HOUSE RESEARCH

Bill Summary

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Article 1: Health Care Cost Containment; Consumer Empowerment

The article requires that the state propose to state employee unions, as part of the collective bargaining process, that state employee health coverage include health savings accounts. The article also establishes requirements for payment disclosure.

1 Health savings accounts. Amends § 43A.23, by adding subd. 4. Requires that state employee health coverage include at least one option that is a health savings account. Requires that the employer contribution to the health savings account be at least as much as that paid by the state toward other plans made available to state employees.

2 Disclosure of payments for health care services. Adds § 62J.81. Requires health care providers to provide consumers with information on the range of health plan company payment rates.

Subd. 1. Required disclosure of payment range. Requires health plan companies, at the request of a consumer, to provide that consumer with the range of health plan company payments for a specific service or services that the consumer may reasonably expect to receive based on the consumer's medical condition. Does not require the provider to disclose health plan company names.

Subd. 2. Applicability. Excludes MA, MinnesotaCare, and GAMC enrollees from the definition of "consumer" for services covered under those programs and excludes payments from these programs from the range.

3 **Payment disclosure.** Adds § 151.214. Requires pharmacies to provide an explanation of pharmacy benefits.

Subd. 1. Explanation of pharmacy benefits. Requires pharmacies to provide an explanation of pharmacy benefits to patients and specifies the information that must be provided.

Subd. 2. No prohibition on disclosure. States that agreements between an employee sponsored health plan or health plan company, or its pharmacy benefit manager, and pharmacies cannot prohibit a pharmacy from disclosing to patients information a pharmacy is required or given the option to provide under subdivision 1.

Article 2: Health Care Cost Containment; Best Practices

This article makes outpatient surgical centers subject to adverse health events reporting requirements. The article also requires the Commissioner of Health and state agencies to undertake initiatives related to best practice guidelines. The article also requires the Commissioner of Human Services to implement disease management initiatives.

1. 1 Best practices and quality improvement. Adds § 62J.43. (a) Requires state agencies to encourage physicians, other health care providers, universities and colleges, health care purchasers, and health plans to adopt best practices guidelines and participate in best practices measurement activities. Requires the Commissioner of Health to facilitate access to the best practices guidelines and quality of care measurement information.

(b) Requires the commissioner to collaborate with a nonprofit Minnesota quality

improvement organization to provide best practices criteria.

(c) Specifies that the criteria must address diabetes and congestive heart failure.

(d) Provides that the Commissioners of Human Services and Employee Relations may use the guidelines to assist in developing contracting strategies. Also requires the Commissioners to report to the legislature by January 1, 2006, on agency use of the best practices guidelines.

(e) Provides that the section does not apply if the best practice guideline authorizes or recommends denial of treatment, food, or fluids on the basis of age, disability, or other specified criteria.

2 Facility. Amends § 144.7063, subd. 3. Makes outpatient surgical centers subject to the adverse health events reporting requirements. (Under current law, these requirements apply only to hospitals.)

3 Disease management programs. Adds § 256B.075.

Subd. 1. General. Requires the Commissioner of Human Services to implement disease management initiatives to improve patient care and health outcomes and reduce health care costs by managing care for recipients with chronic conditions.

Subd. 2. Fee-for-service. Requires the Commissioner to develop and implement a disease management program for MA and GAMC recipients who are not enrolled in the prepaid MA or prepaid GAMC programs and who are receiving services on a fee-for-service basis. Also requires the Commissioner to seek any federal approval necessary to implement this section and obtain federal matching funds.

Subd. 3. Prepaid managed care programs. Requires the Commissioner to ensure that contracting health plans implement appropriate disease management programs for recipients in the prepaid MA, prepaid GAMC, and MinnesotaCare programs.

Subd. 4. Hemophilia. Requires the Commissioner to develop a disease management initiative for Minnesota health care programs for recipients diagnosed with hemophilia.

Article 3: Health Care Cost Containment; Cost-shifting

This article prohibits budget proposals to expand state health care programs unless state health care program reimbursement rates cover provider costs and requires the Commissioner of Human Services to study and present recommendations on state health care program cost-shifting.

1. 1 Limit on state health care program expansion. Amends § 16A.10, by adding subd. 4. Prohibits budget proposals from including any provision that requests new or expanded funding for the expansion of eligibility or covered services for a state health care program, unless state health care program reimbursement rates at the time of expansion will be sufficient to cover estimated provider costs for each major service category.

2 Study of cost-shifting. Requires the Commissioner of Health to evaluate the extent to which MA, MinnesotaCare, and GAMC reimbursement rates result in cost-shifting. Requires the Commissioner to: (1) examine the extent to which state health care program reimbursement

rates vary from private sector rates; (2) examine the extent to which state health care program reimbursement rates cover provider costs; (3) estimate the amount by which state health care program reimbursement rates would need to be increased to match average private sector rates and to cover provider costs; and (4) present recommendations to the legislature on methods to increase state health care program reimbursement rates, over a six-year period, to the average private sector rate and to a level that covers provider costs. Requires the Commissioner to report to the legislature by December 15, 2004, and allows the Commissioner to contract for actuarial services. Specifies the data privacy classification of payment and reimbursement data obtained for the study.

Article 4: Health Care Cost Containment; Reducing Government Mandates

This article reduces health benefit mandates by imposing a moratorium on new ones, restoring legislation to permit reduced-mandate plans for small employers, and repealing a mandate for bone marrow transplants in connection with cancer treatment.

1. 1 Mandated benefits moratorium. Amends § 62J.26, by adding subd. 6. Establishes a moratorium until 2007 on new laws that enact new health benefit mandates. These are laws requiring that insurers cover a particular condition, care received from a particular type of provider, or a particular treatment.

2 Small employer alternative benefit plans. Adds § 62L.056. Reenacts, with some changes, legislation enacted in 1999, which expired on August 1, 2003, based on a sunset provision included in the 1999 law. The idea is to permit the sale of less expensive group health coverage to small employers. The cost savings are sought by exempting these policies from mandated benefit laws, which require coverage of certain conditions, certain types of providers, or certain treatments. This new version clarifies that the exemption from state law includes the human rights act, exempts these plans from loss ratio requirements, does not have an expiration date, permits a completely mandate-less plan design, except for compliance with federal requirements for maternity coverage, and permits participation by health plan companies that are up to 10 percent, rather than up to 3 percent, of the Minnesota market.

3 Repealer; bone marrow transplant mandate. Repeals § 62A.309. Repeals a law enacted in 1995, mandating that private state-regulated health coverage include coverage of autologous bone marrow transplantation (ABMT), which is used in connection with high dose chemotherapy as a treatment for breast cancer.

