House Research Act Summary

CHAPTER: 147 **SESSION:** 2007 Regular Session

TOPIC: Health and Human Services Omnibus Appropriations Bill

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Article 1: Child Welfare Policy

1 **Specific powers.** Amends § 256.01, subd. 2. Clarifies that for a child under the guardianship of the commissioner of human services or a tribe recognized by the Secretary of the Interior, the commissioner may contract with a licensed child placing agency or tribal

social service agency to provide adoption services. Specifies that such a contract must supplement and not replace existing county or tribal social services.

2 **Child.** Amends § 259.24, subd. 3. Clarifies that it is necessary for a child over 14 years old to provide written consent to the adoption by a particular person. Adds that a child of any age who is legally available for adoption and under the commissioner's guardianship cannot refuse or waive the commissioner's agent's efforts to make an adoptive placement. Also provides that a child may not sign a document that relieves a county social service agency of recruiting an adoptive home for the child.

3 **Notice to commissioner; referral for postplacement assessment.** Amends § 259.53, subd. 1. Clarifies that when an adoption petition is filed, the court administrator must immediately transmit a copy of the petition to the commissioner of human services when a child is

- under the guardianship of the commissioner or a licensed child-placing agency according to the child dependency statutes;
- placed by the commissioner, the commissioner' agent, or a licensed child placing agency after the parents have signed a consent to adopt or a placement agreement; or
- placed by a preadoptive custody order for a direct adoptive placement.

4 **Findings; orders.** Amends § 259.57, subd. 1. Clarifies that when an adoption petition is granted and a decree of adoption issued, the court administrator must immediately transmit a copy of the petition to the commissioner of human services when a child is

- under the guardianship of the commissioner or a licensed child-placing agency according to the child dependency statutes;
- placed by the commissioner, the commissioner' agent, or a licensed child placing agency after the parents have signed a consent to adopt or a placement agreement; or
- placed by a preadoptive custody order for a direct adoptive placement.

5 **Reimbursement of costs.** Amends § 259.67, subd. 7.

- Specifies the circumstances under which a licensed child-placing agency or local or tribal social service agency can receive reimbursement for adoption services.
- Adds that tribal social services shall receive reimbursement for adoption services it purchases for or directly provides to an eligible child.
- Requires agencies to enter into a reimbursement agreement with the commissioner before adoption services are provided.
- Allows the commissioner to spend up to $16,000 for each purchase of service agreement, with only one agreement allowed per child.

6 **Reasons for deferral.** Amends § 259.75, subd. 8. Strikes language that allows deferral of listing a child with the adoption exchange if the child, who is at least 14 years old, refuses to consent to an adoption plan.

7 **Duty to ensure placement prevention and family reunification; reasonable efforts.** Amends § 260.012. Requires reasonable efforts to finalize a permanent home for a child to include consideration of homes inside and outside the state.

8 **Indian tribe.** Amends § 260.755, subd. 12. Makes the definition of Indian tribe more inclusive. Refers to Native group under the Alaska Native Claims Settlement Act, and strikes the words "and exercising tribal government powers."

9 **Tribal court.** Amends § 260.755, subd. 20. Deletes "federally recognized" from the definition of "Tribal court."

10 **Identification of extended family members.** Amends § 260.761, subd. 7. Specifies that an agency must make active efforts to identify and locate extended family before placing an Indian child.

11 **Identification of extended family members.** Amends § 260.765, subd. 5. Specifies that an agency must make active efforts to identify and locate extended family before placing an Indian child.

12 **Indian tribe jurisdiction.** Amends § 260.771, subd. 1. Clarifies that an Indian tribe has exclusive jurisdiction over an Indian child who resides or is domiciled on the reservation of the tribe or is a ward of the tribal court no matter where the child resides or is domiciled, except where jurisdiction is otherwise vested in the sate by existing federal law.

13 **Court determination of tribal affiliation.** Amends § 260.771, subd. 2. Makes clear that the federal Indian Child Welfare Act and this chapter, the Minnesota Indian Family Preservation Act, are applicable without exception to any child custody proceeding, as defined in the federal Indian Child Welfare Act, involving an Indian child. Prohibits the court from determining applicability of the federal act or this chapter based on whether the child is part of an existing Indian family or based on the child's contact with the tribe, reservation, society, or off-reservation community.

14 **Placement procedures.** Adds § 260.852.

Subd. 1. Home study. Provides that the state must have procedures in place to comply with the requirements of the Interstate Compact for Placement of Children. Requires the state to conduct and complete a home study, either directly or by contract, within 60 days after the state receives a request to perform a home study from another state under the interstate compact. Requires the state to report to the requesting state the results of the home study within the 60-day time limit. For home studies begun prior to October 1, 2008, if due to circumstances beyond the control of the state, the state may have 75 days to complete the study. Foster and adoptive parent education and training do not have to be completed within the 60-day timeframe.

Subd. 2. Effect of received report. Requires the state to complete a home study at the request of another state, an Indian tribe, or a private agency under contract with another state or Indian tribe, within the 60-day timeframe unless it would be contrary to the welfare of the child.

Subd. 3. Resources. Provides that the state shall not impose any restriction on the use of private agencies to conduct a home study to meet the 60-day requirement.

Subd. 4. Incentive eligibility. Recites that Minnesota is an incentive eligible state. As such the state must have an approved plan as required by the federal government, be in compliance with the federal data requirements, and have data that verify a home study is completed within 30 days.

Subd. 5. Data requirements. Requires the state to submit specific data to the

federal government.

Subd. 6. Definitions. Defines "home study," "interstate home study," and "timely interstate home study."

Subd. 7. Background study requirements for adoption and foster care. States that studies must be conducted in accordance with Minnesota laws regarding background studies.

Subd. 8. Home visits. Requires a home visit be conducted at least every six months by agency staff in the state in which the child is placed. Requires that a report be submitted regarding the home visit.

15 **Investigation.** Amends § 260B.157, subd. 1. Requires the court to order a chemical use assessment in delinquency cases under specified conditions. Requires the court to order a mental health assessment for any youth found to be delinquent.

16 **Notice to foster parents and preadoptive parents and relatives.** Amends § 260C.152, subd. 5. Provides that foster parents, and any preadoptive parents or relative providing care for the child have a right to be heard at any review or hearing held with respect to the child.

17 **General.** Amends § 260C.13, subd. 1. Adds that at any permanency hearing the court shall assure that consultation with the child is done in an age appropriate manner.

18 **Review of court-ordered placements; permanent placement determination.** Amends § 260C.201, subd. 11. States that time spent on a trial home visit does count toward the time requirements under which a permanency hearing must be conducted. Current law provides that the time on a trial home visit does not count in the time calculation. Adds that if the child is on a trial home visit 12 months after the child was placed in care, rather than file a permanency petition, the agency may file a report with the court regarding its efforts to finalize the child's return to the parent's custody. The court may find that this plan is in the best interests of the child and continue this placement. After the court continues the trial home visit, if the placement fails and the child returns to foster care, the court must review the permanent status of the child within 30 days.

19 **Out-of-home placement; plan.** Amends § 260C.212, subd. 1. Provides that in cases where parental rights have been terminated that the out-of-home placement plan must include child-specific recruitment efforts such as relative search and use of state, regional, and national adoption exchanges to facilitate permanent placement of the child. Requires that when a child is discharged from foster care, the parent, adoptive parent or permanent legal custodian and the child, if appropriate, must be given a current copy of the child's health and education records.

20 **Responsible social service agency's duties for children in placement.** Amends § 260C.212, subd. 4. Adds that when a child leaves foster care by reason of reaching the age of majority, the child must be given a copy of the child's health and education report at no cost.

21 **Review of certain child placements.** Amends § 260C.212, subd. 9. Requires negotiation of a voluntary placement agreement between the responsible social service agency and a child's parents when a developmentally delayed or emotionally disturbed child is voluntarily placed outside the home for the sole reason of accessing services that cannot be provided in the family home. Prohibits transfer of legal custody to the agency. Requires the agencies to report to the commissioner of human services the number of children placed under this subdivision, along with any other information the commissioner may require.

22 **Order; retention of jurisdiction.** Amends § 260C.317, subd. 3. Provides that any child who is under the guardianship of the commissioner and who is legally eligible for adoption cannot refuse or waive efforts to recruit, identify, and place the child in an adoptive home.

23 **Care, examination, and treatment.** Amends § 260C.331, subd. 1. Provides that income does not include the earnings of a child over 18 who is transitioning from foster care.

24 **Definitions.** Amends § 626.556, subd. 2. Adds that in the case of sexual abuse, it is considered substantial child endangerment when the alleged abuser is a person who has a significant relationship to the child.

25 **Persons mandated to report.** Amends § 626.556, subd. 3. Makes a technical correction.

26 **Agency responsible for assessing or investigating reports of sexual abuse.** Amends § 626.556 by adding subd. 3e. States that the local welfare agency is responsible for investigating allegations of child sexual abuse if the alleged offender is a parent, guardian, sibling, or an individual in the family unit responsible for the child's care, or a person with a significant relationship to the child if the person resides in the home.

27 **Law enforcement responsibility for investigating maltreatment.** Amends § 626.556 by adding subd. 3f. Provides that law enforcement has the responsibility for investigating any report of child maltreatment if a violation of a criminal statute is alleged. States that law enforcement and the local social service agency must coordinate their investigations.

28 **Duties of local welfare agency and local law enforcement agency upon receipt of a report.** Amends § 626.556, subd. 10.

- Adds sexual abuse by a person with a significant relationship to the child when the person resides in the home or sexual abuse by a sibling, as a maltreatment to be investigated by the local welfare agency.

- Adds that the local welfare agency can share not public information with an Indian's tribal social service agency without violating confidentiality laws in order to implement the Tribal State Agreement.

29 **Law enforcement agency responsibility for investigation; welfare agency reliance on law enforcement fact-finding; welfare agency offer of services.** Amends § 626.556, subd. 10a, including the headnote. Provides that when violation of a criminal statute is alleged, law enforcement is the agency responsible for investigating alleged maltreatment that does not fall under the jurisdiction of the local welfare agency. Adds that the local agency may rely on law enforcement's findings to determine whether threatened harm or maltreatment has occurred if the alleged offender has minor children or lives with minor children.

30 **Duties of local social service agency upon receipt of a report of medical neglect.** Amends § 626.556, subd. 10c. Makes a technical correction.

31 **Notice of determination.** Amends § 626.556, subd. 10f. Requires the commissioner to include in the notice of determination of maltreatment, that the finding of maltreatment may result in the denial of a license application or in a background study disqualification related to employment or services licensed by the departments of Human Services, Health, or Corrections, or from providing services for an unlicensed personal care provider organization.

32 **Revisor's instruction.** Instructs the revisor to renumber certain sections of statute and to change certain references to statute.

Article 2: Children and Family

1 **General.** Amends § 13.46, subd. 2. Adds child care assistance programs to the list of programs able to exchange data for the purpose of monitoring benefits.

2 **Exclusion.** Amends § 16D.13, subd. 3. Adds chapter 119B, child care assistance, to the list of chapters that are prohibited from charging interest on overpayment of benefits.

3 **Family stabilization services.** Amends § 119B.011, by adding subd. 13a. Permits child

care assistance for participants in the new family stabilization services program.

4 **Establishment.** Amends § 119B.035, subd. 1. Discontinues the 3 percent transfer from the basic sliding fee fund to the at-home infant care program.

5 **Eligible participants.** Amends § 119B.05, subd. 1. Allows child care assistance for participants in the new family stabilization services program.

6 **Date of eligibility for assistance.** Amends § 119B.09, subd. 7. Makes a technical change.

7 **Payment of other child care expenses.** Amends § 119B.09, by adding subd. 11. Provides that payments by sources other than the family of all or part of child care expenses do not effect program eligibility. Excludes amount of payments made from family income if the payments are made directly to the child care provider.

8 **Sliding fee.** Amends § 119B.09, by adding subd. 12. Requires conversion of eligibility requirements and parent fee schedules to state median income, based on a family size of three, by July 1, 2008. Requires the commissioner to report to the 2008 legislature with statutory changes needed to codify the changes.

9 **Sliding fee scale.** Amends § 119B.12. Reduces the parental fee, and codifies the fee schedule. The minimum parental fee under the new schedule is $5 per month; under the old schedule it was $10 per month. Provides a July 1, 2007, effective date for this section. Provides a July 1, 2008, effective date for section 119B.09, subdivision 12.

10 **Persons who cannot be authorized.** Amends § 119B.125, subd. 2. Adds that a person found guilty of wrongfully obtaining public assistance by a court, an administrative hearing, or disqualification consent agreement cannot be authorized to be a legal nonlicensed family child care provider.

11 **Subsidy restriction.** Amends § 119B.13, subd. 1. Requires the commissioner to survey rates charged by Minnesota child care providers annually. Adds a special needs rate for school readiness service agreements.

12 **Provider differential for accreditation.** Amends § 119B.13, subd. 3a. Adds a child development associate credential and a post baccalaureate degree in early childhood education to the degrees that entitle a family child care provider to receive a rate differential.

13 **Absent days.** Amends § 119B.13, subd. 7. Expands the child care assistance absent day policy:

- Exempts absences due to the documented medical condition of a parent or sibling who live in the same residence;
- Allows a public health or school nurse to verify illness in lieu of a medical practitioner, and in the case of a child sent home early due to a medical problem, the child care director or lead teacher may verify the illness;
- Allows families with one parent under age 21 who is a student in specified educational program to be exempt from the absent day limits; and
- Allows counties to pay for more absent days than allowed by state law if justified by market conditions and if the policy is in the county plan.

14 **Child care services grants.** Amends § 119B.21, subd. 5. Adds staff training in effective teacher-child interactions, child-focused teaching, and content-driven classroom instruction to the list of activities eligible for child care services grants.

15 **Duties as state agency.** Amends § 256.01, subd. 4. Makes stylistic changes. Specifies how fees for service of a subpoena must be paid and how subpoenas are enforced. Allows

DHS to subpoena witnesses, cooperate with other state agencies, and administer oaths and affirmations.

16 **Administrative simplification; county cost study.** Amends § 256.01, by adding subd. 23. Paragraph (a) requires the commissioner to establish and convene the first meeting of an advisory committee to identify ways to simplify and streamline human services laws and rules.

Paragraph (b) lists composition of the committee. Requires appointments to be made by September 1, 2007.

Paragraph (c) specifies the duties of the committee and requires annual reports to the legislature beginning January 15, 2008.

Paragraph (d) requires the commissioner to consult with the advisory committee and report to the legislature by January 15, 2009, any recommendations to improve effectiveness and efficiency in administration of human services programs.

Paragraph (e) provides an expiration date of June 30, 2012.

17 **Cooperation required.** Amends § 256.015, subd. 7. Permits DHS and county agencies direct access to workers' compensation claim information to determine whether the claimant has reported a pending claim and the amount paid to or on behalf of the claimant.

18 **Authority and purpose.** Amends § 256.017, subd. 1. Adds child care assistance programs to the compliance powers of the commissioner.

19 **Timing and disposition of penalty and case disallowance funds.** Amends § 256.017, subd. 9. Allows penalties withheld under the child care assistance program to be reallocated to counties.

20 **Declaration.** Amends § 256.984, subd. 1. Adds MinnesotaCare and child care assistance programs to the list of programs for which applications must be in writing and contain a specified declaration signed by the applicant.

21 **Expiration of food support benefits and reporting requirements.** Creates § 256D.0516.

> **Subd. 1. Expiration of food support benefits.** Prohibits food support benefits from expiring unless the benefits have not been accessed for 12 months after the month they were issued.
>
> **Subd. 2. Food support reporting requirements.** Requires the commissioner to implement simplified reporting requirements. States that recipient households do not have to report more often than once every six months. Specifies that this provision does not apply to households receiving food supports under the MFIP program.

Provides a February 1, 2008, effective date for subdivision 1, and a May 1, 2008, effective date for subdivision 2.

22 **Legislative approval to move programs or activities.** Amends § 256J.01, by adding subd. 6. Prohibits the commissioner from moving programs or activities funded with MFIP or TANF maintenance of effort funds to other funding sources without legislative approval.

23 **Commissioner's authority to administer block grant funds.** Amends § 256J.02, subd. 1. Adds a reference to the federal Deficit Reduction Act of 2005.

24 **Authority to transfer.** Amends § 256J.02, subd. 4. Adds a reference to the federal Deficit Reduction Act of 2005.

25 **Separate state program for use of state money.** Amends § 256J.021. Clarifies that the Family Stabilization Services program, created in this article, is a separately funded state

program.

26 **Participant.** Amends § 256J.08, subd. 65. Modifies the definition of "participant." Provides an immediate effective date.

27 **Other property limitations.** Amends § 256J.20, subd. 3. Modifies the property limitation on MFIP participants to exclude one vehicle with a loan value less than or equal to $15,000. Permits exclusion of up to $7,500 of the loan value of additional vehicles. Current law allows exclusions of a vehicle with a loan value less than or equal to $7,500.

28 **Income exclusions.** Amends § 256J.21, subd. 2. Excludes cash payments to full-time volunteers in AmeriCorps programs from income when determining MFIP eligibility.

29 **Recertification.** Amends § 256J.32, subd. 6. Requires the county agency to determine whether a single caregiver meets the requirements of the family stabilization services at recertification.

30 **Time limit.** Amends § 256J.42, subd. 1. Clarifies that months during which any cash assistance is received when the assistance unit contains a mandatory member who is disqualified for wrongfully obtaining public assistance, count toward the time limit for the disqualified member. Provides an effective date of October 1, 2007.

31 **Restrictions on sanctions.** Amends § 256J.46, by adding subd. 3. Prohibits sanctions against an MFIP participant for failure to meet the hourly employment plan requirements due to the fact that the participant is not eligible for holiday pay or the employer is closed for a holiday.

32 **Work activity.** Amends § 256J.49, subd.13. Provides specific conditions under which unpaid work experience may be used. It can only be an option if the participant has been unable to obtain or retain paid competitive employment, and no paid work experience programs are available. If the participant does not agree to unpaid work experience, then the employment plan must specify that the unpaid experience will provide specific skills and experience that will enable the participant to obtain higher wages than the participant could earn without the experience.

33 **Assessments.** Amends § 256J.521, subd. 1. Requires an MFIP job counselor to determine if the participant should be referred to the family stabilization services program.

34 **Employment plan; contents.** Amends § 256J.521, subd. 2. Encourages job counselors to allow participants who are working at least 20 hours per week to also participate in employment and training activities in order to meet federal hourly participation rates. Limits sanctions in specified circumstances. Adds that a participant cannot be sanctioned for failure to meet hourly participation rates if the participant is ineligible for holiday pay and the participant's employer is closed for the holiday.

35 **Approval of postsecondary education or training.** Amends § 256J.53, subd. 2. Strikes language that requires MFIP participants to work at least 20 hours per week in order for a postsecondary education or training program to be an approved work activity.

36 **Participation requirements.** Amends § 256J.55, subd. 1. Modifies hourly work participation requirements for single-parent families:

- For single parents with no children under six years of age, work participation must be for at least 130 hours per month (current law mandates 30 to 35 hours per week), and

- For single parents with a child under six years of age, work participation must be for at least 87 hours per month (current law mandates 20 to 35 hours per week).

37 **Family stabilization services.** Creates § 256J.575. Establishes the new family

stabilization services program.

Subd. 1. Purpose. States that this program is designed to serve families who are not making significant progress in MFIP due to a variety of barriers to employment.

Subd. 2. Definitions. Provides definitions of "case manager," "case management," "family stabilization plan," and "family stabilization services."

Subd. 3. Eligibility. Paragraph (a) lists participants eligible for program services:

- A person who meets the requirements for, or has been granted, a hardship extension;
- A person who is applying for SSI or SSDI; and
- A person who is a noncitizen who has been in the United States for 12 months or less.

Paragraph (b) states that families must meet all MFIP eligibility requirements.

Paragraph (c) requires participants who are noncitizens and have been in the country for 12 or fewer months to be provided with English as a second language opportunities and skills training for up to 12 months.

Subd. 4. Universal participation. Requires the participation of all caregivers.

Subd. 5. Case management; family stabilization plans; coordinated services. Paragraph (a) requires the county agency or employment services provider to provide family stabilization services through a case management model.

Paragraph (b) provides the required components of the family stabilization plan.

Paragraph (c) provides the timelines for the case manager's initial meeting with the participant, the completion of the plan, and for periodic reviews. Lists circumstances under which the case manager is to modify the plan.

Subd. 6. Cooperation with services requirements. Lists requirements needed for compliance:

- The participant must engage in family stabilization services for the appropriate number hours per week;
- The case manager must review the participant's progress every six months and revise the plan as needed; and
- Excuses the participant's requirement to comply if the plan's services are unavailable for reasons beyond the control of the participant.

Subd. 7. Sanctions. Paragraph (a) provides a reduction in financial benefits if the participant fails to comply with plan requirements unless compliance has been

excused.

