, without the person's consent, alters a consent form, is liable to the patient for compensatory damages caused by an unauthorized release, plus costs and reasonable attorney's fees.

(f) Upon the written request of a spouse, parent, child, or sibling of a patient being evaluated for or diagnosed with mental illness, a provider shall inquire of a patient whether the patient wishes to authorize a specific individual to receive information regarding the patient's current and proposed course of treatment. If the patient so authorizes, the provider shall communicate to the designated individual the patient's current and proposed course of treatment. Paragraph (a) applies to consents given under this paragraph.

(g) Notwithstanding paragraph (a), a provider must disclose health records relating to a patient's mental health to a law enforcement agency if the law enforcement agency provides the name of the patient and communicates that the:

(1) patient is currently involved in an emergency interaction with the law enforcement agency; and

(2) disclosure of the records is necessary to protect the health or safety of the patient or of another person.

The scope of disclosure under this paragraph is limited to the minimum necessary for law enforcement to respond to the emergency. A law enforcement agency that obtains health records under this paragraph shall maintain a record of the requestor, the provider of the information, and the patient's name. Health records obtained by a law enforcement agency under this paragraph are private data on individuals as defined in section 13.02 and must not be used by law enforcement for any other purpose.

(h) In cases where a provider releases health records without patient consent as authorized by law, the release must be documented in the patient's health record. In the case of a release under paragraph (g), the documentation must include the date and circumstances under which the release was made, the person or agency to whom the release was made, and the records that were released.

Subd. 3b. **Release of records to commissioner of health or Health Data Institute.** Subdivision 3a does not apply to the release of health records to the commissioner of health or the Health Data Institute under chapter 62J, provided that the commissioner encrypts the patient identifier upon receipt of the data.

Subd. 3c. **Independent medical examination.** This section applies to the subject and provider of an independent medical examination requested by or paid for by a third party. Notwithstanding subdivision 3a, a provider may release health records created as part of an independent medical examination to the third party who requested or paid for the examination.

Subd. 3d. **Release of records for family and caretaker involvement in mental health care.** (a) Notwithstanding subdivision 3a, a provider providing mental health care and treatment may disclose health record information described in paragraph (b) about a patient to a family member of the patient or other person who requests the information if:

(1) the request for information is in writing;

(2) the family member or other person lives with, provides care for, or is directly involved in monitoring the treatment of the patient;

(3) the involvement under clause (2) is verified by the patient's mental health care provider, the patient's attending physician, or a person other than the person requesting the information, and is documented in the patient's medical record;

(4) before the disclosure, the patient is informed in writing of the request, the name of the person requesting the information, the reason for the request, and the specific information being requested;

(5) the patient agrees to the disclosure, does not object to the disclosure, or is unable to consent or object, and the patient's decision or inability to make a decision is documented in the patient's medical record; and

(6) the disclosure is necessary to assist in the provision of care or monitoring of the patient's treatment.

(b) The information disclosed under this subdivision is limited to diagnosis, admission to or discharge from treatment, the name and dosage of the medications prescribed, side effects of the medication, consequences of failure of the patient to take the prescribed medication, and a summary of the discharge plan.

(c) If a provider reasonably determines that providing information under this subdivision would be detrimental to the physical or mental health of the patient or is likely to cause the patient to inflict self harm or to harm another, the provider must not disclose the information.

(d) This subdivision does not apply to disclosures for a medical emergency or to family members as authorized or required under subdivision 3a, paragraph (b), clause (1), or paragraph (f).

Subd. 4. **Additional patient rights.** The rights set forth in this section are in addition to the rights set forth in sections 144.651 and 144.652 and any other provision of law relating to the access of a patient to the patient's health records.

Subd. 5. **Costs.** (a) When a patient requests a copy of the patient's record for purposes of reviewing current medical care, the provider must not charge a fee.

(b) When a provider or its representative makes copies of patient records upon a patient's request under this section, the provider or its representative may charge the patient or the patient's representative no more than 75 cents per page, plus $10 for time spent retrieving and copying the records, unless other law or a rule or contract provide for a lower maximum charge. This limitation does not apply to x-rays. The provider may charge a patient no more than the actual cost of reproducing x-rays, plus no more than $10 for the time spent retrieving and copying the x-rays.

(c) The respective maximum charges of 75 cents per page and $10 for time provided in this subdivision are in effect for calendar year 1992 and may be adjusted annually each calendar year as provided in this subdivision. The permissible maximum charges shall change each year by an amount that reflects the change, as compared to the previous year, in the Consumer Price Index for all Urban Consumers, Minneapolis-St. Paul (CPI-U), published by the Department of Labor.

(d) A provider or its representative must not charge a fee to provide copies of records requested by a patient or the patient's authorized representative if the request for copies of records is for purposes of appealing a denial of Social Security disability income or Social Security disability benefits under title II or title XVI of the Social Security Act. For the purpose of further appeals, a patient may receive no more than two medical record updates without charge, but only for medical record information previously not provided. For purposes of this paragraph, a patient's authorized representative does not include units of state government engaged in the adjudication of Social Security disability claims.

Subd. 5a. **Notice of rights; information on release.** A provider shall provide to patients, in a clear and conspicuous manner, a written notice concerning practices and rights with respect to access to health records. The notice must include an explanation of:

(1) disclosures of health records that may be made without the written consent of the patient, including the type of records and to whom the records may be disclosed; and

(2) the right of the patient to have access to and obtain copies of the patient's health records and other information about the patient that is maintained by the provider.

The notice requirements of this paragraph are satisfied if the notice is included with the notice and copy of the patient and resident bill of rights under section 144.652 or if it is displayed prominently in the provider's place of business. The commissioner of health shall develop the notice required in this subdivision and publish it in the State Register.

Subd. 6. **Violation.** A violation of this section may be grounds for disciplinary action against a provider by the appropriate licensing board or agency.

252.21 COUNTY BOARDS MAY MAKE GRANTS FOR DEVELOPMENTAL ACHIEVEMENT CENTER SERVICES FOR CHILDREN WITH DEVELOPMENTAL DISABILITIES.

In order to assist county boards in carrying out responsibilities for the provision of daytime developmental achievement center services for eligible children, the county board or boards are hereby authorized to make grants, within the limits of the money appropriated, to developmental achievement centers for services to children with developmental disabilities. In order to fulfill its responsibilities to children with developmental disabilities as required by sections 125A.03 to 125A.48, and 125A.65, a county board may, beginning January 1, 1983, contract with developmental achievement centers or other providers.

252.22 APPLICANTS FOR ASSISTANCE; TAX LEVY.

Any city, town, governmental entity, nonprofit corporation, or any combination thereof, may apply to the county board for assistance in establishing and operating a developmental achievement center and program for children with developmental disabilities. Application for such assistance shall be on forms supplied by the board. Each applicant shall annually submit to the board its plan and budget for the next fiscal year. No applicant shall be eligible for a grant hereunder unless its plan and budget have been approved by the board.