Article 5: Health Care Cost Containment; Health Plan Competition and Reform

This article changes regulation of health plan companies by permitting file-and-use for health plan forms, permitting for-profit HMOs, permitting acceptance of audits of performance standards by certain organizations, permitting electronic provision of information to enrollees, and transferring HMO regulation from the Commissioner of Health to the Commissioner of Commerce. The article also increases minimum and maximum MCHA premiums, requires coverage of surveillance tests for ovarian cancer, and makes other changes.

1. 1 Approval. Amends § 62A.02, subd. 2. Provides that health insurance forms (issued by commercial insurance companies) will be regulated on a "file-and-use," as opposed to "prior approval," basis. Under current law, a health plan form cannot be sold until it has been filed with and approved by the commissioner. This section would allow commercial insurers to

sell the product immediately after it is filed with the commissioner, without waiting for approval. The commissioner would have 60 days to disapprove the form, or it would be deemed approved. In 2002 the legislature enacted "file-and-use" for premium rates charged by commercial insurers, but not for forms. This section would extend it to forms.

2 Coverage for scalp hair prostheses. Amends § 62A.28. Amends the requirement that health plan companies cover scalp hair prostheses for alopecia areata, by specifying the coverage is subject to coinsurance, deductible, and other types of cost-sharing that apply to similar items of coverage. (Current law makes the coverage subject only to co-payments.)

3 Required coverage. Amends § 62A.30, subd. 2. Requires health plan companies to provide coverage for surveillance tests for ovarian cancer for women who are at risk of ovarian cancer.

4 Ovarian cancer surveillance tests. Amends § 62A.30, by adding subd. 3. Defines "at risk for ovarian cancer" and "surveillance tests for ovarian cancer."

5 Health maintenance organization. Amends § 62D.02, subd. 4. Eliminates the current requirement that health maintenance organizations (HMOs) be Minnesota nonprofit corporations. The effect is to permit for-profit HMOs.

6 Person. Amends § 62D.02, by adding subd. 17. This section goes with the preceding one by defining broadly the type of entity that may be licensed as an HMO in Minnesota.

7 Certificate of authority required. Amends § 62D.03, subd. 1. Conforming change relating to permitting for-profit HMOs.

8 Application review. Amends § 62D.04, subd. 1. Conforming change related to permitting for-profit HMOs.

9 Authority granted. Amends § 62D.05, subd. 1. Conforming change related to permitting for-profit HMOs.

10 Establishment . Amends § 62E.08, subd. 1. Raises the minimum premium for (Minnesota Comprehensive Health Associations) MCHA plans from 101 to 115 percent of the weighted average rate, and raises the maximum premium from 125 to 135 of the weighted average.

11 Approval of state plan premiums. Amends § 62E.091. Makes a conforming change related to the increases in minimum and maximum MCHA premiums in § 62E.08, subd. 1.

12 Audits conducted by a nationally recognized independent organization. Adds § 62Q.37.

Subd. 1. Applicability. Makes this section apply to Blue Cross and Delta Dental, health maintenance organizations, and managed care organizations operating under chapters relating to government health programs.

Subd. 2. Definitions. Defines the terms commissioner, health plan company, nationally recognized independent organization, and performance standard. Performance standard is defined broadly to include standards involving almost everything a health plan company does.

Subd. 3. Audits. Permits state regulators to (continue to) conduct routine audits and investigations of health plan companies. Permits the commissioner to instead accept, in whole or in part, the results of an audit of the relevant performance standard by a nationally recognized independent organization. Permits the commissioner to use a negative finding as the basis for a targeted audit or enforcement action.

Subd. 4. Disclosure of national standards and reports. Requires the health plan company to provide the commissioner with the organization's standards and the final audit report on the health plan company.

Subd. 5. Accreditation not required. Provides that nothing in this section requires a health plan company to become accredited.

Subd. 6. Continued authority. Preserves the current auditing and investigating powers of the commissioners.

Subd. 7. Human Services. Requires the Commissioner of Human Services to use this section consistently with federal law.

Subd. 8. Confidentiality. Provides a data classification for documents related to an audit report accepted by the Commissioner.

13 Electronic transmission of required information. Amends § 72A.20, by adding subd. 37. Permits health plan companies to electronically provide to enrollees information otherwise required to be mailed to them in paper form. This could be e-mail or placing the information on a web page accessible to the enrollee. The health plan company may offer this on either an opt-in or opt-out basis. The enrollee has the right to change back to mail delivery at any time. Private information must be provided in a secure way. An enrollee must be able to call to request a paper copy.

14 Change of health maintenance organization regulatory authority. Transfers regulation of HMOs and similar entities from the Commissioner of Health to the Commissioner of Commerce, effective July 1, 2005.

Article 6: Health Care Cost Containment; Administrative Simplification

This article allows the Board of Medical Practice to conduct final applicant interviews by teleconference, repeals health care provider capital expenditure reporting requirements, and requires the Commissioner of the Human Services to establish an information Web site for oral language interpreter services. The article also requires specified state agencies to evaluate health care reporting requirements.

1. 1 Endorsement; reciprocity. Amends § 147.03, subd. 1. Allows the Board of Medical Practice, upon the request of an applicant, to conduct the final interview of the applicant by teleconference.

2 Information Web site for interpreter services. Amends § 256B.04, by adding subd. 20. Requires the Commissioner of Human Services to establish an information Web site to assist health care providers in obtaining oral language interpreter services. Requires the Commissioner to collect and maintain contact and rate information for interpreters, and make this information available to all health care providers. Provides that the Web site list is not an endorsement by the Commissioner of any particular interpreter.

3 Cost of health care reporting. Requires the Commissioners of Human Services, Health, and Commerce to meet with representatives of health plan companies and hospitals prior to August 30, 2004, and evaluate reporting requirements. Requires the Commissioners to present recommendations for reducing the number of required reports to the legislature by January 15, 2005.

4 Repealer. Repeals § 62J.17 effective the day following final enactment (the section requires health care providers to report major spending commitments, defined as those in excess of $1,000,000, to the Commissioner of Health).

Article 7: Child Care

This article makes changes to the child care assistance programs.

1. 1 Licensed and legal nonlicensed family child care providers; assistance. Amends § 119B.09, subd. 9. Makes child care providers eligible to receive child care assistance subsidies for their own children when they are engaged in certain other work activities for which child care assistance is paid. Prohibits the hours for which a child care provider receives a child care subsidy from overlapping with the hours the provider provides child care services.