Paragraph (b) clarifies that sanctions may be imposed only if the participant clearly has the ability to comply with the plan, but is willfully noncompliant. Requires that this must be confirmed by a behavioral health or medical professional.

Paragraph (c) requires the county agency to review the plan and meet face-to-face with the participant.

Paragraph (d) requires the case manager to attempt at least one home visit if the participant fails to come to the face-to-face meeting. If a face-to-face meeting is not conducted, the county agency must send a written notice to the participant that includes sanction information.

Subd. 8. Funding. Clarifies that the family stabilization services program is a separately funded state program and that expenditures do not count toward the state's TANF maintenance of effort requirements.

38 **Work participation bonus.** Creates § 256J.621. Paragraph (a) provides that persons exiting DWP or terminating MFIP cash assistance with earnings, may be eligible for transitional assistance of $75 per month if the person is employed.

Paragraph (b) states that to be eligible for transitional assistance the participant cannot receive MFIP or DWP assistance and must meet the listed work requirements.

Paragraph (c) provides that expenditures for single caregiver families are maintenance of effort state funds and that expenditures for two-parent families are nonmaintenance of effort state funds. States that months in which a participant receives transitional assistance do not count toward the MFIP 60-month limit.

Provides an effective date of February 1, 2009.

39 **Consolidated fund.** Amends § 256J.626, subd. 1. Allows counties to use funds for case management.

40 **Allowable expenditures.** Amends § 256J.626, subd. 2. Modifies the list of allowable expenditures under the consolidated fund to include telephone service and family stabilization services.

41 **Eligibility for services.** Amends § 256J.626, subd. 3. Includes families receiving family stabilization services in the list of programs to which counties and tribes must give priority when expending consolidated funds.

42 **County and tribal biennial service agreements.** Requires counties and tribes to include strategies they will pursue under the family stabilization services program in their biennial service agreements.

43 **Innovation projects.** Amends § 256J.626, subd. 5. Incorporates family stabilization services into the MFIP consolidated fund by allowing the fund to pay for expenditures related to the new program.

44 **Base allocation to counties and tribes; definitions.** Amends § 256J.626, subd. 6. Makes a technical change.

45 **Performance base funds.** Amends § 256J.626, subd. 7. Changes the allocation of funds.

46 **Quarterly comparison report.** Amends § 256J.751, subd. 2. Updates a federal statutory reference.

47 **Failure to meet federal performance standards.** Amends § 256J.751, subd. 5. Adds a reference to the federal Deficit Reduction Act of 2005. Makes technical changes.

48 **Eligibility for diversionary work program.** Amends § 256J.95, subd. 3. Permits eligibility for certain newly arrived refugees. Provides an immediate effective date.

49 **Funding.** Amends § 256K.45, by adding subd. 6. Provides that any funds appropriated under the Runaway and Homeless Youth Act may be used to fund specified programs, technical assistance, and capacity building. Allows up to 4 percent of the funds to be used to monitor and evaluate programs. States that funds are to be directed to areas with the greatest need.

50 **Eligibility conditions.** Amends §259.67, subd. 4. Adds two criteria for eligibility for adoption assistance: a child adopted according to tribal law without a termination of parental rights, and a child five years of age or older.

51 **Disclosure to commissioner of human services.** Amends § 270B.14, subd. 1. Adds child care assistance programs to the list of programs where the commissioner of revenue may disclose information to the commissioner of human services.

52 **MFIP pilot program; workforce U.**

Subd. 1. Establishment. Establishes a pilot program in Benton and Stearns counties to expand the Workforce U program administered by the Stearns-Benton Employment and Training Council.

Subd. 2. Evaluation. Requires an evaluation of the program. Specifies parameters of the evaluation and that the results of the evaluation must be presented to the legislature by February 15, 2011.

Subd. 3. Expiration. Provides that the Workforce U pilot program expires June 30, 2011.

53 **Leech Lake youth treatment center proposal.** Paragraph (a) instructs the commissioner of human services to provide a planning grant to develop a culturally relevant alcohol and drug treatment center for American Indian youth in the Leech Lake area. States that the grant is to be given to a volunteer board consisting of representatives of specified entities.

Paragraph (b) lists elements the plan must include.

Paragraph (c) states that the plan is due to the legislature no later than September 2008.

54 **Minnesota food support program simplified application.** Directs the commissioner of human services to implement a simplified application form and process by January 1, 2008. Lists elements of the simplified application and process. Provides an effective date of January 1, 2008.

55 **Inspection of legal unlicensed child care providers.** Directs the commissioner of human services, in consultation with the commissioner of health and the counties, to develop a plan for each legally unlicensed child care provider receiving child care assistance funds to receive a one-time home visit. Requires the commissioner to report the plan to the legislature in January 2008.

56 **Commissioner of human services duties; early childhood and school-age professional development training.**

Subd. 1. Development and implementation of an early childhood and school-age professional development system. Requires development of a voluntary professional development system for practitioners; specifies detailed features of such a system. Requires reports from the commissioner; begins phase-in on July 1, 2007, if appropriations are sufficient.

Subd. 2. Two-hour early childhood training. Requires certification of new training to meet the two-hour early childhood development training requirement for new child care practitioners. Requires input from labor unions.

57 **School readiness service agreements.** Allows the commissioner to enter into agreements with up to 50 child care providers (centers and family child care providers) to support school readiness for children and economic stability for parents. Specifies provider rates; provider eligibility requirements; family and child eligibility requirements; and relationships of these agreements to current laws.

58 **Family, friend, and neighbor grant program.** Establishes a grant program for all areas of the state. Specifies program components. Encourages interagency and community collaboration in order to achieve the goals of the program. Requires an evaluation by the commissioner. Provides an immediate effective date.

59 **Child care provider study.** Directs the commissioner, if sufficient resources are provided, to study the implications of restricting state child care subsidies to centers meeting state quality standards. Requires a report by the commissioner no later than January 1, 2010.

60 **Direction to the commissioner.** Instructs the commissioner of human services to issue an RFP for a firm to monitor and evaluate programs receiving funding under the Runaway and Homeless Youth Act.

61 **Not assessing TANF penalties against counties.** Prohibits the state from assessing penalties against counties from October 2006 through October 2007, if the state fails to meet the federal work participation requirements, and the state is penalized by a reduction in the TANF grant.

62 **Prekindergarten exploratory projects.**

Subd. 1. Early childhood allowance. Instructs the commissioners of human services and education to establish three prekindergarten exploratory projects.

Subd. 2. Family eligibility. Authorizes up to a $4,000 annual allowance to parents whose incomes are less than or equal to 185 percent of the federal poverty guidelines to pay for quality school readiness services.

Subd. 3. Quality standards. Sets out the standards a quality school readiness program must meet.

Subd. 4. Eligibility; applications. Reiterates that parents must have incomes less than or equal to 185 percent of the federal poverty guidelines. Specifies that the annual allowance cannot be counted as earned income for the purposes of public assistance programs.

Subd. 5. Expenditures. Provides that this program shall operate during the 2008 and 2009 fiscal years.

Effective date. Makes this section effective the day following final enactment.

63 **Repealer.** (a) Repeals Minnesota Statutes 2006, sections 119B.08, subd. 4 (termination of allocation); 256J.29 (ineligibility for state funded programs); and 256J.626, subd. 9 (report).

(b) Repeals Minnesota Statutes 2006, section 256J.37, subd. 3b (treatment of SSI income), effective February 1, 2008.

(c) Repeals Laws 1997, chapter 8, section 1 (reimbursement for adoption services).

(d) Repeals Minnesota Rules, part 9560.0102, subpart 2, item C (subsidy reimbursement for adoption services).

64 **Effective date.** Makes section 27 (256J.20, subd. 3) effective January 1, 2008, and section 13 (119B.13, subd. 7) effective January 1, 2009.

Article 3: Licensing

1 **Unlicensed emergency relative placement.** Amends § 245A.035 and its head note.

Subd. 1. Emergency placement. Allows a county agency to make the emergency placement of a child with a relative who is not licensed to provide foster care if the requirements of this section are met.

Subd. 2. Cooperation with emergency placement process. Strikes language regarding securing and issuing an emergency foster care license.

Subd. 3. Requirements for emergency placement. Strikes the words "license" and "foster care" and inserts the word "placement."

Subd. 4. Applicant study. Strikes language regarding emergency foster care licenses.

Subd. 5. Child foster care license application. Continues the requirement that relatives complete an application for a foster care license within 10 days of the child's emergency placement. Requires the commissioner of human services to provide written notice to the relative if a background study shows the relative is disqualified under section 245C.14.

Subd. 6. Denial of emergency license. This subdivision is stricken.

2 **County fees for background studies and licensing inspections.** Amends § 245A.10, subd. 2. Changes the fee a county can collect from a family or group family child care provider from an amount not to exceed $100 annually to an amount not to exceed $50 for a one-year license or $100 for a two-year license. Provides that this section is effective January 1, 2008.

3 **Delegation of authority to agencies.** Amends § 245A.16, subd. 1. Because the commissioner will be conducting background studies for all prospective foster and adoptive parents, clarifies the role of county agencies in reporting requirements and performing background studies for adult foster care, family adult day services, and family child care.

4 **Recommendations to the commissioner.** Amends § 245A.16, subd. 3. Specifies that county and private agencies are responsible for background studies for adult foster care, family adult day services, and family child care.

5 **Private agency.** Amends § 245C.02, by adding subd. 14a. Adds the definition of "private agency" to the background studies chapter.

6 **Licensed programs.** Amends § 245C.02, subd. 1.

- Adds family adult day services to programs on which the commissioner must conduct a background study at the time of reapplication for licensure.

- Adds paragraph (d) that requires the commissioner to conduct a background study of persons reapplying for child foster care licensure from July 1, 2007, to June 30, 2009. Sets out the specific information the county or private agency must submit to

the commissioner so that the background study can be completed.

- Adds paragraph (e) that requires the commissioner to conduct a background study of specified individuals who are newly affiliated with a child foster care license holder.

7 **Individual studied.** Amends § 245C.05, subd. 1. Requires that when a background study for child foster care is requested by a private agency, a background study subject must sign a release of information so that the commissioner can release any information from the national crime information database to the private agency. Requires that the subject provide a set of classifiable fingerprints obtained from an authorized agency.

8 **County or private agency.** Amends § 245C.05, by adding subd. 2a. Provides that for background studies related to child foster care, county and private agencies must collect information under subdivision 1 and forward it to the commissioner. This information includes: demographics, Minnesota driver's license number, address of residence for the past five years, and a set of classifiable fingerprints.

9 **Electronic transmission.** Amends § 245C.05, subd. 4. Instructs the commissioner to use an electronic transmission system to send background study results to county and private agencies for background studies conducted for child foster care.

10 **Fingerprints.** Amends § 245C.05, subd. 5. Requires applicants for child foster care licensure to provide the commissioner with a set of classifiable fingerprints obtained from an authorized agency.

11 **Probation officer and corrections agent.** Amends § 245C.05, subd. 7. Provides that a probation officer or corrections agent must notify the commissioner of an individual's conviction of a crime constituting disqualification under section 245C.14, if the individual is affiliated with child foster care.

12 **Background studies conducted by commissioner of human services.** Amends § 245C.08, subd. 1. Requires the commissioner to obtain and review information from the child abuse registry for any state in which the background study subject has resided over the past five years and information from national crime information databases on any applicant for child foster care licensure.

13 **Background studies conducted by a county agency.** Amends § 245C.08, subd. 2. Because the commissioner will be performing background studies on all prospective foster parents, changes in this section clarify the role of county agencies in background studies on adult foster care, family adult day services, and family child care homes.

14 **Temporary personnel agencies, educational programs, and professional services agencies.** Amends § 245C.10, by adding subd. 4. Allows the commissioner to recover up to a $20 fee from these agencies to offset the cost of background studies. Supplemental nursing service agencies and personal care provider organizations also pay up to a $20 fee to offset the cost background studies.

15 **Adult foster care; criminal conviction data.** Amends § 245C.11, subd. 1. Clarifies that this subdivision applies to adult foster care programs.

16 **Jointly licensed programs.** Amends § 245C.11, subd. 2. Clarifies that this subdivision applies to adult foster care programs.

17 **Background study; tribal organizations.** Amends § 245C.12. Allows tribal organizations to contract with the commissioner to obtain background study data on individuals under tribal jurisdiction related to adoptions or child foster care according to section 245C.34. A description of this new statute is found in section 23.

18 **Determining immediate risk of harm.** Amends § 245C.16, subd. 1. Specifies that this section does not apply to a background study related to an initial application for a child foster care license.

19 **Notice to county or private agency.** Amends § 245C.17, by adding subd. 5. Instructs the commissioner to provide a notice of the background study results to the county or private agency that initiated the study on an individual who applied for a child foster care license.

20 **Submission of reconsideration request to county or private agency.** Amends § 245C.21, by adding subd. 1a. Provides that if an individual has been disqualified, the request for reconsideration is to be submitted to the county or private agency that initiated the background study. Instructs the county or private agency to forward the individual's request for reconsideration to the commissioner along with a recommendation whether to set aside the disqualification.

21 **Commissioner's notice of disqualification that is not set aside.** Amends § 245C.23, subd. 2. Requires the commissioner to notify the county or private agency that initiated the child foster care background study of the results of reconsideration.

22 **Adoption background study requirements.** Adds § 245C.33.

Subd. 1. Background studies conducted by the commissioner. Provides that before any child is placed for adoption, the commissioner must conduct a background study for county and private agencies licensed to place children for adoption.

Subd. 2. Information and data provided to county or private agency. Requires the background study subjects to provide the county or private agency with all of the information required in section 245C.05; a set of classifiable fingerprints; and for private agencies, a signed release of information for information received from national crime information databases to the private agency.

Subd. 3. Information and data provided to commissioner. Instructs the county or private agency to forward all the data to the commissioner.

Subd. 4. Information commissioner reviews. Lists the information the commissioner must review. States that the commissioner shall provide this information to the county or private agency that initiated the background study and shall indicate whether the individual has one of the criminal convictions specified in federal law.

23 **Adoption and child foster care background studies; tribal organizations.** Adds § 245C.34.

Subd. 1. Background studies may be conducted by the commissioner. Allows tribal organizations to contract with the commissioner to obtain background study data on individuals under tribal jurisdiction related to adoption or child foster care. Requires that background studies initiated by a tribal organization conform to the provisions of subdivisions 2 and 3.

Subd. 2. Information and data provided to tribal organization. Requires the background study subjects to provide the tribal organization with all of the information required in section 245C.05; a set of classifiable fingerprints; and a signed release of information for information received from national crime information databases to the tribal organization.

Subd. 3. Information and data provided to the commissioner. Instructs the tribal organization to forward all the data to the commissioner.

Subd. 4. Information commissioner reviews. Lists the information the

commissioner must review. States that the commissioner shall provide this information to the tribal organization that initiated the background study and shall indicate whether the individual has one of the criminal convictions specified in federal law.

24 **Other applicable law.** Amends § 259.20, subd. 2. Specifies that in conformity with state and federal law, a completed background study is required before the approval of any foster or adoptive placement in a related or unrelated home.

25 **Best interests of the child.** Amends § 259.29, subd. 1. Specifies that in conformity with state and federal law, a completed background study is required before the approval of any foster or adoptive placement in a related or unrelated home.

26 **Adoption study.** Amends § 259.41.

Subd. 1. Study required before placement; certain relatives excepted. Adds that an approved adoption study and a background study must be completed before a child is placed in a prospective adoptive home.

Subd. 2. Form of study. Lists the components that must be documented in the adoption study.

Subd. 3. Background study. Specifies that in conformity with state and federal law, a completed background study is required before the approval of any foster or adoptive placement in a related or unrelated home. Lists the convictions that would prevent child placement.

27 **Adoption agencies; postplacement assessment and report.** Amends § 259.53, subd. 2. Clarifies that individuals related to the child are required to have a completed background study in compliance with federal law.

28 **Protection of child's best interest.** Amends § 259.57, subd. 2. Specifies that in conformity with state and federal law, a completed background study is required before the approval of any foster or adoptive placement in a related or unrelated home.

29 **Background checks.** Amends § 260C.209.

Subd. 1. Clarifies that the responsible social services agency initiates a background study to be completed by the commissioner.

Subd. 2. Specifies that in conformity with state and federal law, a completed background study is required before the approval of any foster or adoptive placement in a related or unrelated home.

Subd. 3. Specifies that the subject of the background study must submit a set of classifiable fingerprints that will be used by the commissioner to obtain criminal history data from national crime information databases.

Subd. 4. Notice upon receipt. Requires the commissioner to notify the subject of the background study of the results of the study.

30 **Placement decision based on best interest of the child.** Amends § 260C.212, subd. 2. Specifies that in conformity with state and federal law, a completed background study is required before the approval of any foster or adoptive placement in a related or unrelated home.

31 **Licensing moratorium.** Permits a nonpublic school program for children 33 months or older to be excluded from DHS licensure until July 1, 2009. Clarifies that an already licensed nonpublic school program can retain licensure, or that a nonpublic school program

can seek licensure. Provides an immediate effective date.

32 **Annual license review.** Instructs the commissioner of human services to work with counties to determine the cost and to identify sources of funding for annual license reviews of family child care providers. Requires a report to the legislature by January 15, 2008. Provides an immediate effective date.

Article 4: Health Care Policy

1 **Transfers.** Amends § 16A.724, subd. 2. Adds in statute the purpose of the on-going transfer from the health care access fund (HCAF) to the general fund.

2 **Intervention and advocacy program.** Adds § 254A.171. Authorizes DHS to fund, within the limits of available appropriations, voluntary outreach programs targeted at women who deliver children affected by prenatal alcohol or drug use.

3 **Persons detained by law.** Amends § 256B.055, subd. 14. Provides that an MA enrollee, who is charged with a crime and incarcerated in a local jail, workhouse, or correctional facility for less than 12 months, shall have eligibility suspended at the time of incarceration until release. Upon release, requires eligibility to be reinstated without reapplication, if the individual is otherwise eligible.

4 **Treatment of certain monetary gifts.** Amends § 256B.056, by adding subd. 1d. Requires the commissioner to disregard as income any portion of a monetary gift received by an applicant or enrollee that is designated to purchase a prosthetic device not covered by insurance, other third-party payers, or medical assistance.

5 **Formulary committee.** Amends § 256B.0625, subd. 13c. Modifies terminology, changing "board" to "committee."

6 **Drug formulary.** Amends § 256B.0625, subd. 13d. Requires the commissioner, if a single-source drug used by at least 2 percent of fee-for-service MA recipients is removed from the formulary due to failure of the manufacturer to sign a rebate agreement, to notify prescribing practitioners within 30 days of receiving notification from the Centers for Medicare and Medicaid Services that a rebate agreement was not signed. Provides an immediate effective date.

7 **Community health worker.** Amends § 256B.0625, by adding subd. 49. Provides MA coverage for care coordination and patient education services of a community health worker who meets specified criteria.

8 **Co-payments and coinsurance.** Amends § 256L.03, subd. 5. Exempts pregnant women and children from the $6 copayment for nonemergency visits to a hospital emergency room (these individuals are currently exempted from all other MinnesotaCare copayments).

9 **Persons in detention.** Amends § 256L.04, subd. 12. Corrects a cross-reference.

10 **Documentation.** Amends § 256L.17, subd. 3. Eliminates the requirement that the MinnesotaCare asset check-off form specify the asset requirement (current wording refers to an outdated asset limit).

Article 5: Health Care

1 **Transfers.** Amends § 16A.724, subd. 2. Adds in statute the purpose of the on-going transfer from the health care access fund (HCAF) to the general fund. Extends MinnesotaCare as a forecasted program until 2011.

2 **Minnesota health care programs outreach.** Adds § 256.962. Establishes outreach for the Minnesota health care programs.

Subd. 1. Public awareness and education. Requires the commissioner to design and implement a statewide campaign to raise public awareness on the availability of health care coverage through the public programs and the importance

of obtaining and maintaining coverage. [The appropriation for this provision was vetoed.]

Subd. 2. Outreach grants. Requires the commissioner to award grants to public and private organizations to provide information, applications, and assistance in obtaining coverage through the public health care programs.

Subd. 3. Application and assistance. Requires applications to be made available at various locations and requires local human services agencies, hospitals, and health care community clinics to provide direct assistance in completing the application form. Other locations must either provide direct assistance or provide information on where an applicant can receive assistance. Requires counties to offer applications and application assistance when providing child support collection services and local public health agencies and counties to offer applications and application assistance when providing immunization clinics.

Subd. 4. Statewide toll-free telephone number. Requires the commissioner to implement a statewide toll-free telephone number to provide information on public and private health coverage options.

Subd. 5. Incentive program. Requires the commissioner to establish an incentive program for organizations that identify and assist potential enrollees in filling out and submitting applications.

