HOUSE RESEARCH

Bill Summary

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Article 1: Licensing

This article provides for increases in licensing and background study fees.

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

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

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

4 Use. Amends § 245C.32, subd. 2. Increases the fee that the commissioner of human services may charge for the costs of conducting a background study from $12 to $20.

Article 2: State-operated Services

This article provides the commissioner of human services authority to develop pilot projects, implement adult mental health enterprise activities, to develop additional sites for the Minnesota Security Hospital, and to close regional treatment centers.

1. 1 Program design and implementation. Amends § 245.4661, subd. 2. Adds that pilot projects for adult mental health service delivery can utilize appropriations made to regional treatment centers and state-operated services if appropriated specifically by section 246.0136.

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

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

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

Article 3: Health Care

This article makes changes in state health care program administration, reimbursement, and eligibility.

1. 1 Health care access fund. Amends § 16A.724. Requires the commissioner of finance, effective July 1, 2006, to deposit revenues collected from the MA hospital surcharge (1.56 percent of net revenues) and HMO surcharge (.6 percent of premium revenue) into the health care access fund. Requires the commissioner, to the extent that resources in the health care access fund exceed expenditures, to transfer the excess funds to the general fund on June 30 of each year, starting in FY2005.

(a) Transfers may not exceed $192,442,000 in FY 2005 and for FY 2008 and thereafter, may not exceed $50,000,000

(b) For fiscal years 2005 to 2007, classifies MinnesotaCare as a forecasted program and directs the commissioner, as necessary, to reduce transfers from the health care access fund to meet expenditures and transfer funds from the general fund to the health care access fund to meet expenditures.

Provides an effective date of the day following final enactment.

2 Specific powers. Amends § 256.01, subd. 2. A new paragraph (bb) gives the commissioner of human services authority to administer a drug rebate program for drugs purchased for GAMC enrollees. Effective January 1, 2006, limits GAMC drug coverage to prescription drugs that are covered under MA and are provided by manufacturers that have executed GAMC rebate agreements. Dedicates rebates to funding the pharmaceutical assistance program.

A new paragraph (cc) gives the commissioner authority to administer a pharmaceutical assistance program, that may include a drug discount card, assistance to the prescription drug assistance program administered by the Minnesota board on aging, and other efforts to assist citizens in obtaining free or discounted prescription drugs. Also gives the commissioner authority to administer a drug rebate program for any discount card program established, and requires rebates to be used to provide a discount on the prescription drugs provided to enrollees of the discount card program.

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

4 Retention rates. Amends § 256.019, subd. 1. Allows counties to keep one-half of the nonfederal share of MinnesotaCare recoveries, if the recovery is collected and posted by the county agency.

5 State agency hearings. Amends § 256.045, subd. 3. Makes state agency hearings available to applicants aggrieved by an adverse decision to an application or redetermination for a Medicare Part D prescription drug subsidy under section 256B.04, subdivision 4a.

6 Prepaid health plan appeals. Amends § 256.045, subd. 3a. Eliminates the requirement that a prepaid health plan, when a recipient complaint is filed, notify the ombudsman within three working days.

7 Hearing authority. Amends § 256.046, subd. 1. Allows DHS, in lieu of a local agency, to initiate an administrative fraud disqualification hearing when the state agency is directly responsible for administration of the health care program for which benefits were wrongfully obtained.

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

overpayments).

9 Payments. Amends § 256.969, subd. 3a. Reduces inpatient hospital payments by 5 percent, for fee-for-service admissions occurring on or after July 1, 2005. Excludes certain mental health services and services provided by Indian health service facilities from this reduction.

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

11 Third-party payer. Amends § 256B.02, subd. 12. States that a third-party payer includes an entity under contract with the recipient to cover all or part of the recipient's medical costs. Also makes technical changes.

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

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

14 Excess income. Amends § 256B.056, subd. 5. Requires recipients on a one-month spenddown who chose to pay the spenddown amount in advance to pay the spenddown amount on or before the last business day of the month, in order to be eligible for that payment option for the following month. (Current law requires payment by the 20th of the month.) Provides an effective date of March 1, 2006, or upon HealthMatch implementation, whichever is later.

15 Individuals on fixed or excluded income. Amends § 256B.056, subd. 5a. Requires recipients who receive only fixed unearned or excluded income to report and verify their income every 12 months, with the 12-month period beginning the month of application (current law requires this "annually"). Provides an effective date of March 1, 2006, or upon HealthMatch implementation, whichever is later.

16 Individuals with low income. Amends § 256B.056, subd. 5b. Requires recipients not residing in a long-term care facility with slightly fluctuating income below the MA limit to report and verify their income every six months, with the six-month period beginning the month of application (current law requires this to be done semiannually). Provides an effective date of March 1, 2006, or upon HealthMatch implementation, whichever is later.

17 Period of eligibility. Amends § 256B.056, subd. 7. Provides that MA eligibility for retroactive months is determined independently from eligibility for the month of application and future months. States that the 12-month period for purposes of eligibility redetermination begins the month of application. Provides an effective date of March 1, 2006, or upon HealthMatch implementation, whichever is later.

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

19 **Eligibility verification.** Amends § 256B.056, by adding subd. 10. (a) Requires the commissioner to require women who are applying for a continuation of MA following the 60-day postpartum period to complete a renewal form and verify assets.

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

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

(d) Directs the commissioner to require recipients to report and verify new employment income within 10 days, and disenroll recipients who do not provide this verification.

Provides an effective date of July 1, 2005, and specifies procedures for implementing the section prior to and upon implementation of HealthMatch.

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

21 Period of ineligibility. Amends § 256B.0595, subd. 2. Allows a cause of action against a person receiving a transfer of assets, if the transfer was reported to the local agency after the date that advance notice of a period of ineligibility could be provided to the recipient, and the recipient received MA services. States that the section is effective for transfers occurring on or after July 1, 2005.

22 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.

23 Services provided in a hospital emergency room. Amends § 256B.0625, by adding subd. 1a. States that MA does not cover visits to a hospital emergency room that are not for emergency and emergency post stabilization care or urgent care, and does not pay for services provided in that setting that are not for those purposes.

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

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

26 Health services policy committee. Amends § 256B.0625, by adding subd. 3d. Requires the commissioner, after receiving recommendations from specified groups, to establish an 11-member Health Services Policy Committee. Requires the committee to advise the commissioner on health services issues related to health care benefits under state health care programs. Requires the committee to meet at least quarterly and to annually elect a physician chair to work with the commissioner's medical director to establish meeting agendas.

27 Health services policy committee members. Amends § 256B.0625, by adding subd. 3e.

Specifies membership of the health services policy committee.

28 Health services policy committee terms and compensation. Amends § 256B.0625, by adding subd. 3f. Specifies terms, provides for payment of an honorarium and expenses, and states that the committee does not expire.

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

30 Drug utilization review board. Amends § 256B.0625, subd. 13a. Requires the commissioner, after receiving recommendations from professional medical and pharmacy associations and consumer groups, to designate members of the Drug Utilization Review Board. Strikes language requiring members to be selected from lists submitted by professional organizations. Allows the DHS medical director to serve as an ex officio, nonvoting member. Allows members to be reappointed by the commissioner.

31 Formulary committee. Amends § 256B.0625, subd. 13c. Requires the drug formulary committee to be staffed by an employee of DHS who services as an ex officio, nonvoting member. Also designates the medical director as an ex officio, nonvoting member.

32 Payment rates. Amends § 256B.0625, subd. 13e. The amendment to paragraph (a) reduces the actual acquisition cost of a drug from average wholesale price (AWP) minus 11.5 percent to AWP minus 12 percent. Also eliminates obsolete language.

The amendment to paragraph (d) sets the payment amount of drugs administered in an outpatient setting at the lower of the usual and customary cost or the amount established by Medicare. (Strikes language setting the payment amount at the lower of the usual and customary cost, AWP minus 5 percent, the maximum allowable cost, or the rate set by the commissioner.)

A new paragraph (e) allows the commissioner to negotiate reimbursement rates for specialty pharmacy products that are lower than the rates specified in paragraph (a). Allows the commissioner to require state health care program enrollees to obtain specialty pharmacy products from providers with whom the commissioner has negotiated a lower rate. Provides a definition of specialty pharmacy products and requires the commissioner to consult with the formulary committee to develop a list of specialty pharmacy products.

A new paragraph (f) allows the commissioner to require state health care program enrollees to obtain drugs used to treat hemophilia from a comprehensive hemophilia diagnostic center, provided that the center is a covered entity in the 340B drug-pricing program.

33 Prior authorization. Amends § 256B.0625, subd. 13f. The amendment to paragraph (c) requires prior authorization for brand name drugs for mental illness to be automatically granted for 60 days, within 60 days of when a generic drug becomes available. The amendment to paragraph (d) eliminates the July 1, 2005 sunset for a provision that exempts antihemophilic factor drugs, prescribed for the treatment of hemophilia and blood disorders when no generic drug is available, from MA prior authorization under any supplemental drug rebate program or multistate preferred drug list. Provides an effective date of June 30, 2005. A new paragraph (f) allows the commissioner to automatically require prior authorization, for a period not to exceed 180 days, for any drug approved by the U.S. Food and Drug Administration on or after July 1, 2005. Requires the formulary committee to recommend general criteria for prior authorization, but does not require the committee to review each individual drug. Requires the commissioner to follow the general prior authorization provisions, in order to continue prior authorizations after the 180-day period

has expired.

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

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

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

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

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

35 Transportation costs. Amends § 256B.0625, subd. 17. Increases MA reimbursement rates for special transportation services provided to persons who need a stretcher-accessible vehicle from $36 to $60 for the base rate and from $1.40 to $2.40 per mile.

36 **Medically necessary items and services.** Adds § 256B.0632.

Subd. 1. General requirement for coverage. Provides that MA enrollees are eligible to receive, and MA shall provide payment for, only those medical items and services that are within the scope of defined benefits the enrollee is eligible for, and determined by MA to be medically necessary.

Subd. 2. Medical necessity. (a) Requires an item or service, in order to be determined medically necessary, to be recommended by a physician or other licensed healthcare provider practicing within the scope of their practice, and to satisfy the criteria in this section.

(b) The item or service must be required in order to diagnose or treat an enrollee's medical condition; the convenience of the enrollee, the enrollee's family, or a provider shall not be a factor or justification.

(c) Requires the item or service must be safe and effective, and specifies criteria.

(d) Requires the item to be the least costly alternative course of diagnosis or treatment that is adequate for the medical condition of the enrollee, and specifies criteria.

Subd. 3. Determination of commissioner. States that it is the responsibility of the commissioner to ultimately determine what medical items and services are medically necessary. Further states that the fact that a provider has prescribed, recommended, or approved an item or service does not, in itself, make the item or service medically necessary.

Subd. 4. Applicability. Provides that the medical necessity standard in this section is to govern delivery of all services and items to all enrollees or classes of beneficiaries in the MA program. Allows the commissioner to make limited special provisions for particular items or services, such as long-term care, or as required for compliance with federal law.

Subd. 5. Medical protocols. Provides that medical protocols developed using evidence-based medicine that are authorized by the commissioner satisfy the standard of medical necessity. Requires the protocols to be published to all MA providers and managed care organizations.

Subd. 6. Rulemaking. Authorizes the commissioner to adopt any rules necessary to implement this section.

Subd. 7. Application. Provides that this section does not apply if the medical necessity standard or medical protocols authorize or recommend denial of treatment, food, or fluids on the basis of age, disability, and other factors.