2 Subsidy restrictions. Amends § 119B.13, subd. 1. Removes obsolete language. Makes technical changes. Removes language requiring the commissioner to establish absent day payment policies.

3 Absent days. Amends § 119B.13, by adding a subdivision. Limits provider reimbursement payments for absent days.

4 Annual license or certification fee for programs with licensed capacity. Amends § 245A.10, subd. 4. Reduces annual child care licensing fees by one-fourth.

5 Direction to commissioner; provider rates. Amends Laws 2003, First Special Session ch. 14, art. 9, § 34. Extends the provider rate freeze through June 30, 2007. Beginning on July 1, 2005, prohibits counties from reducing reimbursement rates to child care centers below the rates established on July 1, 2003.

6 Temporary ineligibility of military personnel. Requires counties to reserve a family's position under the child care assistance fund if a family has been receiving child care assistance but is temporarily ineligible for assistance due to increased income from active military service. Allows activated military personnel to be temporarily ineligible until deactivated. Also requires counties to reserve a military family's position on the Basic Sliding Fee waiting list if a family is approved to receive child care assistance and reaches the top of the waiting list but is temporarily ineligible for assistance.

Article 8: Economic Supports

This article makes changes to the Food Stamp Employment and Training Program and MFIP.

1. 1 Notices and sanctions. Amends § 256D.051, subd. 1a. Allows participants in the diversionary work program who have children under the age of six to be required to participate in the food stamp employment and training program, but they are not subject to sanction.

2 Persons required to register for and participate in the food stamp employment and training program. Amends § 256D.051, subd. 3a. Makes conforming changes. Exempts participants over the age of 49 and certain participants in the diversionary work program from participating in the food stamp employment and training program.

3 Program funding. Amends § 256D.051, subd. 6c. Prohibits the cost of services for each county's food stamp employment and training program from exceeding the annual allocated amount. Current law prohibits the cost of services for the program from exceeding an average of $400 per participant.

4 Family cap. Amends § 256J.24, subd. 6. Allows a proportional share of the income received on behalf of a child who is excluded from the MFIP program due to the family cap to be considered when determining the MFIP benefit.

5 Rental subsidies; unearned income. Amends § 256J.37, subd. 3a. Removes obsolete language. Increases the amount of public and assisted rental subsidies counted as unearned

income when calculating the MFIP cash grant from $50 to $200. Excludes certain caregivers from the requirement to count up to $200 of the housing subsidy as income.

6 Length of program. Amends § 256J.53, subd. 1. Limits postsecondary education or training to 12 months in order for it to be an approved work activity under the MFIP program.

Article 9: Health Care

This article contains provisions related to state administered health care programs. The article coordinates the prescription drug program with the Medicare prescription drug benefit, modifies eligibility criteria and benefits for MA, GAMC, and MinnesotaCare, and makes other related changes.

1. 1 Eligibility. Amends § 256.955, subd. 2a. Requires prescription drug program enrollees who are age 65 or older to apply for the Medicare prescription drug card, if available. Provides an effective date of July 1, 2004, or when enrollment for the Medicare drug discount card is available, whichever is later.

2 Eligibility. Amends § 256.955, subd. 2b. Requires prescription drug program enrollees who are disabled to apply for the Medicare prescription drug card, if available. Provides an effective date of July 1, 2004, or when enrollment for the Medicare drug discount card is available, whichever is later.

3 Prescription drug coverage. Amends § 256.955, subd. 3. Prohibits the prescription drug program from covering drugs that, for a specific enrollee, are covered under a Medicare drug discount card plan subsidy, unless specified criteria are met.

4 Application procedures and coordination with medical assistance and Medicare drug discount card. Amends § 256.955, subd. 4. Requires prescription drug program enrollees who are also enrolled in the Medicare drug discount card plan to obtain prescription drugs at a pharmacy enrolled as a provider in both the Medicare drug discount plan and the prescription drug program.

5 Pharmacy reimbursement. Amends § 256.955, subd. 6. Prohibits the commissioner from reimbursing pharmacies enrolled in the prescription drug program, until the Medicare drug discount card subsidy has been exhausted, unless specified criteria are met.

6 Asset limitations for families and children. Amends § 256B.056, subd. 3c. Clarifies the burial plot and burial expense exemption from the MA asset standard for families and children. Requires burial expenses funded by annuities or life insurance policies to irrevocably designate the individual's estate as contingent beneficiary, to the extent proceeds are not used for payment of burial expenses.

7 Employed persons with disabilities. Amends § 256B.057, subd. 9. Specifies that increases in social security benefits shall not be counted as income until July 1 of each year, for purposes of the MA employed persons with disabilities eligibility category. Provides a July 1, 2004 effective date.

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

9 Dental services. Amends § 256B.0625, subd. 9. Effective January 1, 2005, eliminates the $500 annual benefit limit for MA dental services provided to enrollees age 21 and over who are not pregnant.

10 Exceptions. Amends § 256B.0631, subd. 2. Exempts MA recipients expected to reside for at least 30 days in a GRH facility from co-payments. (This is added to an existing provision that exempts recipients expected to reside at least 30 days in a hospital, nursing home, or

ICF/MR.) Requires the only income of exempt recipients to be a personal needs allowance and requires the exemption be approved by the centers for Medicare and Medicaid studies. Provides an effective date of 90 days after federal approval or January 1, 2005, whichever is later.

11 Definitions. Amends § 256B.69, subd. 2. Reinstates one-month "rolling eligibility" for aged, blind, or disabled persons under PMAP. This allows individuals to remain eligible for MA through the last day of the month following the month in which they become ineligible for the program.

12 General assistance medical care; eligibility. Amends § 256D.03, subd. 3. Prohibits GAMC coverage for persons eligible for emergency MA. Lowers the income limit for GAMC hospital-only coverage from 175 percent to 150 percent of FPG, effective July 1, 2005. Effective July 1, 2004, allows individuals with assets above the regular GAMC asset standard of $1,000 per assistance unit to be eligible for GAMC hospital-only coverage. Effective July 1, 2004, provides GAMC eligibility for undocumented noncitizens or nonimmigrants diagnosed with active or latent tuberculosis, for the duration of the need for tuberculosis treatment.

13 General assistance medical care; services. Amends § 256D.03, subd. 4. Eliminates the $500 annual limit on dental services for GAMC enrollees and the 50 percent copayment for restorative dental services, effective January 1, 2005. Effective January 1, 2005, exempts from GAMC copayments recipients receiving Group Residential Housing payments whose available income is limited to a personal needs allowance.