Subd. 6. School districts. Requires school districts to provide information to each student on the availability of health care coverage through the health care programs and to provide an application and application assistance to families who qualify for a free or reduced priced lunch. Requires the district to ensure that applications and information on application assistance are available at early childhood education sites and public schools in the district. Requires the district to designate an enrollment specialist to provide application assistance and follow-up services with families who are eligible for the free or reduced priced lunch program or who have indicated an interest in receiving information. Requires each district to provide a link on their Web site to information on how to obtain an application and application assistance.

Subd. 7. Renewal notice. Requires the commissioner to send a renewal notice to enrollees notifying the enrollee of the need to renew eligibility. Requires the managed care plans to provide a follow-up call to enrollees at least 60 days prior to the enrollee's renewal date. Requires the commissioner to provide the managed care plans with the end of coverage dates on the monthly rosters.

3 **Primary care access initiative.** Adds § 256.963. Requires the commissioner to award a grant to implement in Hennepin and Ramsey Counties a Web-based primary care access pilot project to connect patients with a primary care medical home and schedule patients into available community-based appointments as an alternative to nonemergency use of the hospital emergency room. Requires the commissioner, in consultation with the Minnesota Hospital Association, to conduct an evaluation of the pilot project and submit results to the Legislature by January 15, 2009.

4 **Disproportionate numbers of low-income patients served.** Amends § 256.969, subd. 9. Amends language that requires all GAMC expenditures made by DHS and by managed care plans to be considered Medicaid disproportionate share hospital (DSH) payments during the current biennium. The new language requires the following to be considered DSH payments during this period: (1) GAMC fee for service inpatient and outpatient hospital

payments made by DHS; and (2) certified public expenditures made by Hennepin County Medical Center (HCMC). HCMC must report necessary data retroactively to comply with this provision. This section is effective retroactive to July 1, 2005.

5 **Quarterly payment adjustment.** Amends § 256.969, subd. 27. Amends language governing the state match for quarterly payment adjustments that are scheduled to be paid to hospitals beginning July 1, 2007. This section allows all payments made under section 256B.199, not just "nonstate" payments, to be used to earn federal funds for these adjustments. Reduces an existing rateable reduction from 4 to 3 percent, effective July 1, 2009, provides additional payments to Gillette and Bethesda hospitals, and makes other changes.

6 **Competitive bidding.** Amends § 256B.04, subd. 14. Allows the commissioner to utilize volume purchase through competitive bidding and negotiation, to provide nonemergency medical transportation services level of need determinations, disbursement of public transportation passes and tokens, and volunteer and recipient mileage and parking reimbursement. Prohibits the commissioner from using volume purchase through competitive bidding for special transportation services.

7 **Level of need determination.** Amends § 256B.04, by adding subd. 14a. Requires nonemergency medical transportation level of need determinations to be performed by a physician, a licensed practical nurse, a registered nurse working under the direct supervision of a physician, a physician's assistant, a nurse practitioner, or a discharge planner. Prohibits level of need determinations from being performed more than semiannually on any individual, unless the individual's circumstances have sufficiently changed. Exempts individuals residing in licensed nursing facilities from a level of need determination, and states that these individuals are eligible for special transportation services. Provides that individuals determined to require stretcher transportation are presumed to maintain that level of need until otherwise determined by a person authorized to perform a level of need determination or for six months, whichever is sooner.

8 **Eligibility verification.** Amends 256B.056, subd. 10. Strikes the requirement for the commissioner to modify the application form to health care programs to require more detailed information in order to verify assets and income. Also removes the requirement that a change in income be reported within ten days and verified within ten days upon notification that an increase in income that affects eligibility.

9 **Circumcision.** Amends § 256B.0625, subd. 3f. Limits MA coverage for all circumcisions to those that are medically necessary. Strikes language that limits this provision to newborn circumcisions and eliminates an exemption for circumcisions required because of a well-established religious practice.

10 **Co-payments.** Amends § 256B.0631, subd. 1. Modifies the MA co-payment requirements by eliminating the co-payments for services provided on or after January 1, 2009, except for the co-payment on nonemergency visits to an emergency room and co-payments on prescription drugs. Sets a $7/month maximum for copayments on prescription drugs.

11 **Collection.** Amends § 256B.0631, subd. 3. States that MA reimbursement to providers and managed care plans shall not be increased as a result of removal of the copayments effective January 1, 2009.

Makes a conforming change related to the $7/month maximum for prescription drug copayments.

12 **Reimbursement under other state health care programs.** Amends § 256B.0644. Allows a dental service provider to satisfy the state health care program participation requirement if the provider accepts new MA, GAMC, and MinnesotaCare patients who are children with special health care needs. Defines "children with special health care needs" as children up

to age 18 who require health and related services beyond that required by children generally and who have or are at risk for a specified chronic physical, developmental, behavioral, or emotional condition, and other conditions designated by the commissioner after consultation with representatives of pediatric dental providers and consumers.

13 **Payments reported by governmental entities.** Amends § 256B.199. Modifies language that requires DHS to seek federal matching funds during the upcoming biennium for certain payments made by HCMC, Regions Hospital, and Fairview University Medical Center. The new language requires DHS also to seek federal matching funds for GAMC fee-for-service inpatient and outpatient hospital payments made by the department. Also eliminates the June 30, 2009, sunset for the section and a DHS report to the legislature. Provides an immediate effective date.

14 **Physician and dental reimbursement.** Amends § 256B.76. For dental services provided on or after June 30, 2007, sets MA reimbursement for critical access dental providers at 30 percent above the rate that would otherwise be paid. Strikes language that allows reimbursement, within the limits of the available appropriation, to be increased to 50 percent above the rate that would otherwise be paid. Also strikes language requiring the commissioner to establish a reimbursement schedule and provider specific limits for critical access dental providers, and to notify providers of this schedule and limits.

15 **Reimbursement for family planning services.** Adds § 256B.764. Increases the MA reimbursement rate by 25 percent for family planning services provided by a community clinic, on or after July 1, 2007.

16 **General assistance medical care; eligibility.** Amends § 256D.03, subd. 3. The amendment to paragraph (c) adds a clarifying reference to general assistance medical care (GAMC).

The amendment to paragraph (e) exempts GAMC applicants and recipients who are homeless from having to transition to MinnesotaCare.

Provides a January 1, 2007, effective date.

17 **General assistance medical care; services.** Amends § 256D.03, subd. 4. Provides GAMC coverage for care coordination and patient education services provided by a community health worker, and for sign language interpreter services provided by an enrolled health care provider. Effective January 1, 2008, limits GAMC prescription drug coverage to prescription drugs that are covered under MA and are provided by manufacturers that have executed GAMC rebate agreements. Requires GAMC drug coverage to conform to MA standards.

This section also modifies the GAMC co-payments for services provided on or after January 1, 2009, by eliminating all copayments except for a $25 copayment on nonemergency visits to emergency rooms and copayments on prescription drugs. Sets a $7/month maximum for prescription drug copayments. Provides that GAMC reimbursement rates shall not be increased as a result of removal of the copayments effective January 1, 2009.

18 **Scope.** Amends 256L.01, subd. 1. Makes a technical change to the MinnesotaCare definition section related to a cross-reference.

19 **Gross individual or gross family income.** Amends § 256L.01, subd. 4. Modifies the MinnesotaCare definition of gross income for the farm self-employed, by eliminating the requirement that depreciation be added back in. Also makes conforming changes to the 12-month eligibility period change. States that the section is effective July 1, 2007, or upon federal approval, whichever is later.

20 **Covered health services.** Amends § 256L.03, subd. 1. Makes a conforming change related to eliminating the limited benefit set for single adults in MinnesotaCare. Provides an effective date of January 1, 2008.

21 **Inpatient hospital services.** Amends § 256L.03, subd. 3. Increases the income limit at and above which the inpatient hospital limit applies to parents and relative caretakers, from 175 percent to 200 percent of FPG, with a further increase to 215 percent of FPG effective July 1, 2009. Removes obsolete language. Provides an effective date of July 1, 2008.

22 **Copayments and coinsurance.** Amends § 256L.03, subd. 5. Exempts pregnant women and children from the $6 copayment for nonemergency visits to a hospital emergency room (these individuals are currently exempted from all other copayments). Makes conforming changes to the increase in the income limit above which parents and relative caretakers are subject to the inpatient hospital limit, and also makes a technical change. Provides an effective date of July 1, 2008.

23 **Single adults and households with no children.** Amends § 256L.04, subd. 7. Effective January 1, 2008, increases the income eligibility limit from 175 percent to 200 percent of federal poverty guidelines (FPG) for single adults and households without children in MinnesotaCare. Also states that this eligibility limit will be increased to 215 percent of FPG effective July 1, 2009.

24 **Application and information availability.** Amends § 256L.05, subd. 1. Requires application and application assistance to be provided at these additional sites: Head Start program sites, public housing councils, crisis nurseries, child care centers, early childhood education and preschool program sites, legal aid offices, and libraries.

25 **MinnesotaCare enrollment by county agencies.** Amends § 256L.05, subd. 1b. Makes conforming changes to the reinstatement of the annual renewal period.

26 **Commissioner's duties.** Amends § 256L.05, subd. 2. Removes the requirement that applicants and enrollees verify earned and unearned income and submit the names of their employers and a contact name and telephone number for each employer for purposes of verifying income and the availability of employer-subsidized health coverage.

27 **Renewal of eligibility.** Amends § 256L.05, subd. 3a. Returns the renewal period to 12 months instead of every six months. Provides an effective date of July 1, 2007, or upon federal approval.

28 **General requirements.** Amends § 256L.07, subd. 1. Contains a change related to the income eligibility limit increase. This section also contains a change related to the switch to annual renewal. Provides an effective date of July 1, 2007, or upon federal approval.

29 **Exception for certain adults.** Amends § 256L.07, subd. 6. Makes conforming changes to the reinstatement of the annual renewal period.

30 **Eligibility as Minnesota resident.** Amends § 256L.09, subd. 4. Allows an applicant who is living in a shelter to use that address as a residence for MinnesotaCare eligibility.

31 **Critical access dental providers.** Amends § 256L.11, subd. 7. Makes technical changes to the language requiring the commissioner to pay the prepaid health plans an amount sufficient to cover the rate increase to critical access dental providers.

32 **Premium determination.** Amends § 256L.15, subd. 1. Eliminates premiums for members of the military who enroll in MinnesotaCare within 24 months following the member's tour of active duty. This exemption applies for 12 months so long as the individual or family remains eligible for the program during this period. Provides an expiration date of June 30, 2010. Provides an effective date of July 1, 2007, or upon federal approval.

33 **Sliding fee scale; monthly gross individual or family income.** Amends § 256L.15, subd.

2. Eliminates the MinnesotaCare premium increases passed in 2003 and 2005. Provides an effective date of July 1, 2007, or upon federal approval.

34 **Exception for transitioned adults.** Amends § 256L.15, subd. 4. Makes conforming charges to the reinstatement of the annual renewal period. Provides a January 1, 2007, effective date.

35 **Limit on total assets.** Amends § 256L.17, subd. 2. Exempts worker's compensation settlements received due to a work-related injury from total net assets for purposes of MinnesotaCare eligibility. Provides an effective date of July 1, 2007, or upon federal approval.

36 **Exception for certain adults.** Amends § 256L.17, subd. 7. Makes conforming changes due to the reinstatement of the annual renewal period.

37 **Hennepin County pilot project.** Requires the commissioner of human services to support a pilot project in Hennepin County to demonstrate the effectiveness of alternative strategies to redetermine eligibility for certain recipient populations in the MA program.

38 **Pharmacy report on DRA impact.** Requires the commissioner of human services to report to the legislature by January 1, 2008, on the fiscal impact of the Deficit Reduction Act on the Minnesota Medicaid pharmacy program, and specifies report topics.

Provides an immediate effective date.

39 **Chiropractic coverage.** Requires the commissioner of human services, through the Health Services Policy Committee, to study whether MA coverage for chiropractic services should be expanded to include initial and progress exams, and to report recommendations to the legislature by January 15, 2008.

40 **Implementation.** Requires DHS to implement the amendments related to federal reimbursement for expenditures that qualify for disproportionate share hospital (DSH) reimbursement on the earliest date for which the federal government grants approval.

41 **Repealer.** (a) Repeals Minnesota Statutes, section 256B.0625, subds. 5a to 5k (MA coverage of intensive early intervention behavior therapy services for autism) effective July 1, 2007.

(b) Repeals Minnesota Statutes, section 256.956 (purchasing alliance stop-loss fund) effective September 1, 2007.

(c) Repeals Minnesota Statutes, section 256L.035 (limited benefit set for MinnesotaCare) effective January 1, 2008.

(d) Repeals Minnesota Statutes, sections 256B.0631, subdivision 4 (copayments for MA uncollected debt) effective January 1, 2009.

Article 6: Continuing Care Policy

1 **Balancing long-term care; report required.** Changes from January 15 to August 15 the reporting date for the biennial report on long-term care services for the elderly that must be submitted by the commissioners of health and human services.

2 **Amount of support grant; use.** Amends § 252.32, subd. 3. Adds language to the family support grant program maximum grant amount allowing for any legislatively authorized cost of living adjustments.

3 **Purpose and goals.** Amends § 256.476, subd. 1. Removes obsolete language related to the consumer support grant program.

4 **Definitions.** Amends § 256.476, subd. 2. Adds "other authorized representatives" to the list of people who may make decisions or purchase supports within the consumer support grant program.

5 **Eligibility to apply for grants.** Amends § 256.476, subd. 3. Removes obsolete language.

6 **Support grants; criteria and limitations.** Amends § 256.476, subd. 4. Replaces "a person's family" with "a person's legal representative, or other authorized representative."

7 **Reimbursement, allocations, and reporting.** Amends § 256.476, subd. 5. Removes obsolete language.

8 **Consumer responsibilities.** Amends § 256.476, subd. 10. Replaces "the person's family" with "other authorized representative."

9 **Office of ombudsman for long-term care; local programs.** Amends § 256.974. Modifies terminology, changing the name of the Office of Ombudsman for Older Minnesotans to the Office of Ombudsman for Long-Term Care. Updates federal statutory citations.

10 **Long-term care facility.** Amends § 256.9741, subd. 1. Modifies the definition of long-term care facility, to give the office of ombudsman for older Minnesotans jurisdiction over "a licensed or registered residential setting which provides or arranges for the provision of home care services."

11 **Client.** Amends § 256.9741, subd. 3. Includes as a client of the office of ombudsman for older Minnesotans an individual receiving home care services.

12 **Posting.** Amends § 256.9742, subd. 3. Requires counties to provide clients receiving long-term care consultation services or home and community-based services with information on the office of ombudsman. (Current law limits this requirement to clients receiving a consumer support grant or service allowance.) Also corrects terminology.

13 **Access to long-term care and acute care facilities and clients.** Amends § 256.9742, subd. 4. Eliminates the requirement that the ombudsman for older Minnesotans comply with the requirements of the patients' bill of rights when communicating with clients and inspecting records of a facility.

14 **Prohibition against discrimination or retaliation.** Amends § 256.9742, subd. 6. Includes in the definition of adverse action, for purposes of a prohibition against retaliation against an individual for filing a complaint, any restriction of rights specified in section 144A.751 (the hospice bill of rights).

15 **Classification.** Amends § 256.9744, subd. 1. Updates federal statutory references.

16 **Electronic meetings.** Amends § 256.975, by adding subd. 2a. Allows the Board on Aging to conduct meetings by telephone or other electronic means, as long as specified conditions are met.

17 **Notice of relocation assistance.** Amends § 256B.0621, subd. 11. Requires the commissioner to establish a process with the Centers for Independent Living that allows persons residing in nursing facilities to receive information about the available community support options that may enable a person to relocate to the community if certain criteria are met.

18 **Day treatment services.** Amends § 256B.0625, subd. 23. Clarifies that MA covers day treatment services for children, notwithstanding Minnesota Rules.

19 **Personal care assistant.** Amends § 256B.0655, subd. 1f. Replaces a rule reference to personal care assistant training requirements with a statutory reference that incorporates the language of the rule.

20 **Personal care provider responsibilities.** Amends § 256B.0655, by adding subd. 12. Specifies responsibilities of the personal care provider.

21 **Personal care provider; employment prohibition.** Amends § 256B.0655, by adding subd. 13. Prohibits personal care providers from employing a person to provide personal care services, if the person: (1) refuses to disclose criminal history; (2) has been convicted of a crime related to the provision of personal care services; (3) has jeopardized the health or welfare of a vulnerable adult; or (4) is using or is dependent on mood-altering chemicals and other criteria are met.

22 **Supervision of personal care services.** Amends § 256B.0655, by adding subd. 14.

Requires personal care services to a qualified recipient to be under the supervision of a qualified professional. Specifies duties of the qualified professional.

23 **Transition assistance.** Amends § 256B.0911, subd. 3b. Requires transition assistance to include information about the Centers for Independent Living and other organizations that can help with relocation efforts.

24 **Exemptions and emergency admissions.** Amends § 256B.0911, subd. 4b. Eliminates the exemption from federal screening requirements for persons with mental illness or a developmental disability. Requires nursing facilities to provide information to all persons admitted regarding their right to request and receive long-term care consultation services.

25 **Screening requirements.** Amends § 256B.0911, subd. 4c. Removes paragraph (c), which requires the long-term care consultation team to recommend a case mix classification for persons admitted to a certified nursing facility and authorizes nursing facilities to conduct certain assessments. Makes conforming changes.

26 **Payment for long-term care consultation services.** Amends § 256B.0911, subd. 6. Strikes a cross-reference to the performance based nursing facility contracting system, which was never implemented.

27 **Withholding.** Amends § 256B.0911, by adding subd. 6a. Allows the commissioner to withhold payments, penalties, and interest to nursing facilities whose payments to counties for long-term care consultation services are more than two months delinquent, and to return the withheld amount to the county to whom the delinquent payments were due.

28 **Reimbursement for certified nursing facilities.** Amends § 256B.0911, subd. 7. Strikes language requiring the commissioner to request a waiver from CMS allowing team approval of Medicaid payments for nursing facility care. Also strikes language stating that an individual has a choice and makes the final decision between nursing facility and community placement.

29 **Eligibility for funding for services for nonmedical assistance recipients.** Amends § 256B.0913, subd. 4. Adds a statutory reference to MA asset transfer penalties, in a provision that denies eligibility for alternative care services to persons who are ineligible for MA due to an asset transfer penalty. Also provides that persons who are ineligible for MA because their home equity exceeds $500,000 are also ineligible for alternative care.

30 **Services covered under alternative care.** Amends § 256B.0913, subd. 5. Modifies the list of services for which alternative care funding may be used.

31 **Services; service definitions; service standards.** Amends § 256B.0913, subd. 5a. Clarifies the list of elderly waiver services that are not covered under alternative care, by specifying that alternative care does not cover benefits defined under section 256B.0625 that meet primary and health care needs. Also provides that alternative care funds must not supplant client cost-sharing and premiums for health care benefits and services, or entitlement programs and services in which an individual has chosen not to enroll. Modifies terminology, changing references to "county" to "lead agency."

32 **Requirements for individual care plan.** Amends § 256B.0913, subd. 8. Modifies terminology, changing references to "county" to "lead agency" and "county of service" to "case manager." Defines "county of service."

33 **Contracting provisions for providers.** Amends § 256B.0913, subd. 9. Modifies terminology, changing references to "county" to "lead agency."

34 **Allocation formula.** Amends § 256B.0913, subd. 10. Removes obsolete language. Changes the date by which the commissioner shall allocate to counties alternative care funds from July 1 of each year to July 15 of each year. Modifies terminology, changing references to "county" to "lead agency."

35 **Targeted funding.** Amends § 256B.0913, subd. 11. Modifies terminology, changing references to "county" to "lead agency."

36 **Client fees.** Amends § 256B.0913, subd. 12. Modifies terminology, changing references to

"county" to "lead agency." Makes technical changes.

37 **Lead agency biennial plans.** Amends § 256B.0913, subd. 13. Modifies terminology, changing references to "county" to "lead agency."

38 **Provider requirements, payment, and rate adjustments.** Amends § 256B.0913, subd. 14. Modifies terminology, changing references to "county" to "lead agency."

39 **County certification of persons providing adult foster care to related persons.** Amends § 256B.0919, subd. 3. Removes a statutory reference to the alternative care program.

40 **Cost and statistical data audits.** Amends § 256B.27, subd. 2a. Gives the commissioner greater flexibility in conducting required audits of nursing facilities. Eliminates the requirement that 15 percent of nursing homes be audited each year and instead allows the 15 percent requirement to be met by audits focused on an individual nursing facility, a group of facilities, or targeting specific data categories in multiple facilities. Eliminates the requirement that all audits be conducted on-site, and also allows data to be collected electronically, in person, or by other means.

41 **In general.** Amends § 256B.431, subd. 1. Modifies the date by which the commissioner is required to notify nursing facilities of the rates for the following year, changing the date from May 1 to August 15.

42 **Property costs after July 1, 1988.** Amends § 256B.431, subd. 3f. Changes the federal index utilized for the replacement-cost-new per bed limit annual adjustment.