37 **Limiting coverage of health care services for public programs.** Adds § 256B.0633.

Subd. 1. Prior authorization of services. (a) Effective July 1, 2005, requires prior authorization under MA, GAMC, and MinnesotaCare for the services described in subdivision 2. Requires prepaid health plans to use prior authorization unless the plan is otherwise using evidence-based practices.

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

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

38 Participation required for reimbursement under other state health care programs. Amends § 256B.0644. Exempts persons providing dental services from the requirement that providers participate in state health care programs in order to serve as providers for state and public employees, workers' compensation, and MCHA.

39 Fee-for-service. Amends § 256B.075, subd. 2. Directs the commissioner to develop and implement a pilot intensive care management project for MA children with complex and chronic medical issues who are not able to participate in the metro-based U Special Kids program due to geographic distance.

40 Policy, applicability, purpose, and construction; definition. Amends § 256B.15, subd. 1. States that all provisions in section 256B.15, subdivisions 1, 1d, 1f, 1g, 1h, 1i, and 1j that relate to the continuation of a recipient's life estate or joint tenancy interests in real property after death of the recipient, for purposes of recovering medical assistance, are effective only for life estates and joint tenancies established on or after August 1, 2003.

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

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

42 Facility fee payment. Amends § 256B.32, subd. 1. Reduces fee-for-service payments for outpatient hospital facility services by 5 percent, for services provided on or after July 1, 2005. Exempts Indian health service facilities from this reduction.

43 Limitation of choice. Amends § 256B.69, subd. 4. Specifies that the PMAP exemption for persons enrolled in individual health plans applies only to non-Medicare plans.

44 Payment reduction. Amends § 256B.69, by adding subd. 5i. Reduces managed care payments by 2.01 percent under MA, and 2.20 percent under GAMC, for services provided on or after January 1, 2006. Excludes payments for nursing home services, home and community-based waivers, and payments to demonstration projects for persons with disabilities from this reduction.

45 Hospital outpatient reimbursement. Amends § 256B.75. Reduces fee-for-service payments for outpatient hospital facility services by 5 percent, for services provided on or after July 1, 2005. Exempts Indian health service facilities from this reduction.

46 General assistance medical care; eligibility. Amends § 256D.03, subd. 3. Eliminates GAMC eligibility for individuals with incomes greater than 75 percent but not exceeding 175 percent of FPG (those individuals eligible for GAMC hospital-only coverage). Establishes a GAMC spenddown at 50 percent of FPG. Allows GAMC eligibility for persons who reside in group residential housing who can meet a spenddown using the cost of remedial services. Makes other conforming changes. Provides an October 1, 2005 effective date.

47 General assistance medical care; services. Amends § 256D.03, subd. 4. The amendment to paragraph (b) states that GAMC does not cover sex reassignment surgery and strikes language that allowed coverage of gender reassignment surgery and related services if the individual began receiving gender reassignment services prior to July 1, 1995. Makes conforming changes related to the elimination of GAMC hospital-only coverage for individuals with incomes greater than 75 percent but not exceeding 175 percent of FPG. Also corrects a cross-reference. Provides various effective dates.

48 **General assistance medical care; medical necessity.** Amends § 256D.03, by adding subd. 4a. Requires a medical item or service to meet the medical necessity standards in § 256B.0632, in order to be covered under GAMC.

49 Payments after October 1, 2005. Amends § 256D.03, by adding subd. 10. Requires GAMC payments made on or after October 1, 2005 to be made from the health care access fund.

50 Social security number required. Amends § 256D.045. States that GA applicants who refuse to provide a Social Security number because of a well-established religious objection may be eligible for GAMC. Provides an effective date of March 1, 2006, or upon HealthMatch implementation, whichever is later.

51 Child. Amends § 256L.01, subd. 1a. Allows individuals who are enrolled in postsecondary

education to qualify under MinnesotaCare as a "child" only if they are under age 19, and do not have private sector health coverage available through the postsecondary education institution or parents. The higher age limit for "child" of 21 will apply only to individuals not enrolled in postsecondary education. Provides an effective date of July 1, 2005, or upon federal approval, whichever is later. Specifies procedures for implementing the section prior to and upon implementation of HealthMatch.

52 Gross individual or gross family income. Amends § 256L.01, subd. 4. Requires gross income for the non-farm self-employed to be calculated using the MA families with children methodology for determining allowable and nonallowable self-employment expenses and countable income. Specifies that gross individual or family income for purposes of MinnesotaCare means income calculated for the six-month period of eligibility. (This is consistent with a recent law change requiring enrollees to renew eligibility every six months, effective October 1, 2004.) Eliminates the requirement that applicants report the most recent financial situation of the family if it has changed from the period of time covered by the federal income tax form. Provides an effective date of March 1, 2006, or upon HealthMatch implementation, whichever is later.

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

54 Covered health services. Amends § 256L.03, subd. 1. Makes a conforming change related to elimination of MinnesotaCare eligibility for adults without children. Provides an October 1, 2005 effective date.

55 Inpatient hospital services. Amends § 256L.03, subd. 3. Makes a conforming change related to elimination of MinnesotaCare eligibility for adults without children and the reduction in the income limit for parents. Provides an October 1, 2005 effective date.

56 Co-payments and coinsurance. Amends § 256L.03, subd. 5. Adds MinnesotaCare copays of $3 per nonpreventive visit and $6 for nonemergency visits to a hospital-based emergency room. Limits these co-pays to one per day per provider. Also makes a conforming change related to the reduction of the income limit for parents. Provides a January 1, 2006 effective date for the copayment change and an October 1, 2005, date for the conforming change.

57 Medical necessity. Amends § 256L.03, by adding subd. 7. Requires a medical item or service to meet the medical necessity standards under section 256B.0632, in order to be covered under MinnesotaCare.

58 Families with children. Amends § 256L.04, subd. 1. Effective October 1, 2005, eliminates MinnesotaCare eligibility for parents, grandparents, foster parents, relative caretakers, and legal guardians ages 21 and over with gross incomes that exceed 175 percent of FPG. (The income limit for these groups under current law is 275 percent of FPG.) Strikes obsolete language related to the definition of dependent sibling.

59 Social Security number required. Amends § 256L.04, by adding subd. 1a. Requires applicants for MinnesotaCare coverage to provide a Social Security number. Prohibits the commissioner from denying eligibility if an applicant is awaiting issuance of a Social Security number. Provides exemptions for newborns and individuals who refuse to provide a number because of well-established religious objections. Provides an effective date of March 1, 2006, or upon HealthMatch implementation, whichever is later.

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

61 Applications for other benefits. Amends § 256L.04, by adding subd. 2a. Requires individuals and families, in order to be eligible for MinnesotaCare, to take all necessary steps to obtain the benefits described in 42 CFR 435.608 (annuities, pensions, retirement, and disability benefits). Provides an effective date of March 1, 2006, or upon HealthMatch implementation, whichever is later.

62 Applicants potentially eligible for medical assistance. Amends § 256L.04, subd. 8. Makes conforming changes related to the elimination of MinnesotaCare eligibility for adults without children. Provides an October 1, 2005 effective date.

63 Commissioner's duties. Amends § 256L.05, subd. 2. Directs the commissioner, in determining MinnesotaCare eligibility, to require applicants and enrollees seeking renewal to verify both earned and unearned income, and if employed to submit to their employers a form to verify whether they and dependents have access to employer subsidized coverage. Provides an effective date of July 1, 2005, and specifies procedures for implementing the section prior to and upon implementation of HealthMatch.

64 Effective date of coverage. Amends § 256L.05, subd. 3. Provides that the effective date of coverage under MinnesotaCare for newly adoptive children is the month of placement or the month placement is reported, whichever is later, rather than the date of entry into the family. Provides that the effective date of coverage for other new family members is the first day of the month following the month in which the change is reported, rather than the first day of the month following the month in which eligibility is approved or at renewal. Provides an effective date of March 1, 2006, or upon HealthMatch implementation, whichever is later.

65 Renewal of eligibility. Amends § 256L.05, subd. 3a. For purposes of MinnesotaCare eligibility renewal, specifies that the first six-month period of eligibility begins the month the application is received by the commissioner (current law refers to the month after the month the application is approved). Provides an effective date of March 1, 2006 or upon HealthMatch implementation, whichever is later.

66 Availability of private insurance. Amends § 256L.05, subd. 5. Makes a conforming change related to elimination of MinnesotaCare eligibility for adults without children. Provides an October 1, 2005 effective date.

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

68 General requirements. Amends § 256L.07, subd. 1. The amendment to paragraph (b) states that beginning October 1, 2005, parents, grandparents, foster parents, relative caretakers, and legal guardians age 21 and over are no longer eligible for MinnesotaCare if their gross incomes exceeds 175 percent of FPG. Provides that pregnant women whose income rises above 275 percent of FPG remain eligible for MinnesotaCare through the end of the 60-day postpartum period.

An amendment to paragraph (c) reduces, from 12 to six months, the notice period given children who are no longer eligible for MinnesotaCare under the MCHA exception. (This exception allows children in households with incomes above the program income limit to remain on the program if ten percent of family income is less than the premium for a $500 deductible policy available through the Minnesota Comprehensive Health Association.)

Makes conforming changes and eliminates obsolete language.

Provides an effective date of March 1, 2006, or upon HealthMatch implementation, whichever is later.

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

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

70 Voluntary disenrollment for members of military. Amends § 256L.07, subd. 5. Allows MinnesotaCare enrollees who are members of the military, and their families, who voluntarily disenroll when one or more family members are called to active duty, to reenroll during or following that member's tour of active duty. Requires income and asset increases reported at the time of reenrollment to be disregarded and provides a good cause exemption from the requirement that persons voluntarily disenrolling not reenroll for four calendar months. Provides an effective date of July 1, 2005.

71 Residency requirement. Amends § 256L.09, subd. 2. Makes a conforming change related to elimination of MinnesotaCare eligibility for adults without children. Also strikes an obsolete cross-reference. Provides an October 1, 2005 effective date.

72 Enrollees 18 or older. Amends § 256L.11, subd. 6. Makes conforming changes related to elimination of MinnesotaCare eligibility for adults without children and the reduction in the income limit for parents. Corrects cross-references. Provides an October 1, 2005 effective date.

73 Co-payments and benefit limits. Amends § 256L.12, subd. 6. Strikes a reference to the MinnesotaCare limited benefit set provided under current law to adults without children with incomes greater than 75 percent but not exceeding 175 percent of FPG. (This is related to elimination of eligibility for adults without children and the repeal of the limited benefit set.) Provides an October 1, 2005, effective date.

74 Rate setting; rateable reduction. Amends § 256L.12, by adding subd. 9b. For services provided on or after January 1, 2006, reduces MinnesotaCare payment rates to managed care plans by 1.83 percent.

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

A new paragraph (c) increases MinnesotaCare premiums by ten percent, effective July 1, 2005.

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

76 Exceptions to sliding scale. Amends § 256L.15, subd. 3. Increases the annual premium for MinnesotaCare children in families with incomes not exceeding 150 percent of FPG, from

$48 to $60 per year. Provides an effective date of March 1, 2006, or upon HealthMatch implementation, whichever is later, except that the premium increase is effective July 1, 2005.