14 Income. Amends § 256L.01, subd. 5. Amends the MinnesotaCare definition of income, to require the commissioner to use reasonable methods to calculate gross earned and unearned income, including projecting income based on income received within the last 30 days, 90 days, or last 12 months.

15 Covered health services. Amends § 256L.03, subd. 1. Makes a conforming change related to the change in MinnesotaCare dental coverage in section 256L.03, subdivision 3b.

16 Dental services effective January 1, 2005. Amends § 256L.03, by adding subd. 3b. Eliminates MinnesotaCare coverage of dental services for single adults and households without children, and for parents, grandparents, and other specified individuals with incomes greater than 75 percent of FPG. Removes the $500 annual benefit limit for dental services provided to nonpregnant adults.

(a) Provides the following dental coverage under MinnesotaCare, effective January 1, 2005.

(b) For parents, grandparents, foster parents, relative caretakers, and legal guardians with incomes not exceeding 75 percent of FPG, provides dental coverage at the MA level with no annual benefit limit. No coverage is provided for orthodontic services. (Under current law, single adults and households without children with incomes not exceeding 75 percent of FPG, and parents, grandparents and other specified groups, receive coverage, subject to a $500 annual benefit limit.)

(c) For pregnant women and children under age 21, provides dental coverage at the MA level.

17 Co-payments and coinsurance. Amends § 256L.03, subd. 5. Adds MinnesotaCare co-pays of $3 per nonpreventive visit and $6 for nonemergency visits to a hospital-based emergency room. Limits these co-pays to one per day per provider. Provides a January 1, 2005 effective date.

18 Limited benefits coverage for certain single adults and households without children. Amends § 256L.035. Provides coverage under the MinnesotaCare limited benefit set for vision

services (excluding dispensing, fitting, and adjustment of eyeglasses and contacts and eye exams to determine refractive state) and supplies and equipment for diabetic testing and insulin administration. Requires a $5 co-payment for nonpreventive optometrist visits. Exempts, from the MinnesotaCare limited benefit set co-payments, enrollees receiving Group Residential Housing payments whose available income is limited to a personal needs allowance. Provides a January 1, 2005 effective date.

19 Effective date of coverage. Amends § 256L.05, subd. 3. Changes the effective date of MinnesotaCare coverage for newly adopted children to the month of placement or the month placement is reported, whichever is later, and for other new members to the first day of the month following the month in which the change is reported. (Under current law, the date of coverage for adopted children is the date of entry into the family and the date of coverage for other new members is the first day of the month following the month in which eligibility is approved or at renewal.)

20 General requirements. Amends § 256L.07, subd. 1. Eliminates language that allows MinnesotaCare enrollees who exceed program income limits to remain enrolled until the last day of the calendar month following the month in which the commissioner determines the income limit has been exceeded.

21 Other health coverage. Amends § 256L.07, subd. 3. States the persons entitled to Medicare who do not apply or who refuse coverage are not eligible for MinnesotaCare. (Strikes a current law provision that prohibits individuals from refusing Medicare coverage.) Provides that cost-effective health coverage is considered health coverage for purposes of the four-month uninsured requirement, if the insurance is continued after MA no longer considers it cost-effective or MA is closed.

22 Federal approval. Requires the Commissioner of Human Services to request federal approval to exempt from co-payments MA recipients receiving a personal needs allowance. Requires this request to be made by July 1, 2004 and requires the Commissioner to provide copies to legislative chairs. If federal approval is not obtained, requires the Commissioner to seek federal approval to exempt from co-payments all who can qualify for an exemption.

23 Repealer.

Subd. 1. Prescription drug program. Repeals section 256.955, subdivisions 1, 2, 2a, 2b, 3, 4, 4a, 5, 6, 7, and 9 (prescription drug program) effective January 1, 2006.

Subd. 2. MinnesotaCare outreach grants. Repeals section 256L.04, subdivision 11 (MinnesotaCare outreach grants) effective July 1, 2004.

Article 10: Long-Term Care

This article modifies the nursing facility survey process, provides funding for professional liability costs and makes other changes related to long-term care.

1. 1 Exceptions for replacement beds after June 30, 2003. Amends § 144A.071, subd. 4c. Provides an exception to the nursing home moratorium to allow the Commissioner of Health to license and certify a new 60-bed facility in Austin, as long as: (1) 45 of the new beds are transferred from a 45-bed facility in Austin under common ownership that is closed and 15 of the new beds are transferred from a 182-bed facility in Albert Lea under common ownership; (2) the commissioner is authorized to negotiate budget-neutral closures; and (3) money is available from planned closures of facilities under common ownership to make the proposal budget-neutral. Requires the bed capacity of the Albert Lea facility to be reduced by 15 beds and requires 20 beds at the new facility to be used for a special care unit for persons

with Alzheimer's disease or related dementias.

2. 2 Training and education for nursing facility providers. Amends § 144A.10, subd. 1a. Modifies existing requirements that apply to the Commissioner of Health's role in training and educating providers about new regulations. Requires training of long-term care providers and survey inspectors to be done jointly. Requires the Commissioner to consult with experts and make available training resources on current standards of practice and the use of technology. Eliminates language requiring the Commissioner, within available resources, to develop clinical standards, conduct joint work related to hazards, and identify areas of research.

3 Agency quality improvement program; annual report on survey process. Amends § 144A.10, by adding subd. 17. (a) Directs the Commissioner of Health to establish a quality improvement program for the nursing facility survey and complaint process, and to consult with specified parties in implementing the program. Requires the Commissioner to submit to the legislature an annual quality improvement report, beginning December 15, 2004.

(b) Specifies areas of analysis that must be included in the report.

(c) Requires the report to identify and explain inconsistencies and patterns across state regions, include analyses and recommendations for quality improvement, and provide action plans to address problems identified.

4 Procedures for federally required survey process. Adds § 144A.101. Requires the Commissioner of Health to follow various procedures as part of the federal survey process.

Subd. 1. Applicability. States that the section applies to certification and enforcement activities by the Commissioner related to regular, expanded, or extended federal surveys.

Subd. 2. Statement of deficiencies. Requires the Commissioner to provide facilities with draft statements of deficiencies at the time of the survey exit process, and with completed statements of deficiencies within 15 working days of the exit process.

Subd. 3. Surveyor notes. Requires the Commissioner to provide facilities with formal surveyor notes, excluding resident, family, and staff interviews, upon request, when the completed statement of deficiencies is provided. Requires survey notes to be redacted to protect confidentiality. Requires facilities to pay for the cost of copying and redacting.