43 **Replacement-costs-new per bed limit effective October 1, 2007.** Amends § 256B.431, subd. 17e. Modifies a statutory reference.

44 **Rate increases for October 1, 2005, and October 1, 2006.** Amends § 256B.431, subd. 41. Amends the nursing facility COLAs for the existing biennium by allowing DHS to waive application deadlines under extraordinary circumstances. Provides an immediate effective date that is retroactive to October 1, 2005.

45 **Authority.** Amends § 256B.49, subd. 11. Adds Centers for Independent Living to the groups serving on an advisory committee. Allows interested persons to be on a list to receive notice of certain changes to disability services policies at least 30 days before any effective dates.

46 **Alternative care pilot projects.** Amends Laws 2000, chapter 340, section 19. Changes the expiration date of the pilot projects from June 30, 2005, to June 30, 2007. Makes this change in expiration date retroactive from June 29, 2005, for activities related to discontinuation of the pilot projects.

47 **Licensure; services for youth with disabilities.** Paragraph (a) requires the commissioner of human services, upon recommendation of a county agency, to grant a license with any necessary variances to a nonresidential program for youth that provides services to youth under age 21 during non-school hours. Specifies that the nonresidential youth program is subject to the conditions of any variances granted and with certain other statutory protections.

Paragraph (b) requires the commissioner, by February 1, 2008, to recommend amendments to licensure requirements to allow for licensure of appropriate services for school-age youth with disabilities under age 21. Specifies certain duties of the commissioner as part of developing the recommendations. Requires the recommendations to be provided to the legislature.

Article 7: Continuing Care

1 **Criteria for review.** Amends § 144A.073, subd. 4. Requires the commissioner of health to consider, when evaluating moratorium exception projects, the "extent to which the applicant demonstrates the continuing need for nursing facility care in the community and adjacent communities."

2 **Contribution amount.** Amends § 252.27, subd. 2a. Adds language to assure that the parental contributions are an eligible expense for pre-tax health flexible spending accounts.

3 **Licensing exception.** Adds § 252.295. Authorizes the following downsizing projects and rate increases for intermediate care facilities for persons with mental retardation (ICFs/MR):

(a) two six-bed facilities to replace a 15-bed facility in Minneapolis;

(b) one six-bed facility to replace a 21-bed facility in Chisholm; and

(c) a rate increase for a six-bed facility in Hibbing.

4 **Disability linkage line.** Amends § 256.01, by adding subd. 24. Requires the commissioner of human services to establish a disability linkage line. Specifies what must be provided by the disability linkage line.

5 **Consumer information and assistance; senior linkage.** Amends § 256.975, subd. 7. Requires the Minnesota Board on Aging, through the Senior LinkAge Line, to incorporate information about housing with services establishments and consumer rights into the MinnesotaHelp.info network's long-term care database to help consumers compare services and costs among establishments and with other in-home services. Establishments and their home care providers must provide information to DHS for inclusion on the Web site. Provides an immediate effective date.

6 **Access to medical services.** Amends § 256B.0625, subd. 18a. Provides that MA covers sign language interpreter services, regardless of the number of employees a health care provider has. (Under current procedure, providers with 15 or more employees must pay for sign language interpretation, while the county human services agency pays for services if a provider has fewer than 15 employees.)

7 **Self-directed supports option.** Amends § 256B.0625, by adding subd. 49. Specifies that MA covers the self-directed supports option upon federal approval. Makes this section effective upon federal approval of the state Medicaid plan amendment. Requires the commissioner to inform the Revisor's Office when approval is obtained.

8 **Prior authorization; time limits.** Amends § 256B.0651, subd. 7. Requires personal care provider agencies to request a new PCA assessment or service update, at least 60 days prior to the end of the current authorization time period. Requires the request to be made on a form approved by the commissioner.

9 **Assessment.** Amends § 256B.0655, subd. 1b. Requires service updates to be completed by telephone, used when there is no need for an increase in PCA services, and used for two consecutive assessments if followed by a face-to-face assessment. Requires service updates to be completed on a form approved by the commissioner. Adds personal care provider agencies to the list of entities for whom requests for assessment must be completed by the commissioner within 30 days.

10 **Assessment and service plan.** Amends § 256B.0655, subd. 3. Specifies procedures that a personal care provider agency must follow when requesting a county public health nurse to conduct a personal care assistant services assessment. Requires requests for a change in service authorization submitted by providers to be made on a form approved by the commissioner.

11 **Public health nurse assessment rate.** Amends § 256B.0655, subd. 8. Effective July 1, 2008, reduces the payment rate by 25 percent for personal care assistant services assessments not completed on time.

12 **Self-directed supports option.** Creates § 256B.0657.

Subd. 1. Definition. Defines "self-directed supports option."

Subd. 2. Eligibility. Establishes eligibility for the self-directed supports option.

Subd. 3. Eligibility for other services. Specifies that selection of the self-directed supports option does not restrict access to other medically necessary care and services under the MA state plan.

Subd. 4. Assessment requirements. Paragraph (a) lists the requirements that self-directed supports option assessments must meet.

Paragraph (b) requires the county public health nurse or certified public health nurse under contract with the county to report the results of assessments and recommendations to the commissioner and the recipient.

Subd. 5. Self-directed supports option plan requirements. Paragraph (a) specifies the requirements for the self-directed supports option plan.

Paragraph (b) lists duties of the commissioner.

Subd. 6. Services covered. Paragraph (a) lists the services covered under the self-directed supports option.

Paragraph (b) specifies that items, supports, and related services purchased under this option are not considered home care services.

Subd. 7. Noncovered services. Lists services and supports that are not eligible for payment under the self-directed supports option.

Subd. 8. Self-directed budget requirements. Specifies how the budget for the provision of the self-directed supports option shall be determined.

Subd. 9. Quality assurance and risk management. Paragraph (a) requires the commissioner to establish quality assurance and risk management measures for use in developing and implementing self-directed plans and budgets. Specifies what shall be included in the quality assurance and risk management measures.

Paragraph (b) requires the commissioner to provide ongoing technical assistance and resource and educational materials for families and recipients selecting the self-directed option.

Paragraph (c) requires performance assessment measures to be identified in consultation with the stakeholder group.

Subd. 10. Fiscal support entity. Paragraph (a) requires each recipient to choose a fiscal support entity provider certified by the commissioner to make payments for services, items, supports, and administrative costs related to managing the self-directed service plan. Requires recipients to also choose the payroll, agency with choice, or the fiscal conduit model of financial and service management.

Paragraph (b) lists requirements of the fiscal support entity.

Paragraph (c) gives the commissioner the authority to perform certain actions.

Subd. 11. Stakeholder consultation. Requires the commissioner to consult with a statewide consumer-directed services stakeholder group. Lists who must be included in the group. Requires the commissioner to seek recommendations on specified issues from the stakeholder group.

Makes subdivisions 1 to 10 effective upon federal approval of the state Medicaid plan amendment. Requires the commissioner to inform the Revisor when federal approval is obtained. Makes subdivision 11 effective July 1, 2007.

13 **Assessment and support planning.** Amends § 256B.0911, subd. 3a. The amendment to paragraph (a) adds that assessment and support planning will be provided to individuals in order to determine eligibility for waiver or alternative care program services.

Adds paragraph (g) which allows an individual to make the final decision regarding placement after the screening assessment.

Adds requirements to paragraph (h) that the treatment team must provide information regarding the role of assessment and planning in waiver and alternative care eligibility determination, and the consultant's decision regarding the individual's need for nursing facility level of care. Also requires long-term care consultation teams to provide interested persons with information about reverse mortgages and incentives to use them.

Adds paragraph (i) which provides that the face-to-face eligibility assessment is valid for no more than 60 calendar days after the assessment. Prohibits the eligibility start date from ever being prior to the assessment date.

14 **Transition to housing with services.** Amends § 256B.0911, by adding subd. 3c. Requires housing with services establishments that provide assisted living services to inform prospective residents about the availability of transitional consultation services prior to executing a lease or contract with the prospective resident. Transitional consultation service delivery requirements are outlined.

15 **Medicaid waiver for elderly services.** Amends § 256B.0915. The amendment to subdivision 1 clarifies that the provision of elderly waiver services must comply with the service definitions and provider standards in the waiver.

The amendment to subdivision 1a provides a definition of, and requirements for, case management services, and services provided by a case aide. Also provides a definition of county of service.

The amendment to subdivision 1b changes terminology by replacing references to "county" with "lead agency."

The amendment to subdivision 1c strikes outdated language.

The amendment to subdivision 2 updates language related to federal waiver and state plan amendments.

The amendment to subdivision 3 replaces a reference to "county" with "lead agency."

The amendment to subdivision 3b sets the conversion rate for persons moving from a

nursing home to the elderly waiver with consumer directed community support services. Also requires the cost of adaptations to be included when determining total monthly costs.

The amendments to subdivisions 3c and 3d replace references to "county" with "lead agency."

The amendment to subdivision 3e specifies requirements for setting the customized living service rate, adds a reference to class F home care providers delivering customized living services, changes terminology, and makes other changes.

The amendment to subdivision 3f replaces references to "county" with "lead agency."

The amendment to subdivision 3g replaces references to "counties" with "lead agencies" and makes related changes.

The amendment to subdivision 3h clarifies payment rates for 24-hour customized living services and defines 24-hour supervision. This amendment is effective the day following final enactment.

The amendment to subdivision 6 clarifies that care plans are implemented by the county "of service."

The amendment to subdivision 7 clarifies that individuals for whom a prepaid plan is liable for nursing home or elderly waiver services are not eligible to also receive county-administered elderly waiver services.

The amendment to subdivision 8 adds managed care organizations to the list of entities that are not liable for damages, injuries, or liabilities related to participation in consumer-directed community support services.

The amendment to subdivision 9 replaces a reference to "county" with "lead agency."

16 **Quality assurance system established.** Amends § 256B.095. Extends the expiration date of the quality assurance system from June 30, 2009, to June 30, 2014. Adds paragraph (d), which allows the quality assurance system to be expanded to include programs for persons with disabilities and older adults beginning July 1, 2007.

17 **Membership.** Amends § 256B.0951, subd. 1. Extends the expiration date of the quality assurance commission from June 30, 2009, to June 30, 2014.

18 **Quality management; assurance; and improvement system for Minnesotans receiving disability services.** Adds § 256B.096.

Subd. 1. Scope. Requires the commissioner to develop a statewide quality assurance and improvement system for Minnesotans receiving disability services in order to improve quality of services provided. Lists the disability services included.

Subd. 2. Stakeholder advisory group. Requires the commissioner to consult with a stakeholder advisory group on the development and implementation of the state quality management, assurance, and improvement system. Lists who must be included in the advisory group.

Subd. 3. Annual survey of service recipients. Requires the commissioner, in

consultation with the advisory group, to conduct an annual independent statewide survey of between 5 and 10 percent of service recipients, randomly selected, to determine the effectiveness and quality of disability services. Requires the survey to be consistent with the system performance expectations of the CMS quality management requirements and framework, and to be field tested during 2008.

Subd. 4. Improvements for incident reporting, investigation, analysis, and follow-up. Requires the commissioner to improve the system of incident reporting.

Subd. 5. Biennial report. Requires the commissioner to 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.

Requires the commissioner to provide a preliminary report by January 15, 2008, on several issues including priorities for meeting federal requirements, progress on the annual survey, and appropriations necessary to implement an annual survey once field testing is completed.

19 **Contracts for services for ventilator dependent persons.** Amends § 256B.431, subd. 2e. Effective July 1, 2007, or upon opening a unit dedicated to the care of ventilator dependent persons in partnership with Mayo Health Systems, whichever is later, sets the payment rate for ventilator dependent persons residing in a nursing facility in Waseca County licensed for 70 beds at 300 percent of the facility's highest RUG rate.

20 **Allowable interest expense.** Amends § 256B.431, subd. 17a. Increases the allowed interest on debt related to the cost of purchasing or replacing depreciable equipment, from 6 to 10 percent of the total historical project cost. Provides an October 1, 2007, effective date.

21 **Alternate rates for nursing facilities.** Amends § 256B.434, subd. 4. The amendment to paragraph (c) extends for two years, through the fiscal year beginning July 1, 2010, the ban on automatic inflations adjustments for nursing facility operating rates.

A new paragraph (e) allows nursing facilities to receive reimbursement for costs associated with compliance with existing or expected requirements of life safety code provisions or other federal regulations governing sprinkler systems, if: (1) the expenses were incurred on or after January 1, 2005, and before December 31, 2008; (2) the costs were not otherwise reimbursed as part of a moratorium exception project or a construction project; and (3) the total allowable costs are less than the minimum threshold. Requires the commissioner to provide qualifying nursing facilities with a rate adjustment beginning October 1, 2007, and ending September 30, 2008. Specifies procedures for applying for and calculating the rate adjustment. Requires equal percentage reductions in rate adjustments to qualifying facilities, if the costs from all projects exceed the appropriation. Requires facilities that use estimated costs when requesting a rate adjustment to report to the commissioner on the use of these funds, and allows the commissioner to recoup funds, if a facility fails to provide a report or if expenditures are less than the amount received under the rate adjustment.

22 **Nursing facility rate increases beginning October 1, 2007.** Amends § 256B.434, by adding subd. 19. Provides a nursing facility rate increase of 1.87 percent for the rate year beginning October 1, 2007. Seventy-five percent of the money must be used for compensation-related increases for eligible employees. Of that amount, 67 percent must be used for an equal hourly percentage wage increase for all eligible employees. The portion of the rate increase not set aside for employee compensation must be paid to facilities effective October 1, 2007. Facilities may apply for the compensation-related portion and shall receive the increase, retroactive to October 1, 2007, once the plan is approved. Plan

requirements are outlined.

23 **Payment of public employees retirement association costs.** Amends § 256B.434, by adding subd. 20. For nursing facilities that participate in the Public Employees Retirement Association (PERA), requires the component of their payment rate associated with PERA costs to be determined each rate year, beginning October 1, 2007. Directs the commissioner to subtract out PERA costs from the rate in effect on September 30, and then add to the payment rate in effect on October 1 an amount equal to reported PERA costs, for the year ending on the most recent September 30 for which data is available.

24 **Big Stone County rate adjustment.** Amends § 256B.437, by adding subd. 11. Requires the commissioner to 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. Requires the adjustment to be calculated using the procedures that currently apply to planned closure rate adjustments.

25 **Rebasing of nursing facility operating cost payment rates.** Amends § 256B.441, subd. 1. Requires the commissioner to rebase nursing facility rates, using the statistical and cost report filed by each nursing facility for the rate period ending one year prior to the rate year. Requires the new operating cost payment rates resulting from rebasing to take effect October 1, 2008, and be phased-in over eight rate years through October 1, 2015. Requires rates to be rebased October 1, 2016, and every two years after that date. Requires property rates to be rebased effective October 1, 2014. Strikes language requiring the commissioner to establish and phase-in a new value-based nursing facility reimbursement system.

26 **Definitions.** Amends § 256B.441, subd. 2. Makes a conforming change in a cross-reference.

27 **Administrative costs.** Amends § 256B.441, subd. 5. Adds information technology and Web sites to the list of nursing facility administrative costs.

28 **Allowed costs.** Amends § 256B.441, subd. 6. Modifies the definition of "allowed costs," by removing a reference to reasonableness and stating that all references to costs in the section shall be assumed to refer to allowed costs.

29 **Dietary costs.** Amends § 256B.441, subd. 10. Modifies the definition of dietary costs, by eliminating references to the direct costs of raw food and special dietary supplements.

30 **Direct costs category.** Amends § 256B.441, subd. 11. Provides a more detailed definition of direct care costs.

31 **External fixed costs.** Amends § 256B.441, subd. 13. Adds an additional statutory reference to planned closure rate adjustments, includes in the definition single bedroom incentives, and makes related changes.

32 **Facility average case mix index.** Amends § 256B.441, subd. 14. Specifies the weights for RUGs classifications.

33 **Facility type groups.** Amends § 256B.441, by adding subd. 14a. Classifies facilities into two groups – C and NC/R80 (facilities that are hospital-attached or are rule 80 facilities) and freestanding (all other facilities).

34 **Fringe benefit costs.** Amends § 256B.441, subd. 17. Eliminates from the definition of fringe benefit costs the requirement that they be available to all employees who work at least 20 hours per week.

35 **Housekeeping costs.** Amends § 256B.441, subd. 20. Clarifies that these costs are not limited to those items specified.

36 **Maintenance and plant operations costs.** Amends § 256B.441, subd. 24. Clarifies that these costs are not limited to those items specified.

37 **Other direct care costs.** Amends § 256B.441, by adding subd. 28a. Provides a definition of these costs.

38 **Peer groups.** Amends § 256B.441, subd. 30. Defines peer groups as three groups comprised of specified counties.

39 **Prior system operating cost payment rate.** Amends § 256B.441, subd. 31. Defines this term to mean the operating cost payment rate in effect on September 30, 2008, not including planned closure rate adjustments or single bedroom incentives.

40 **Raw food costs.** Amends § 256B.441, by adding subd. 33a. Provides a definition of this cost category.

41 **Related organization.** Amends § 256B.441, subd. 34. Modifies this definition.

42 **Social services costs.** Amends § 256B.441, subd. 38. States that this category includes the cost of employees who manage and process admissions.

43 **Therapy costs.** Amends § 256b.441, by adding subd. 42a. Provides a definition of this cost category.

44 **Calculation of quality add-on for the rate year beginning October 1, 2007.** Amends § 256B.441, by adding subd. 46a. Establishes a quality add-on of up to .3 percent for the rate year beginning October 1, 2007.

45 **Calculation of operating cost per diems.** Amends § 256B.441, by adding subd. 48. Specifies the method for calculating the direct care per diem, other care-related per diem, other operating per diem.

46 **Determination of total care-related per diem.** Amends § 256B.441, by adding subd. 49. Provides that the total care-related per diem for each facility is the sum of the direct care per diem and the other care-related per diem.

47 **Determination of total care-related limit.** Amends § 256B.441, by adding subd. 50. Requires a limit on the total care-related per diem to be determined for each peer group and each facility type group. Limits a facility's total care-related per diem to 120 percent of the median for the facility's peer and facility type group. Beginning October 1, 2016, bases the total care-related limit on each facility's quality score. Specifies related requirements.

48 **Determination of proximity adjustments.** Amends § 256B.441, by adding subd. 50a. Requires the commissioner to adjust care-related and other-operating cost limits, for nursing facilities with lower limits located within 20 miles of another nursing facility of the same group type located in a different geographic peer group with higher limits.

49 **Determination of other operating limit.** Amends § 256B.441, by adding subd. 51. Requires a limit on the other operating per diem to be determined for each peer group. Limits a facility's other operating per diem to 105 percent of the median for its peer group.

50 **Exception allowed for specialized care.** Amends § 256B.441, by adding subd. 51a. For rate years beginning October 1, 2016, allows the commissioner to negotiate increases of up to 50 percent in the care-related limit for facilities that provide specialized care, at a cost to the general fund that does not exceed $600,000 per year. Specifies procedures and the criteria to be used by the commissioner in selecting facilities.

51 **Determination of efficiency incentive.** Amends § 256B.441, by adding subd. 52. Establishes an efficiency incentive for those facilities below the other operating per diem limit, equal to 50 percent of the difference between a facility's other operating per diem and the other operating per diem limit, up to a maximum of $3.

52 **Calculation of payment rate for external fixed costs.** Amends § 256B.441, by adding subd. 53. Specifies the procedure for calculating the payment rate for external fixed costs. Removes planned closure rate adjustments and single bed room incentives from the payment rate for external fixed costs.

53 **Determination of total payment rates.** Amends § 256B.441, by adding subd. 55. Provides that in rate years in which rates are rebased, the total payment rate shall be the sum of the total care-related payment rate (with the direct care portion multiplied by the RUGs weight), other operating payment rate, efficiency incentive, external fixed cost rate, and the property rate.

54 **Rate increase; phase-in of rebased operating payment rates.** Amends § 256B.441, by adding subd. 56. (a) For the rates years beginning October 1, 2008, to October 1, 2015,

requires the operating cost payment rate calculated under this section (the rebased rate) to be phased-in by blending that rate with the operating cost payment rate determined under the alternative payment system. Specifies phase-in percentages. For the rate year beginning October 1, 2015, provides that the operating payment rate for each facility shall be the rebased rate. Requires the blending of rates to be performed separately for each RUG's class.

(b) Requires a portion of the funds received under this subdivision that are in excess of the operating cost payment rates that a facility would have received under the alternative payment system to be subject to the requirement in § 256B.434, subdivision 19, which requires 75 percent of the money be used for compensation-related costs and specifies other requirements.

55 **Hold harmless.** Amends § 256B.441, by adding subd. 58. For the rate years beginning October 1, 2008, to October 1, 2016, provides that no nursing facility shall receive an operating cost payment rate less than its rate under section 256B.434.

56 **Appeals.** Amends § 256B.441, by adding subd. 59. Allows facilities to appeal payment rate determinations.