77 Public health care programs and certain trusts. Adds § 501B.895.

Policy, applicability and purpose. Paragraph (a). States that it is the public policy of the state that all individuals use all available resources to pay for long-term care before turning to Minnesota health care program funds. Directs that any irrevocable inter vivos trust or similar instrument created on or after July 1, 2005, shall be revocable by operation of law for the sole purpose of payment of health care and long-term care service costs through a Minnesota public health care program. States that any inter vivos irrevocable trust or similar instrument shall be deemed to be located in and subject to the laws of this state. States such an instrument is created as of the date it is fully executed by all of the settlers or others.

Paragraph (b). Defines irrevocable inter vivos trusts for purposes of this section as a trust or similar instrument executed by a grantor, or anyone with authority to act upon the grantor's behalf, to an individual or an entity with a fiduciary responsibility who will manage the trust for the benefit of the grantor or others.

Paragraph (c). Provides that if there is a conflict between this section and the provisions of an irrevocable trust created on or after July 1, 2005, this section shall control.

Paragraph (d). Provides that this section does not apply to trusts that qualify as excluded assets as special needs trusts under 42 U.S.C. § 1396p (d)(4)(a) and (c).

Effective date. Provides that this section is effective the day following final enactment and applies to all trusts first created on or after July 1, 2005, and applies to all interests in real or personal property regardless of the date the interest was created, reserved or acquired.

78 Time limits; claim limits; liens on life estates and joint tenancies. Amends § 514.981, subd. 6. Amends a section dealing with MA liens, to provide that all provisions related to the continuation of a recipient's life estate or joint tenancy interests in real property after death of the recipient, for purposes of recovering medical assistance, are effective only for life estates and joint tenancies established on or after August 1, 2003.

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

79 **Use of a broker to manage special transportation services.** Amends Laws 2003, 1st Sp. Session chapter 14, article 12, section 93. Prohibits the commissioner of human services from using a broker or coordinator to manage special transportation services for fee-for-service enrollees residing in a nursing home until July 1, 2006. Strikes obsolete language related to a review of special transportation services.

80 Advisory committee on non-emergency transportation services. Directs the commissioner of human services to establish a seven-member advisory committee on MA non-emergency transportation services. Specifies membership and requires the committee to monitor and evaluate the provision of these services and present recommendations for any necessary changes to the commissioner.

81 Planning process for managed care. Requires the commissioner of human services to develop a planning process to implement at least one additional managed care arrangement to provide services (excluding continuing care services) to MA fee-for-service enrollees, effective January 1, 2007. Specifies membership of an advisory committee and requires the department to seek any additional federal authority necessary to provide basic health care

services through contracted managed care arrangements.

82 **Federal approval related to medical assistance income limit for pregnant women and special work expense deduction.** Requires the commissioner of human services, by July 1, 2005, to apply for any federal waivers and approvals necessary to retain the MA income limit for pregnant women at 200 percent of FPG and not apply the special work expense deduction for infants and pregnant women, while continuing to receive SCHIP funding. Requires the commissioner to update the relevant committee chairs and ranking minority members on the status of the waiver request.

83 Federal approval. (a) Requires the commissioner of human services to seek federal waivers and approvals necessary to allow the commissioner to charge MA recipients sliding scale premiums.

(b) Requires the commissioner to seek federal waivers and approvals necessary to count the income of unrelated persons in a household under MinnesotaCare.

84 Health care financing report. Requires the commissioner of human services to develop recommendations to simplify the financing of publicly funded health care programs, and report to the relevant legislative committee chairs during the 2007 session.

85 General provisions governing the change in effective date for life estate and joint tenancy interest provisions.

Subd. 1. Establishment of a life estate or joint tenancy interest. Specifies when a life estate or joint tenancy interest is established.

Subd. 2. Medical assistance. Defines "medical assistance" as the medical assistance, general assistance medical care, and alternative care programs.

Subd. 3. Lien notices. States that lien notices against life estate or joint tenancy interests established prior to August 1, 2003 end and become unenforceable upon the death of the life tenant or joint tenant and shall be disregarded by examiners of title and not carried forward. States that this subdivision does not apply if the terms of the life estate provide otherwise.

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

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

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

87 Immunity. Provides the commissioner of human services, county agencies, elected officials and their employees with immunity from liability for actions taken pursuant to the 2003 act that continued life estate and joint tenancy interests.

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

88 Repealer.

(a) Repeals sections 256L.035 (MinnesotaCare limited benefit set), 256L.04, subdivision 7 (MinnesotaCare eligibility for adults without children), and 256L.09, subdivisions 1, 4, 5, 6, and 7 (MinnesotaCare durational residency requirement for adults without children),

effective October 1, 2005.

(b) Repeals section 256.955 (prescription drug program) effective January 1, 2006.

(c) Repeals section 256B.075, subd. 5 (June 30, 2006, expiration date for DHS disease management initiatives) and section 295.581 (prohibition on non-MinnesotaCare transfers from health care access fund) effective the day following final enactment.

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

Article 4: Nursing Facility Reimbursement

This article requires the commissioner of human services to establish a new nursing facility reimbursement system and contains other provisions related to nursing facilities.

1. 1 **Exceptions for replacement beds.** Amends § 144A.071, subd. 4a. Provides an exception to the nursing facility moratorium for two facilities.

(1) Allows a facility in Columbia Heights with 122 beds to remove from layaway status 35 of 98 beds placed on layaway in a previous exception, and relicense and recertify these beds in stages in a newly constructed nursing facility in Ramsey located on a long-term care campus.

(2) Allows a facility in Anoka with 57 beds to remove from layaway status an additional 33 of the 98 beds and relicense and recertify these beds in a newly constructed nursing facility in Anoka County not closer than five miles from any other facility, along with 57 beds relocated from the facility in Anoka.

(3) Requires beds to be relicensed and recertified prior to June 30, 2009.

(4) Requires payments rates of the new facilities to be equal to those of the existing facilities.

(5) Allows the facilities to annually certify to the commissioner that they are discharging eight or more individuals per year for each newly licensed bed. Requires reductions in facility payment rates if these targets are not met or if facilities fail to provide annual certification.

2 Extension of approval for a facility in Otter Tail county. Amends § 144A073, by adding subd. 10a. Directs the commissioner of health to extend approval for an additional 24 months for a moratorium exception project proposed by a nursing facility in Otter Tail county and approved by the commissioner on December 20, 2002, as part of the competitive moratorium exception process.

3 Nursing facility rate increases beginning July 1, 1999 and July 1, 2000. Amends § 256B.431, subd. 28. Eliminates a reference to determining future nursing facility rates under "any other section" (a conforming change to establishment of a new nursing facility reimbursement system).

4 Facility rate increases effective July 1, 2000. Amends § 256B.431, subd. 29. Eliminates a reference to determining future nursing facility rates under "any other section" (a

conforming change to establishment of a new nursing facility reimbursement system).

5 Exclusion of raw food cost adjustment. Amends § 256B.431, subd. 35. Requires adjustments for raw food costs related to providing special diets based on religious beliefs to not be included in the support services per diem under the new reimbursement system, and instead added to the external fixed costs payment rate.

6 Nursing facility rate increases beginning October 1, 2005, and October 1, 2006. Amends § 256B.431, by adding subd. 41. Increases nursing facility total operating payment rates by 2.2 percent for the rate year beginning October1, 2005, and by 1 percent for the rate year beginning October1, 2006. Requires at least two-thirds of each year's adjustment to be used for employee salaries, benefits, and associated costs. Requires each facility to report to the commissioner on how the additional funding was used. Allows costs for salary and benefits increases incurred by facilities since July 1, 2003 to be counted toward the amount required to be spent on salaries and benefits. (Note: a rider in article 10, section 2, subdivision 7, increases these percentages to 2.553 percent for each year.)

7 Rate increase for facilities in Stearns, Sherburne, and Benton counties. Amends § 256B.431, by adding subd. 42. Effective October 1, 2005, requires operating payment rates of nursing facilities in Stearns, Sherburne, and Benton counties to be increased to be equal, for a RUGs rate with a weight of 1.00, to the 30th percentile of the geographic group III rate for the same RUGs weight. Provides that the subdivision applies only if it results in a rate increase.

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

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

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

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

12 Related organization costs. Amends § 256B.432, by adding subd. 6a. Specifies that costs applicable to services, capital assets, and supplies furnished to a nursing facility by a related organization may be included in the allowable cost of the facility at the purchase price paid and at the cost incurred by the related organization, if these prices or costs do not exceed that of comparable services, assets, or supplies that could be purchased elsewhere. States that the related organization's costs must not include markup or profit. If the related organization makes sales to nonrelated organizations, states that the cost to the nursing facility is the nonrelated organization's price, if sales to such organizations are at least 50 percent of total annual sales.

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

14 Alternate rates for nursing facilities. Amends § 256B.434, subd. 4. Provides that the annual inflation adjustment for nursing facilities under the alternative payment system applies only to the property-related payment rate, for the rate years beginning July 1, 2005 through July

1, 2009. Also provides that beginning in 2005, the property rate adjustment for nursing homes reimbursed under both the alternative payment and cost-based systems shall be effective October 1. Allows facilities in the alternative payment system to receive property rate adjustments for building projects.

15 Facility rate increases. Amends § 256B.434, subd. 4a. Eliminates a reference to determining future nursing facility rates under "any other section" (a conforming change to establishment of a new nursing facility reimbursement system).

16 Facility rate increases effective July 1, 2000. Amends § 256B.434, subd. 4b. Eliminates a reference to determining future nursing facility rates under "any other section" (a conforming change to establishment of a new nursing facility reimbursement system).

17 Facility rate increases effective January 1, 2002. Amends § 256B.434, subd. 4c. Eliminates a reference to determining future nursing facility rates under "any other section" (a conforming change to establishment of a new nursing facility reimbursement system).

18 Facility rate increases effective July 1, 2001. Amends § 256B.434, subd. 4d. Eliminates a reference to determining future nursing facility rates under "any other section" (a conforming change to establishment of a new nursing facility reimbursement system).

19 Phase-out of alternative payment system contracts. Amends § 256B.434, by adding subd. 18. Requires nursing facilities reimbursed under the alternative payment system to cease their contractual agreement with the commissioner effective October 1, 2009. Requires these facilities to be paid the contract payment rate for the remainder of the phase-in period.

20 Phase-out of rule 50 property rates. Amends § 256B.434, by adding subd. 19. Effective October 1, 2006, eliminates property payment rates under the rule 50 cost-based system.

21 Case mix indices. Amends § 256B.438, subd. 3. If new case mix indices are implemented together with a new payment system, provides that the requirement that rates be rebased in manner that is budget neutral for each facility does not apply.

22 Nursing facility reimbursement system effective October 1, 2005. Adds § 256B.441.

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

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

(c) Requires the commissioner to phase-in the new system beginning October 1, 2006, with full phase-in completed by October 1, 2010.

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

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

"External fixed costs category" means costs related to the nursing home surcharge, licensure fees, long-term care consultation fees, family advisory council fees,

scholarships, planned closure rate adjustments, property taxes and property insurance, and PERA.

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

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

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

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

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

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

Subd. 44. Calculation of direct care per diem costs. Requires the commissioner to calculate for each facility the normalized per diem cost for direct care services, by dividing total allowable costs for direct care services by standardized days.

Subd. 45. Calculation of support services per diem costs. Requires the commissioner to calculate for each facility the per diem cost for support services by dividing total allowable costs for support services by resident days.

Subd. 46. Calculation of a quality score. (a) Requires the commissioner to determine a quality score for each facility, using the quality measures established, according to methods determined by the commissioner in consultation with stakeholders and experts. Exempts these measures from chapter 14.