Subd. 4. Posting of statements of deficiencies. Requires the Commissioner to include a facility's response to citations and other specified information, when posting facility deficiencies on the agency web site. Requires the Commissioner to note on the web site if deficiencies are under dispute.

Subd. 5. Survey revisits. Requires the Commissioner to conduct revisits within 15 calendar days of the date by which corrections will be completed, in cases when category 2 or 3 remedies are in place. Allows the Commissioner to conduct revisits by phone or written communications, if the highest scope and severity score does not exceed level E.

Subd. 6. Family councils. Requires family councils to be interviewed as part of the survey process and invited to participate in the exit conference.

5 Interagency agreement with department of health. Amends § 256.01, by adding subd. 21.

Requires the Commissioner of Human Services to amend the interagency agreement with the Commissioner of Health related to certification of nursing facilities for participation in MA, to require the Commissioner of Health to comply, beginning July 1, 2005, with action plans included in the annual quality improvement report required under § 144A.10, subd. 17.

6 Designation of areas to receive metropolitan rates. Amends § 256B.431, by adding subd. 40.

(a) For rate years beginning on or after July 1, 2004, requires nursing facilities located in areas designated as metropolitan areas by the federal Office of Management and Budget to be considered metro, in order to:

(1) determine rate increases; and

(2) establish nursing facility reimbursement rates for the new nursing facility reimbursement system.

(b) Provides that paragraph (a) applies only if designation as a metro facility results in a higher level of reimbursement for the facility.

Effective date. Provides a July 1, 2004, effective date.

7 Professional liability costs. Amends § 256B.431, by adding subd. 41. (a) Requires the Commissioner of Human Services to provide nursing homes reimbursed under the cost-based (Rule 50) and alternative payment systems with a rate adjustment for the rate year beginning July 1, 2004, to pay for professional liability insurance premiums increases above five percent. (Facilities whose rates are determined under the interim and settle-up rate provisions are not eligible for a rate adjustment.) Specifies that the adjustment is one-time and shall not be included in a facility's base for future rate years.

(b) States that nursing facilities are eligible for an adjustment if their increase in premiums for professional liability insurance was five percent or more between CY 2002 and CY 2003. Requires nursing facilities to provide specified information to the Commissioner.

(c) Requires the Commissioner to review information submitted, and compute a per diem payment amount by dividing allowable increased costs (that portion of the cost increase above five percent) by actual resident days.

(d) Requires the rate adjustments to be implemented if the state MA cost is $1,550,000 or less. If the projected cost is higher than $1,550,000, requires the Commissioner to proportionally decrease each facility's rate adjustment to keep spending within this limit.

8 Alternate rates for nursing facilities. Amends § 256B.434, subd. 4. Prohibits inflation adjustments for nursing facility operating costs under the alternative payment system, for fiscal years 2006 and 2007.

9 Grants to Medicare certified home care agencies.

Subd. 1. Grant availability. Requires the Commissioner of Human Services to make grants available to Medicare certified home care agencies to pay professional liability insurance premiums greater than 5 percent from the previous year. Specifies that the grants are one-time and shall not be included in an agency's payment rate.

Subd. 2. Eligibility for grants. States that an agency is eligible if it experienced a rate increase of more than 5 percent between calendar years 2002 and 2003 and provides

premium and other specified information to the commissioner.

Subd. 3. Requires the commissioner to provide grants equal to an agency's allowable increased costs, as defined in the subdivision.

Subd. 4. State share; federal match. Requires the commissioner to proportionally reduce grants if state spending on grants is projected to exceed $150,000. Requires any federal match obtained to be used to provide grants.

10 Nursing facility scholarship program. Removes the nursing facility scholarship per diem from nursing facility rates for the rate year beginning July 1, 2004.

11 Progress report. Requires the Commissioner of Health to include in the quality improvement report due December 15, 2004 progress reports and implementation plans on: (1) an analysis of defensive documentation; (2) the nursing home providers work group; and (3) independent informal dispute resolution.

12 Resubmittal of requests for federal waivers and approvals. Requires the Commissioner of Health to seek federal approvals and changes necessary to implement the alternative nursing home survey process. Requires the Commissioner to seek changes in the federal policy that mandates imposition of sanctions without an opportunity to correct, solely as a result of a facility's previous deficiencies.

13 Repealer; nursing facility scholarships. Repeals the nursing facility scholarship program (§ 256B.431, subd. 36), effective July 1, 2004.

Article 11: Continuing Care

This article modifies provisions related to TEFRA parental fees, the HIV program, home- and community-based waivered services, and ICFs/MR.

1. 1 Contribution amount. Amends § 252.27, subd. 2a. Modifies the sliding scale for parental fees reducing fees for parents with incomes within certain ranges. Exempts certain one-time income from being counted as income for the purposes of establishing the parental fee.

2 Program established. Amends § 256.9365, subd. 1. Requires the Commissioner of Human Services to establish cost-sharing provisions for the HIV insurance program that are consistent with those that are established for employed persons with disabilities.

3 Distribution of funds; partnerships. Amends § 256B.0916, subd. 2. Establishes an additional priority category for the MR/RC waiver based on the need to serve persons whose consumer support grant exception amount was eliminated in 2004.

4 Division of cost. Amends § 256B.19, subd. 1. Removes language requiring a division of costs between the state and counties for the cost of placements that have exceeded 90 days in ICFs/MR that have seven or more beds. Makes this section effective the day following final enactment. Under current law, beginning July 1, 2004, the division of costs is 80 percent state funds and 20 percent county funds.

5 Report. Amends § 256B.49, by adding a subdivision. Expands the information required in an annual waivered services report.

6 ICF/MR Plan. Requires the Commissioner of Human Services to consult with ICF/MR providers, advocates, counties, and consumer families to develop recommendations and legislation concerning the future services provided to people now served in ICFs/MR. Requires the recommendations to be reported to the house and senate committees with jurisdiction over health and human services policy and finance issues by December 15, 2004. Lists several items the Commissioner must consider in preparing the report. Makes this section effective the day following final enactment.

7 Consumer directed community support; independent evaluation and stakeholder participation. Requires the commissioner to consult with specified entities in conducting a required independent evaluation of the new consumer directed community support option under the home- and community-based waiver programs. Lists the items the evaluation must include. Requires the preliminary findings to be presented to the legislature by February 15, 2005.

Article 12: DHS Program Integrity and Administration

This article contains provisions related to DHS claims against third parties, other program integrity initiatives, life estate and joint tenancy interests, and program administration.