Any city, town, or county is authorized, at the discretion of its governing body, to make grants from special tax revenues or from its general revenue fund to any nonprofit organization, governmental or corporate, within or outside its jurisdiction, that has established a developmental achievement center for children with developmental disabilities. Nothing contained herein shall in any way preclude the use of funds available for this purpose under any existing statute or charter provision relating to cities, towns, and counties.

252.23 ELIGIBILITY REQUIREMENTS.

A developmental achievement center shall:

(1) provide developmental services to children with developmental disabilities who can benefit from the program of services; and

(2) comply with all rules duly adopted by the commissioner of human services.

252.24 DUTIES OF COUNTY BOARDS.

Subdivision 1. **Selection of developmental achievement centers.** The county board shall administer developmental achievement services. The county board shall ensure that transportation is provided for children who fulfill the eligibility requirements of section 252.23, clause (1), utilizing the most efficient and reasonable means available. The county board may contract for developmental achievement services and transportation from a center which is licensed under the provisions of sections 245A.01 to 245A.16, 252.28, and 257.175, and in the board's opinion, best provides daytime developmental achievement services for children with developmental disabilities within the appropriation and resources made available for this purpose. Daytime developmental achievement services administered by the county board shall comply with standards established by the commissioner pursuant to subdivision 2 and applicable federal regulations.

Subd. 2. **Supervision of projects; promulgation of rules.** The commissioner of human services shall closely supervise any developmental achievement center receiving a grant under sections 252.21 to 252.25. The commissioner shall promulgate rules in the manner provided by

law as necessary to carry out the purposes of sections 252.21 to 252.25, including but not limited to rules pertaining to facilities for housing developmental achievement centers, administration of centers, and eligibility requirements for admission and participation in activities of the center.

Subd. 3. **Payment procedure.** The board at the beginning of each year, shall allocate available money for developmental achievement services for disbursement during the year to those centers that have been selected to receive grants and whose plans and budgets have been approved. The board shall, from time to time during the fiscal year, review the budgets, expenditures and programs of the various centers and if it determines that any amount of funds are not needed for any particular center to which they were allocated, it may, after 30 days' notice, withdraw such funds as are unencumbered and reallocate them to other centers. It may withdraw all funds from any center upon 90 days' notice whose program is not being administered in accordance with its approved plan and budget.

Subd. 4. **Fees.** The county board may, with the approval of the commissioner, establish a schedule of fees for daytime developmental achievement services. No child, or family of a child, with developmental disabilities shall be denied daytime developmental achievement services because of an inability to pay such a fee.

Subd. 5. **Developmental achievement centers: salary adjustment per diem.** The commissioner shall approve a two percent increase in the payment rates for day training and habilitation services vendors effective July 1, 1991. All revenue generated shall be used by vendors to increase salaries, fringe benefits, and payroll taxes by at least three percent for personnel below top management. County boards shall amend contracts with vendors to require that all revenue generated by this provision is expended on salary increases to staff below top management. County boards shall verify in writing to the commissioner that each vendor has complied with this requirement. If a county board determines that a vendor has not complied with this requirement for a specific contract period, the county board shall reduce the vendor's payment rates for the next contract period to reflect the amount of money not spent appropriately. The commissioner shall modify reporting requirements for vendors and counties as necessary to monitor compliance with this provision.

252.25 BOARD OF DIRECTORS.

Every city, town, governmental entity, nonprofit corporation, or combination thereof, establishing a developmental achievement center for children with developmental disabilities shall, before it comes under the terms of sections 252.21 to 252.25, appoint a board of directors for the center program. When any city or town singly establishes such a center, such board shall be appointed by the chief executive officer of the city or the chair of the governing board of the town. When any combination of cities, towns, or nonprofit corporations, establishes such a center, the chief executive officers of the cities or nonprofit corporations and the chair of the governing bodies of the towns shall appoint the board of directors. If a nonprofit corporation singly establishes such a center, its chief executive officer shall appoint the board of directors of the center. Membership on a board of directors while not mandatory, should be representative of local health, education and welfare departments, medical societies, mental health centers, associations concerned with developmental disabilities, civic groups, and the general public. Nothing in sections 252.21 to 252.25 shall be construed to preclude the appointment of elected or appointed public officials or members of the board of directors of the sponsoring nonprofit corporation to such board of directors, or public schools from administering programs under their present administrative structure.

252.261 EXISTENCE.

Any daytime activity center in existence on September 1, 1977, shall be deemed to be a developmental achievement center for the purposes of sections 252.21 to 252.25.

252.275 SEMI-INDEPENDENT LIVING SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES.

Subd. 5. **Displaced hospital workers.** Providers of semi-independent living services shall make reasonable efforts to hire qualified employees of regional treatment center developmental disability units who have been displaced by reorganization, closure, or consolidation of regional treatment center developmental disability units.

254A.02 DEFINITIONS.

Subd. 7. **Intoxicated person.** "Intoxicated person" means a person whose mental or physical functioning is substantially impaired as a result of the use of alcohol, or other drugs.

Subd. 9. **Program director.** "Program director" means the director of any approved treatment program responsible under Laws 1973, chapter 572 for the examination, treatment or making of recommendations with respect to care and treatment of any person subject to the provisions of Laws 1973, chapter 572.

Subd. 12. **Area mental health board or area board.** "Area mental health board" or "area board" means a board established pursuant to sections 245.61 to 245.69.

Subd. 14. **Youth.** "Youth" means any person 18 years of age or under.

Subd. 15. **Underserved populations.** "Underserved populations" means identifiable groups of significant numbers which do not have available to them sufficient programs and services designed to meet their special alcoholism and chemical dependency needs.

Subd. 16. **Affected employee.** "Affected employee" means an employee whose job performance is substantially affected by chemical dependency.

254A.085 HENNEPIN COUNTY PILOT ALTERNATIVE FOR CHEMICAL DEPENDENCY SERVICES.

The commissioner of human services shall grant variances from the requirements of Minnesota Rules, parts 9530.4100 to 9530.4450, and the commissioner of health shall grant variances from the requirements of Minnesota Rules, parts 4665.0100 to 4665.9900, that are consistent with the provisions of this section and do not compromise the health or safety of the clients, to establish a nonmedical detoxification pilot program in Hennepin County. The program shall be designed to provide care in a secure shelter for persons diverted or referred from detoxification facilities, so as to prevent chronic recidivism and ensure appropriate treatment referrals for persons who are chemically dependent. For purposes of this section, a "secure shelter" is a facility licensed by the commissioner of human services under Minnesota Rules, parts 9530.4100 to 9530.4450, and this section, and by the commissioner of health as a supervised living facility to provide care for chemically dependent persons. A secure shelter is considered a treatment facility under section 253B.02, subdivision 19. The secure facility authorized by this section shall be licensed by the commissioner of human services only after the county has entered into a contract for the detoxification program authorized by section 254A.086.