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

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

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

Subd. 47. Calculation of payment rate for direct care services. Requires the commissioner to provide recommendations to the legislature by February 15, 2006, on a methodology for a direct care service payment rate that does not increase expenditures beyond the limits of the appropriation. Also requires the commissioner to include recommendations on options to recognize changes in direct care staff hours that may require a supplemental appropriation.

Subd. 48. Calculation of payment rate for support services. States that the payment rate for support services shall be a fixed amount adjusted for the facility's peer group and geography. Specifies the methodology to be used to calculate this payment rate.

Subd. 49. Calculation of quality add-on. States that the payment rate for the quality add-on is a variable amount based on each facility's quality score. For the rate year beginning October 1, 2006, provides that the maximum quality add-on is 3 percent and that the add-on is not subject to the phase-in. Allows the commissioner to increase the maximum quality add-on as new quality measures are incorporated and existing measures updated or improved. Specifies the methodology to be used to calculate the quality add-on.

Subd. 50. Geographic adjustments of labor-related costs. Directs the commissioner to determine adjusters for the labor-related share of the operating rate. This is determined by dividing the sum of compensation for all facilities in an economic development region by facilities' total compensated hours, and then dividing this by the sum of compensation for all facilities in the state divided by total compensated hours.

Subd. 51. Adjuster for operating payment rates. Requires the commissioner to provide legislative committee chairs, by January 15 of odd-numbered years, with information on adjusters for direct care and support service costs. The information must include the projected change in the CPI-U, and costs and savings to the state of adjusting payment rates by the CPI. Also allows the commissioner to describe other factors or methods for adjusting rates.

Subd. 52. Calculation of payment rate for external fixed costs. Specifies the methods the commissioner must use to calculate the payment rate for external fixed costs.

Subd. 53. Phase-in. Specifies timing and procedures for phasing-in rates determined under the new reimbursement system.

(a) Requires the rates in effect on June 30, 2006 to remain in effect through

September 30, 2006.

(b) Specifies notice requirements for the new blended rates.

(c) Limits the automatic rate adjustment for facilities in the alternative payment system to the property payment rate. For facilities reimbursed under the cost-based system, requires property rates to continue to be determined as specified in rule.

(d) Requires the operating payment rate under the prior rate setting method for the rate years beginning October 1, 2006, to be the rate in effect on June 30, 2006. For the rate years beginning October 1, 2007 and October 1, 2008, requires the commissioner to use the amounts in effect on the prior September 30.

(e) Specifies the indices to be used for index maximization (the classification of a resident who could be assigned to more than one category to the category with the highest case mix index).

(f) to (i) Establish the following schedule of blended rates for the phase-in period:

October 1, 2006: 10 percent of the rate is determined under the new system and 90 percent under the prior rate-setting method.

October 1, 2007: 40 percent of the rate is determined under the new system and 60 percent under the prior rate-setting method.

October 1, 2008: 70 percent of the rate is determined under the new system and 30 percent under the prior rate-setting method.

Beginning October 1, 2009, 100 percent of the rate must be determined under the new system.

(j) For the rate years beginning October 1 of 2006, 2007, and 2008, provides that if the rate determined under this subdivision for a facility is less than the rate in effect on September 30, 2006, the actual operating payment rate shall be the rate in effect on September 30, 2006. For the rate year beginning October 1, 2009, limits any rate reduction under this section to no more than $10 less than the rate in effect on September 30, 2006. For rate years beginning on or after October 1, 2010, for facilities for which the rate determined under this section is less than the rate in effect on September 30, 2010, provides that the actual operating payment rate is the rate determined under this section.

Subd. 54. Audit authority. Establishes procedures and criteria for desk and field audits by the commissioner.

Subd. 55. Remedies for disputes. Establishes procedures for provider appeals and review of appeals by the commissioner.

Subd. 56. Interim rates. Requires the commissioner to determine interim payment rates for nursing facilities with no cost history. Specifies the methodology for

determining interim rates. Allows the commissioner to negotiate interim rates when a facility is purchased by an unrelated party.

23 Notice to residents. Amends § 256B.47, subd. 2. Makes changes in cross-references, to conform to the establishment of a new reimbursement system.

24 Moratorium project deadline extension in Aitkin County. Requires the commissioner of health to extend project approval until December 31, 2006, for a nursing home moratorium exception project to remodel a 48-bed facility in Aitkin county, approved under the competitive moratorium exception process in 2002. (Under current law, approval expires after 18 months, unless construction has commenced; exceptions approved between July 1, 2001, and June 30, 2003, have had approval extended an additional 18 months.)

25 Moratorium project deadline extension in Renville County. Requires the commissioner of health to extend project approval until December 31, 2006, for a nursing home moratorium exception project to remodel a 60-bed facility in Renville county, approved under the competitive moratorium exception process in 2002.

26 **Recommendations for criteria and rate negotiations for nursing facilities.** Requires the commissioner of human services to provide recommendations to the legislature by December 15, 2006 defining criteria and rate negotiations for nursing facilities that provide specialized care or that have extenuating circumstances. Also requires the commissioner to provide recommendations to the legislature by December 15, 2006 on changes to the current nursing facility property system.

Article 5: Continuing Care for the Elderly and Disabled

This article modifies provisions related to continuing care for the elderly and disabled.

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.

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

3 Employed persons with disabilities. Amends § 256B.057, subd. 9. Requires the commissioner, effective July 1, 2005, to reimburse MA enrollees who qualify as employed persons with disabilities (MA-EPD) for cost-effective Medicare Part B premiums, regardless of income. (Current law limits reimbursement to enrollees with incomes not exceeding 200 percent of FPG.) Also provides that inflation adjustments for Social Security benefits do not count as income for MA-EPD enrollees until July 1 of each year.

4 Long-term care partnership. Adds § 256B.0571. Directs the commissioner to establish a long-term care partnership program and specifies program requirements.

Subd. 1 through 7. Define terms.

Subd. 8. Program established. (a) Requires the commissioner of human services, in cooperation with the commissioner of commerce, to establish the Minnesota partnership for long-term care program to finance long-term care through a combination of private insurance and MA.

(b) In order to participate, requires individuals to: (1) be a Minnesota resident, (2) purchase a partnership policy that is delivered, issued, or renewed on or after the effective date of this section, and maintain the partnership policy; and (3) exhaust the minimum benefits of the policy.

Subd. 9. Medical assistance eligibility. (a) Requires the commissioner to determine eligibility according to paragraphs (b) and (c).

(b) Requires the commissioner, after disregarding the amount of assets exempted under MA, to disregard an additional amount of assets equal to the dollar amount of coverage utilized under the partnership policy.

(c) Requires the commissioner to consider the individual's income according to MA requirements.

Subd. 10. Approved policies. (a) Requires a partnership policy to meet all the requirements in paragraphs (b) to (h).

(b) Minimum coverage must be for not less than three years and for a dollar amount equal to 36 months of nursing home care, and must provide for home health care days to be substituted for nursing home care days at a 2:1 ratio.

(c) Minimum daily benefits must be $150 for nursing home care or $75 for home care, with these benefit amounts adjusted annually for purposes of both payment of benefits to the insured and minimum requirements for an approved policy.

(d) A third party must be entitled to receive notice if a policy is about to lapse, and an additional 30-day grace period must be granted following notification of that person.

(e) The policy must cover nursing home, home care, and care management services, and up to14 days of nursing care in a hospital while waiting for long-term care placement.

(f) Payment for nursing care in a hospital must not exceed the daily benefit amount for nursing home care.

(g) A partnership policy must offer, as an option for an adjusted premium, an elimination period of not more than 180 days.

(h) Requires an issuer of a partnership policy to comply with any federal law or regulations authorizing partnership policies in Minnesota. Gives the commissioner authority to enforce this paragraph.

Subd. 11. Limitations on estate recovery. Prohibits the state from seeking recovery against the estate of an individual who participated in the partnership program, or the individual's spouse, for MA benefits received by that individual.

Subd. 12. Effective date. (a) Provides that if any provision of the section is prohibited by federal law, no provision shall become effective until federal law is changed to

permit full implementation. Specifies requirements for providing notice of federal law changes or approval.

(b) If federal law is changed to allow for a waiver of any provisions prohibited by federal law, directs the commissioner to apply for waivers, and provides that the provision shall become effective upon federal approval, and provision of notice.

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

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

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

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

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

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

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

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

12 Skilled and intermediate nursing care. Amends § 256B.0625, subd. 2. Provides an exemption from the requirement that a hospital be classified under federal law as a sole community provider in order to receive MA payments for swing bed services. This exemption applies to facilities that had an agreement with the commissioner, as of January 1, 2004, to provide swing bed services.

Background: Federal law defines a sole community provider as a hospital that is located more than 35 miles from other hospitals, or meets other specified criteria related to patient use of other hospitals, distance or travel time, or lack of access to other hospitals. Federal law requires sole community providers to be reimbursed under the Medicare prospective payment system. Critical access hospitals are exempt from this prospective payment system and are reimbursed on a cost basis. A determination has therefore been made that critical access hospitals no longer qualify for swing bed services under current state law, since they cannot be classified as sole community providers.

Provides that the section is effective the day following final enactment and applies to swing

bed services provided on or after March 5, 2005.

13 Eligibility for services. Amends § 256B.0913, subd. 2. Makes alternative care services available to persons age 65 or older who would be MA-eligible within 120 days of admission to a nursing facility. Currently, alternative care services are available to persons who become MA-eligible within 180 days of admission to a nursing facility.

14 Eligibility for funding for services for nonmedical assistance recipients. Amends § 256B.0913, subd. 4. Changes the length of time within which a person must become eligible for MA from 180 days to 120 days of admission to a nursing facility.

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

16 Quality assurance system established. Amends § 256B.095. Extends the sunset date for the quality assurance system from June 30, 2007, to June 30, 2009.

17 Membership. Amends § 256B.0951, subd. 1. Extends the sunset date for the Quality Assurance Commission from June 30, 2007, to June 30, 2009.

18 Quality assurance teams. Amends § 256B.0952, subd. 5. Modifies per diem payments for quality assurance team members for time spent on alternative quality assurance process matters. Under current law, only team members who do not receive a salary or wages from an employer may receive per diem payments from the county. This proposal allows for any team member to be paid a per diem for time spent on alternative quality assurance process matters.

19 Process components. Amends § 256B.0953, subd. 1. Modifies the random sample of program consumers by reducing the minimum sample size from three to two consumers.

20 Division of cost. Amends § 256B.19, subd. 1. Modifies the division of costs between the state and counties for the cost of placements that have exceeded 90 days in ICFs/MR that have seven or more beds. Makes the division of costs 95 percent state funds and 5 percent county funds. Makes this section effective the day following final enactment. Under current law, the division of costs is 80 percent state funds and 20 percent county funds.

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

22 ICF/MR rate increases beginning October 1, 2005, and October 1, 2006. Amends § 256B.5012, by adding subd. 6. Increases ICF/MR total operating payment rates by 2 percent, for the rate years beginning October 1, 2005 and October 1, 2006. Requires at least two-thirds of each year's adjustment to be used for employee salaries, benefits, and associated costs. Requires facilities to report to the commissioner on how the additional funding is used. (Note: a rider in article 10, section 2, subdivision 7, increases these percentages to 2.553 percent for each year.)

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

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

money sufficient to cover the state share of actuarial and administrative costs for FYs 2006 through 2009. Specifies the following:

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

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

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

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

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

(1) skilled nursing visit;

(2) physical therapy visit;

(3) occupational therapy visit;

(4) speech therapy visit; and

(5) home health aide visit.