1. 1 Authorization for test sites for health care programs. Amends § 256.01, by adding subd. 2a. Authorizes the Commissioner of Human Services, in cooperation with county agencies, to test and compare administrative models to demonstrate and evaluate outcomes of integrating health care program business processes and points of access. (This is to be done in coordination with the development and implementation of HealthMatch, the automated eligibility system for MA, GAMC, and MinnesotaCare.) Requires the Commissioner, based on the evaluation, to recommend an administrative model for statewide implementation.
2 Retention rates. Amends § 256.019, subd. 1. Allows county agencies to retain 25 percent of MinnesotaCare recovery collections, when the recovery is collected and posted by the county.
3 Hearing authority. Amends § 256.046, subd. 1. Allows DHS, in lieu of a local agency, to initiate administrative fraud disqualification hearings, in lieu of a criminal action when a criminal action has not been pursued, for MinnesotaCare enrollees who are adults without children, and upon federal approval, all remaining categories of MinnesotaCare enrollees except children through age 18.
4 Third-party payer. Amends § 256B.02, subd. 12. Specifies that "third-party payer" includes an entity under contract with the recipient to cover all or part of the recipient's medical costs.
5 Competitive bidding. Amends § 256B.04, subd. 14. States that MA, GAMC, and MinnesotaCare rate changes do not affect volume purchase/competitive bid contract payments, unless specifically identified.
6 Excess income. Amends § 256B.056, subd. 5. If an individual is ineligible for MA payment of long-term care services due to an uncompensated transfer, allows only long-term care expenses that are greater than the average MA nursing facility rate to be deducted, along with other incurred medical expenses, from excess income for purposes of a spenddown. Allows recipients on a one-month spenddown who pay the spenddown in advance to pay this amount by the last business day of the month (current law requires payment by the 20th day of the month.) Provides that the amendment related to the date of payment is effective upon implementation of HealthMatch.
7 Notice. Amends § 256B.056, by adding subd. 8a. Requires the state agency to be given notice of monetary claims against a person, entity, or corporation that may be liable to pay all or part of the cost of medical care, when the state agency has paid or become liable for the cost of care. Specifies procedures for notification.
8 Joinder of state in actions against third parties. Amends § 256B.056, by adding subd. 8b. Requires an MA recipient or the recipient's legal representative asserting a claim against a third party potentially liable for the recipient's medical costs to join the state agency as a party to the claim.
9 Settlement. Amends § 256B.056, by adding subd. 8c. Requires the state agency to be granted

first recovery from a liable third party, if there is a judgment, award, or settlement of an action or claim by or on behalf of an MA recipient to recover damages from a third party potentially liable for a recipient's medical costs.

10 Period of ineligibility. Amends § 256B.0595, subd. 2. Allows a cause of action if a transfer was reported to a local agency after the date by which notice of a period of ineligibility affecting the next month can be provided to the recipient, and the recipient received MA services.

11 General assistance medical care; eligibility. Amends § 256D.03, subd. 3. Requires assets transferred for less than fair market value to be included, when determining eligibility for individuals applying for GAMC hospital-only coverage. (Current law applies this requirement only to persons applying for full GAMC coverage.)

12 Social security number required. Amends § 256D.045. States that an individual who refuses to provide a social security number because of a well established religious objection may be eligible for GAMC.

13 Social security number required. Amends § 256L.04, by adding subd. 1a. Requires MinnesotaCare applicants to provide a social security number. Provide exceptions for persons awaiting issuance of a social security number, newborns, and individuals who refuse to provide a social security number because of well-established religious objections.

14 Cooperation in establishing third-party liability, paternity, and other medical support. Amends § 256L.04, subd. 2. Requires MinnesotaCare enrollees to comply with the notice and settlement requirements of § 256B.056, subdivisions 8a and 8c.

15 Applications for other benefits. Amends § 256L.04, by adding subd. 2a. Requires individuals and families, in order to remain eligible for MinnesotaCare, to take all steps necessary to obtain other benefits, including retirement and disability benefits and pensions. Requires applicants and enrollees to apply for other benefits within 30 days.

16 Limitation. Amends § 549.02, by adding subd. 3. Exempts the state agency from being liable for costs to any prevailing defendant.

17 Disbursements; taxation and allowance. Amends § 549.04. Exempts the state agency from being liable for disbursements to any prevailing defendant.

18 Continuation of life estates and joint tenancy interests in real estate.

Subd. 1. Exemption for certain nursing facility residents. Exempts recipients who were permanent residents of a nursing facility on August 1, 2003, and who had established a life estate or joint tenancy interest in real estate prior to August 1, 2003, from DHS recoveries based on the continuation of these interests after the recipient's death.

Subd. 2. Temporary prohibition on recovery. Prohibits the Commissioner of Human Services from making recoveries related to the continuation of a recipient's life estate or joint tenancy interests in real estate, for decedents who die between August 1, 2003, and July 31, 2005, who had established a life estate or joint tenancy interest prior to August 1, 2003.

Subd. 3. Refund of amounts recovered. Requires the commissioner and county agencies to refund amounts recovered.

Subd. 4. Lien notices. Provides that lien notices related to life estate or joint tenancy interests described in subdivisions 1 and 2 shall have no effect beyond the death of the recipient and shall be disregarded by examiners of title and not carried forward to subsequent certificates of title.

Subd. 5. Immunity. Provides the commissioner, county agencies, elected officials, and their employees with immunity for actions taken related to the continuation of life estate and joint tenancy interests.

Subd. 6. Definitions. Defines when a life estate or joint tenancy interest is established, and when a recipient is a permanent resident of a nursing facility.

Article 13: Miscellaneous

This article contains a variety of provisions related to programs operated by or entities regulated by the Commissioners of Health and Human Services. Provisions in the article modify the status of loans in grant programs, restrict the use of state family planning grant funds, establish a process to review requests for hospital moratorium exceptions, modify the definition of a housing with services establishment, permit a single benefit demonstration project, modify benefits for MSA recipients who are relocating from a Rule 36 facility, permit GRH agreements with supportive housing establishments, permit limitations for certain persons under the Patients' and Resident's Bill of Rights, modify the definition of "patient services," and add an exclusion to the gross revenues subject to provider taxes.

1. 1 Status of previous awards. Amends § 144.148, by adding subd. 9. Requires the Commissioner of Health to regard previous loans and grants awarded under the Rural Hospital Grant Program as grants.