The pilot program established under this section must have standards for using video and advocacy group members for monitoring and surveillance to ensure the safety of clients and staff. In addition, in hiring staff, the program must ensure that the criminal background check requirements of Minnesota Rules, part 9543.3040, are met; and the commissioner of human services must ensure compliance with chapter 245C. The program administrator and all staff of a secure shelter who observe or have personal knowledge of violations of section 626.556 or 626.557 must report to the Office of the Ombudsman for Mental Health and Developmental Disabilities within 24 hours of its occurrence, any serious injury, as defined in section 245.91, subdivision 6, or the death of a person admitted to the shelter. The ombudsman shall acknowledge in writing the receipt of all reports made to the ombudsman's office under this section. Acknowledgment must be mailed to the facility and to the county social service agency within five working days of the day the report was made. In addition, the program administrator and staff of the facility must comply with all of the requirements of section 626.557, the Vulnerable Adults Act. If the program administrator does not suspend the alleged perpetrator during the pendency of the investigation, reasons for not doing so must be given to the ombudsman in writing.

The licenseholder, in coordination with the commissioner of human services, shall keep detailed records of admissions, length of stay, client outcomes according to standards set by the commissioner, discharge destinations, referrals, and costs of the program. The commissioner of human services shall report to the legislature by February 15, 1996, on the operation of the program and shall include recommendations on whether such a program has been shown to be an effective, safe, and cost-efficient way to serve clients.

254A.086 CULTURALLY TARGETED DETOXIFICATION PROGRAM.

The commissioner of human services shall provide technical assistance to enable development of a special program designed to provide culturally targeted detoxification services in accordance with section 254A.08, subdivision 2. The program must meet the standards of Minnesota Rules, parts 9530.4100 to 9530.4450, as they apply to detoxification programs. The program established under this section must have standards for using video and advocacy group members for monitoring and surveillance to ensure the safety of clients and staff. In addition,

in hiring staff, the program must ensure that the criminal background check requirements of Minnesota Rules, part 9543.3040, are met; and the commissioner of human services must ensure compliance with chapter 245C. The program administrator and all staff of the facility must report to the Office of the Ombudsman for Mental Health and Developmental Disabilities within 24 hours of its occurrence, any serious injury, as defined in section 245.91, subdivision 6, or the death of a person admitted to the shelter. The ombudsman shall acknowledge in writing the receipt of all reports made to the ombudsman's office under this section. Acknowledgment must be mailed to the facility and to the county social service agency within five working days of the day the report was made. In addition, the program administrator and staff of the facility must comply with all of the requirements of section 626.557, the Vulnerable Adults Act. The program shall be designed with a community outreach component and shall provide services to clients in a safe environment and in a culturally specific manner.

254A.12 AFFECTED EMPLOYEES.

County boards may enter into one or more purchase of service agreements to provide services to employers to develop personnel practices for prevention of alcoholism and other chemical dependency, and to assist affected employees in gaining access to care through identification and referral services.

254A.14 SERVICES TO YOUTH AND OTHER UNDERSERVED POPULATIONS.

Subdivision 1. **Identification.** County boards may enter into one or more purchase of service agreements to provide services related to the prevention of chemical dependency to persons and groups which have responsibility for, and access to, youth and other underserved populations. The boards may also enter into purchase of service agreements to assist youth and other underserved populations in gaining access to care.

Subd. 2. **Treatment facilities.** If, as a result of programs authorized under subdivision 1, significant numbers of persons are identified for whom treatment and aftercare programs are not available, county boards may request funds from the commissioner to develop treatment and aftercare capabilities.

Subd. 3. **Grants for treatment of high-risk youth.** The commissioner of human services shall award grants on a pilot project basis to develop culturally specific chemical dependency treatment programs for minority and other high-risk youth, including those enrolled in area learning centers, those presently in residential chemical dependency treatment, and youth currently under commitment to the commissioner of corrections or detained under chapter 260. Proposals submitted under this section shall include an outline of the treatment program components, a description of the target population to be served, and a protocol for evaluating the program outcomes.

254A.15 AFFIRMATIVE OUTREACH.

The commissioner shall design and implement a plan of affirmative outreach to encourage utilization of the services authorized in sections 254A.031, 254A.12, and 254A.14. The plan may include purchase of services by the commissioner to carry out the plan.

254A.16 RESPONSIBILITIES OF THE COMMISSIONER.

Subd. 5. **Professional standards.** The commissioner may by rule adopt any or all of the standards for chemical dependency professionals established by the Institute for Chemical Dependency Professionals of Minnesota, Inc., when professional standards are necessary in the regulation of chemical dependency programs, treatment facilities, or services or whenever the commissioner may require individuals involved in providing chemical dependency treatment to be qualified and have demonstrated competence in assessment and treatment skills. The commissioner may also by rule provide that persons certified by the Institute for Chemical Dependency Professionals of Minnesota, Inc., are deemed competent to perform the functions of chemical dependency professionals.

254A.175 CHEMICAL DEPENDENCY TREATMENT MODELS FOR FAMILIES WITH POTENTIAL CHILD PROTECTION PROBLEMS.

The commissioner shall explore and experiment with different chemical dependency service models for parents with children who are found to be in need of chemical dependency

treatment pursuant to an assessment under section 626.556, subdivision 10, or a case plan under section 260C.201, subdivision 6, or 260C.212. The commissioner shall tailor services to better serve this high-risk population, which may include long-term treatment that allows the children to stay with the parent at the treatment facility.

254A.18 STATE CHEMICAL HEALTH INDEX MODEL.

The commissioner of human services, in consultation with the Chemical Abuse Prevention Resource Council, shall develop and test a chemical health index model to help assess the state's chemical health and coordinate state policy and programs relating to chemical abuse prevention and treatment. The chemical health index model shall assess a variety of factors known to affect the use and abuse of chemicals in different parts of the state including, but not limited to, demographic factors, risk factors, health care utilization, drug-related crime, productivity, resource availability, and overall health.