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

25 Provider rate increases. Amends § 256B.765. Increases reimbursement rates for specified community-based long-term care providers by 2 percent, for the rate years beginning October 1, 2005, and October 1, 2006. Requires at least two-thirds of each year's adjustment to be used for employee salaries, benefits, and associated costs. Requires each provider to report to the commissioner on how the additional funding was used. Also makes technical changes in codification. (Note: a rider in article 10, section 2, subdivision 7, increases these percentages to 2.553 percent for each year.)

26 ICF/MR plan. Requires the commissioner 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 January 15, 2006. Lists several items the commissioner must consider in preparing the report. Makes this section effective the day following final enactment.

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

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

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

30 Waiver amendment. Requires the commissioner to submit a waiver amendment to CMS consistent with sections 0and 0by August 1, 2005.

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

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

33 Dental access for persons with disabilities. Requires the commissioner of human services to study access to dental services for persons with disabilities and present recommendations for improving access to the legislature by January 15, 2006.

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

35 **Report to legislature.** Requires the commissioner of human services, in consultation with specified parties, to report to the legislature by February 1, 2006 on the redesign of case management services

Article 6: Miscellaneous

This article modifies the duties of the commissioner and requires a study on deemed income of sponsors of noncitizens.

1. 1 Specific powers. Amends § 256.01, subd. 2. Modifies the duties of the commissioner by requiring the commissioner to authorize the method of payment to or from DHS. Provides that this authorization includes the receipt or disbursement of funds held by DHS in a fiduciary capacity as part of the programs administered by DHS.

2 Annual report. Amends § 256.01, by adding subd. 23. Requires the commissioner to annually report the number of eligible applicants who applied for MA, GAMC, and MinnesotaCare who had not lived in Minnesota for the 12 months prior to the application month. Specifies that the report shall indicate the number of applicants by state or category of foreign country of prior residence.

3 Direction to commissioner; study on deemed income of sponsors of noncitizens. Requires the commissioner to assess county compliance with deeming of income and assets of sponsors of noncitizens required under the MA, GAMC, GA, MFIP, and MinnesotaCare programs. Requires the commissioner to report findings on county compliance and make recommendations to ensure compliance to the legislative committees with jurisdiction over human services by January 15, 2006.

Article 7: Mental Health Services

This article establishes standards for treatment foster care. It includes mental health telemedicine and psychiatric consultation as covered services for the various medical assistance programs. It provides for transitional youth intensive rehabilitative mental health services.

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

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

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

2 Emergency admission. Amends § 245.4885 by adding subd. 1a. Requires a level of care determination to be completed within three working days if a child is admitted for emergency treatment in treatment foster care, a residential treatment facility, an acute care hospital, or held for emergency treatment under section 253B.05, subdivision 1.

This section is effective July 1, 2006.

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

This section is effective July 1, 2006.

4 Examiner. Amends section 253B.02, subd. 7. Provides that only a physician or psychologist may be appointed by the court to conduct an examination. Allows advanced practice registered nurses certified in mental health to conduct examinations, but excludes them from conducting court-ordered examination.

5 Mental health telemedicine. Amends § 256B.0625 by adding a subd. 46. Adds coverage, subject to federal approval, for mental health telemedicine services to the medical assistance program.

6 Treatment foster care services. Amends § 256B.0625 by adding subd. 47. Adds coverage, subject to federal approval, for treatment foster care services to the medical assistance program.

7 Psychiatric consultation to primary care practitioners. Amends § 256B.0625 by adding subd. 48. Adds coverage for psychiatric consultation to primary care providers to the medical assistance program.

This section is effective January 1, 2006.

8 Determination of client eligibility. Amends § 256B.0943. Provides that a child with autism spectrum disorder may receive a diagnostic assessment once every three years, at the request of a parent, to determine continued eligibility for therapeutic support services.

9 Treatment foster care. Adds § 256B.0946.

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

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

- Case management must comply with the Minnesota Rules, parts 9520.0900 to 9520.0926, excluding subparts 6 and 10;
- Psychotherapy and skills training must comply with section 256B.0943; and
- Family psychoeducation services must be supervised by a mental health professional.

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

Paragraph (a). Provides the requirements for the diagnostic assessment that must be performed. States that this assessment is to be conducted within 180 days prior to the

start of services and must be completed annually until the child is age 18.

Paragraph (b). Provides that the placing county must conduct the level of care evaluation with an instrument approved by the commissioner.

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

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

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

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

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

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

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

This section is effective July 1, 2006.

10 Transitional youth intensive rehabilitate mental health services. Adds§ 256B.0947.

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

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

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

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

Subd. 3. Eligibility for transitional youth. To be eligible for the services in this

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

Subd. 4. Provider certification and contract requirements. States that a provider must have a contract with the host county and be certified by the commissioner of human services. Directs the commissioner to establish procedures for counties and providers to submit contracts and other documentation that will allow the commissioner to determine whether standards in this section are met.

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

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

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

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

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

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

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

treatment team, family and significant others.

- Interventions must promote positive interpersonal relationships.

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

Paragraph (b). Provides that payment will not be made to more than one entity for each recipient on a given day except as indicated in paragraph (c).

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

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

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

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

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

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

11 General assistance medical care; services. Amends § 256D.03, subd. 4. Adds mental health telemedicine and psychiatric consultation to the list of covered services under the general assistance medical care program.

This section is effective January 1, 2006.

12 Covered health services. Amends § 256L.03, subd. 1. Adds mental health telemedicine and psychiatric consultation to the list of covered services under the MinnesotaCare program.

This section is effective January 1, 2006.

Article 8: Health Policy

This article contains provisions related to programs and entities administered or regulated by the commissioner of health. The article: increases fees related to wells, health care facilities, vital records, environmental laboratories, and food and beverage establishments; establishes a rural pharmacy grant program; makes changes related to loan forgiveness programs; establishes reporting requirements related to parental/guardian abortion notification; establishes requirements related shaken baby syndrome and postpartum depression education; establishes a voluntary trauma system; establishes a cancer drug repository program; limits the use and eligibility of family planning grants; establishes an abortion alternatives grant program; establishes the "Unborn Child Pain Prevention Act;" eliminates the Office of Unlicensed Complementary and Alternative Health Care Practice; and makes other changes.

1. 1 Abortion notification data. Amends § 13.3806, subd. 21. Adds a cross-reference to the Data Practices Act to the new abortion notification data provisions in § 144.3431.

2 Health information technology and infrastructure advisory committee. Adds § 62J.495. Establishes the Health Information Technology and Infrastructure Advisory Committee. (A similar work group was established in 2004 (Minnesota Laws, ch. 288, art. 7, § 7). The establishment of the Health Information Technology and Infrastructure Advisory Committee is meant to continue this work group.)

Subd. 1. Legislative findings and purpose. Adds a statement of purpose, stating that there is a need for collaboration among various stakeholders in designing and implementing a statewide interoperable health information infrastructure.

Subd. 2. Establishment; members; duties. Directs the commissioner of health to establish the Health Information Technology and Infrastructure Advisory Committee to advise the commissioner on:

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

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

Subd. 3. Annual Report. Requires the commissioner of health to prepare annual reports outlining progress in implementing a statewide health information

infrastructure and recommending future projects, due January 30 each year.

Subd. 4. Expiration. States that this section expires June 30, 2009.

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

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

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

- $175 for new wells (the current fee is $150);
- $35 for each well sealing (the current fee is $30);
- $35 for the single well sealing fee (the current fee is $30);
- $175 for dewatering well construction (the current fee is $175); and
- $875 for dewatering well construction of five or more wells (the current fee is $750).

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

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

- $150 annually for wells that are not in use under a maintenance permit (the current fee is $125 annually);
- $175 for construction of a monitoring well (the current fee is $150);
- $150 annually for monitoring wells that are unsealed under a maintenance permit (the current fee is $125 annually);
- $175 for monitoring wells used as a leak detection device at single motor fuel retail outlets, single petroleum build storage sites (excluding tank farms) or single agricultural chemical facility sites (the current fee is $150);
- $150 annually for a maintenance permit for unsealed monitoring wells (the current fee is $125);
- $175 for the notification fee for groundwater thermal exchange devices (the current fee is $150);
- $175 for a vertical heat exchanger (the current fee is $150);
- $150 for dewatering unsealed dewatering wells (current fee is $125), except for projects with more than five wells, the fee increases to $750 for a single permit (the current fee is $625; and

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

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

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

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

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

- requires a person to file an application and renewal application fee to renew the explorer's license by the date stated on the license and adds a renewal license fee of $75;

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

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

8 License, permit, and survey fees. Amends § 144.122. Increases license fees for hospitals, nursing homes, and outpatient surgical centers as follows:

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

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

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

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

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

11 Rural pharmacy planning and transition grant program. Adds § 144.1476. Establishes the

rural pharmacy planning and transition grant program.

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

Subd. 2. Grants authorized; eligibility. Requires the commissioner of health to award grants to eligible rural communities or health care providers in eligible rural communities for the purpose of planning, establishing, keeping in operation, or providing health services the preserve access to prescription medication and the skills of pharmacists. To be eligible for the grants, applicants must develop a strategic plan that includes: (1) a needs assessment; (2) a feasibility assessment; and (3) an implementation plan. The grants may be used: (1) to implement transition projects; (2) to develop practices that integrate pharmacy and health care facilities; (3) to establish a pharmacy provider cooperative; or (4) for initiatives that maintain local access to prescription medications and the skills of pharmacists.

Subd. 3. Funding. Requires fee revenues collected by the Board of Pharmacy to pay anticipated operating expenditures and fund the rural pharmacy grant program. Limits the administrative use of funds appropriated for the rural pharmacy grant program to ten percent.

Subd. 4. Consideration of grants. Requires the commissioner of health to appoint a committee to determine which applicants will receive grants. The committee members must include, but are not limited to: two rural pharmacists; two rural health care providers; one representative of a statewide pharmacist organization; and one representative of the board of pharmacy. A representative of the commissioner of health may also serve in an ex officio status. When determining who shall receive grants, the committee must take the following into account: improving/maintaining access to prescription medications and the skills of pharmacists; changes in service populations; the extent pharmacy needs are not being met by other providers; financial condition; the integration of pharmacy services into existing health care services; and community support. Allows the commissioner of health to take into account other relevant factors.

Subd. 5. Allocation of grants. Requires the commissioner to establish a deadline for receiving applications and to make a final funding decision within 60 days of the deadline. Requires applicants to file no later than March 1 of each fiscal year for grants made that fiscal year. Allows applicants to apply each year they are eligible. Limits each grant to $50,000 a year and prohibits the use of the funds to retire debt from capital expenditures made prior to the date the program was initiated.

Subd. 6. Evaluation. Requires the commissioner of health to evaluate the overall effectiveness of the program and allows the collection of progress reports and other information needed for the evaluation. The commissioner of health or grantees may request the expertise of an academic institution to assist in the program evaluation. Requires the commissioner of health to compile summaries of successful grant projects and other model community efforts and make the information available to communities seeking to address local pharmacy issues.

12 Definition. Amends § 144.148, subd. 1. Paragraph (b) modifies the definition of an "eligible rural hospital" for the purposes of the rural hospital capital improvement grant program by

increasing the population limit for an eligible hospital's community from less than 10,000 to less than 15,000. The increase retains eligibility for current and prospective critical access hospitals. Paragraph (c) is modified to add electronic health records system to the definition of "eligible project" for the purposes of the Rural Hospital Capital Improvement Grant Program.