57 **Implementation delay.** Amends § 256B.441, by adding subd. 58. Requires the commissioner, within six months prior to the effective date of: (1) rebasing property rates under subd. 1; (2) quality-based rate limits under subd. 50; and (3) the removal of planned closure rate adjustments and single bed room incentives from fixed costs under subd. 53, to compare the average operating cost for all facilities combined with the average MA operating payment rates. Prohibits each provision from taking effect until the average MA operating payment rate is at least 92 percent of the average operating cost.

58 **Medical assistance reimbursement.** Amends § 256B.49, by adding subdivision 16a. Instructs the commissioner of human services to 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. Specifies the requirements that a provider must meet before being eligible for medical assistance reimbursement.

59 **ICF/MR rate increases effective October 1, 2007, and October 1, 2008.** Amends § 256B.5012, by adding subd. 7. Provides rate increases of 2 percent for the rate year beginning October 1, 2007, and 2 percent for the rate year beginning July 1, 2008, for intermediate care facilities for persons with mental retardation (ICFs/MR). Seventy-five percent of the money must be used for compensation-related increases for eligible employees. Of that amount, 67 percent must be used for an equal hourly percentage wage increase for all eligible employees. The portion of the rate increase not set aside for employee compensation must be paid to facilities effective October 1, 2007. Facilities may apply for the compensation-related portion and shall receive the increase, retroactive to October 1, 2007, once the plan is approved. Plan requirements are outlined.

60 **Alternative services; elderly and disabled persons.** Amends § 256B.69, subd. 23. Extends the developmental disability pilot project for two years. Limits expansion of MnDHO projects for an additional year.

61 **Services for deaf-blind persons.** Creates § 256C.261. Paragraph (a) requires the commissioner to combine the existing biennial base level funding for deaf-blind services into a single grant program. Specifies how grants will be awarded and for what purpose.

Paragraph (b) allows the commissioner to make grants for services and training provided by organizations and to develop and administer consumer-directed services.

Paragraph (c) specifies who is eligible for a grant.

Paragraph (d) allows deaf-blind service providers to provide intervenor services as part of the service package provided with grant funds.

62 **Moratorium on the development of group residential housing beds.** Amends § 256I.04, subd. 3. Modifies the list of exceptions for new GRH beds by adding several new beds to various facilities.

63 **Supplementary rate for certain facilities serving chemically dependent males.** Amends § 256I.05, by adding subd. 1h. Beginning July 1, 2007, requires Ramsey County to negotiate a supplementary rate in addition to the maximum GRH rate, not to exceed $737.87 per month, including any inflationary adjustments, for a specified GRH provider located in Ramsey County that serves recovering and chemically dependent males and provides 24-hour-a-day supervision.

64 **Supplementary rate for certain facilities; Hennepin County.** Amends § 256I.05, by adding subd. 1i. Requires a county agency to negotiate a supplementary rate in addition to the maximum rate, not to exceed $700 per month, including any legislatively authorized inflationary adjustments, up to the available appropriation, 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. Makes this section effective immediately.

65 **Supplementary rate for certain facilities; Crow Wing County.** Amends § 256I.05, by adding subd. 1j. Beginning July 1, 2007, requires Crow Wing County to negotiate a supplementary rate in addition to the maximum GRH rate, not to exceed $700 per month, including any inflationary adjustments, for a GRH provider located in Crow Wing County for a new 65-bed facility that will serve a chemically dependent persons operated by a GRH provider that currently operates a 304-bed facility in Minneapolis and a 44-bed facility in Duluth which opened in January 2006.

66 **Supplementary rate for certain facilities; Stearns County.** Amends § 256I.05, by adding subd. 1k. Beginning July 1, 2007, requires county agencies to negotiate a supplementary service rate in addition to the maximum rate, not to exceed $700 per month, including any legislatively authorized inflationary adjustments, for a GRH provider located in Stearns County that operates a 40-bed facility, that received certain specified financing and serves chemically dependent clientele, providing 24-hour-a-day supervision.

67 **Supplementary rate for certain facilities; St. Louis County.** Amends § 256I.05, by adding subd. 1l. Beginning July 1, 2007, requires county agencies to negotiate a supplementary service rate in addition to the maximum rate, not to exceed $700 per month, including any legislatively authorized inflationary adjustments, for a GRH provider located in St. Louis County that operates a 30-bed facility, that received certain specified financing and serves chemically dependent clientele, providing 24-hour-a-day supervision.

68 **Supplemental rate for certain facilities; Hennepin and Ramsey Counties.** Amends § 256I.05, by adding subd. 1m. Authorizes a county agency to negotiate a supplemental service rate not to exceed $700 per month or the existing monthly rate, whichever is higher, for a group residential housing provider that operates two 10-bed facilities, one in Hennepin County and one in Ramsey County, which provide community support and 24-hour supervision to individuals with mental health needs who have been chronically unsheltered. Provides a July 1, 2008, effective date.

69 **Repayment delay.** Amends Laws 2006, ch. 282, art. 20, § 37. (a) Exempts Fillmore, Steele, and St. Louis counties, which overspent their allowed MR/RC waiver program amounts in calendar year 2004 and 2005 from paying back the amount of overspending. Current law requires counties that overspent to pay back to the state the amount of

overspending by May 31, 2007. [The appropriation for this provision was vetoed.]

(b) Exempts Carver County from repaying the amount of overspending until June 30, 2009.

Makes this section effective immediately.

70 **Assistive technology recommendations.**

Subd. 1. Review. During the 2008-09 biennium, requires the Council on Disability to facilitate a statewide review of the assistive technology needs of people with disabling conditions and seniors. Requires the council to identify entities involved in providing assistive technology supports.

Subd. 2. Recommendations. Requires the council to present recommendations to the chairs of the legislative committees having jurisdiction over human services, by January 1, 2009.

71 **Provider rate increases.** Provides rate increases of 2 percent beginning October 1, 2007, and 2 percent beginning October 1, 2008, for specified community-based providers and programs. Seventy-five percent of the money must be used for compensation-related increases for eligible employees. Of that amount, 67 percent must be used for an equal hourly percentage wage increase for all eligible employees. Providers must certify to DHS that they have increased employee compensation and wages as required.

72 **Minnesota Rules.** Requires the Department of Administration to publish adopted rules in the State Register making the terminology changes specified in section 84 in Minnesota Rules. Specifies that upon publication of the State Register, the terminology changes in Minnesota Rules are adopted without further administrative action.

73 **Housing with services and home care providers study; report.** Requires the commissioner of human services to study how the state can assist the elderly in selecting long-term care services that meet their needs, reflect their preferences, and enable them to maintain financial self-sufficiency. Requires the study to include surveys of consumers and providers of housing with services, assisted living, and in-home services, and an evaluation of the role of the long-term care consultation program. Requires a preliminary report to be submitted to the chairs of the legislative committees with jurisdiction over health and human services policy and finance by February 15, 2008, and a final report by December 15, 2008.

74 **Provider rate increase.** Provides a rate increase for a day training and habilitation provider in St. Louis County.

75 **Revisor's instruction.** Directs the Revisor of Statutes to change certain specified terms wherever they appear in Minnesota Statutes.

76 **Repealer.** Repeals Minnesota Statutes, §§ 252.21 (county boards may make grants for developmental achievement center services for children with developmental disabilities); 252.22 (applicants for assistance; tax levy); 252.23 (eligibility requirements); 252.24 (duties of county boards); 252.25 (board of directors); 252.261 (existence); 252.275, subd. 5 (SILS; displaced hospital workers); 256.9743 (outdated reporting requirement for Board on Aging); 256B.0913, subds. 5b (adult foster care rate), 5c (residential care services; supportive services; health-related services), 5d (assisted living services), 5e (further assisted living requirements), 5f (payment rates for assisted living services and residential care), 5g (provisions governing direct cash payments), and 5h (cash payments to persons); and 256B.441, subdivisions 12 (definition of economic development region), 16 (definition of final rate), 21 (definition of labor-related portion), 26 (definition of nursing costs), 28 (definition of operating costs), 42 (definition of support services category), and 45 (outdated language related to a report on operating payment rate methodology).

Article 8: Mental Health

1 **Janitorial contracts for rehabilitation programs and extended employment providers.** Amends § 16C.155. Requires the commissioner of administration to ensure that a percentage of janitorial service contracts are for rehabilitation and extended employment providers. The total value of the contracts reserved must exceed 19 percent of the total value of contracts in the previous fiscal year.

2 **Other professionals.** Amends § 148C.11, subd. 1. Extends the sunset allowing certain mental health providers to provide integrated dual-diagnosis treatment to July 1, 2009.

3 **Mental illness.** Amends § 245.462, subd. 20. Adds to the definition of a "person with serious and persistent mental illness" an adult who has a mental illness and has been treated by a crisis team two or more times within the preceding 24 months.

4 **Responsibility not duplicated.** Amends § 245.465, by adding subd. 3. Provides that the county is not responsible for paying for mental health services if the services are covered by the individual's health plan.

5 **Mental health service delivery and finance reform.** Creates § 245.4682.

Subd. 1. Policy. Requires the commissioner of human services to undertake a series of reforms to improve the mental health care system.

Subd. 2. General provisions. Paragraph (a) requires the commissioner to

- Consult with stakeholders;
- Report to the legislature and the State Advisory Council on Mental Health by January 15, 2008, recommendations for legislation to implement mental health system reform;
- Withhold implementation of changes until after the release of the January 15, 2008, report;
- Ensure continuity of care for consumers of mental health services who may be affected by the reform;
- Provide accountability;
- Ensure client access to protections and appeals;
- Make necessary budget transfers.

Paragraph (b) provides that the commissioner is to ensure any transfer of state grants to health care programs does not exceed the value of services being transferred for the latest 12-month period for which data is available.

Paragraph (c) requires that the appropriation for the reform cannot be expended after December 31, 2010, unless approved by the legislature.

Subd. 3. Projects for coordination of care. Paragraph (a) authorizes the commissioner to fund up to three pilot projects to implement the integrated physical and mental health service system. Requires each project to include at least one health

maintenance organization, community integrated service network, or accountable provider network, or county-based purchasing entity that is eligible to contract with the commissioner as a prepaid health plan, and the county or counties within the service area.

Paragraph (b) requires the commissioner to work with stakeholders to:

- Establish criteria for approving projects and soliciting proposals;
- Determine specifications for contracts;
- Begin implementation of the projects no earlier than January 1, 2009;
- Waive any administrative rule inconsistent with project implementation;
- Allow potential bidders at least 90 days to respond to requests for proposals; and
- Conduct an independent evaluation of the effectiveness of the projects.

Paragraph (c) provides that the commissioner may enroll any person with serious mental illness or emotional disturbance who is eligible for medical assistance in the prepaid plan of their choice within the project service area unless the individual is eligible for home and community-based services, or has a basis for exclusion from the prepaid plan.

Paragraph (d) states that the commissioner shall involve advocacy organizations in the development and distribution of information designed to educate potential enrollees.

Paragraph (e) allows the commissioner to assign a person who does not chose to remain in fee-for-service, or declines to choose a plan, to the prepaid plan participating in the preferred integrated network.

Paragraph (f) allows a person enrolled in a prepaid plan to disenroll at any time;

Paragraph (g) instructs the commissioner, in consultation with stakeholders, to evaluate the pilot projects and refine the design of the projects. Requires a report to the legislature.

Paragraph (h) instructs the commissioner to apply for federal waivers.

Paragraph (i) states that payment for Medicaid service providers for the months of May and June will be paid no earlier than July 1 of the same calendar year.

6 Availability of community supports. Amends § 245.4712, subd. 1.

- Provides the definition and description of community support services.
- Requires community support services to use all available funding streams and requires counties to maintain funding for services not covered by other funding

streams;

- Instructs the commissioner to collect data on community support programs.

7 **Duties of the county board.** Amends § 245.4874 by adding subd. 2. Provides that the county is not responsible for paying for mental health services if the services are covered by the individual's health plan.

8 **Children's mental health grants.** Creates § 245.4889. Reestablishes the commissioner's authority to provide grants for children's mental health services.

9 **Special contracts bordering states.** Amends § 245.50, subd. 5. Adds that the specified licensed professionals in a bordering state can act as an examiner when a Minnesota resident is admitted to a facility in the bordering state.

10 **Program.** Amends § 245.98, subd. 2. Expands the program for compulsive gamblers to include inpatient and outpatient treatment and rehabilitation services for residents in different settings, including temporary or permanent residential settings for mental health or chemical dependency, and individuals in jails or correctional facilities.

11 **Mental health training requirements.** Creates § 245A.175. Requires that prior to nonemergency placement of a child, licensed foster care providers must complete two hours of training regarding children's mental health issues. Adds that at least one hour of the required annual 12-hour foster parent training be completed on children's mental health issues and treatment.

12 **County portion for cost of care.** Amends § 246.54, subd. 1. Provides the percentage of the cost of care that is a county's responsibility when a resident is in a Regional Treatment Center. Requires the county pay 0 percent for the first 30 days, 20 percent for 31-60 days, and 50 percent for any days over 60. Current law requires counties to pay 20 percent of the cost of care. If payments received by the state exceed 80 percent of the cost of care for days 31-60, or 50 percent for any days over 60, the county is responsible for paying the state only the remaining amount. Provides that this section is effective January 1, 2008.

13 **Exceptions.** Amends § 246.54, subd. 2. Provides that a county is liable for the 10 percent cost of care for individuals who are committed as mentally ill and dangerous, sexual psychopaths, and sexually dangerous persons.

14 **Petition and report required.** Amends § 253B.185, by adding subd. 8. Requires the county attorney, if good cause exists, to file a petition within 120 days of referral from the commissioner of corrections or receipt of a preliminary determination by a court for the civil commitment of a sexually dangerous person or a person with a sexual psychopathic personality. Instructs the commissioner of human services to submit a report to the legislature by February 1 of each year regarding compliance with this section.

15 **Duties of commissioner related to chemical health.** Amends § 254A.25. Instructs the commissioner of human services to develop a directory of licensed chemical dependency treatment programs.

16 **Mental health certified peer specialist.** Creates § 256B.0615.

Subd. 1. Scope. Specifies, subject to federal approval, that mental health certified peer specialist services for eligible individuals are covered by medical assistance.

Subd. 2. Establishment. Creates the program model.

Subd. 3. Eligibility. Provides that consumers of intensive rehabilitative mental health services and adult rehabilitative mental health services are eligible to receive peer specialist services.

Subd. 4. Peer support specialist program providers. Instructs the commissioner to develop a peer support certification process so programs can bill medical assistance for services provided. Allows programs to be freestanding or within existing mental health community provider centers.

Subd. 5. Certified peer specialist training and certification. Directs the commissioner to develop a training and certification process for the individual peer specialists. Sets out minimum requirements that a person must be at least 21 years old, have a high school diploma or its equivalent, have had a primary diagnosis of mental illness, be a former or current consumer of mental health services, and demonstrate leadership and advocacy skills.

17 **Definitions.** Amends § 256B.0622, subd. 2. Modifies the definition of "treatment team" in the intensive rehabilitative mental health services statute to include certified peer specialists.

18 **Qualifications of provider staff.** Amends § 256B.0623, subd. 5. Adds certified peer specialists to the list of providers of adult rehabilitative mental health services. Requires that the peer specialist work under the clinical supervision of a mental health professional.

19 **Intensive mental health outpatient treatment.** Amends § 256B.0625, by adding subd. 51. Adds, subject to federal approval, that medical assistance will cover intensive mental health outpatient treatment for dialectical behavior therapy. States that this section is effective July 1, 2008, subject to federal approval.

20 **Mental health case management.** Amends § 256B.0625, subd. 20. Strikes language that provides grants to counties for mental health services. Sets out the county share of cost for mental health case management services, and clarifies that prepaid medical assistance, general assistance medical care, and MinnesotaCare coverage includes mental health case management. States that this section is effective January 1, 2009, subject to specific exceptions.

21 **Treatment foster care services.** Amends § 256B.0625, subd. 47. Changes the effective date for medical assistance coverage of treatment foster care services from July 1, 2006, to July 1, 2009. This coverage is subject to federal approval.

22 **Required preservice and continuing education.** Amends § 256B.0943, subd. 8. Requires the commissioner to approve curricula for parent team training for mental health behavioral aides.

23 **Payment rates.** Amends § 256B.0945, subd. 4. Clarifies that when a child is in a residential treatment program, prepaid medical assistance covers only the treatment portion of per diem costs, and does not include payment for foster care services. Provides an effective date of January 1, 2009.

24 **Limitation of choice.** Amends § 256B.69, subd. 4. Lists individuals who are exempt from participating in PMAP, including children with severe emotional disturbance, except if the child is eligible for and declines enrollment in an approved preferred integrated network plan. Provides an effective date of January 1, 2009.

25 **Payment for covered services.** Amends § 256B.69, subd. 5g. Excludes mental health services added as covered benefits after December 31, 2007, from the payment reduction mandated under this subdivision.

26 **Payment reduction.** Amends § 256B.69, subd. 5h. Excludes mental health services added as covered benefits after December 31, 2007, from the payment reduction mandated under this subdivision.

27 **Critical access mental health rate increase.** Amends § 256B.763. Requires a 23.7 percent increase in payment rates to mental health providers, and a 2.3 percent increase for individual and family skills training by children's therapeutic services and support providers. Provides an effective date of January 1, 2008.

28 **General assistance medical care; services.** Amends § 256D.03, subd. 4. Makes the

mental health benefit set under GAMC the same as those offered under medical assistance effective January 1, 2008, except case management is effective January 1, 2009.

29 **Covered health services.** Amends § 256L.03, subd. 1. Makes the mental health benefit set under MinnesotaCare the same as those offered under medical assistance effective January 1, 2008, except case management is effective January 1, 2009.

30 **Co-payments and coinsurance.** Amends § 256L.03, subd. 5. Excludes mental health services from the $3 co-payment for nonpreventive visits.

31 **Rate setting; ratable reduction.** Amends § 256L.12, subd. 9a. Excludes payments for mental health services added as covered benefits after December 31, 2007, from the payment reduction to managed care plans under MinnesotaCare.

32 **Compulsive gambling assessment required.** Amends § 609.115, subd. 9. Expands the definition of assessor to provide more flexibility in determining who may conduct compulsive gambling assessments, strikes obsolete language related to rates paid for assessments, and requires the commissioner to standardize assessment rates.

33 **Report.** Instructs the commissioner to make a report to the legislature by January 15, 2008, regarding state funds transferred to counties for the continued employment of state registered nurses. Prohibits the transfer of funds before the report date and states that this section does not apply to positions vacated by routine attrition.

34 **Case management; best practices.** Requires the commissioner to make recommendations for changes to adult mental health case management that are consistent with evidence-based and best practices.

35 **Regional children's mental health initiative.**

Subd. 1. Pilot project authorized; purpose. Establishes a two-year pilot project to improve children's mental health service coordination, communication, and processes in specified counties in south central Minnesota. Provides that the purpose of this initiative is to plan and develop new children's mental health programs and services.

Subd. 2. Goals. Lists goals of the initiative.

Subd. 3. Director's council. Provides that the director's council will govern the operations of the initiative; members will represent each of the 11 counties participating in the pilot project.

Subd. 4. Regional children's mental health initiative team. States that team members shall reflect the cultural, demographic, and geographic diversity of the region. Provides a list of representatives that will compose the team.

Subd. 5. Authority. Provides that the initiative will have the authority to develop and implement specific programs:

- flexible funding payments;
- transition to self-sufficiency;
- crisis response; and
- integrated services for complex conditions.

Subd. 6. Evaluation and report. Requires the initiative to develop a method to measure program effectiveness. Requires an interim report no later than December 31, 2008, and a final report no later than December 31, 2009.

36 Minnesota family investment program and children's mental health pilot project.

Subd. 1. Pilot project authorized. Instructs the commissioner of human services to fund a two-year pilot project to measure the impact of children's mental health needs on MFIP participants' ability to obtain and maintain employment.

Subd. 2. Provider and agency proposals. Paragraph (a). Instructs providers and agencies to submit proposals defining how they will identify program participants, connect families with services, incorporate these services into the participant's employment plan, and how they will measure program outcome.

Paragraph (b). Provides that agencies and providers will inform MFIP participants of available developmental and emotional screening tools, the purpose of the screenings, and how the screenings may be used to modify the participants' employment plans.

Subd. 3. Program components. Provides that participants must give written consent for participation in the program and screening. Directs the providers to assist recipients in arranging for referrals indicated by the screening results. Requires that screening tools be approved by the commissioner.

Subd. 4. Program evaluation. Directs the commissioner to conduct an evaluation of the pilot project.

Subd. 5. Work activity. Provides that participant involvement in screenings and subsequent referral and services shall count as work activity.

37 Social and economic costs of gambling.

Subd. 1. Report. Instructs the commissioner of human services, in consultation with specified entities, to prepare a report that addresses the process and funding mechanisms of completing a study on issues listed in subdivisions 2 and 3. The report is to be submitted to the legislature by December 1, 2007.