256.969 PAYMENT RATES.

Subd. 27. **Quarterly payment adjustment.** (a) In addition to any other payment under this section, the commissioner shall make the following payments effective July 1, 2007:

(1) for a hospital located in Minnesota and not eligible for payments under subdivision 20, with a medical assistance inpatient utilization rate greater than 17.8 percent of total patient days as of the base year in effect on July 1, 2005, a payment equal to 13 percent of the total of the operating and property payment rates;

(2) for a hospital located in Minnesota in a specified urban area outside of the seven-county metropolitan area and not eligible for payments under subdivision 20, with a medical assistance inpatient utilization rate less than or equal to 17.8 percent of total patient days as of the base year in effect on July 1, 2005, a payment equal to ten percent of the total of the operating and property payment rates. For purposes of this clause, the following cities are specified urban areas: Detroit Lakes, Rochester, Willmar, Alexandria, Austin, Cambridge, Brainerd, Hibbing, Mankato, Duluth, St. Cloud, Grand Rapids, Wyoming, Fergus Falls, Albert Lea, Winona, Virginia, Thief River Falls, and Wadena; and

(3) for a hospital located in Minnesota but not located in a specified urban area under clause (2), with a medical assistance inpatient utilization rate less than or equal to 17.8 percent of total patient days as of the base year in effect on July 1, 2005, a payment equal to four percent of the total of the operating and property payment rates. A hospital located in Woodbury and not in existence during the base year shall be reimbursed under this clause.

(b) The state share of payments under paragraph (a) shall be equal to federal reimbursements to the commissioner to reimburse nonstate expenditures reported under section 256B.199. The commissioner shall ratably reduce or increase payments under this subdivision in order to ensure that these payments equal the amount of reimbursement received by the commissioner under section 256B.199, except that payments shall be ratably reduced by an amount equivalent to the state share of a four percent reduction in MinnesotaCare and medical assistance payments for inpatient hospital services.

(c) The payments under paragraph (a) shall be paid quarterly beginning on July 15, 2007, or upon federal approval of federal reimbursements under section 256B.199, whichever occurs later.

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

(e) The commissioner shall maximize the use of available federal money for disproportionate share hospital payments and shall maximize payments to qualifying hospitals. In order to accomplish these purposes, the commissioner may, in consultation with the nonstate entities identified in section 256B.199, adjust, on a pro rata basis if feasible, the amounts reported by nonstate entities under section 256B.199 when application for reimbursement is made to the federal government, and otherwise adjust the provisions of this subdivision.

(f) By January 15 of each year, beginning January 15, 2006, the commissioner shall report to the chairs of the house and senate finance committees and divisions with jurisdiction over funding for the Department of Human Services the following estimates for the current and upcoming federal and state fiscal years:

(1) the difference between the Medicare upper payment limit and actual or anticipated medical assistance payments for hospital services;

(2) the amount of federal disproportionate share hospital funding available to Minnesota and the amount expected to be claimed by the state; and

(3) the methodology used to calculate the results reported for clauses (1) and (2).

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

(h) This section sunsets on June 30, 2009. The commissioner shall report to the legislature by December 15, 2008, with recommendations for maximizing federal disproportionate share hospital payments after June 30, 2009.

256.9743 REPORTING.

By February 1, 1989, the Board on Aging shall recommend methods for expanding and funding local ombudsman programs to serve clients receiving in-home services or care in acute care facilities.

256B.0913 ALTERNATIVE CARE PROGRAM.

Subd. 5b. **Adult foster care rate.** The adult foster care rate shall be considered a difficulty of care payment and shall not include room and board. The adult foster care rate shall be negotiated between the county agency and the foster care provider. The alternative care payment for the foster care service in combination with the payment for other alternative care services, including case management, must not exceed the limit specified in subdivision 4, paragraph (a), clause (6).

Subd. 5c. **Residential care services; supportive services; health-related services.** For purposes of this section, residential care services are services which are provided to individuals living in residential care homes. Residential care homes are currently licensed as board and lodging establishments under section 157.16, and are registered with the Department of Health as providing special services under section 157.17 except settings that are currently registered under chapter 144D. Residential care services are defined as "supportive services" and "health-related services." "Supportive services" means services as defined in section 157.17, subdivision 1, paragraph (a). "Health-related services" means services covered in section 157.17, subdivision 1, paragraph (b). Individuals receiving residential care services cannot receive homemaking services funded under this section.

Subd. 5d. **Assisted living services.** For the purposes of this section, "assisted living" refers to supportive services provided by a single vendor to clients who reside in the same apartment building of three or more units which are not subject to registration under chapter 144D and are licensed by the Department of Health as a class A home care provider or a class E home care provider. Assisted living services are defined as up to 24-hour supervision, oversight, and supportive services as defined in section 157.17, subdivision 1, paragraph (a), individualized home care aide tasks as defined in Minnesota Rules, part 4668.0110, and individualized home management tasks as defined in Minnesota Rules, part 4668.0120, provided to residents of a residential center living in their units or apartments with a full kitchen and bathroom. A full kitchen includes a stove, oven, refrigerator, food preparation counter space, and a kitchen utensil storage compartment. Assisted living services must be provided by the management of the residential center or by providers under contract with the management or with the county.

Subd. 5e. **Further assisted living requirements.** (a) Individuals receiving assisted living services shall not receive both assisted living services and homemaking services. Individualized means services are chosen and designed specifically for each resident's needs, rather than provided or offered to all residents regardless of their illnesses, disabilities, or physical conditions. Assisted living services as defined in this section shall not be authorized in boarding and lodging establishments licensed according to sections 157.011 and 157.15 to 157.22.

(b) For establishments registered under chapter 144D, assisted living services under this section means either the services described in subdivision 5d and delivered by a class E home care provider licensed by the Department of Health or the services described under section 144A.4605 and delivered by an assisted living home care provider or a class A home care provider licensed by the commissioner of health.

Subd. 5f. **Payment rates for assisted living services and residential care.** (a) Payment for assisted living services and residential care services shall be a monthly rate negotiated and authorized by the county agency based on an individualized service plan for each resident and may not cover direct rent or food costs.

(b) The individualized monthly negotiated payment for assisted living services as described in subdivision 5d or 5e, paragraph (b), and residential care services as described in subdivision 5c, shall not exceed the nonfederal share in effect on July 1 of the state fiscal year for which the rate limit is being calculated of the greater of either the statewide or any of the geographic groups according to subdivision 4, paragraph (a), clause (6).

(c) The individualized monthly negotiated payment for assisted living services described under section 144A.4605 and delivered by a provider licensed by the Department of Health as a class A home care provider or an assisted living home care provider and provided in a building that is registered as a housing with services establishment under chapter 144D and that provides 24-hour supervision in combination with the payment for other alternative care services, including case management, must not exceed the limit specified in subdivision 4, paragraph (a), clause (6).

Subd. 5g. **Provisions governing direct cash payments.** A county agency may make payment from their alternative care program allocation for direct cash payments to the client for the purpose of purchasing the services. The following provisions apply to payments under this subdivision:

(1) a cash payment to a client under this provision cannot exceed the monthly payment limit for that client as specified in subdivision 4, paragraph (a), clause (6); and

(2) a county may not approve any cash payment for a client who meets either of the following:

(i) has been assessed as having a dependency in orientation, unless the client has an authorized representative. An "authorized representative" means an individual who is at least 18 years of age and is designated by the person or the person's legal representative to act on the person's behalf. This individual may be a family member, guardian, representative payee, or other individual designated by the person or the person's legal representative, if any, to assist in purchasing and arranging for supports; or

(ii) is concurrently receiving adult foster care, residential care, or assisted living services.