13 Rural health initiatives. Amends § 144.1483. Removes clause (2), eliminating the requirement of the commissioner of health to develop and implement a program to help rural communities establish community health centers (the Rural Community Health Center Grant Program is repealed in section 6 of this bill).

14 Definitions. Amends § 144.1501, subd. 1. Adds a definition for "dentist" and "pharmacist" for the purposes of the health professional education loan forgiveness program.

15 Creation of account. Amends § 144.1501, subd. 2. Adds dentists agreeing to deliver at least 25 percent of their yearly patient encounters to state public program enrollees or patients receiving sliding fee schedule discounts to the list of those eligible for a health professional education loan forgiveness program. Also adds pharmacists agreeing to practice in designated rural areas to the list of individuals who the commissioner of health is required to distribute money to from the health professional education loan forgiveness program account.

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

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

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

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

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

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

acceptable upon the initial receipt.

Paragraph (e) clarifies that the fee for verifying information from vital records is for processing the request and increases the fee from $8 to $9. Adds that the fee is nonrefundable and due at the time of application.

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

19 Vital records surcharge. Amends § 144.226, subd. 4. Increases the vital record nonrefundable surcharge fee from $2 to $4.

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

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

22 Abortion notification data. Adds § 144.3431.

Subd. 1. Reporting form. Requires the department of health to prepare a reporting form for use by physicians and facilities that perform abortions. Specifies that the form must cover:

- The number of minors or women for whom a guardian was appointed and for whom the physician provided the parent/guardian notification required in current law; of that number, how many notices were provided in person and how many by mail; and how many women who were the subjects of these notifications obtained an abortion from the reporting physician or facility;

- The number of minors or women for whom a guardian was appointed and for whom the physician performed an abortion without providing the parent/guardian notification required in current law; how many of those women were emancipated minors; and how many of the cases involved each of the following: (1) the abortion was required to prevent death and there was insufficient time to provide the notification, (2) the abortion was authorized in writing by the person entitled to notification, or (3) the pregnant minor was the victim of sexual or physical abuse or neglect, which had been reported to the authorities.

- The number of abortions performed for which judicial authorization was received and parent/guardian notification was not provided;

- The county of residence where the woman resides, where the abortion was performed, and where judicial bypass was obtained;

- The age and race of the woman;

- The process used to inform the woman of the judicial bypass, whether

court forms were provided to her, and whether the physician or physician's agent made court arrangements for the woman; and

- How soon after visiting the abortion facility the woman went to court.

Subd. 2. Forms to physicians and facilities. Requires physicians and facilities to obtain these forms from department of health.

Subd. 3. Submission. Requires reports to be made by April 1 each year for the previous calendar year. Requires the department of health to maintain as confidential data information that would identify a woman who had an abortion or received judicial authorization for an abortion, an individual who received a parent/guardian notification, or a reporting physician or facility.

Subd. 4. Failure to report as required. Reports that are more than 30 days late are subject to a $500 late fee for each additional 30-day period or portion of a 30-day period. If a report is not filed more than one year after it is due, department of health must seek a court order directing the physician or facility to report. Allows the court to assess attorney fees and costs against a noncomplying party.

Makes private: data related to enforcement actions that would identify a woman who had an abortion or received judicial authorization for an abortion, an individual who received a parent/guardian notification, or a reporting physician or facility.

Subd. 5. Public records. Requires the department of health to issue a public report each September 30 containing statistics for the prior calendar year derived from the form specified in subdivision 2.

The report must also include statistics obtained from court administrators on the following: total number of judicial bypass petitions, number of cases in which a guardian ad litem was appointed, number of cases where counsel was appointed, number of cases granted by the court because of a finding of maturity and basis for the finding, number of petitions granted on the basis that the abortion would be in the minor's best interests and basis for that finding, number of denials from which an appeal was filed, number of appeals in which a denial was affirmed, number of appeals in which a denial was reversed.

The report must accumulate information included in prior years' reports. The report must be presented in a way that that would not identify a woman who had an abortion or received judicial authorization for an abortion, an individual who received a parent/guardian notification, or a reporting physician or facility.

Subd. 6. Modification of requirements. Allows the department of health to modify the reporting dates and consolidate forms or reports for administrative convenience or fiscal savings, as long as a report is issued at least annually.

Subd. 7. Suit to compel statistical report. Allows a group of ten or more citizens to seek an injunction to require department of health to issue the public report if

department of health fails to do so.

Subd. 8. Attorney fees. Requires the court to award attorney fees to a prevailing plaintiff. If the defendant wins and the court finds the plaintiff's suit was frivolous and in bad faith, requires the court to award attorney fees to the defendant.

Subd. 9. Severability. States that if any part of the section is found unconstitutional, any valid provisions are intended to remain in effect.

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

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

24 Restricted construction or modification. Amends § 144.551, subd. 1. Adds clause (19) to exempt critical access hospitals (established under § 144.1483, clause (10) and section 1820 of the federal Social Security Act who delicensed beds after the Balanced Budget Act of 1997) from the existing hospital construction moratorium provided they do not exceed the limits established in federal law. Several critical access hospitals reduced the number of licensed beds between 1998 and 2003 to comply with the limit of 15 beds established in federal law in 1997. In 2003, the federal limit was increased to 25; this change would allow hospitals to adjust to the federal change.

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

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

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

relief provided the person or facility acted in good faith.

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

27 Establishing a voluntary trauma system. Adds § 144.601. States that the legislature finds that death and disability due to major trauma can be reduced with a statewide trauma system and that the best system would be a voluntary one with the criteria established by the commissioner of health.

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

29 Statewide trauma system criteria. Adds § 144.603.

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

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

30 Trauma triage and transportation. Adds § 144.604.

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

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

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

This section is effective July 1, 2009.

31 Designating trauma hospitals. Adds § 144.605.

Subd. 1. Naming privileges. Prohibits a hospital from using the terms "trauma center" or "trauma hospital" in its name or advertising, or otherwise indicating that it has

trauma capabilities unless the hospital has been designated a trauma hospital by the commissioner of health.

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

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

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

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

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

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

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

32 Interhospital transfers. Adds § 144.606.

Subd. 1. Written procedures required. Requires level III and IV trauma centers to

have predetermined, written procedures for rapidly and efficiently transferring major trauma patients to definitive care.

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

33 Trauma registry. Adds § 144.607.

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

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

Subd. 3. Application of other law. States that sections 144.661 to 144.665 (traumatic brain injury and spinal cord injury registry statutes) apply to major trauma reported to the statewide trauma system except section 144.662, clause (2) and section 144.664, subdivision 3, which require persons with traumatic brain/spinal cord injuries (or their families) to be notified of available rehabilitative resources and services in Minnesota.

34 Trauma advisory council. Adds § 144.608.

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

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

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

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

Subd. 1. Definitions. Defines "cancer drug," "cancer drug repository," "cancer

supply," "Board of Pharmacy," "dispense," "distribute," "donor," "medical facility," "medical supplies," "pharmacist," "pharmacy," "practitioner," "prescription drug," "side effects of cancer," "single-unit-dose packaging," and "tamper-evident unit dose packaging" for the purposes of the program.

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

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

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

(b) A pharmacy or medical facility volunteering to participate (the program is voluntary) must submit the following information to the Board of Pharmacy: their name, address, and telephone number; the name and telephone number of a pharmacist or other person knowledgeable of the pharmacy's or medical facility's participation in the program; and a statement that they meet the eligibility requirements in paragraph (a) and the chosen level of participation under paragraph (c).

(c) A pharmacy or medical facility may participate by either accepting, storing and dispensing the drugs and supplies OR accepting and storing the drugs and supplies and donating them to a participating pharmacy or medical facility that dispenses the drugs and supplies.

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

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

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

Paragraph (b) sets the criteria for cancer drugs. *Cancer drugs* must: (1) be accompanied by a cancer drug repository donor form signed by the person making the donation (or their authorized representative) as required in paragraph (d); (2) have an expiration date at least six months later than the date the drug was donated; (3) be in their original, unopened, tamper-evident unit dose packaging that includes the

drug's lot number and expiration date (singe unit doses may be accepted if the single unit dose packaging is unopened); and (4) not be adulterated or misbranded.

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

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

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

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

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

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

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

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

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

- requiring that drugs and supplies be dispensed to individuals meeting the eligibility requirements of subdivision 4 in the following order of priority: (1) uninsured, (2) enrolled in MA, GAMC, MinnesotaCare, Medicare, or

other public assistance health care, and (3) all other eligible individuals.

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

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

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

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

Subd. 11. Liability. Exempts manufacturers of drugs and supplies (unless they exercise bad faith) from civil or criminal liabilities for injury, death, or loss to a person or property due to participation in the cancer drug repository program. Exempts medical facilities, pharmacies, pharmacists, practitioners, or donors participating in the program from civil liability for injuries or deaths of individuals to whom cancer drugs or supplies were dispensed. States that no disciplinary action shall be taken for unprofessional conduct related to donating, accepting, distributing or dispensing cancer drugs or supplies unless there was reckless, wanton, or intentional misconduct, or malpractice unrelated to the quality of the cancer drug or supply.

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

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

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

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

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

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

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

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

39 Family planning grant funds not used to subsidize abortion services. Adds § 145.417. Limits the use and eligibility for family planning grants and establishes application requirements.

Subd. 1. Definitions. Defines the terms "abortion," "family planning grant funds," "family planning services," "nondirective counseling," and "public advocacy" for the purposes of the section.

Subd. 2. Uses of family planning grant funds. States that no family planning grant funds be: (1) spent to directly or indirectly subsidize abortion services or administrative expenses; (2) paid or granted to an organization or an affiliate of an organization that provides abortion services, unless the affiliate is independent; or (3) paid or granted to an organization that has adopted or maintains a policy that considers abortion part of a continuum of family planning services, reproductive health services or both.

Subd. 3. Organizations receiving family planning grant funds. States that an organization receiving family planning grant funds must: (1) provide nondirective counseling relating to pregnancy, but may not directly refer patients seeking abortion services to any organization that provides abortion services; (2) not display or distribute materials about abortion services to patients; (3) not engage in public advocacy promoting the legality or accessibility of abortion; and (4) be separately incorporated from any affiliated organization that provides abortion services.

Subd. 4. Independent affiliates that provide abortion services. States that an organization receiving family planning grants must not be affiliated with an organization that provides abortion services unless the organizations are independent from each other. In order to be independent, the organizations must not share any of the following: (1) the same or similar name; (2) medical/non-medical facilities; (3) expenses; (4) employee wages/salaries; or (5) equipment or supplies. Organizations receiving family planning grants that are affiliated with organizations providing abortion services must maintain financial records to demonstrate independence and compliance with this subdivision and demonstrate that no direct or indirect economic or marketing benefit from the family planning grants was received by the organization providing abortion services.

Subd. 5. Independent audit. Requires an organization applying for a family planning grant to submit a copy of the organization's most recent independent audit with the grant application to ensure compliance with this section. Requires the audit to have been conducted within two years of the application submission.

Subd. 6. Organizations receiving Title X funds. Provides that nothing in this section requires organizations receiving Title X funds under the Public Health Act to stop providing any services required as a condition of receiving those funds.

Subd. 7. Severability. States that if any part of the section is found unconstitutional, the balance of the section remains in effect.

40 Positive abortion alternatives. Adds § 145.4231. Establishes the positive abortion alternatives grant program.

Subd. 1. Definitions. Defines "abortion" and "unborn child" for purposes of the program.