Subd. 2. Issues to be addressed. Mandates that the study address the following:

- policies and practices in the state to legalize or prohibit gambling;
- the relationship between gambling and crime in the state;
    - the relationship between expanded gambling and increased rates of problem gambling;
- the social impact of gambling;
- the economic impact of gambling; and
- any other issues deemed necessary.

Subd. 3. Quantification of social and economic impact. States that the study is to quantify the impacts on state, local, and tribal governments; and on Minnesota's communities and social institutions.

38 **Revisor's instruction.** Instructs the revisor to change statutory references to the children's mental health act, and to correct internal references.

39 **Repealer.** Repeals Minnesota Rules, part 9585.0030, the $100 cap on payment for a compulsive gambling assessment.

Article 9: Department of Health Policy

1 **Definitions.** Amends § 62J.17, subd. 2. Adds a definition of "specialty care" and removes definitions of "access," "cost," and "date of the major spending commitment."

2 **Expenditure reporting.** Amends § 62J.17, subd. 4a. Provides that health care facilities must report to the commissioner on all major spending commitments and includes information that must be included. Removes current language.

3 **Prospective review and approval.** Amends § 627J.17, subd. 6a. Removes obsolete language.

4 **Exceptions.** Amends § 62J.17, subd. 7. Removes some exceptions to the reporting requirements, including spending to replace existing equipment and spending for remodeling and repairs.

5 **Cost containment data to be collected from providers.** Amends § 62J.41, subd. 1. Adds to the list of information health care providers are required to collect and report.

6 **Uniform billing form CMS 1450.** Amends § 62J.52, subd. 1. Allows Medicare critical access hospitals using method II billing to include professional fees on the CMS 1450.

7 **Uniform billing form CMS 1500.** Amends § 62J.52, subd. 2. Allows Medicare critical access hospitals using method II billing to include professional fees on the CMS 1450.

8 **General characteristics.** Amends § 62J.60, subd. 2. Specifies that standardized labels must come before the human data elements on the Minnesota uniform health care identification card.

9 **Human readable data elements.** Amends § 62J.60, subd. 3. Specifies that the standard label for service type on the Minnesota uniform health identification card is "Svc Type."

10 **Approval.** Amends § 62Q.80, subd. 3. Strikes language that allows the commissioner to only approve a program awarded a community access program grant from the U.S. Department of Health and Human Services.

11 **Establishment.** Amends § 62Q.80, subd. 4. Eliminates a reference to the initiative using money collected from premium payments to capture federal funds.

12 **Report.** Amends § 62Q.80, subd. 13. Delays by one year, from January 15, 2007, to January 15, 2008, the date on which the initiative must submit its first quarterly status report. Also delays by one year, from January 15, 2009, to January 15, 2010, the date by which an evaluation of the program must be submitted to the commissioners of health and commerce and the legislature.

13 **Sunset.** Amends § 62Q.80, subd. 14. Extends the sunset of the statutory language authorizing the initiative by one year, from December 31, 2011, to December 31, 2012.

14 **Public interest review.** Amends § 144.552. Adds to the requirements for public interest review plans in cases where an existing hospital seeks to construct a new hospital and specifies aspects that must be included in these plans. Requires the commissioner to monitor the implementation of the plans, and provides the hospital must submit a report to the commissioner describing how the project met the original plan.

15 **Process when hospital need is determined.** Amends § 144.553, subd. 3.

- Adds the same plan requirements as in section 14 to plans submitted by existing hospitals in cases where the commissioner has determined a new hospital is

needed in a particular area.

- Updates cross-references.

- Requires the legislative appointees to the advisory committee to include, at least, the chairs of the senate and house committees on health care policy.

- Requires the commissioner to monitor the implementation of the plans, and provides the hospital must submit a report to the commissioner describing how the project met the original plan.

16 **Diagnostic imaging facilities.** Amends § 144.565. Modifies reporting requirements for diagnostic imaging services.

Subd. 1. Utilization and services data; economic and financial interests. Also applies the requirements to providers of diagnostic imaging services, specifies a March 1 annual reporting date, and modifies the list of information that must be provided.

Subd. 2. Commissioner's right to inspect records. (No change to this subdivision.)

Subd. 3. Separate reports. Requires reports to include only services billed by the provider submitting the report, and requires separate annual reports if capacity, technical services, or professional services are leased to another provider. Strikes language related to separate reports for facilities that are not attached or contiguous to a hospital.

Subd. 4. Definitions. Modifies the definition of diagnostic imaging facility to refer to facilities that are not a hospital or location licensed at a hospital and makes other related changes. Adds definitions for the following terms: diagnostic imaging service, portable equipment, and provider of diagnostic imaging services. Also modifies the definition of fixed equipment and mobile equipment.

Subd. 5. Reports open to public inspection. States that reports filed under this section are open to public inspection.

17 **Methicillin-resistant staphlococcus aureus control programs.** Adds § 144.585. Requires hospitals to establish a MRSA control program that meets the MDH recommendations that will be published January 15, 2008. States the infection control practices that MDH must consider in developing the MRSA recommendations.

18 **Information about treatment.** Amends § 144.651, subd. 9. States that patients may be accompanied by family or a representative or both. (Current law provides for one or the other.)

19 **Participation in planning treatment; notification of family members.** Amends § 144.651, subd. 10. Provides that a chosen representative may include a doula of the patient's choice.

20 **Right to associate.** Amends § 144.651, subd. 26.

- Adds that residents of health care facilities have the right to visitation by the

patient's health care agent, and the right to visitation and health care decision-making by a person designated by the patient.

- Adds that the patient, conservator, or legal guardian of the patient must be given the opportunity to designate a person who is not related as one who will have the status of next of kin. If a patient has a health care directive or has appointed a health care agent, that prevails over a designation under this paragraph for making health care decisions. Allows the unrelated person to be identified by the patient or the patient's family.

21 **Annual reports on community benefit, community care amounts, and state program underfunding.** Amends § 144.699 by adding subd. 5. Requires the commissioner to do an annual report on hospitals' community care, community benefit and underpayment for state public health care programs. Requires that it be reported in terms of total dollars and as a percentage of each hospital's operating costs.

22 **Suggested form; provisions that may be included.** Amends § 145C.05. Adds that a health care directive may include a limitation on the health care agent visiting the principal when the principal is a patient in a health care facility.

23 **Visitation.** Amends § 145C.07, by adding subd. 5. Allows a health care agent to visit the principal in a health care facility regardless of whether the principal retains decision-making capacity. Lists three circumstances under which visitation will not be allowed.

24 **Initial licensure fee.** Amends § 148.6445, subd. 1. Decreases the initial licensure fee for occupational therapists from $180 to $145, and for occupational therapy assistants from $100 to $80.

25 **Licensure renewal fee.** Amends § 148.6445, subd. 2. Decreases the biennial license renewal fee for occupational therapists from $180 to $145, and for occupational therapy assistants from $100 to $80.

26 **Fees.** Adds § 148.785. Establishes fixed rate application and license related fees for physical therapists and physical therapy assistants.

27 **Definitions.** Adds § 148.995.

Subd. 1. Applicability. Provides that the definitions in this section apply to sections 148.995 to 148.997.

Subd. 2. Certified doula. Defines "certified doula" as a person certified by one of the listed organizations to perform doula services.

Subd. 3. Commissioner. Refers to the commissioner of health.

Subd. 4. Doula services. States that "doula services" include emotional and physical support during pregnancy, labor, birth and postpartum.

States that this section is effective on July 1, 2007.

28 **Registry.** Adds § 148.996.

Subd. 1. Establishment. Requires the commissioner to maintain a registry of certified doulas.

Subd. 2. Qualifications. States the requirements for a doula to be included in the

registry.

Subd. 3. Criminal background check. Requires the commissioner to conduct criminal background checks on the persons listed on the doula registry. Requires that criminal behavior of applicants be indicated on the registry.

Subd. 4. Renewal. States that a doula may be in the registry for three years, then the doula is required to reapply.

Subd. 5. Public access. Requires the commissioner to provide a web-link to the registry on the Department of Health's website.

States that this section is effective on July 1, 2007.

29 **Fees.** Adds § 148.997. Provides an application fee of $130 and a background check fee of $6. States that these fees are nonrefundable. States that this section is effective on July 1, 2007.

30 **Fee.** Amends § 148B.53, subd. 3. Provides the fixed fee rates that are to be charged by the board.

31 **Application procedure; documentation; initial inspection.** Amends 149A.52, subd. 3. Allows for an appropriate fee to accompany the application for license to operate a crematory.

32 **Fees.** Adds § 149.65. Sets out the fee requirements for mortuary science.

Subd. 1. Generally. States that this section establishes fees for registrations, examinations, licenses and late fees.

Subd. 2. Mortuary science fees. Sets out the fee schedule for mortuary science

- $50 for the initial and renew registration for interns
- $100 for the mortuary science examination
- $125 for initial and renewal licenses
- $25 late fee for past due license renewals
- $200 for licenses by endorsement

Subd. 3. Funeral directors. Requires a $125 license renewal fee for funeral directors and a $25 late fee.

Subd. 4. Funeral establishments. Requires a $300 initial and renewal fee for funeral establishments and a $25 late fee.

Subd. 5. Crematories. Requires a $300 initial and renewal fee for crematories and a $25 late fee.

33 **Reports to commissioner.** Amends § 149A.97, subd. 7. Sets the fee that must accompany a funeral provider's annual accounting of each trust.

34 **License required annually.** Amends § 157.16, subd. 1. Requires that only one license be

issued to nonprofit organizations operating special event food stands at one-day events.

35 **Injunctive relief report.** Requires the commissioner to report recommendations to the legislature by December 15, 2007, on how to fund the costs of bringing actions for injunctive relief relating to housing with services establishments, under section 144G.02.

36 **Hearing aid dispenser fees.** Prohibits any increase in fees relating to hearing aid dispensers until the Department of Health reports to the legislature regarding the need and reasons for such increases.

37 **Appropriation.** Provides an appropriation to the commissioner of health from the state government special revenue fund for the implementation of the doula registry.

38 **Repealer.** Repeals Minnesota Rules, part 4610.2800 (mortuary science fees).

Article 10: Department of Health

1 **Demonstration project.** Amends § 62Q.80, by adding subd. 1a. Requires the commissioner of health to award a five-year demonstration project grant to a community-based health care initiative, to develop a health care coverage program within Carlton, Cook, Lake, and St. Louis counties.

2 **Minnesota health records act.** Adds § 144.291. Provides a name for this act and defines key terms.

Subd. 1. Gives this act the title "Minnesota Health Records Act."

Subd. 2. Defines terms, including, but not limited to, the following: "health record," "identifying information," "individually identifiable form," "medical emergency" and "record locator service."

3 **Patient rights.** Adds § 144.292. Describes the rights patients have regarding health records.

Subd. 1. Scope. States that patients have the rights set out in this section regarding treatment and health records.

Subd. 2. Patient access. Requires a provider to provide a patient with information relating to diagnosis, treatment and prognosis if the patient so requests.

Subd. 3. Additional patient rights. Provides cross-references to other patient rights.

Subd. 4. Notice of rights; information on release. Requires providers to provide patients with a written notice of practices and rights relating to health records. States requirements of this notification. Requires the commissioner of health to develop the notice that is required.

Subd. 5. Copies of health records to patients. Provides that if a patient makes a written request, then a provider must furnish the patient with copies of the patient's health record or the portion relating to the condition specified by the patient. States that the patient may pay a reasonable cost for the copies. States that a provider may provide a summary of the record if the patient so consents.

Subd. 6. Cost. Specifies the amounts that may be charged and conditions for copying health records.

Subd. 7. Withholding health records from patient. Allows a provider to withhold the health record from a patient if the provider reasonably determines the information is detrimental to the patient.

Subd. 8. Form. Requires the Department of Health to develop a form that patients may use to request access to health records.

4 **Release or disclosure of health records.** Adds § 144.293. Regulates how and in what circumstances health records may be released.

Subd. 1. Release or disclosure of health records. Allows health records to be released as provided in this section and sections 144.294 and 144.295.

Subd. 2. Patient consent to release of records. Prohibits disclosure of health records without signed and dated consent from the patient, authorization in law, or representation that that provider holds consent from the patient.

Subd. 3. Release from one provider to another. Provides that a patient's health record must be given to another provider at the patient's request. Allows the furnishing provider to keep a copy and makes the patient responsible for the cost of furnishing the information.

Subd. 4. Duration of consent. Provides that consent is valid for one year, or less if so specified.

Subd. 5. Exceptions to consent requirement. Provides reasons for providing health records without consent, including, but not limited to:

- a medical emergency
- necessary for current treatment of the patient

Subd. 6. Consent does not expire. States the reasons for which a patient's consent to the release of health records does not expire after one year.

Subd. 7. Exception to consent. States that the consent requirement does not apply to releases to the commissioner of health or the Health Data Institute, so long as the patient identifier information is encrypted.

Subd. 8. Record locator service. (a) Allows a provider or group purchaser to provide patient information to a record locator service without consent from the patient. States that a provider that uses a record locator service may not access patient information without consent. States that this consent does not expire, but may be revoked by the patient. Provides that only a provider may access information in a record locator service.

(b) States the requirements of an audit log that must be maintained by an entity maintaining a record locator service.

(c) Prohibits group purchasers from requiring providers to participate in a record

locator service.

(d) Provides that entities that operate a record locator service must provide a way in which patients may exclude their information from the record locator service.

Subd. 9. Documentation of release. Requires releases of health records without consent to be documented in the health record. Specifies the information that a releasing provider must document when a record is released based on a representation from the provider.

Subd. 10. Warranties regarding consents, requests, and disclosures. (a) States the warranties made by a person when requesting health records by consent.

(b) States the warranties made by a provider when requesting health records by consent.

(c) States the warranties made by a person releasing health records.

5 **Records relating to mental health.** Adds § 144.294. Provides special regulations that apply only to mental health records.

Subd. 1. Provider inquiry. Requires a provider to receive authorization from a patient, who is being seen for mental illness, before certain relatives may be told about the patient's treatment.

Subd. 2. Disclosure to law enforcement agency. Requires disclosure of health records relating to a patient's mental health to law enforcement if the patient is involved in an emergency situation with law enforcement, or if it is necessary to protect the health and safety of an individual. Limits this disclosure to the minimum necessary and classifies records received by law enforcement as private.

Subd. 3. Records release for family and caretaker; mental health care. Provides the conditions and limitations for a provider to disclose mental health care and treatment information to a patient's family member.

6 **Disclosure of health records for external research.** Adds § 144.295.

Subd. 1. Methods of release. Provides requirements for disclosing health records for medical or scientific research. Allows authorization to be established if a patient does not respond to two mailings that give notice of possible release of medical records.

Subd. 2. Duties of researcher. Requires a provider to make certain determinations when releasing a record for research, including, but not limited to, the following:

- The recipient has adequate safeguards to protect the record
- The use or disclosure of an individually identifiable record is necessary for research
- The use or disclosure does not violate any limitations under which the record

was created

7 **Copies of videotapes.** Adds § 144.296. States that a provider may not release a copy of a videotape of a child victim or alleged victim of abuse without a court order.

8 **Independent medical examination.** Adds § 144.297. Allows a provider to release health records for an independent medical examination to the third party who requested or paid for the examination.

9 **Penalties.** Adds § 144.298.

Subd. 1. Licensing action. Provides that violation of this act may be grounds for disciplinary action by the appropriate licensing board.

Subd. 2. Liability of provider or other person. Provides criteria for the court to consider when determining liability in disputes involving disclosure of health records.

Subd. 3. Liability for record locator service. Creates liability for the record locator service for a negligent or intentional violation of section 144.293, subdivision 8.

10 **Interconnected electronic health record grants.** Amends § 144.3345.

Subd. 1. Definitions. Allows an "eligible community e-health collaborative" to consist of two (rather than three, as in current statute) or more eligible health care entities.

Subd. 2. Grants authorized. Adds to the list of eligible grantees for the interconnected electronic health record grants. Allows for community clinics, regional or community-based health information exchange organizations, community health boards, and boards of health to receive grants. (Currently, only eligible community e-health collaboratives may receive these grants.)

Subd. 3. Allocation of grants. Requires grant applications to include a plan for the used of data exchange standards, in addition to requirements already in statute.

Subd. 4. Evaluation and report. (No change to current statute.)

11 **Registration procedures.** Amends § 144D.03, subd. 1. Increases the annual registration fee for housing with service establishments from $35 to $155.

12 **Federally qualified health centers.** Adds § 145.9269.

Subd. 1. Definitions. Defines "federally qualified health center" for purposes of this section.

Subd. 2. Allocation of subsidies. Requires the commissioner to distribute subsidies to certain federally qualified health centers to improve services to low-income populations. States the method for determining the amount of each subsidy.

13 **Health promotion program.** Requires the commissioner of health and State Community Health Services Advisory Committee to develop a plan to fund and implement a health promotion program. Provides requirements for aspects to be included in the program. States that the plan must be completed by October 1, 2007, and shared with the Legislative Health Care Access Commission.

14 **Cervical cancer prevention and human papilloma virus vaccine study.** Requires the commissioner of health to reconvene the cervical cancer elimination study to conduct a study on the human papilloma virus vaccine. Requires the commissioner to submit a report to the legislature by February 1, 2008.

15 **Revisor's instruction.** Instructs the revisor to update and correct cross-references.

16 **Repealer.** Repeals section 144.335 (access to health records). Repeals Laws 2006, chapter 249, section 6 (sunset provision).

Article 11: Miscellaneous Policy

1 **Prescription electronic reporting system.** Amends § 13.381, subd. 16a. States that data in the prescription electronic reporting system is governed by Minnesota Statutes, section 152.126.

2 **Radiation therapy facility construction.** Amends § 144.5509. Places a two-year moratorium on the construction of any radiation therapy facility located in the following counties: Hennepin, Ramsey, Dakota, Washington, Anoka, Carver, Scott, St. Louis, Sherburne, Benton, Stearns, Chisago, Isanti, and Wright. Provides an exception for the relocation or reconstruction of an existing facility owned by a hospital, if the relocation or reconstruction is within one mile of the existing facility. Provides an exception for a facility in Wright County that meets specified conditions. Provides an expiration date of August 1, 2009.

3 **Dispensing by protocol.** Amends § 148.235, by adding a subdivision. Provides that a registered nurse employed by a family planning agency may dispense oral contraceptives prescribed by a licensed practitioner, such as a physician or advance practice registered nurse, pursuant to dispensing protocol. The protocol must meet the requirements for dispensing and labeling the drugs as set forth in sections 151.01, subdivision 30, and 151.212, subdivision 1.

4 **Nonresident pharmacies.** Amends § 151.19, subd. 2. Requires nonresident pharmacies, as a condition of registration with the board of pharmacy, to dispense medications in unit-dose packaging or comply with § 151.415, subd. 5 (delivering medications dispensed for a nursing home resident directly to the contract pharmacist or pharmacy), upon the request of a resident of a long-term care facility or an agent of the resident.

5 **Long-term care resident access to pharmaceuticals act.** Adds § 151.415.

Subd. 1. Title; citation. States that the section may be cited as the long term care resident access to pharmaceuticals act.

Subd. 2. Definitions. Defines board, contract pharmacy, long-term care pharmacy, and original dispensing pharmacy.

Subd. 3. Authorization to administer and repackage drugs. (a) Allows a contract pharmacist or pharmacy to repackage a resident's prescription drugs which have been lawfully dispensed from bulk prescription containers into a unit-dose system.

(b) Allows a long-term care facility to administer repackaged drugs. Requires the contract pharmacy to notify the long-term care facility whenever drugs are dispensed according to this subdivision and certify that the repackaging and dispensing comply with this subdivision.

(c) Allows drugs to be dispensed for a resident of a long-term care facility if: (1) the

drug is dispensed by the original dispensing pharmacy according to a current, valid prescription; (2) the original bulk prescription container is delivered directly to the contract pharmacist or pharmacy; (3) the contract pharmacist or pharmacy verifies the name and strength of the drug and other specified information; (4) the contract pharmacist or pharmacy verifies the validity and accuracy of the prescription; (5) the contract pharmacist or pharmacy repackages the drug in board-approved unit-dose packaging; (6) the resident obtains medications from or at a discounted rate under the resident's state or federal health assistance program or a private health insurance plan; and (7) an informed consent form has been signed by the resident or the authorized representative.

(d) Requires the contract pharmacy to maintain specified information for at least two years.

Subd. 5. Duties of the original dispensing pharmacy. Requires the original dispensing pharmacy, upon request, to deliver medications directly to the contract pharmacist or pharmacy, and provide specified information to the contract pharmacist or pharmacy.

Subd. 6. Redispensing of returned drugs prohibited. Prohibits unused repackaged drugs returned to any pharmacy from being redispensed.

Subd. 7. Immunity for civil liability. Provides a contract pharmacist or pharmacy and its employees or agents, and a long-term care facility and its employees or agents, with immunity from civil liability.