Subd. 5h. **Cash payments to persons.** (a) Cash payments to a person or a person's family will be provided through a monthly payment and be in the form of cash, voucher, or direct county payment to a vendor. Fees or premiums assessed to the person for eligibility for health and human services are not reimbursable through this service option. Services and goods purchased through cash payments must be identified in the person's individualized care plan and must meet all of the following criteria:

(1) they must be over and above the normal cost of caring for the person if the person did not have functional limitations;

(2) they must be directly attributable to the person's functional limitations;

(3) they must have the potential to be effective at meeting the goals of the program; and

(4) they must be consistent with the needs identified in the individualized service plan. The service plan shall specify the needs of the person and family, the form and amount of payment, the items and services to be reimbursed, and the arrangements for management of the individual grant.

(b) The person, the person's family, or the legal representative shall be provided sufficient information to ensure an informed choice of alternatives. The local agency shall document this information in the person's care plan, including the type and level of expenditures to be reimbursed.

(c) Persons receiving grants under this section shall have the following responsibilities:

(1) spend the grant money in a manner consistent with their individualized service plan with the local agency;

(2) notify the local agency of any necessary changes in the grant expenditures;

(3) arrange and pay for supports; and

(4) inform the local agency of areas where they have experienced difficulty securing or maintaining supports.

(d) The county shall report client outcomes, services, and costs under this paragraph in a manner prescribed by the commissioner.

256J.24 FAMILY COMPOSITION; ASSISTANCE STANDARDS; EXIT LEVEL.

Subd. 6. **Family cap.** (a) MFIP assistance units shall not receive an increase in the cash portion of the transitional standard as a result of the birth of a child, unless one of the conditions under paragraph (b) is met. The child shall be considered a member of the assistance unit according to subdivisions 1 to 3, but shall be excluded in determining family size for purposes of determining the amount of the cash portion of the transitional standard under subdivision 5. The child shall be included in determining family size for purposes of determining the food portion of the transitional standard. The transitional standard under this subdivision shall be the total of the cash and food portions as specified in this paragraph. The family wage level under this subdivision shall be based on the family size used to determine the food portion of the transitional standard.

(b) A child shall be included in determining family size for purposes of determining the amount of the cash portion of the MFIP transitional standard when at least one of the following conditions is met:

(1) for families receiving MFIP assistance on July 1, 2003, the child is born to the adult parent before May 1, 2004;

(2) for families who apply for the diversionary work program under section 256J.95 or MFIP assistance on or after July 1, 2003, the child is born to the adult parent within ten months of the date the family is eligible for assistance;

(3) the child was conceived as a result of a sexual assault or incest, provided that the incident has been reported to a law enforcement agency;

(4) the child's mother is a minor caregiver as defined in section 256J.08, subdivision 59, and the child, or multiple children, are the mother's first birth; or

(5) any child previously excluded in determining family size under paragraph (a) shall be included if the adult parent or parents have not received benefits from the diversionary work program under section 256J.95 or MFIP assistance in the previous ten months. An adult parent or parents who reapply and have received benefits from the diversionary work program or MFIP assistance in the past ten months shall be under the ten-month grace period of their previous application under clause (2).

(c) Income and resources of a child excluded under this subdivision, except child support received or distributed on behalf of this child, must be considered using the same policies as for other children when determining the grant amount of the assistance unit.

(d) The caregiver must assign support and cooperate with the child support enforcement agency to establish paternity and collect child support on behalf of the excluded child. Failure to cooperate results in the sanction specified in section 256J.46, subdivisions 2 and 2a. Current support paid on behalf of the excluded child shall be distributed according to section 256.741, subdivision 15.

(e) County agencies must inform applicants of the provisions under this subdivision at the time of each application and at recertification.

(f) Children excluded under this provision shall be deemed MFIP recipients for purposes of child care under chapter 119B.

256J.29 INELIGIBILITY FOR STATE-FUNDED PROGRAMS.

Beginning July 1, 2007, legal noncitizens ineligible for federally funded cash or food benefits due to 1996 changes in federal law and subsequent relevant enactments, who are eligible for state-funded MFIP cash or food assistance, will be ineligible for state-funded MFIP under this chapter.

256J.37 TREATMENT OF INCOME AND LUMP SUMS.

Subd. 3b. **Treatment of Supplemental Security Income.** The county shall reduce the cash portion of the MFIP grant by up to $125 for an MFIP assistance unit that includes one or more SSI recipients who reside in the household, and who would otherwise be included in the MFIP assistance unit under section 256J.24, subdivision 2, but are excluded solely due to the SSI recipient status under section 256J.24, subdivision 3, paragraph (a), clause (1). If the SSI recipient or recipients receive less than $125 of SSI, only the amount received shall be used in calculating the MFIP cash assistance payment. This provision does not apply to relative caregivers who could elect to be included in the MFIP assistance unit under section 256J.24, subdivision 4, unless the caregiver's children or stepchildren are included in the MFIP assistance unit.

256J.561 UNIVERSAL PARTICIPATION REQUIRED.

Subdivision 1. **Implementation of universal participation requirements.** (a) All caregivers whose applications were received July 1, 2004, or after, are immediately subject to the requirements in subdivision 2.

(b) For all MFIP participants who were exempt from participating in employment services under section 256J.56 as of June 30, 2004, between July 1, 2004, and June 30, 2005, the county, as part of the participant's recertification under section 256J.32, subdivision 6, shall determine whether a new employment plan is required to meet the requirements in subdivision 2. Counties shall notify each participant who is in need of an employment plan that the participant must meet with a job counselor within ten days to develop an employment plan. Until a participant's employment plan is developed, the participant shall be considered in compliance with the participation requirements in this section if the participant continues to meet the criteria for

an exemption under section 256J.56 as in effect on June 30, 2004, and is cooperating in the development of the new plan.

256J.62 UNIVERSAL PARTICIPATION IN EMPLOYMENT SERVICES.

Subd. 9. **Continuation of certain services.** Only if services were approved as part of an employment plan prior to June 30, 2003, at the request of the participant, the county may continue to provide case management, counseling, or other support services to a participant:

(1) who has achieved the employment goal; or

(2) who under section 256J.42 is no longer eligible to receive MFIP but whose income is below 115 percent of the federal poverty guidelines for a family of the same size.

These services may be provided for up to 12 months following termination of the participant's eligibility for MFIP.

256J.626 MFIP CONSOLIDATED FUND.