2 Public interest review. Adds § 144.552. Requires hospitals or organizations seeking an exception to the hospital moratorium to submit a plan to the Commissioner of Health explaining the public interest. The applicant must pay the commissioner for the cost of the review, and the commissioner may request information from the applicant or others as needed. The commissioner must submit findings within specified time limits to the Health and Human Services Policy and Finance Committee chairs on whether the plan is in the public interest. In making the recommendations, the commissioner if required to consider:

(1) how the plan would affect access to care or improved services;

(2) how the plan would affect nearby acute-care hospitals financially;

(3) how the plan would affect nearby hospitals' staffing;

(4) how the plan would affect services to low-income or nonpaying patients relative to existing services; and

(5) the views of affected parties.

3 Optional registration. Amends § 144D.025. Allows a supportive housing establishment to register as a housing with services establishment.

4 Family planning grant use limited. Adds § 145.417.

Subd. 1. Definitions. Defines "abortion," "family planning grant funds," family planning services," "nondirective counseling," and "public advocacy." Family planning grant funds include maternal and child health block grants, family planning special projects grants, grants to eliminate health disparities and any other state grant program

where funds may be used to fund family planning services.

Subd. 2. Uses of family planning grant funds. Provides that no family planning grant funds may be used to subsidize abortion services or administrative expenses, paid or granted to an organization that provides abortion services.

Subd. 3. Organizations receiving family planning grant funds. Provides that recipients of family planning grant funds may provide non-directive counseling relating to pregnancy, but may not refer patients to organizations that provide abortion services. Recipients may not display or distribute marketing materials about abortion services, may not publicly advocate for abortion legality or accessibility, and must be separately incorporated from any affiliate that provides abortion services.

Subd. 4. Independent affiliates providing abortion services. Prohibits recipients of family planning grant funds from affiliation with organizations that provide abortion services unless specified criteria for independence are met. These include no sharing of name, facilities, payroll, or equipment and supplies as well as maintenance of separate financial records.

Subd. 5. Independent audit. Requires submission of an independent audit with an application for family planning grant funds.

Subd. 6. Organizations receiving Title X funds. Provides that this section does not prohibit provision of any services required to be provided as a condition of receiving federal Title X funds.

Subd. 7. Severability. Provides that if any portion of this section is found to be unconstitutional, that portion is severable and the balance of the section is to remain effective.

5 Rules; evaluation. Amends § 246B.04. Makes a technical correction.

6 Administrative restriction. Amends § 253B.02, by adding a subdivision. Defines "administrative restriction." Requires the commissioner to establish policies and procedures regarding the use of administrative restriction.

7 Safety. Amends § 253B.02, by adding a subdivision. Defines "safety."

8 Security. Amends § 253B.02, by adding a subdivision. Defines "security."

9 Administrative restriction. Amends § 253B.03, by adding a subdivision. (a) Prohibits administrative restriction from being used for the convenience of staff, for retaliation for filing complaints, or as a substitute for program treatment. Prohibits administrative restriction from involving any further deprivation of privileges than is necessary.

(b) Allows administrative restriction to include separate and secure housing.

(c) Prohibits patients under administrative restriction from being limited in access to their attorney.

This section is effective the day following final enactment.

10 Legislative findings and purpose. Adds § 253B.184. (a) Finds that sexual psychopathic personalities and sexually dangerous persons civilly committed to the Minnesota sex offender program are a significantly different population from other patients and residents protected by the Patients' and Residents' Bill of Rights and the Patients' Bill of Rights. Lists

the ways in which persons civilly committed to the Minnesota sex offender program are different from other patients and residents.

(b) Authorizes the commissioner to limit the statutory rights under the Patients' and Residents' Bills of Rights of individuals committed to the sex offender program in order to ensure the safety and security of the treatment facility, staff, other patients, and the public, and to maintain a safe environment in which treatment can be best provided.

11 Rights of patients committed under this section. Amends § 253B.185, by adding a subdivision. (a) Allows the commissioner or the commissioner's designee to limit the statutory rights described in paragraph (b) for patients committed to the Minnesota sex offender program. Allows the statutory rights to be limited as necessary to maintain a therapeutic environment and the security of the facility, to prevent crime, or to protect the safety and well-being of patients, staff, and the public. Allows limitation of statutory rights to be applied facility-wide, to parts of the facility, or to individual patients.

(b) Allows the head of a secure treatment facility to limit certain statutory rights of patients and residents. Lists the statutory rights that may be limited.

(c) Prohibits patients committed to a secure treatment facility from maintaining a civil cause of action to enforce the Patients' and Residents' Bills of Rights.

This section is effective the day following final enactment.

12 Single benefit demonstration. Amends § 256.01, by adding subd. 14a. Permits the Commissioner of Human Services to conduct a demonstration program under certain conditions, to demonstrate the impact of a single benefit level on the rate of permanency for children in long-term foster care through transfer of permanent legal custody or adoption. Requires the program to be cost neutral and permits the Commissioner to use certain funds in a specified manner.

13 Special needs. Amends § 256D.44, subd. 5. Allows MSA recipients who are relocating from a Rule 36 facility to receive, in addition to the MSA standard of assistance, an additional amount equal to the maximum allotment authorized by the federal Food Stamp Program.

14 License required. Amends § 256I.04, subd. 2a. Allows the Commissioner of Human Services to enter into GRH agreements with supportive housing establishments developed and funded in whole or in part with funds provided as part of the plan to end long-term homelessness voluntarily registered under section 144D.025.

15 Patient services. Amends § 295.50, subd. 9b. Excludes home and community-based waivered services, targeted case management, and other specified MA services from the definition of "patient services" for purposes of the MinnesotaCare provider tax. Also states that services "provided to" supervised living facilities, housing with services establishments, and other specified entities are not patient services. Provides a retroactive effective date of January 1, 2004.

16 Exemptions. Amends § 295.53, subd. 1. Excludes from gross revenues subject to the MinnesotaCare provider tax Medicare cost-sharing paid by MA and services identified in and provided under an individualized education plan. Also updates terminology. Provides a retroactive effective date of January 1, 2004.

Article 14: Health and Human Service Forecast Adjustments

This article contains Health and Human Services forecast adjustments for fiscal years 2004 and 2005. For further information, see the spreadsheet.