Subd. 2. Eligibility for grants. Paragraph (a). Directs the commissioner of health to make grants for reasonable expenses to programs that provide information, referral and assistance for women to secure necessary services and to assist women in carrying their pregnancies to term.

Paragraph (b). Provides that an eligible program, in addition to providing information and referral in paragraph (a), may provide the necessary services to assist women in carrying their pregnancies to term.

Paragraph (c). Provides that to be eligible for a grant, a program must, among other things, be a private, nonprofit corporation; be free of charge; have the purpose of assisting and encouraging women to carry their pregnancies to term; ensure that none of the funds are spent to encourage or counsel a woman to have an abortion not necessary to prevent her death; and have had an alternatives to abortion program in existence for at least one year as of July 1, 2005.

Paragraph (d). States that paragraph (c) is inseverable from the subdivision.

Paragraph (e). Provides that any organization or affiliate of an organization that provides, promotes or refers for abortions is ineligible to receive a grant.

Subd. 3. Duties of the commissioner. Provides that the commissioner of health shall make grants no later than July 1, 2006. Instructs the commissioner to monitor each grantee to ensure compliance with the purposes and requirements of subdivision 2. If a program does not adhere to the requirements, the commissioner is instructed to cease funding the program.

Subd. 4. Severability. Contains a severability clause, except as instructed for subdivision 2, paragraph (c).

Subd. 5. Supreme court jurisdiction. Gives the Minnesota Supreme Court original jurisdiction in cases challenging the constitutionality of this section. Requires the court to expedite the resolution of such cases.

41 Unborn child pain prevention. Adds § 145.4232.

Subd. 1. Short title. States that this act shall be cited as the "Unborn Child Pain Prevention Act."

Subd. 2. Definitions. Provides definitions for the purposes of this section.

(1) Abortion. Defines abortion as the term is used in section 144.343, subdivision 3.

(2) Attempt to perform an abortion. Defines attempt to perform an abortion as it is used in section 145.4241, the Woman's Right to Know Act.

(3) Unborn child. Defines unborn child as the term is used in section 145.4241, the Woman's Right to Know Act.

(4) Medical emergency. Defines medical emergency as the term is used in section 145.4241, the Woman's Right to Know Act.

(5) Physician. Defines physician as the word is used in section 145.4241, the Woman's Right to Know Act.

Subd. 3. Unborn child pain prevention. Directs that prior to performing an abortion on an unborn child who is of 20 weeks gestational age or more, the physician or the physician's agent shall inform the female if an anesthetic would eliminate or alleviate pain to the unborn child caused by the method of abortion. Provides that the physician or physician's agent shall inform the woman of risks associated with the anesthetic. Provides that with the woman's consent, the physician shall administer the anesthetic.

Subd. 4. Criminal penalties. Provides that any person who knowingly or recklessly performs or attempts to perform an abortion in violation of this section is guilty of a felony. States the penalty does not apply to the woman upon whom the abortion is performed.

Subd. 5. Civil remedies. Paragraph (a). Provides that actual and punitive damages may be sought by any person upon whom an abortion has been performed, the father or grandparents of an unborn child, against a person who knowingly or recklessly performed an abortion in violation of this section. Provides that actual and punitive

damages may be sought by any person upon whom an abortion has been attempted against the person who attempted the abortion in knowing or reckless disregard of this section.

Paragraph (b). Provides that the plaintiff will be awarded reasonable attorney's fees if the plaintiff prevails. Provides the defendant will be awarded reasonable attorney's fees if the defendant prevails and the court finds the plaintiff's suit was frivolous and brought in bad faith.

Subd. 6. Protection of privacy. Provides that if the woman does not consent to disclosure of her identity in a civil or criminal proceeding, the court shall make a ruling whether to preserve her anonymity. The order shall be accompanied by specific findings, including how the order is narrowly tailored and how there are no less restrictive alternatives available. Provides that this section cannot be construed to conceal the identity of the plaintiff or a witness from the defendant.

Subd. 7. Severability. Provides a severability clause.

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

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

44 Postpartum depression education and information. Adds § 145.906. Paragraph (a) requires the commissioner of health to work with health care facilities and licensed health care and mental health professionals, mental health advocates, consumers and families in Minnesota to develop materials and information about postpartum depression. Paragraph (b) requires physicians, traditional midwives, and other licensed health care professionals providing prenatal care to women to make available to women and their families information about postpartum depression. Paragraph (c) requires hospitals and other health care facilities to provide departing new mothers and fathers, and other family members as appropriate, with written information about postpartum depression including its symptoms, methods of coping with the illness, and treatment resources.

45 AIDS prevention grants. Amends § 145.924. Prohibits the use of AIDS prevention grants for any web sites, pamphlets, or other communications that contain sexually explicit images or language.

46 Community clinic grants. Amends § 145.9268. Modifies various provisions of the Rural Community Clinic Grant Program.

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

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

services because they are unable to pay. (In current law, a sliding fee scale is the only procedure eligible.)

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

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

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

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

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

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

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

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

- eliminating the prioritization order of project activities the commissioner shall use in awarding grants;

- adding electronic health records systems to the list of project activities the commissioner may award grants for; and

- adding building or expanding an existing facility to the list of project activities the commissi oner may award grants for.

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

47 Scope. Amends § 146A.11. Modifies the information required on the complementary and

alternative health care bill of rights to conform with the elimination of the Office of Unlicensed Complementary and Alternative Health Care Practice.

48 Exemptions. Amends § 147A.08. Makes conforming changes to correct references displaced by section 9 of this article.

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

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

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

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

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

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

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

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

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

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

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

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

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

57 Risk categories. Amends § 157.20, subd. 2a. Adds a risk category for schools for the purpose of food and beverage establishment inspections. Requires elementary and secondary school food service establishments to be inspected based on the frequency assigned by their risk category, or the Richard B. Russell National School Lunch Act, whichever is more restrictive.

58 Health-related licensing board. Amends § 214.01, subd. 2. Removes the Office of Unlicensed Complementary and Alternative Health Care Practice established pursuant to section 146A.02 from the definition of "health-related licensing board."

59 Fee adjustment. Amends § 214.06, subd. 1. Modifies requirements of health and non-health related licensing boards by requiring fee adjustments to be "based on" anticipated expenditures (current law requires that they be "as closely as possible equal to" anticipated expenditures). Adds cross references to section 144.1476 (the rural pharmacy grant program) and health related licensing board programs to the list of programs a health board may adjust fees in order to sufficiently fund. Provides an exception for health related licensing boards, allowing them to have anticipated expenditures in excess of anticipated revenues in a biennium by using accumulated surplus revenues from fees collected in previous bienniums. Removes a requirement that fees be credited to the health occupations licensing account in the state government special revenue fund (adds this requirement to a new subdivision with additional requirements as discussed in the next section).

60 Health occupations licensing account. Amends § 214.06 by adding subd. 1a. Requires that collected fees be credited to the health occupations licensing account in the state government special revenue fund. Requires the commissioner of finance to track, separately, each health related board's revenues and expenditures.

61 Child care provider training; dangers of shaking infants and young children. Adds § 245A.034. Requires the commissioner of health to provide a video presentation to all licensed child care providers as part of their initial and ongoing training. The commissioner shall also provide child care providers (at cost) a copy of the approved video about the dangers of shaking infants and young children also given to hospitals pursuant to section 144.574. Allows legal nonlicensed child care providers to participate at their option, in a video presentation session.

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

63 Provision of long-term care insurance. Amends § 471.61 by adding subd. 5. Allows any political subdivision (or subdivisions acting jointly) to contract with an insurance company for the voluntary purchase of long-term care insurance by the employees and their

dependents of the political subdivision(s). Allows the coverage to be either a group policy or individual coverage.

64 Rule amendment. Requires the commissioner of health to amend Minnesota Rules, part 4626.2015, subparts 3 item c and 6, item b (related to food manager qualifications) to conform with section 0of this article. Allows the commissioner to use the good cause exemption (Minn. Stat. § 14.388, subd. 1, clause (3)). States that section 14.386 does not apply, except as provided in section 14.388.

65 Direction to commissioner; dental review. Requires the commissioner of health, in consultation with dental associations, licensed dental and public health professionals, and others, to review the leadership and advisory role of the department of health including the usefulness or utilizing a dental director. Requires the review to include prevention, health disparities, and critical access issues. The review must be reported to the legislature by January 15, 2006.

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

67 Repealer. Paragraph (a) repeals the following: § 13.383, subdivision 3, regarding the treatment of health occupations investigative data; § 13.411, subdivision 3, regarding licensing data; § 144.1502, the dentist loan forgiveness program; § 144.1486, the Rural Community Health Centers Grant Program; § 146A.01, subdivisions 2 and 5 and § 146A.02 through § 146A.10, regarding the Office of Unlicensed Complementary and Alternative Health Care Practice; and § 157.215, the pilot project involving food and beverage service establishment HACCP quality assurance practices.

Paragraph (b) repeals the Family Planning Special Projects Grant Program (§ 145.925 and the relevant Minnesota Rules (parts 4700.19 to 4700.2500)) effective March 31, 2006 or upon the implementation of the Family Planning Project section of the 1115 waiver, whichever is later.

Article 9: Department of Human Services Forecast Adjustment

This article makes forecast adjustments to specified human services programs for fiscal year 2005.

Article 10: Appropriations

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

the fiscal years ending June 30, 2006, and June 30, 2007. Provides a summary of appropriations by fund.

2 Commissioner of human services.

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

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

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

- Nonfederal share transfers. Allows the commissioner to transfer the nonfederal share of activities for which federal administrative reimbursement is appropriated to the special revenue fund.

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

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

- Capitation rate increase. Provides that of the health care access fund appropriations to the University of Minnesota in the higher education omnibus appropriations bill, a specific amount is to be used to increase the capitation payments under Minnesota Statutes, section 256B.69. States this provision shall not expire.

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

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

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

Subd. 4. Children and economic assistance grants.

- Children's services grants. Children's mental health grants base adjustment. Increases the general fund base for costs associated with long-term care provider cost-of-living adjustment.
- Children and community services grants. Children's community service grants base adjustment. Increases the general fund base for costs associated with the long-term care provider cost-of-living adjustment.

Subd. 5. Basic health care grants.

- Updating federal poverty guidelines. States that annual updates to the federal poverty guidelines are effective each July 1, following publication by the United States Department of Health and Human Services.
- Health care access fund spending authority. Allows the commissioner of human services, with the approval of the commissioner of finance, and after notification of the chairs of the relevant house finance committee and senate budget division, to expend money appropriated from the health care access fund for MinnesotaCare and general assistance medical care. Allows the commissioner to expend the money in either fiscal year of the biennium and to transfer unencumbered appropriation balances between these two programs within or between fiscal years for the biennium ending June 30, 2007.
- Full funding for diagnosis related group payment adjustment. Appropriates increases for MA Basic Care-Families and Children, MA Basic Care-Elderly and Disabled and GAMC in order to provide full funding for the diagnosis-related groups for hospitals located in Greater Minnesota under Minnesota Statutes, section 256.969, subdivision 26.
- Specifies the appropriations for each program:
- MinnesotaCare grants. Provides that receipts from federal participation pertaining to administrative costs of the health care reform waiver shall be deposited as nondedicated revenue in the health care access fund. Provides that receipts received as a result of federal participation pertaining to grants shall be deposited in the federal fund and shall offset health care

access funds for payments to providers.

- MA basic health care-families and children.

- MA basic health care-elderly and disabled.