Subd. 7. **Performance base funds.** (a) Beginning calendar year 2005, each county and tribe will be allocated 95 percent of their initial calendar year allocation. Counties and tribes will be allocated additional funds based on performance as follows:

(1) for calendar year 2005, a county or tribe that achieves a 30 percent rate or higher on the MFIP participation rate under section 256J.751, subdivision 2, clause (8), as averaged across the four quarterly measurements for the most recent year for which the measurements are available, will receive an additional allocation equal to 2.5 percent of its initial allocation; and

(2) for calendar year 2006, a county or tribe that achieves a 40 percent rate or a five percentage point improvement over the previous year's MFIP participation rate under section 256J.751, subdivision 2, clause (8), as averaged across the four quarterly measurements for the most recent year for which the measurements are available, will receive an additional allocation equal to 2.5 percent of its initial allocation; and

(3) for calendar year 2007, a county or tribe that achieves a 50 percent rate or a five percentage point improvement over the previous year's MFIP participation rate under section 256J.751, subdivision 2, clause (8), as averaged across the four quarterly measurements for the most recent year for which the measurements are available, will receive an additional allocation equal to 2.5 percent of its initial allocation; and

(4) for calendar year 2008 and yearly thereafter, a county or tribe that achieves a 50 percent MFIP participation rate under section 256J.751, subdivision 2, clause (8), as averaged across the four quarterly measurements for the most recent year for which the measurements are available, will receive an additional allocation equal to 2.5 percent of its initial allocation; and

(5) for calendar years 2005 and thereafter, a county or tribe that performs above the top of its annualized range of expected performance on the three-year self-support index under section 256J.751, subdivision 2, clause (7), will receive an additional allocation equal to five percent of its initial allocation; or

(6) for calendar years 2005 and thereafter, a county or tribe that performs within its range of expected performance on the annualized three-year self-support index under section 256J.751, subdivision 2, clause (7), will receive an additional allocation equal to 2.5 percent of its initial allocation.

(b) Performance-based funds for a federally approved tribal TANF program in which the state and tribe have in place a contract under section 256.01, addressing consolidated funding, will be allocated as follows:

(1) for calendar year 2006 and yearly thereafter, a tribe that achieves the participation rate approved in its federal TANF plan using the average of four quarterly measurements for the most recent year for which the measurements are available, will receive an additional allocation equal to 2.5 percent of its initial allocation; and

(2) for calendar years 2006 and thereafter, a tribe that performs above the top of its annualized range of expected performance on the three-year self-support index under section 256J.751, subdivision 2, clause (7), will receive an additional allocation equal to five percent of its initial allocation; or

(3) for calendar years 2006 and thereafter, a tribe that performs within its range of expected performance on the annualized three-year self-support index under section 256J.751, subdivision 2, clause (7), will receive an additional allocation equal to 2.5 percent of its initial allocation.

(c) Funds remaining unallocated after the performance-based allocations in paragraph (a) are available to the commissioner for innovation projects under subdivision 5.

(d)(1) If available funds are insufficient to meet county and tribal allocations under paragraph (a), the commissioner may make available for allocation funds that are unobligated and available from the innovation projects through the end of the current biennium.

(2) If after the application of clause (1) funds remain insufficient to meet county and tribal allocations under paragraph (a), the commissioner must proportionally reduce the allocation of each county and tribe with respect to their maximum allocation available under paragraph (a).

Subd. 9. **Report.** The commissioner shall, in consultation with counties and tribes:

(1) determine how performance-based allocations under subdivision 7, paragraph (a), clauses (2) and (3), will be allocated to groupings of counties and tribes when groupings are used to measure expected performance ranges for the self-support index under section 256J.751, subdivision 2, clause (7); and

(2) determine how performance-based allocations under subdivision 7, paragraph (a), clauses (2) and (3), will be allocated to tribes.

The commissioner shall report to the legislature on the formulas developed in clauses (1) and (2) by January 1, 2004.

256J.65 SELF-EMPLOYMENT INVESTMENT DEMONSTRATION PROGRAM.

(a) A caregiver who enrolls and participates in the SEID program as specified in section 268.95, may, at county option, be exempted from other employment and training participation requirements for a period of up to 24 months, except for the school attendance requirements as specified in section 256J.54.

(b) The following income and resource considerations apply to SEID participants:

(1) an unencumbered cash reserve fund, composed of proceeds from a SEID business, is not counted against the grant if those funds are reinvested in the business and the value of the business does not exceed $3,000. The value of the business is determined by deducting outstanding encumbrances from retained business profit; and

(2) the purchase of capital equipment and durable goods of an amount up to $3,000 during a 24-month project period is allowed as a business expense.

(c) SEID participants with a county-approved employment plan are also eligible for employment and training services, including child care and transportation.

525.921 DEFINITIONS.

Subdivision 1. **Scope.** For the purposes of sections 525.921 to 525.9224 the terms defined in this section have the meanings given them.

Subd. 1a. **Anatomical gift.** "Anatomical gift" means a donation of all or part of a human body to take effect upon or after death.

Subd. 3. **Decedent.** "Decedent" means a deceased individual and includes a stillborn infant or an embryo or fetus that has died of natural causes in utero.

Subd. 3a. **Document of gift.** "Document of gift" means a card, a statement attached to or imprinted on a motor vehicle operator's or chauffeur's license, a will, or other writing used to make an anatomical gift.

Subd. 4. **Donor.** "Donor" means an individual who makes an anatomical gift of all or part of the individual's body.

Subd. 4a. **Enucleator.** "Enucleator" means an individual who has completed a course in eye enucleation conducted and certified by the department of ophthalmology of any accredited college of medicine, and holds a valid certificate of competence for completing the course.

Subd. 5. **Hospital.** "Hospital" means a facility licensed, accredited, or approved as a hospital under the laws of any state or a facility operated as a hospital by the United States government, a state, or a subdivision of a state.

Subd. 6. **Part.** "Part" means organs, tissues, eyes, bones, arteries, blood, other fluids and any other portions of a human body.

Subd. 7. **Person.** "Person" means an individual, corporation, government or governmental subdivision or agency, business trust, estate, trust, partnership or association, or any other legal entity.

Subd. 8. **Physician or surgeon.** "Physician" or "surgeon" means an individual licensed or otherwise authorized to practice medicine and surgery or osteopathy and surgery under the laws of any state.

Subd. 8a. **Procurement organization.** "Procurement organization" means a person licensed, accredited, or approved under the laws of any state for procurement, distribution, or storage of human bodies or parts.

Subd. 9. **State.** "State" includes any state, district, commonwealth, territory, insular possession, and any other area subject to the legislative authority of the United States of America.

Subd. 10. **Technician.** "Technician" means an individual who is appropriately trained to remove or process a part.