1. 1 Health and human services forecast adjustments. Amends Laws 2003, First Special Session chapter 14, article 13C, sec. 1. Adjusts fiscal years 2004 and 2005 appropriations from the general, state government special revenue, health care access, federal TANF, lottery prize, and special revenue funds.
2. 2 Total appropriation. Amends Laws 2003, First Special Session chapter 14, article 13C, sec. 2, subd. 1. Adjusts fiscal years 2004 and 2005 appropriations to the commissioner of human services from the general, state government special revenue, health care access, federal TANF, and lottery cash flow funds. Makes other technical changes.
3. 3 Revenue and pass-through. Amends Laws 2003, First Special Session chapter 14, article 13C, sec. 2, subd. 3. Adjusts fiscal year 2004 and 2005 appropriations to the commissioner of human services from the federal TANF fund. Makes conforming changes.
4. 4 Basic health care grants. Amends Laws 2003, First Special Session chapter 14, article 13C, sec. 2, subd. 6. Adjusts fiscal year 2004 and 2005 appropriations to the commissioner of human services from the general fund and the health care access fund.
5. 5 Health care management. Amends Laws 2003, First Special Session chapter 14, article 13C, sec. 2, subd. 7. Adjusts fiscal year 2004 and 2005 appropriations to the commissioner of human services from the general fund.
6. 6 Continuing care grants. Amends Laws 2003, First Special Session chapter 14, article 13C, sec. 2, subd. 9. Adjusts fiscal year 2004 and 2005 appropriations to the commissioner of human services from the general fund.
7. 7 Economic support grants. Amends Laws 2003, First Special Session chapter 14, article 13C, sec. 2, subd. 11. Adjusts fiscal year 2004 and 2005 appropriations to the commissioner of human services from the general and federal TANF funds.
8. 8 Total appropriation. Amends Laws 2003, First Special Session chapter 14, article 13C, sec. 10, subd. 1. Adjusts fiscal year 2004 and 2005 appropriations to the commissioner of human services from the general fund.
9. 9 Child care. Amends Laws 2003, First Special Session chapter 14, article 13C, sec. 10, subd. 2. Adjusts fiscal year 2004 and 2005 appropriations to the commissioner of human services for MFIP child care.
10. 10 Effective date. Makes sections 1 to 9 effective the day following final enactment, unless specified otherwise.

Article 15: Appropriations

This article contains the Health and Human Services, Board of Chiropractic Examiners, and Veterans Home Board supplemental appropriations for fiscal years 2004 and 2005. For further information, see the spreadsheet.

1. 1 Health and human services appropriations. Appropriates general, state government special revenue, health care access, federal TANF, and lottery prize funds to the agencies and for the purposes specified for fiscal years 2004 and 2005.
2. 2 Commissioner of Human Services.

Subd. 1. Total appropriation. Appropriates general revenue, health care access, federal

TANF, lottery prize, and other funds to the commissioner for fiscal years 2004 and 2005.

Subd. 2. Agency management. Appropriates general revenue funds for agency management in fiscal years 2004 and 2005.

Subd. 3. Revenue and pass-through. Appropriates federal TANF funds for fiscal year 2005.

- Appropriates additional funding for use with the working family tax credit program.

Subd. 4. Children's services grants. Appropriates federal reimbursement for privatized adoption grant and foster care recruitment grant expenditures for fiscal years 2004 and 2005 for specified purposes.

Subd. 5. Children's services management.

Subd. 6. Basic health care grants. Appropriates general and health care access funds for MinnesotaCare grants, MA basic health care grants, GAMC grants, other health care grants, and for the prescription drug program.

- Transfers $70,000,000 from the health care access fund to the general fund.
- Specifies payment dates for capitation and performance withhold payments for certain months.
- Requires the Commissioner of Finance to compare projected state spending for specified programs in specified bienniums, and requires the Commissioner of Human Services to present a plan to the legislature if the projected state spending exceeds the previous biennium's spending by a specified amount.
- Permits the commissioner to expend appropriations for the prescription drug program in either year of the biennium and permits unspent funds to be available for fiscal year 2006.

Subd. 7. Health care management. Appropriates general, health care access, and other funds in fiscal year 2005 for health care policy administration and health care operations.

Subd. 8. State-operated services. Appropriates general funds for fiscal years 2004 and 2005 for state-operated-services.

- Specifies the temporary cost of care for individuals in temporary confinement to the Minnesota sex offender program.

Subd. 9. Continuing care grants. Appropriates general and lottery prize funds for community social services, aging and adult service grants, deaf and hard-of-hearing service grants, mental health grants, community support grants, MA long-term care waivers and home care grants, MA long-term care facilities grants, alternative care grants, group residential housing grants, and chemical dependency entitlement and

nonentitlement grants.

- Appropriates money to the Northstar Problem Gambling Alliance for specified purposes, contingent upon matching funds.
- Directs the commissioner to limit new TBI waiver caseload growth.
- Directs the commissioner to limit new CADI waiver caseload growth.
- Adjusts nursing facilities' per diem total payment rates for the nursing facility scholarship program.
- Effective July 1, 2004, requires the commissioner to increase payment rates for services and individual or service limits by up to one half of one percent for home- and community-based waivered services for the elderly, DT&H services for adults with MR/RC, the group residential housing supplementary service rate, chemical dependency service rates, consumer support grants, and home- and community-based services for alternative care services. Requires the commissioner to increase allocations made to county agencies to assure up to a one half of one percent increase in state spending for MR/RC, CADI, CAC, and TBI services.

Subd. 10. Continuing care management.

Subd. 11. Economic support grants. Appropriates general and federal TANF funds for fiscal year 2005 for the MFIP program, work grants, other economic support grants, child support enforcement grants, general assistance grants, and Minnesota supplemental aid grants.

- Requires federal food stamps employment and training funds received as reimbursement of MFIP consolidated fund grant expenditures to be deposited in the general fund for specified fiscal years and directs the commissioner to make conforming changes.
- Permits the commissioner to make up to 5 percent of a county's future basic sliding fee child care assistance allocation available to the county in the present year.
- Reduces the base for basic sliding fee child care.

3. 3 Commissioner of Health.

Subd. 1. Total appropriation. Appropriates general funds and health care access funds for fiscal years 2004 and 2005 to the Commissioner of Health.

Subd. 2. Health quality and access. Appropriates health care access funds for fiscal year 2005 for health quality and access.

- Appropriates funds for the evaluation of health care providers cost-shifting.

Subd. 3. Management and support services. Appropriates funds for fiscal year 2005 for management and support services.

Subd. 4. Health protection. Appropriates general funds for fiscal year 2005 for health

protection.

1. Transfers the lead abatement fund to the Department of Health from the Department of Education.

- 4 Board of chiropractic examiners . Appropriates special revenue funds for contested case activity for the Board of Chiropractic Examiners.
- 5 Veterans home board. Appropriates general funds to the veterans home board for fiscal year 2005.
- 6 Sunset of uncodified language. Provides that all uncodified language in the Appropriations article expires June 30, 2005, unless a different date is explicit.
- 7 Effective date. Provides that all provisions in the Appropriations article are effective July 1, 2004, unless a different effective date is specified.