Subd. 8. Handling fee. Allows a contract pharmacist or pharmacy to charge a monthly fee of no more than 250 percent of the MA dispensing fee for each drug repackaged, but no more than $100 per month for each individual resident.

6 Identification requirement for schedule II or III controlled substance. Amends § 152.11, by adding subd. 2d. States that dispensers must require persons purchasing a controlled substance to present valid photographic identification, unless the purchaser or the person for whom the prescription is written in known to the dispenser.

7 Schedule II and III controlled substances prescription electronic reporting system. Adds § 152.26.

Subd. 1. Definitions. Defines terms.

Subd. 2. Prescription electronic reporting system. (a) Requires the board of pharmacy to establish, by January 1, 2009, an electronic system for reporting the information required under subdivision 4 for controlled substances dispensed within the state. Exempts reporting for small quantities.

(b) Allows the board to contract with a vendor for technical assistance in designing, implementing, and maintaining the electronic reporting system.

Subd. 3. Prescription electronic reporting advisory committee. (a) Requires the board to convene an advisory committee and specifies membership and duties.

(b) Requires the advisory committee to advise the board on the development and operation of the electronic reporting system, and lists specified issues.

(c) Requires the Board of Pharmacy, after consultation with the advisory committee, to present recommendations and draft legislation on issues addressed by the advisory committee under paragraph (b) to the legislature by December 15, 2007.

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

(1) name of the prescriber;

(2) national provider identifier of the prescriber;

(3) name of the dispenser;

(4) national provider identifier of the dispenser;

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

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

(7) date the prescription was written;

(8) date the prescription was filled;

(9) name and strength of the controlled substance;

(10) quantity of controlled substance prescribed; and

(11) quantity of controlled substance dispensed.

(b) Requires the information to be submitted by a procedure and in a format established by the board.

(c) Exempts from data submittal requirements controlled substance prescriptions dispensed for persons residing in a nursing facility or intermediate care facility, receiving assisted living or waiver services, receiving medication intravenously, receiving hospice and other end-of-life care, and receiving services from a home care provider.

(d) Prohibits a dispenser from submitting data unless notice is given to the patient of the reporting requirement.

Subd. 5. Use of data by board. (a) Requires the board to develop and maintain a database, and to encrypt data that could identify an individual prescriber or dispenser. Allows the data base to be used by permissible users for identifying: (1) individuals who obtain controlled substances in quantities or with a frequency inconsistent with generally recognized standards; and (2) individuals who present forged, false, or altered prescriptions.

(b) Prohibits permissible users from accessing the database, without a search warrant or court order, for the sole purpose of identifying prescribers with unusual or excessive prescribing patterns.

(c) Prohibits personnel of an occupational licensing board or agency from accessing the database for the purpose of obtaining information related to a disciplinary action against a prescriber.

(d) Requires the board to remove data from the database 12 months from the date the data was received.

Subd. 6. Access to reporting system data. (a) Classifies the data as private data, except as indicated in this subdivision.

(b) Lists permissible users of the database.

(c) Specifies data security requirements that permissible users must follow.

(d) Prohibits the board from releasing data unless it is provided with satisfactory evidence that the person requesting the information is entitled to receive the data.

(e) Prohibits the board from releasing the name of a prescriber without written consent or a valid search warrant or court order.

(f) Requires the board to maintain a log of all persons who access the data and to ensure that any user complies with the data security requirements.

Subd. 7. Disciplinary action. (a) Provides that dispensers who knowingly fail to submit data are subject to disciplinary action by the appropriate health licensing board.

(b) Provides that a prescriber or dispensers who knowing discloses data in violation of data privacy laws shall be subject to disciplinary action by the appropriate health licensing board and appropriate civil penalties.

Subd. 8. Evaluation and reporting. Requires the board to evaluate the prescription electronic reporting system and to report to the legislature by January 15, 2010.

Subd. 9. Immunity from liability; no requirement to obtain information. (a) Provides immunity from civil, criminal, or administrative liability for a pharmacist, prescriber, or other dispenser making a report to the program in good faith.

(b) Provides civil, criminal, or administrative liability for a pharmacist, prescriber, or other dispenser who requests, receives, or uses information from the program in good faith.

Provides an effective date of July 1, 2007, or upon receipt of sufficient nonstate funds to implement the program, whichever is later.

8 **Duties of county board.** Amends §245.4874. Adds clarifying language.

9 **Transfer to correctional facility.** Amends § 253B.185, subd. 2. Deletes an obsolete cross-reference. The reference to section 609.108, subdivision 6, was repealed by Laws 2006, chapter 260, article 1, section 48.

10 **Rules for chemical dependency care.** Amends § 254A.03, subd. 3. Deletes words of limitation.

11 **Program and service guidelines.** Amends § 254A.16, subd. 2. Limits the commissioner to providing program and service guidelines and technical assistance to county boards in carrying out services under section 245A.08 (detoxification centers). Current law includes services under section 254A.12 (affected employees), 254A.14 (services to youth and other underserved populations), and chapter 256E (community social services). Sections 254A.12 and 254A.14 are being repealed.

12 **Chemical dependency treatment allocation.** Amends § 254B.02, subd. 1. Changes the requirement that the commissioner allocate funds to the American Indian chemical dependency tribal account equal to the amount allocated in fiscal year 1997. New language requires the commissioner to reserve 6 percent for tribal allocation.

13 **Administrative adjustment.** Amends § 254B.02, subd. 5. Deletes language that instructs the commissioner to advance local agencies 25 percent of their administrative allowance. Deletes language regarding adjustments for over- or under-payments.

14 **Local agency duties.** Amends § 254B.03, subd. 1. Deletes language capping rates for vendors.

15 **Local agencies to pay state for county share.** Amends § 254B.03, subd. 3. Simplifies language so that this section now provides that local agencies shall pay the state for the county share of services they authorized.

16 **Payment; denial.** Amends § 254B.06, subd. 3. Deletes language that allows the commissioner to charge a county 100 percent of payments made for chemical dependency treatment services if the county-approved invoice is received by the commissioner more than 120 days after the last date of service provided.

17 **Day treatment services.** Amends § 256B.0625, subd. 23. Adds a reference to Minnesota Rules related to day treatment service payment limitations.

18 **Provider entity clinical infrastructure requirements.** Amends § 256B.0943, subd. 6. Requires children's therapeutic services and supports providers of day treatment to have a supervisor present and to have the supervisor review, approve, and sign the client's treatment plan, or change in treatment plan. Current language allows the provider to perform these functions.

19 **Service delivery criteria.** Amends § 256B.0943, subd. 9. Requires day treatment programs to be available at least one day a week for a three-hour time block. Current language states for a "minimum" three-hour time block.

20 **Documentation and billing.** Amends § 256B.0943, subd. 11. States that a provider cannot bill for anything other than direct service time.

21 **Excluded services.** Amends § 256B.0943, subd. 12. Provides that activities that are not direct service time are not eligible for medical assistance payment.

22 **Definitions.** Amends § 256E.35, subd. 2. Corrects a statutory reference.

23 **Repealer.** Amends Laws 2005, chapter 98, article 3, section 25. Strikes the repeal of section 245.713, subdivision 2 (allocation formula for mental health services). States that this section has a retroactive effective date of August 1, 2005.

24 **Federal grants.** Requires the board of pharmacy to apply for applicable federal grants or other nonstate funds to establish and implement the prescription electronic reporting system.

This section has an immediate effective date.

25 **Board of Pharmacy.** Prohibits the Board of Pharmacy from increasing license fees of pharmacists or pharmacies to adequately fund the prescription electronic reporting system, without specific authority from the legislature.

This section has an immediate effective date.

26 **Board of Medical Practice.** Requires the Board of Medical Practice to convene a workshop on the appropriate prescribing of controlled substances for pain management, and report to the legislature by December 15, 2007.

27 **Repealer.** (a) Repeals Minnesota Statutes, §§ 254A.02, subds. 7 (definition of "intoxicated person"), 9 (definition of "program director"), 12 (definition of "area mental health board or area board"), 14 (definition of "youth"), 15 (definition of "underserved populations"), and 16 (definition of "affected employee"); 254A.085 (Hennepin County pilot alternative for chemical dependency services); 254A.086 (culturally targeted detoxification program); 254A.12 (affected employees); 254A.14 (services to youth and other underserved populations); 254A.15 (affirmative outreach); 254A.16, subd. 5 (professional standards); 254A.175 (chemical dependency treatment models for families with potential child protection problems); 254A.18 (state chemical health index model); 256J.561, subd. 1 (implementation of universal participation requirements); 256J.62, subd. 9 (continuation of certain services); and 256J.65 (self-employment investment demonstration project).

(b) Repeals Minnesota Rules, part 9503.0035, subpart. 2 (child care centers; first aid training).

Article 12: Miscellaneous

1 **General.** Amends § 43A.23, subd. 1. Exempts the state employee group insurance program from being required to expand dependent coverage to include an eligible employee's unmarried child under the age of 25. Requires the program to comply with dependent coverage requirements that applied prior to the expansion of coverage under sections 2 and 6 of this article.

2 **Dependent.** Amends § 62E.02, subd. 7. Modifies the definition of "dependent" to mean an unmarried child who is under the age of 25. Provides a January 1, 2008, effective date.

3 **62H required provisions.** Amends § 62H.02. Makes conforming changes related to the agricultural cooperative health plan for farmers.

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

4 **Legislative oversight.** Amends § 62J.07, subd. 1. Requires the Legislative Commission on Health Care Access (LOC) to present recommendations to the legislature by January 15, 2008, on how to achieve the goal of universal health coverage.

5 **Reports to the commission.** Amends § 62J.07, subd. 3. Requires state agencies to provide the LOC with assistance and technical support and authorizes the LOC to convene subcommittees to provide additional assistance and advice.

6 **Dependent.** Amends § 62L.02, subd. 1. Extends dependent coverage to an unmarried child under the age of 25. Provides a January 1, 2008, effective date.

7 **Prescribing and filing.** Amends § 151.37, subd. 2. Provides that a prescription or drug order is not valid if it is based solely on an online questionnaire, unless it can be established that the prescription or order was based on a documented patient evaluation adequate to establish a diagnosis and identify underlying conditions and contraindications.

8 **Identification requirement for schedule II or III controlled substance.** Amends § 152.11, by adding subd. 2d. (a) States that dispensers must require persons purchasing a controlled substance to present valid photographic identification, unless the purchaser or the person for whom the prescription is written in known to the dispenser.

(b) States that this subdivision applies only to purchases not covered by a health plan company or other third-party payer. Requires the Board of Pharmacy to report to the

legislature by July 1, 2009, on any complaints related to this subdivision and whether this subdivision creates barriers to access.

9 **Assessor standards; rules; assessment time limits.** Amends § 169A.70, subd. 4. Allows an assessor to have a financial conflict of interest subject to the conditions specified in section 245A.20, subdivision 3. Provides an immediate effective date.

10 **Chemical use assessments.** Adds §254A.20. Specifies who is responsible for doing chemical use assessments under certain circumstances, and the time limit for doing the assessments.

Subd. 1. Persons arrested outside of home county. Provides that when a person is arrested and taken into custody outside of the person's county of residence, a chemical use assessment must be completed by the person's county of residence within three weeks after the assessment is initially requested. If the assessment is not performed within the time limit, the county where the person is to be sentenced must perform the assessment. Financial responsibility is determined under Minnesota Statutes, chapter 256G.

Subd. 2. Probation officer as contact. Provides that when a person is on probation or under correctional supervision, and an assessment is required, the assessor is required to contact the person's probation officer to verify or supplement the information provided by the person.

Subd. 3. Financial conflicts of interest. Prohibits any direct or shared financial interest or referral relationship resulting in shared financial gain with a treatment provider. However, a county may contract with an assessor having a conflict under the two narrow exceptions under this subdivision.

Effective date. Provides that this section is effective July 1, 2007, except subdivision 3, is effective the day following final enactment.

11 **Controlled substance prescriptions; abuse prevention.** Adds § 256B.0636. Requires the commissioner of human services to develop and implement a plan to monitor the use of controlled substances by state health care program enrollees, develop a mechanism to prevent abuses, and provide education to program enrollees on the proper use of controlled substances.

12 **Chemical assessment required.** Amends § 609.115, subd. 8. Allows an assessor to have a financial conflict of interest subject to the conditions specified in section 245A.20, subdivision 3. Provides an immediate effective date.

13 **Interpreter services work group.** Paragraph (a) requires the commissioner of health to convene a work group to study the provision of interpreter services to patients in medical and dental care settings.

Paragraph (b) requires the work group to develop findings and recommendations on assuring access to interpreter services, compliance with federal law and guidance, developing a quality assurance program, and identifying funding mechanisms.

Paragraph (c) requires the work group to present recommendations to the commissioner and to the chairs of the house and senate health policy and finance committees by January 15, 2008.

Paragraph (d) provides that the work group expires after submission of the report.

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

14 **Agricultural cooperative health plan for farmers.** Requires the commissioner of commerce to authorize a joint-self insurance pilot project administered by a trust sponsored by one or more agricultural cooperatives for the purpose of offering health coverage to members of the cooperatives and their families. Specifies project requirements and evaluation and project extension procedures.

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

15 **Health plan purchasing pool study group.**

Subd. 1. Creation; membership. Establishes a health care purchasing pool study group to study and make recommendations regarding the creation of a voluntary, statewide health plan purchasing pool to contract directly with providers to provide affordable health coverage to state residents. Specifies the membership of the study group and requires appointments to be made within 30 days of the effective date of the act.

Subd. 2. Study; report. Requires the study group to make recommendations on specified issues related to the creation, maintenance, and funding of a voluntary, statewide purchasing pool to provide comprehensive, cost-effective, and medically appropriate coverage to all public and private employees in Minnesota and all Minnesota residents. Requires the study group to submit a report and draft legislation to the legislative chairs of 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. Requires state agencies to provide the study group with any requests for information necessary to complete the report.

Subd. 4. Removal; vacancies; expenses. Provides that the removal of members, vacancies, and expenses are governed by section 15.059.

Subd. 5. Expiration. Provides that this section expires after submission of the report under subdivision 2.

Effective date. Provides an immediate effective date.

16 **Repealer.** Repeals Minnesota Statutes, section 62A.301 (coverage for full-time students).

Article 13: Children's Health Programs; MinnesotaCare

1 **Extended coverage for children.** Amends § 256B.057, by adding subd. 2c. Provides two months of extended MA eligibility for children who become ineligible for the program due to excess income. Provides that these children are deemed automatically eligible for MinnesotaCare until renewal. Provides an effective date of October 1, 2008, or upon federal approval.

2 **Families with children.** Amends § 256L.04, subd. 1. Exempts children formerly enrolled in MA and automatically deemed eligible for MinnesotaCare from the MinnesotaCare income limit, until renewal. Provides an effective date of October 1, 2008, or upon federal approval.

3 **Exception for certain children.** Amends § 256L.07, by adding subd. 7. Exempts until renewal children formerly enrolled in MA and automatically deemed eligible for MinnesotaCare from the requirements that MinnesotaCare enrollees have no access to employer-subsidized coverage, no access to employer-subsidized coverage through the current employer for 18 months prior to application or reapplication, and no other health coverage while enrolled or for at least four months prior to application and renewal.

4 **Definition; children's health program.** Adds § 256L.22. For purposes of sections 256L.22 to 256L.28, defines "children's health program" as the MA and MinnesotaCare programs to the extent they provide health coverage to children. Provides an effective date of October 1, 2008, or upon federal approval.

5 **Health care eligibility for children.** Adds § 256L.24.

> **Subd. 1. Applicability.** States that this section applies to children who are enrolled in a children's health program.
>
> **Subd. 2. Application procedure.** Requires that the commissioner develop an application form for children's health programs for children that is easily understandable and does not exceed four pages in length. States that the MinnesotaCare requirements for the availability of applications and application assistance, and application submittal, apply to children's health programs.
>
> **Subd. 3. Premiums.** Requires children enrolled in MinnesotaCare to pay MinnesotaCare premiums.
>
> **Subd. 4. Eligibility renewal.** Requires children to renew eligibility every 12 months.

Provides an effective date of October 1, 2008, or upon federal approval.

6 **Assistance to applicants.** Adds § 256L.26. Requires the commissioner to assist children in choosing a managed care organization by: (1) establishing a Web site to provide information about managed care organizations and to allow online enrollment; (2) make applications and information on managed care organizations available in a manner consistent with civil rights laws and regulations; and (3) make benefits educators available to assist applicants in choosing a managed care organization. Provides an effective date of October 1, 2008, or upon federal approval.

7 **Federal approval.** Adds § 256L.28. Requires the commissioner to seek all federal waivers and approvals necessary to implement sections 256L.22 to 256L.28, including but not limited to those necessary to: (1) coordinate MA and MinnesotaCare coverage for children; and (2) maximize receipt of federal MA match by increasing income standards through the use of more liberal income methodologies. Provides an effective date of October 1, 2008, or upon federal approval.

Article 14: Health Care Reform Policy

1 **Hospital information reporting disclosure.** Amends § 62J.82. Requires the Minnesota Hospital Association to include on their public web-based system information on hospital specific performance on measures of care related to acute myocardial infarction, heart failure, and pneumonia. Beginning January 1, 2009, requires inclusion of hospital-specific performance measures for hospital-acquired infections. Requires the commissioner of health to provide a link to the reported information on the MDH web site. Allows the commissioner to take action against the license of a hospital that does not provide the

required information.

Article 15: Health Care Reform

1 **Evidence-based health care guidelines.** Adds § 62J.431. Specifies criteria for evidence-based guidelines.

2 **Health information technology and infrastructure.** Amends § 62J.495. Requires all hospitals and health care providers, by January 15, 2015, to have in place an interoperable electronic health records system. Requires the commissioner of health, in consultation with the health information technology and infrastructure advisory committee, to develop a statewide plan to meet this goal, including uniform standards. Requires uniform standards to be adopted by January 1, 2009, with a status report due to the legislature by January 15, 2008. Requires the advisory committee to provide recommendations to the commissioner for encouraging innovative health care applications using information technology and systems to improve and reduce the cost of care. Extends the expiration date of the section, from June 30, 2009, to June 30, 2015.

3 **Electronic health record system revolving account and loan program.** Adds § 62J.496.

Subd. 1. Account establishment. Establishes an account to provide loans to eligible borrowers to install or support an interoperable health record system.

Subd. 2. Eligibility. Defines "eligible borrower." Requires applicants to submit a loan application to the commissioner of health and specifies requirements for the application.

Subd. 3. Loans. (a) Allows the commissioner of health to make no interest loans on a first-come, first-served basis. Limits the total accumulative loan principal to $1.5 million per loan. Gives the commissioner discretion over the size and number of loans made.

(b) Allows the commissioner to prescribe forms, establish an application process, and impose an application fee.

(c) Requires repayment of the principal no later than two years from the date of the loan, and requires amortization within six years from the date of the loan.

(d) Credits repayments to the account.

Subd. 4. Data classification. Classifies data collected by the commissioner as private data on individuals and nonpublic data.

4 **Uniform electronic transactions and implementation guide standards.** Adds § 62J.536

Subd. 1. Electronic claims and eligibility transactions required. (a) Beginning January 15, 2009, requires group purchasers to accept from health care providers the eligibility for a health plan transaction described in specified federal regulations, and beginning July 15, 2009, requires group purchasers to accept from health care providers the health care claims or equivalent encounter information transaction described in specified federal regulations.

(b) Beginning January 15, 2009, requires group purchasers to transmit to providers the eligibility for a health plan transaction, and beginning December 1, 2009, requires

group purchasers to transmit to providers the health care payment and remittance advice transaction.

(c) Beginning January 15, 2009, requires health care providers to submit to group purchasers the eligibility for a health plan transaction, and beginning July 15, 2009, requires health care providers to submit to group purchasers the health care claims or equivalent encounter transaction.

(d) Beginning January 15, 2009, requires health care providers to accept from group purchasers the eligibility for a health plan transaction, and beginning December 15, 2009, requires health care providers to accept from group purchasers the health care payment and remittance advice transaction.

(e) Requires each transaction to require use of a single, uniform guide to the implementation guides.

(f) Requires all group purchasers and health care providers to exchange claims and eligibility information electronically, and prohibits group purchasers from imposing any fee for use of the transactions.

(g) Provides that the subdivision does not prohibit group purchasers and health care providers from using a direct data entry, Web-based methodology.

Subd. 2. Establishing uniform, standard companion guides. (a) Requires the commissioner of health to adopt rules at least 12 months prior to the timelines in subdivision 1, establishing and requiring group purchasers and health care providers to use the transactions and the uniform, standard companion guides.

(b) Requires the commissioner to consult with the Minnesota Administrative Uniformity Committee on development of the companion guides.

(c) Prohibits group purchasers and health care providers from adding to or modifying the companion guides.

(d) Prohibits the commissioner, in adopting rules, from requiring data that is not essential for the purposes of subdivision 1.