525.9211 MAKING, AMENDING, REVOKING, AND REFUSING TO MAKE ANATOMICAL GIFTS BY INDIVIDUAL.

Subdivision 1. **Title.** This section may be cited as the "Darlene Luther Anatomical Gift Act."

Subd. 2. **Requirements.** (a) An individual who is at least 18 years of age, or a minor with the written consent of a parent or legal guardian, may (i) make an anatomical gift for any of the purposes stated in section 525.9215, paragraph (a), (ii) limit an anatomical gift to one or more of those purposes, or (iii) refuse to make an anatomical gift.

(b) An anatomical gift may be made by a will or by a document of gift signed by the donor. If the donor cannot sign, the document of gift must be signed by another individual and by two witnesses, all of whom have signed at the direction and in the presence of the donor and of each other, and state that it has been so signed.

(c) If a document of gift is attached to or imprinted on a donor's motor vehicle operator's or chauffeur's license, the document of gift must comply with paragraph (b). Revocation, suspension, expiration, or cancellation of the license does not invalidate the anatomical gift.

(d) A document of gift may designate a particular physician or surgeon to carry out the appropriate procedures. In the absence of a designation or if the designee is not available, the donee or other person authorized to accept the anatomical gift may employ or authorize any physician, surgeon, technician, or enucleator to carry out the appropriate procedures.

(e) An anatomical gift by will takes effect upon death of the testator, whether or not the will is probated. If, after death, the will is declared invalid for testamentary purposes, the validity of the anatomical gift is unaffected.

(f) A donor may amend or revoke an anatomical gift, not made by will, only by:

(1) a signed statement;

(2) an oral statement made in the presence of two individuals;

(3) any form of communication during a terminal illness or injury addressed to a health care professional or member of the clergy; or

(4) the delivery of a signed statement to a specified donee to whom a document of gift had been delivered.

(g) The donor of an anatomical gift made by will may amend or revoke the gift in the manner provided for amendment or revocation of wills, or as provided in paragraph (f).

(h) An anatomical gift that is not revoked by the donor before death is irrevocable and does not require the consent or concurrence of any person after the donor's death. An anatomical gift designation made by a will, a designation on a driver's license or Minnesota identification card made under section 171.07, subdivision 5, or a health care directive under chapter 145C, and not revoked, establishes the intent of the person making the designation and may not be overridden by any other person. For a donor's revocation of an anatomical gift made by a document of gift to be valid, the donor must use one of the methods of revocation in paragraph (f).

(i) An individual may refuse to make an anatomical gift of the individual's body or part by (i) a writing signed in the same manner as a document of gift, or (ii) any other writing used to identify the individual as refusing to make an anatomical gift. During a terminal illness or injury, the refusal may be an oral statement or other form of communication.

(j) In the absence of contrary indications by the donor, an anatomical gift of a part is neither a refusal to give other parts nor a limitation on an anatomical gift under section 525.9212 or on a removal or release of other parts under section 525.9213.

(k) In the absence of contrary indications by the donor, a revocation or amendment of an anatomical gift is not a refusal to make another anatomical gift. If the donor intends a revocation to be a refusal to make an anatomical gift, the donor shall make the refusal pursuant to paragraph (i).

525.9212 MAKING, REVOKING, AND OBJECTING TO ANATOMICAL GIFTS, BY OTHERS.

(a) Any member of the following classes of persons, in the order of priority listed, may make an anatomical gift of all or a part of the decedent's body for an authorized purpose, unless the decedent has made a refusal to make that anatomical gift that is unrevoked at the time of death:

(1) the spouse of the decedent;

(2) an adult son or daughter of the decedent;

(3) either parent of the decedent;

(4) an adult brother or sister of the decedent;

(5) a grandparent of the decedent; and

(6) a guardian of the decedent at the time of death or a health care agent or proxy appointed by the decedent under a health care directive as defined in section 145C.01, a living will under chapter 145B, or other similar document executed in another state and enforceable under the laws of this state.

(b) An anatomical gift may not be made by a person listed in paragraph (a) if:

(1) a person in a prior class is available at the time of death to make an anatomical gift;

(2) the person proposing to make an anatomical gift knows of a refusal or contrary indications by the decedent; or

(3) the person proposing to make an anatomical gift knows of an objection to making an anatomical gift by a member of the person's class or a prior class.

(c) An anatomical gift by a person authorized under paragraph (a) must be made by (i) a document of gift signed by the person, or (ii) the person's telegraphic, recorded telephonic, or other recorded message, or other form of communication from the person that is contemporaneously reduced to writing and signed by the recipient.

(d) An anatomical gift by a person authorized under paragraph (a) may be revoked by any member of the same or a prior class if, before procedures have begun for the removal of a part from the body of the decedent, the physician, surgeon, technician, or enucleator removing the part knows of the revocation.

(e) A failure to make a decision as to an anatomical gift under paragraph (a) is not an objection to the making of an anatomical gift.

525.9213 AUTHORIZATION BY CORONER OR MEDICAL EXAMINER OR LOCAL PUBLIC HEALTH OFFICIAL.

(a) The coroner or medical examiner may release and permit the removal of a part from a body within that official's custody, for transplantation or therapy, if:

(1) the official has received a request for the part from a hospital, physician, surgeon, or procurement organization;

(2) the official has made a reasonable effort, taking into account the useful life of the part, to locate and examine the decedent's medical records and inform persons listed in section 525.9212, paragraph (a), of their option to make, or object to making, an anatomical gift;

(3) the official does not know of a refusal or contrary indication by the decedent or objection by a person having priority to act as listed in section 525.9212, paragraph (a);

(4) the removal will be by a physician, surgeon, or technician; but in the case of eyes, by one of them or by an enucleator;

(5) the removal will not interfere with any autopsy or investigation; and

(6) the removal will be in accordance with accepted medical standards.

(b) If the body is not within the custody of the coroner or medical examiner, the local public health officer may release and permit the removal of any part from a body in the local public health officer's custody for transplantation or therapy if the requirements of paragraph (a) are met.

(c) An official releasing and permitting the removal of a part shall maintain a permanent record of the name of the decedent, the person making the request, the date and purpose of the request, the part requested, and the person to whom it was released.

525.9214 ROUTINE INQUIRY AND REQUIRED REQUEST; SEARCH AND NOTIFICATION.

(a) If, at or near the time of death of a patient, there is no documentation in the medical record that the patient has made or refused to make an anatomical gift, the hospital administrator or a representative designated by the administrator shall discuss with the patient or a relative of the patient the option to make or refuse to make an anatomical gift and may request the making of an anatomical gift pursuant to section 525.9211 or 525.9212. The request must be made with reasonable discretion and sensitivity to the circumstances of the family. A request is not required if the gift is not suitable, based upon accepted medical standards, for a purpose specified in section 525.9215. An entry must be made in the medical record of the patient, stating the name of the individual making the request, and the name, response, and relationship to the patient of the person to whom the request was made.