- General assistance medical care grants. States that GAMC drug rebate revenues collected for claims with a warrant date prior to June 30, 2007, shall be deposited in the general fund and that the pharmaceutical discount program implementation is delayed until July 1, 2007.

- Prescription drug program grants. Prescription drug program to medicare Part D transition. Allows the commissioner, with the approval of the commissioner of finance and after notice to specified committees of both legislative bodies, to transfer fiscal year 2006 appropriations between the medical assistance program and the prescription drug program.

- Health care grants-other assistance

Subd. 6. Health care management. Provides the appropriations, and their sources, for the following operations:

- Health care policy administration

- Health care access fund transfers expiration. Provides that the commissioner of finance's authorization to transfer designated funds from the health care access fund shall expire July 1, 2005.

- Health care access fund transfers. States that the transfer of funds between the health care access fund and the general fund authorized under Minnesota Statutes, section 16A.724, supersede transfers authorized in Laws 2003, First Special Session chapter 14, article 13C, section 2, subdivision 7, paragraph (a). States that this provision is effective the day following final enactment.

- Administrative base adjustment. Increases the health care access fund base for implementation of business process redesign in health care.

- Minnesota senior health options reimbursement. Appropriates federal administrative reimbursement from the Minnesota senior health options project to the commissioner of finance for this activity.

- Utilization review. Provides that federal administrative reimbursement for utilization review activities by a professional review organization shall be dedicated to the commissioner for these purposes. States that a portion of these funds must be used for activities to decrease unnecessary pharmaceutical costs in medical assistance.

- Health care operations

Subd. 7. Continuing care grants. Provides the appropriations and the amounts that may be spent for the following purposes:

- Aging and adult services grant.

- Medicare Part D. Gives the appropriation amount for grants to the Board on Aging for information and assistance for Medicare Part D implementation. Allows the money to be used in either year of the biennium.

- Alternative care grants.

- Alternative care transfer. Provides that any money not spent does not cancel but shall be transferred to the medical assistance account.

- Alternative care base. Increases the alternative care base.

- Alternative care implementation of changes to eligibility.

- Medical assistance grants-long-term care facilities.

- Long-term care provider rate increase. States that the provider rate increases in Minnesota Statutes, sections 256.431, subdivision 41, 256B.5012, subdivision 6, and 256B.765, subdivision 3, shall be adjusted to reflect 2.553 percent increases effective October 1, 2006 and October 1, 2007. Provides that these increases become part of the base-level funding for fiscal years 2008 and 2009. States that these increases replace, and are not in addition to, the percentage increases in the specified statutes.

- Medical assistance grants-long-term care waivers and home care grants.

- Limiting growth in community alternatives for disabled individuals waiver. Provides that the commissioner for each year of the biennium ending June 30, 2007, shall make available additional allocations for home and community-based services. States that the priorities for allocation of funds shall be for individuals anticipated to be discharged from institutional settings or who are at imminent risk of a placement in an institutional setting.

- Limiting growth in TBI waiver. Provides that the commissioner for each year of the biennium ending June 30, 2007, shall make available additional allocations for home and community-based services. States that the priorities for allocation of funds shall be for individuals anticipated to be discharged from institutional settings or who are at imminent risk of a placement in an institutional setting.

- Limiting growth in MR/RC waiver. Provides that the commissioner for each year of the biennium ending June 30, 2007, shall limit the new diversion caseload growth in the MR/RC waiver to 50 additional allocations. States that the priority for allocations shall be awarded to support individuals whose health and safety needs result in an imminent risk of an institutional placement.

- Quality Assurance Commission. Appropriates funds for the Quality Assurance Commission.

- Mental health grants.

- Mental health grant base. Provides the base level funding for mental health grants.

- Restructuring of adult mental health services. Allows the commissioner to make transfers that do not increase the state share of costs to effectively implement the restructuring of adult mental health services.

- Compulsive gambling prevention and education. Provides allocations to the commissioner for a grant to the Northstar Problem Gambling Alliance.

- Deaf and hard-of-hearing grants. Provides an increase to the base level of funding.

- Chemical dependency entitlement grants.

- Chemical dependency non-entitlement grants.

- Other continuing care grants. Provides an increase to the base level of funding.

Subd. 8. Continuing care management.

- Quality assurance commission. Provides an appropriation to the commissioner for the quality assurance commission. States that this funding is added to the base appropriation for the fiscal year beginning July 1, 2006.

Subd. 9. State-operated services.

- Evidence-based practice for methamphetamine treatment. Provides appropriations to the commissioner to support development of evidence based practice for methamphetamine treatment at the chemical dependency program in Willmar.

- Transfer authority related to state-operated services. Allows the commissioner to transfer funds between fiscal years of the biennium with

the approval of the commissioner of finance.

- Base adjustment for state-operated services utilization. Increases the base fund for state-operated services forensic operations with corresponding adjustments to nondedicated revenue estimates.

3 Commissioner of health.

Subd. 1. Provides the total appropriations for the commissioner of health.

- TANF appropriations. Appropriates TANF funds to the commissioner for home visiting and nutritional services. States that funding shall be distributed to community health boards and tribal governments. Appropriates TANF funds to the commissioner for decreasing racial and ethnic disparities in infant mortality.

- TANF carry forward. Allows unexpended monies of the TANF appropriation to carry forward to the second year of the biennium.

- MN AIDS project. States that the Minnesota AIDS Project is ineligible for any grants from the commissioner or the Department of Health.

Subd. 2. Community and family health promotion.

- Health occupation licensing. Allocates from the appropriations for the health occupations licensing account, money for the rural pharmacy planning and transition grant program.

- Shaken baby video. Makes an appropriation from the special revenue fund to the commissioner to provide a video to hospitals on shaken baby syndrome. States that the commissioner is to assess a fee to the hospitals and to deposit revenue received in the special revenue fund.

- Positive abortion alternatives. Makes an appropriation for administrative costs of the positive abortion alternatives program implementation. Provides an appropriation to provide positive abortion alternatives.

Subd. 3. Policy quality and compliance.

- Occupational therapy fee holiday. Suspends the commissioner's authority to collect the license renewal fee for fiscal years 2006 and 2007.

Subd. 4. Health protection.

Subd. 5. Minority and multicultural health.

Subd. 6. Administrative and support services.

4 Veterans nursing homes board. Provides appropriations for the board.

Veterans homes special revenue account. Provides that the general fund appropriations may be transferred to a veterans homes special revenue account in the special revenue fund.

Health-related boards.

Subd. 1. Total appropriation. Provides the general appropriations for the boards. States that appropriations are from the special revenue fund except where noted. Provides that funds may not be expended in excess of anticipated revenues.

Subd. 2. Board of behavioral health and therapy.

Subd. 3. Board of chiropractic examiners.

Subd. 4. Board of dentistry.

Subd. 5. Board of dietetic and nutrition practice. Allows the board to lower its fees by an amount not to exceed $36,000 in years 2006 through 2009.

Subd. 6. Board of marriage and family therapy.

Subd. 7. Board of medical practice.

Subd. 8. Board of nursing. Allows the board to lower its fees by specified amounts.

Subd. 9. Board of nursing home administrators.

Subd. 10. Board of optometry.

Subd. 11. Board of pharmacy. Appropriates additional money from the general fund to operate the cancer drug repository program.

Subd. 12. Board of physical therapy.

Subd. 13. Board of podiatry.

Subd. 14. Board of psychology.

Subd. 15. Board of social work. Allows the board to temporarily reduce fees. Provides a list of fee reductions by licensure classification.

Subd. 16. Board of veterinary medicine.

Emergency medical services board. Provides the appropriations for the board. Allocates money from the special revenue fund for health professional services activity.

Council on disability. Provides the appropriations for the council.

Ombudsman for mental health and mental retardation. Provides the appropriations for the ombudsman.

Ombudsman for families. Provides the appropriation for the ombudsman.

Transfers.

Subd. 1. Grants. Allows the commissioner of human services, with the approval of

the commissioner of finance, and after notification to the chairs of the relevant senate budget division and house finance committee, to transfer unencumbered appropriation balances for the biennium ending June 30, 2007, within fiscal years among MFIP, general assistance, medical assistance, MFIP child care assistance, Minnesota supplemental aid, and group residential housing programs, and the entitlement portion of the consolidated chemical dependency treatment fund.

Subd. 2. Administration. Provides that positions, salary money, and nonsalary administrative money may be transferred within the departments of human services and health and within the programs operated by the veterans nursing homes board with the approval of the commissioner of finance.

Subd. 3. Prohibited transfers. Provides that the legislature must approve any grant money transferred within the Departments of Human Services and Health and within the programs operated by the Veterans Nursing Homes Board.

11 Indirect costs not to fund programs. States that the commissioners of health and of human services shall not use indirect cost allocations to pay for the operational costs of any program for which they are responsible.

12 Sunset of uncodified language. Provides that all uncodified language in this article expires on June 30, 2007, unless a different expiration date is explicit.

13 Effective date. States that the provisions in this article are effective July 1, 2005, unless a different effective date is specified.

Article 11: Option B Spending

1. 1 Conditional effective date. Provides that the policies and appropriations in this article are effective only if H.F. 1644 is passed. The amounts indicated in this article are appropriated to the commissioner of human services for the purposes indicated in the years indicated.

2 General assistance medical care; eligibility. Amends § 256D.03, subdivision 3.

- Adds that an individual who resides in group residential housing and can meet a spenddown using the cost of remedial services received through group residential housing may be eligible for general assistance medical care.

- Provides a spenddown to 75 percent of the federal poverty guidelines using a six-month budget period.

- States this section is effective October 1, 2005.

3 Inpatient hospital services. Amends § 256L.03, subd. 3. Modifies this provision, as found in article 3, to reinstate references to parents on MinnesotaCare with incomes greater than 175 percent of FPG.

4 Co-payments and coinsurance. Amends § 256L.03, subd. 5. Modifies this provision, as found in article 3, to reinstate references to parents on MinnesotaCare with incomes greater than 175 percent of FPG.

5 Families with children. Amends § 256L.04, subd. 1. Modifies this provision, as found in article 3, to eliminate eligibility for parents on MinnesotaCare with incomes greater than 190 percent of FPG. (The article 3 provision eliminates eligibility for parents with incomes greater than 175 percent of FPG.)

6 Enrollees 18 or older. Amends § 256L.11, subd. 6. Modifies this provision, as found in article 3, to reinstate references to parents on MinnesotaCare with incomes greater than 175 percent of FPG.

7 Increase in GAMC funding related to spenddown standard. Provides appropriations to increase the general assistance medical care spenddown standard from 50 percent to 75 percent of the federal poverty guidelines.

8 Increase in MinnesotaCare funding related to income standard for parents. Appropriates additional funds to the appropriations in article 10, section 2, subdivision 5, paragraph (a).

9 MinnesotaCare outreach grants. Provides that the repeal of Minnesota Statutes 2004, section 256L.04, subdivision 11, shall not take effect.

10 Funding for MinnesotaCare outreach grants. Adds appropriations to article 10, section 2, subdivision 5, paragraph (f). Provides that federal administrative reimbursement resulting from MinnesotaCare outreach is appropriated to the commissioner for this purpose.

11 Home care services reimbursement rates. Adds appropriations to article 10, section 2, subdivision 7, paragraph (d), to provide additional increases in reimbursement rates for home health services. States that the commissioner must recalculate the rates in Minnesota Statutes, section 256B.763 to reflect these additional appropriations.

12 Other provisions. States that the amendments in this article supersede and shall be implemented in place of the amendments or repealers to those sections in article 3.