Subd. 3. Definition. Provides a definition of "health care provider."

5 **Definitions.** Amends § 62J.692, subd. 1. Adds to the definition of "eligible trainee FTEs" to include the number of trainees at training sites located in Minnesota with currently active medical assistance enrollment status and a National Provider Identification number, rather than a medical assistance provider number, as under current statute. Provides that training in nursing facilities is not eligible for funds. Provides a January 1, 2008, effective date.

6 **Distribution of funds.** Amends § 62J.692, subd. 4. Modifies the medical education and research costs distribution formula by eliminating the education factor and distributing the funds through a formula that reflects a summation of the public program volume factor and a new supplemental public program volume factor that provides a supplemental payment of 20 percent to each training site's grant if the training site's public program revenue accounted for at least .98 percent of the total public program revenue received by all eligible training sites. The new distribution formula also makes an initial distribution of $5.35 million to be distributed to University of Minnesota Medical Center-Fairview, the

University of Minnesota School of Dentistry, and the Academic Health Center. Provides a January 1, 2008, effective date.

7 **Report.** Amends § 62J.692, subd. 5. Makes conforming changes to correspond with the change in the distribution formula. Provides a January 1, 2008, effective date.

8 **Federal financial participation.** Amends § 62J.692, subd. 8. Removes the provision that required the commissioner of health to transfer state funds to the commissioner of human services to maximize federal funds available, if the commissioner of human services determines that federal participation is available for medical education and research. Provides a January 1, 2008, effective date.

9 **Required disclosure of estimated payment.** Amends § 62J.81, subd. 1. Clarifies provisions that require health care providers and health plan companies to provide information to consumers on payments received or provided and enrollee costs. Changes terminology from "reimbursement" to "allowable payment" and also requires information on the amount due from the enrollee and enrollee out-of-pocket expenses to be provided. Also specifies in more detail the information that must be provided when consumers have no applicable public or private coverage. Provides an August 1, 2007, effective date.

10 **Evaluation of provider performance.** Adds § 62Q.101.

> **Subd. 1. Use of patient-paid charges.** Prohibits a health plan company or a vendor of risk management services from including patient-paid costs or charges as a factor in evaluating the performance of a health care provider.
>
> **Subd. 2. Performance targets; reasonable basis and disclosure required.** Requires a health plan company or a vendor of risk management services, in evaluating the performance of a health care provider, to: (1) conduct the evaluation using a bona fide baseline upon practice experience of the provider group; and (2) disclose the baseline to the health care provider in writing prior to the beginning of the time period used for the evaluation.

11 **Definition.** Amends § 62Q.165, subd. 1. States that it is the commitment of the state to achieve universal coverage by 2011 (current law contains this commitment, with no date). Provides a July 1, 2007, effective date.

12 **Goal.** Amends § 62Q.165, subd. 2. States that it is the goal of the state to reduce the number of Minnesotans who do not have health coverage, so that by January 1, 2011, all Minnesota residents have access to affordable health care. (Deletes language that set the state goal as reducing the percentage of Minnesotans without health coverage to less than 4 percent by January 1, 2000.) Provides a July 1, 2007, effective date.

13 **Yearly reports.** Amends § 144.698, subd. 1. Requires hospitals and outpatient surgical centers to include additional information in their annual reports to the commissioner of health.

14 **Health promotion and wellness.** Adds § 145.985. Allows community health boards to work with schools, health care providers, and others to coordinate health and wellness programs in their communities. Allows boards to: (1) provide instruction, technical assistance, and recommendations on how to evaluate project outcomes; (2) assist with on-site health and wellness programs; and (3) encourage health and wellness programs consistent with the Centers for Disease Control and Prevention's Community Guide and goals consistent with that organization's Healthy People 2010 initiative.

15 **Performance payments.** Amends § 256.01, subd. 2b. The amendment to paragraph (a) requires the commissioner of human services to provide performance payments to clinics as well as medical groups that demonstrate optimum care in serving individuals with chronic diseases. Allows the commissioner to receive any federal match made available through

MA for managed care oversight, for purposes of the pay-for-performance system for medical groups serving persons with chronic diseases.

A new paragraph (b), effective July 1, 2009, or upon federal approval, requires the commissioner to develop and implement a patient incentive program for state health care program enrollees who meet personal health goals established with their provider to manage a chronic disease or condition.

16 **Provider-directed care coordination services.** Amends § 256B.0625, by adding subd. 49. Requires the commissioner to develop and implement a provider-directed care coordination program for MA recipients receiving services under fee-for-service. Requires the program to pay primary care clinics for care coordination for persons who have complex and chronic medical conditions. Provides a January 1, 2008, effective date.

17 **Health care payment system reform.**

Subd. 1. Payment reform plan. Requires the commissioners of employee relations, human services, commerce, and health to develop a plan to promote and facilitate changes in payment rates and methods of paying for health care, in order to: reward cost-effective primary and preventive care; reward evidence-based care; discourage underutilization, overuse, and misuse; reward the use of the most cost effective settings, drugs, devices, providers, and treatments; and encourage consumers to maintain good health and use the health care system appropriately.

Subd. 2. Report. Requires the commissioners to present a report on and proposed legislation for the plan to the legislature by December 15, 2007.

Provides a July 1, 2007 effective date.

18 **Community initiatives to cover uninsured and underinsured.** Requires the commissioner of health to provide planning grants to up to three community partnerships to develop a comprehensive proposal to provide health care services to uninsured and underinsured individuals with chronic conditions through an integrated community partnership system.

19 **Care coordination pilot projects.**

Subd. 1. Pilot projects. Requires the commissioner of human services to develop and administer up to four pilot projects for children and adults with complex health care needs who are enrolled in fee-for-service MA. Requires at least two grantees to focus on children with autism or complex/multi-diagnoses physical conditions. States that the purpose of the projects is to pilot primary care clinic models of care delivery focused on care coordination and family involvement in order to: (1) incent and support 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 cost-effective practice; and (6) encourage consumers to maintain good health and use the health care system appropriately.

(b) Requires the projects to use designated care professionals and clinics to serve as a patient's medical home and coordinate services.

Subd. 2. Requirements. Specifies requirements that health care professionals or

clinics must meet to be designated a medical home under the pilot project.

Subd. 3. Evaluation. Requires projects to be evaluated based on patient and provider satisfaction, clinical process and outcome measures, program costs and savings, and economic impact on health care providers. Lists other criteria for evaluation.

Subd. 4. Rulemaking. Exempts the commissioner from rulemaking requirements. Requires public comment on the request for proposals.

Subd. 5. Care coordination payments. States that grantees are not eligible for care coordination payments under section 256B.0625, subdivision 49.

20 MERC distribution formula. Requires the commissioner of health to evaluate the effect of the 2007 revisions to the medical education and research costs (MERC) distribution formula on sponsoring institutions and clinical training sites with low numbers of eligible trainee FTEs, and present to the legislature by January 15, 2008, recommendations for any formula changes necessary to ensure the financial viability of clinical medical education at those institutions and sites.

21 Health care transformation task force.

Subd. 1. Task force. (a) Requires the governor to convene a health care transformation task force to advise the governor on activities to transform the health care system, and to develop a statewide action plan. Specifies membership of the task force.

(b) Requires the Department of Health to provide staff support. Allows the task force to accept outside resources.

Subd. 2. Public and stakeholder engagement. Requires the commissioner of health to review available research to determine Minnesotan's views on health care issues, and report findings to the task force.

Subd. 3. Duties. (a) Requires the task force, by February 1, 2008, to develop and present to the legislature and the governor a statewide plan to transform the health care system to improve affordability, quality, access, and health status. Specifies plan requirements. Requires the plan to include specific and measurable goals and deadlines for:

(1) actions that will reduce health care expenditures by 20 percent by January 2011, and limit the rate of growth in health care spending to the change in the CPI plus two percentage points each year thereafter;

(2) actions to increase affordable health coverage options and strategies to ensure that all Minnesotans will have health care coverage by January 2011;

(3) actions to improve the quality and safety of health care and reduce disparities;

(4) actions that will improve health status and reduce the rate of preventable chronic illness;

(5) proposed changes to state health care purchasing and payment strategies to

promote quality and lower costs;

(6) actions that will promote appropriate and cost-effective investment in new facilities, technologies, and drugs;

(7) options on serving small employers and their employees and self-employed individuals; and

(8) actions to reduce administrative costs.

22 **Repealer.** (a) Repeals § 62J.052, subd. 1 (requirement that health care providers provide specified information on payments and charges) effective August 1, 2007.

(b) Repeals § 62J.692, subd. 10 (transfer of cigarette tax revenue dedicated to the Academic Health Center to the commissioner of health for MERC) effective January 1, 2008.

Article 16: Public Health Policy

1 **Window fall prevention device code**. Amends § 16B.61 by adding subd. 3b. Requires the commissioner of labor and industry to adopt rules relating to window fall prevention devices. Specifies requirements for those rules and requires the commissioner to report to the legislature by February 15, 2008.

2 **Fees for variances.** Amends § 103I.101, subd. 6. Changes the variance fee from $175 to $215. Becomes effective July 1, 2008.

3 **Well notification fee.** Amends § 103I.208, subd. 1. Increases the well notification fees to be paid by property owners. Provides July 1, 2008, as the effective date.

(1) From $175 to $215 for a new water supply well

(2) From $35 to $50 for well sealing for each well

(3) From $175 to $215 for construction of a dewatering well for each well, and from $875 to $1075 for projects comprising five or more dewatering wells

4 **Permit fee.** Amends § 103I.208, subd. 2. Increases permit fees paid by property owners. Provides July 1, 2008, as the effective date.

(1) From $150 to $175 for a water supply well that is not in use under a maintenance permit

(2) From $175 to $215 for construction of a monitoring well

(3) From $150 to $175 for a monitoring well that is unsealed under a maintenance permit

(4) From $175 to $215 for the construction fee for monitoring wells used as a leak detection device and from $150 to $175 for an annual fee for a maintenance permit for unsealed monitoring wells

(5) From $175 to $215 for groundwater thermal exchange devices

(6) From $175 to $ 215 for vertical heat exchangers

(7) From $150 to $175 for dewatering well and from $750 to $875 for projects involving

five or more wells

(8) From $175 to $215 for an elevator boring

5 **Disclosure of wells to buyer.** Amends § 103I.235, subd. 1. Increases the fee for a completed well disclosure certificate by $5 and the amount the county recorder or registrar of titles must transfer to the commissioner of health for each well disclosure certificate.

6 **Fees for diagnostic laboratory services; exceptions.** Amends § 144.123.

Subd. 1. Who must pay. Prohibits a fee for any biological material submitted to or requested by the Department of Health to gather information for disease prevention or control.

Subd. 2. Fee amounts. Requires the commissioner of health to charge handling fees for certain specimens for diagnostic purposes and provides for an increase in these fees.

7 **Tests of infants for heritable and congenital disorders.** Amends § 144.125.

Subd. 1. Duty to perform testing. Increases the fee the commissioner must charge for the costs of conducting testing for congenital disorders in infants from $61 to $101.

Subd. 2. Determination of tests to be administered. Requires the commissioner to consider the adequacy of analytical methods, rather than laboratory methods, as is currently in statute, when determining whether a certain test must be administered.

Subd. 3. Objection of parents to test. (No change to current statute.)

8 **Medical assistance.** Amends § 144.9507 by adding subd. 6. Prohibits medical assistance reimbursement for lead risk assessment from replacing or decreasing existing state and local funding for lead-related activities.

9 **Lead abatement program.** Amends § 144.9512. Requires the commissioner of health to make grants to the nonprofit that is currently operating the CLEARCorps lead hazard reduction project to provide swab team services. (Current law provides for an application process for grantees.) Removes obsolete grant application language and updates references to the nonprofit. Adds to the list of services that may be performed by the nonprofit, including the following:

- Blood lead screening of children and pregnant women
- Case management services
- Certain mandated risk assessments

Removes a provision that allows the commissioner to establish a component of the grant program for removal and replacement of deteriorated paint in residential properties. Removes provisions stating that it is not necessary for swab teams to do environmental testing and requires the commissioner to establish a program to do this type of testing.

10 **Early hearing detection and intervention act.** Adds § 144.966.

Subd. 1. Definitions. Provides definitions of key terms in this section.

Subd. 2. Newborn hearing screening advisory committee. (a) Requires the commissioner of health to create a newborn hearing screening advisory committee. States that the duties of the advisory committee include the following:

- Develop protocols for screening and early intervention services for children
- Design protocols to track children from birth to age three who are at risk for delayed onset of permanent hearing loss
- Design a technical assistance program for screening facilities
- Design implementation and evaluation of follow-up systems
- Evaluate program outcomes to increase effectiveness and ensure culturally appropriate services.

(b) Sets out the requirements for committee membership, including that there must be one representative from the listed groups and no less than two members who are deaf or hard-of-hearing.

Subd. 3. Early hearing detection and intervention programs. Requires hospitals to establish early hearing detection and intervention (EHDI) programs. States the requirements of EHDI programs, including the following:

- Provide parents with information regarding costs, risks and benefits of screening and comply with parental consent
- Develop policies and procedures for screening based on recommendations from the Department of Health
- Provide training and monitoring of persons responsible for performing the hearing tests
- Test newborns before discharge or, for newborns expected to remain in the hospital for a prolonged period, prior to three months of age, or when medically feasible
- Inform the parents or parent, the primary care physician and the Department of Health of the results of the hearing screening in accordance with recommendations of the Department of Health
- Collect performance data specified by the Department of Health

Subd. 4. Notification and information. (a) Requires notification to parents, the primary care physician, and the Department of Health to occur prior to discharge or no later than 10 days following testing.

(b) States that persons attending a birth outside a hospital must provide parents with information as to where to have their infant screened.

(c) Requires a professional conducting the diagnostic procedure to confirm the hearing loss to report the results to the parents, primary care provider, and Department of Health, according to Department of Health recommendations.

Subd. 5. Oversight responsibility. States that the Department of Health is responsible for oversight of UNHS programs, including reviewing performance data collected by the hospitals.

Subd. 6. Civil and criminal immunity and penalties. (a) States that physicians and hospitals may not be held civilly or criminally liable for failure to conduct a hearing screening test.

(b) States that health professionals and hospitals may not be held civilly or criminally liable for any acts in compliance with this section, including providing information required by this section.

Subd. 7. Fees. Requires the commissioner of health to charge laboratory service fees so that the total collected will approximate the costs of implementing and maintaining a system to follow up infants, provide technical assistance, a tracking system, data management, and evaluation.

11 **Basic life support.** Amends § 144E.101, subd. 6. Modifies the application of a variance that may be granted by the board to end when the ambulance service renews its license. (Currently, only a temporary variance may be granted, which continues up to one year from the date of issuance.)

12 **Interhospital; interfacility transfer.** Amends § 144E.127. Adds a provision for interfacility transfers.

Subd. 1. Interhospital transfers. Gives a title to this paragraph of current law.

Subd. 2. Interfacility transfers. Provides that licensees with a primary service area located outside certain metropolitan counties and cities may substitute one EMT with a registered first responder, so long as there is one of the following individuals in the patient compartment and that individual is trained in ambulance equipment and protocols:

- EMT or EMT-paramedic;
- Physician;
- Registered nurse; or
- Physician's assistant

13 **Repayment for volunteer training.** Amends § 144E.35, subd. 1.

- Allows a licensed ambulance service to receive certain reimbursement from the board. (Currently the political subdivision or nonprofit hospital or corporation that operates the ambulance service receives the reimbursement.)

- Raises the maximum reimbursement for a volunteer ambulance attendant from $450 to $600 for a basic course and from $225 to $275 for a continuing education course.

14 **Fees.** Inserts a new section of law allowing the board to charge certain fees.

Subd. 1. Verification of licensure. Allows the board to charge a licensee $25 to verify their licensure status for other veterinary licensing boards.

Subd. 2. Continuing education review. Allows the board to charge a sponsor $50 to review and approve individual continuing education materials. Exempts materials meeting the board's preapproval criteria as contained in Minnesota Rules.

15 **Minnesota veterans home employees; excluded from commissary privileges.** Amends § 198.075. Provides an exception to the longstanding prohibition stating that Minnesota's veterans homes may provide no commissary privileges to any employee. The bill would authorize the homes to make an exception for an employee who works a second shift that is consecutive with a regularly scheduled shift. In that situation, the veterans homes would be allowed to provide to that employee one free meal at the home on the day of the extra shift.

16 **Lead risk assessments.** Amends § 256B.0625 by adding subd. 49. (a) States that medical assistance will cover certain lead risk assessments as of October 1, 2007, or six months after federal approval, whichever is later. Provides for medical assistance coverage for a one-time on-site investigation of a recipient's home for recipients under 21 years and with certain blood lead levels.

(b) States the activities for which the lead risk assessor's time is covered by medical assistance, including the following:

- gathering samples and data, including meter readings
- interviewing family members
- providing a report with the results

States certain lead risk assessment activities that are not covered by medical assistance.

(c) Specifies the methodology of medical assistance coverage for lead risk assessment.

17 **Community and family health improvement.** Removes the family planning base reduction.

18 **Study of blood lead test methods.** Requires the commissioner of health, in collaboration with others, to evaluate blood lead testing methods and report to the legislature by January 15, 2008.

19 **Window safety education.** Requires the commissioner to conduct a window safety educational campaign and to create a window safety program. Requires the commissioner to report to the legislature by March 1, 2011, and to submit yearly progress reports. States information that must be included in the final report.

20 **Revisor's instruction.** Updates statutory references.

21 **Repealer.** Repeals Laws 2004, chapter 288, article 6, section 27, which relates to a transfer of funds for prevention of fetal alcohol spectrum disorder.

Article 17: Public Health

1 **Family home visiting programs.** Amends § 145A.17. Adds to the goals of the current

family home visiting programs.

Subd. 1. Establishment; goals.

- Requires the commissioner to promote collaboration among the teams of professionals that perform visits from the fields of public health nursing, social work and early childhood education.

- Requires that preference be given to the lowest-income families and families that fall under certain criteria. Adds homelessness, risk of long-term welfare dependence, and other factors that may be determined by the commissioner.

Subd. 2. (Repealed under current law)

Subd. 3. Requirements for programs; process. (a) Requires an entity that receives funding to provide the commissioner with a written plan that describes its approach. States certain requirements that all entities must meet to receive funding.

(b) States that the visiting programs must meet certain requirements, most of which are already in statute, except connecting families with other community resources is an added requirement.

(c) States that visiting programs must offer group meetings at least once per month, when possible, for families with additional needs.

Subd. 4. Training. Requires the commissioner to provide training for home visitors and lists seven requirements of that training, including the following:

- building effective relationships with families

- effective methods of parent education and home visit conduct

- early childhood development to age five

- diverse cultural practices

- recruiting, supervising and retaining staff

- increasing services to the underserved

- child welfare and protective services

Subd. 5. Technical assistance. (No change to current law)

Subd. 6. Outcome and performance measures. Adds to the areas in which the commissioner must determine ways to measure outcomes, including:

- rates of children accessing quality early care and education services;

- program retention rate;
- number of home visits performed versus the number planned; and
- participant satisfaction.

Subd. 7. Evaluation. Adds performance measures to the evaluation of this program.

Subd. 8. Report. (No change to current law)

Subd. 9. No supplanting of existing funds. (No change to current law)

2 **Water level standards.** (a) Requires that until the commissioner adopts rules, the health risk limit for all contaminants in private wells meet the more stringent of the state or federal standards.

(b) Requires the commissioner of health to begin the rulemaking process, by March 1, 2008, for setting health risk limits for commonly detected contaminants.

(c) Requires the commissioner to adopt health risk limits for the ten most commonly detected contaminants, by March 1, 2009.

(d) Requires the commissioner to report to the legislature by February 1, 2008.

3 **Funding for environmental justice mapping.** Requires the commissioner of health, with the commissioner of the Pollution Control Agency, to apply for federal funding to renew and expand the state's environmental justice mapping. Requires the commissioner of health to work with the Pollution Control Agency and the Department of Agriculture to create an environmental public health tracking system. States that the commissioner shall report to the legislature as to additional funding sources. Provides an immediate effective date for this section.

4 **Fragrance-free schools pilot project.**

Subd. 1. Purpose. Directs the health commissioner to develop a fragrance-free schools pilot project.

Subd. 2. Education. Directs the health commissioner, in collaboration with the education commissioner and the Minneapolis Board of Education to establish a working group to recommend an education campaign in the Minneapolis public schools to inform students and parents about the harmful effects of using fragrant products in schools.

Makes this section effective immediately.

5 **Medical assistance coverage for arsenic testing.** Requires the commissioner of human services to ensure medical assistance coverage for arsenic testing.

Article 18: Human Services Forecast Adjustment

This article provides forecast adjustments in fiscal year 2007 for certain human services programs.

Article 19: Human Services Appropriations

This article provides appropriations for the Departments of Health, Human Services, and health-related boards. For more information, see the Fiscal Analysis Department spreadsheet.