(b) The following persons shall make a reasonable search for a document of gift or other information identifying the bearer as a donor or as an individual who has refused to make an anatomical gift:

(1) a law enforcement officer, firefighter, paramedic, or other emergency rescuer finding an individual who the searcher believes is dead or near death;

(2) a hospital or emergency care facility, upon the admission or presentation of an individual at or near the time of death, if there is not immediately available any other source of that information; and

(3) a medical examiner or coroner upon receipt of a body.

(c) If a document of gift or evidence of refusal to make an anatomical gift is located by the search required by paragraph (b), clause (1), and the individual or body to whom it relates is taken to a hospital, the hospital must be notified of the contents and the document or other evidence must be sent to the hospital. If a body is taken to a morgue, the person who discovered the body must notify the person's dispatcher. A dispatcher notified under this section must notify the state's federally designated organ procurement organization and inform the organization of the deceased's name, donor status, and location.

(d) If, at or near the time of death of a patient, a hospital knows that an anatomical gift has been made pursuant to section 525.9212, paragraph (a), or a release and removal of a part has been permitted pursuant to section 525.9213, or that a patient or an individual identified as in transit to the hospital is a donor, the hospital shall notify the donee if one is named and known to the hospital; if not, it shall notify an appropriate procurement organization. The hospital shall cooperate in the implementation of the anatomical gift or release and removal of a part.

(e) A person who fails to discharge the duties imposed by this section is not subject to criminal or civil liability.

525.9215 PERSONS WHO MAY BECOME DONEES; PURPOSES FOR WHICH ANATOMICAL GIFTS MAY BE MADE.

(a) The following persons may become donees of anatomical gifts for the purposes stated:

(1) a hospital, nonprofit organization in medical education and research, physician, surgeon, or procurement organization, for transplantation, therapy, medical or dental education, research, or advancement of medical or dental science;

(2) an accredited medical or dental school, college, or university for education, research, advancement of medical or dental science;

(3) an approved chiropractic college for education; or

(4) a designated individual for transplantation or therapy needed by that individual.

(b) An anatomical gift may be made to a designated donee or without designating a donee. If a donee is not designated or if the donee is not available or rejects the anatomical gift, the anatomical gift may be accepted by any hospital or procurement organization.

(c) If the donee knows of the decedent's refusal or contrary indications to make an anatomical gift or that an anatomical gift by a member of a class having priority to act is opposed by a member of the same class or a prior class under section 525.9212, paragraph (a), the donee may not accept the anatomical gift.

525.9216 DELIVERY OF DOCUMENT OF GIFT.

(a) Delivery of a document of gift during the donor's lifetime is not required for the validity of an anatomical gift.

(b) If an anatomical gift is made to a designated donee, the document of gift, or a copy, may be delivered to the donee to expedite the appropriate procedures after death. The document of gift, or a copy, may be deposited in any hospital, procurement organization, or registry office that accepts it for safekeeping or for facilitation of procedures after death. On request of an interested person, upon or after the donor's death, the person in possession shall allow the interested person to examine or copy the document of gift.

525.9217 RIGHTS AND DUTIES AT DEATH.

(a) Rights of a donee created by an anatomical gift are superior to rights of others except with respect to autopsies under section 525.9221, paragraph (b). A donee may accept or reject an anatomical gift. If a donee accepts an anatomical gift of an entire body, the donee, subject to the terms of the gift, may allow embalming and use of the body in funeral services. If the gift is of a part of a body, the donee, upon the death of the donor and before embalming, shall cause

the part to be removed without unnecessary mutilation. After removal of the part, custody of the remainder of the body vests in the person under obligation to dispose of the body.

(b) The time of death must be determined by a physician or surgeon who attends the donor at death or, if none, the physician or surgeon who certifies the death. Neither the physician or surgeon who attends the donor at death nor the physician or surgeon who determines the time of death may participate in the procedures for removing or transplanting a part unless the document of gift designates a particular physician or surgeon pursuant to section 525.9211, paragraph (d).

(c) If there has been an anatomical gift, a technician may remove any donated parts and an enucleator may remove any donated eyes or parts of eyes, after determination of death by a physician or surgeon.

525.9218 COORDINATION OF PROCUREMENT AND USE.

The procurement organizations, after consultation with hospitals, shall establish agreements or affiliations for coordination of procurement and use of human bodies and parts.

525.9219 SALE OR PURCHASE OF PARTS PROHIBITED.

(a) A person may not knowingly, for valuable consideration, purchase or sell a part for transplantation or therapy, if removal of the part is intended to occur after the death of the decedent.

(b) Valuable consideration does not include reasonable payment for the removal, processing, disposal, preservation, quality control, storage, transportation, or implantation of a part.

(c) A person who violates this section is guilty of a felony and upon conviction is subject to a fine not exceeding $50,000 or imprisonment not exceeding five years, or both.

525.9221 EXAMINATION, AUTOPSY, APPLICABLE LAW, LIABILITY.

(a) An anatomical gift authorizes any reasonable examination necessary to assure medical acceptability of the gift for the purposes intended.

(b) The provisions of sections 525.921 to 525.9224 are subject to the laws of this state governing autopsies.

(c) A hospital, physician, surgeon, coroner, medical examiner, local public health officer, enucleator, technician, or other person, who acts in accordance with sections 525.921 to 525.9224 or with the applicable anatomical gift law of another state or a foreign country or attempts in good faith to do so is not liable for that act in a civil action or criminal proceeding.

(d) An individual who makes an anatomical gift pursuant to section 525.9211 or 525.9212, and the individual's estate are not liable for any injury or damage that may result from the making or the use of the anatomical gift.

(e) The provision or use of any part of a human body, including blood, blood components, bone marrow, or solid organs from living donors, for the purpose of injection, transfusion, or transplantation in the human body is the rendition of a health care service by each person participating in the provision or use and is not a sale of goods, as that term is defined in section 336.2-105, paragraph (1), or a sale of a product.

525.9222 TRANSITIONAL PROVISIONS.

Sections 525.921 to 525.9224 apply to a document of gift, revocation, or refusal to make an anatomical gift signed by the donor or a person authorized to make or object to making an anatomical gift before, on, or after the effective date of sections 525.921 to 525.9224.

525.9223 UNIFORMITY OF APPLICATION AND CONSTRUCTION.

Sections 525.921 to 525.9224 shall be applied and construed to effectuate their general purpose to make uniform the law with respect to the subject of sections 525.921 to 525.9224 among states enacting it.

525.9224 SHORT TITLE.

Sections 525.921 to 525.9224 may be cited as the "Uniform Anatomical Gift Act (1987)."