ONE HUNDRED FOURTEENTH DAY

St. Paul, Minnesota, Monday, May 12, 2008

The Senate met at 11:00 a.m. and was called to order by the President.

CALL OF THE SENATE

Senator Clark imposed a call of the Senate. The Sergeant at Arms was instructed to bring in the absent members.

Prayer was offered by the Chaplain, Rev. Jim Borgschatz.

The members of the Senate gave the pledge of allegiance to the flag of the United States of America.

The roll was called, and the following Senators answered to their names:

Anderson	Erickson Ropes	Langseth	Ortman	Sieben
Bakk	Fischbach	Larson	Pappas	Skoe
Berglin	Foley	Latz	Pariseau	Skogen
Betzold	Frederickson	Limmer	Pogemiller	Sparks
Bonoff	Gerlach	Lourey	Prettner Solon	Stumpf
Carlson	Gimse	Lynch	Rest	Tomassoni
Chaudhary	Hann	Marty	Robling	Torres Ray
Clark	Higgins	Metzen	Rosen	Vandeveer
Cohen	Ingebrigtsen	Michel	Rummel	Vickerman
Dahle	Johnson	Moua	Saltzman	Wergin
Day	Jungbauer	Murphy	Saxhaug	Wiger
Dibble	Koch	Olseen	Scheid	
Dille	Koering	Olson, G.	Senjem	
Doll	Kubly	Olson, M.	Sheran	

The President declared a quorum present.

The reading of the Journal was dispensed with and the Journal, as printed and corrected, was approved.

MESSAGES FROM THE HOUSE

Mr. President:

I have the honor to announce the passage by the House of the following Senate File, herewith returned: S.F. No. 3140.

Albin A. Mathiowetz, Chief Clerk, House of Representatives

Returned May 8, 2008

Mr. President:

I have the honor to announce the passage by the House of the following Senate File, AS AMENDED by the House, in which amendments the concurrence of the Senate is respectfully requested:

S.F. No. 1128: A bill for an act relating to employment; modifying use of personal sick leave benefits; amending Minnesota Statutes 2006, section 181.9413.

Senate File No. 1128 is herewith returned to the Senate.

Albin A. Mathiowetz, Chief Clerk, House of Representatives

Returned May 8, 2008

Senator Erickson Ropes moved that S.F. No. 1128 be laid on the table. The motion prevailed.

Mr. President:

I have the honor to announce the passage by the House of the following Senate File, AS AMENDED by the House, in which amendments the concurrence of the Senate is respectfully requested:

S.F. No. 3056: A bill for an act relating to natural resources; modifying permanent school fund provisions; providing for disposition of proceeds from sale of administrative sites; modifying certain requirements for environmental learning centers; appropriating money; amending Minnesota Statutes 2006, sections 16A.06, by adding a subdivision; 84.027, by adding a subdivision; 84.0857; 84.0875; 94.16, subdivision 3; 127A.30.

Senate File No. 3056 is herewith returned to the Senate.

Albin A. Mathiowetz, Chief Clerk, House of Representatives

Returned May 8, 2008

Senator Frederickson moved that the Senate do not concur in the amendments by the House to S.F. No. 3056, and that a Conference Committee of 3 members be appointed by the Subcommittee on Conference Committees on the part of the Senate, to act with a like Conference Committee appointed on the part of the House. The motion prevailed.

Mr. President:

I have the honor to announce that the House has adopted the recommendation and report of the Conference Committee on Senate File No. 875, and repassed said bill in accordance with the report of the Committee, so adopted.

S.F. No. 875: A bill for an act relating to employment; increasing and indexing the minimum wage; eliminating the training wage; requiring notice to new employees; amending Minnesota Statutes 2006, section 177.24, subdivision 1, by adding a subdivision.

Senate File No. 875 is herewith returned to the Senate.

Albin A. Mathiowetz, Chief Clerk, House of Representatives

Returned May 8, 2008

Mr. President:

I have the honor to announce that the House has adopted the recommendation and report of the Conference Committee on Senate File No. 3775, and repassed said bill in accordance with the report of the Committee, so adopted.

S.F. No. 3775: A bill for an act relating to solid waste; establishing a pilot program to collect and process used paint; requiring reports.

Senate File No. 3775 is herewith returned to the Senate.

Albin A. Mathiowetz, Chief Clerk, House of Representatives

Returned May 8, 2008

Mr. President:

I have the honor to announce the following change in the membership of the Conference Committee on House File No. 6:

Delete the name of Davnie and add the name of Mariani.

Albin A. Mathiowetz, Chief Clerk, House of Representatives

Transmitted May 12, 2008

REPORTS OF COMMITTEES

Senator Pogemiller moved that the Committee Reports at the Desk be now adopted. The motion prevailed.

Senator Pogemiller, from the Committee on Rules and Administration, to which was referred

H.F. No. 4223 for comparison with companion Senate File, reports the following House File was found not identical with companion Senate File as follows:

GENERAL ORDERS		CONSENT CALENDAR		CALENDAR	
H.F. No.	S.F. No.	H.F. No.	S.F. No.	H.F. No.	S.F. No.
4223	3857				

Pursuant to Rule 45, the Committee on Rules and Administration recommends that H.F. No.

4223 be amended as follows:

Delete all the language after the enacting clause of H.F. No. 4223, the second engrossment; and insert the language after the enacting clause of S.F. No. 3857, the first engrossment; further, delete the title of H.F. No. 4223, the second engrossment; and insert the title of S.F. No. 3857, the first engrossment.

And when so amended H.F. No. 4223 will be identical to S.F. No. 3857, and further recommends that H.F. No. 4223 be given its second reading and substituted for S.F. No. 3857, and that the Senate File be indefinitely postponed.

Pursuant to Rule 45, this report was prepared and submitted by the Secretary of the Senate on behalf of the Committee on Rules and Administration. Amendments adopted. Report adopted.

Senator Pogemiller, from the Committee on Rules and Administration, to which was referred

H.F. No. 3380 for comparison with companion Senate File, reports the following House File was found not identical with companion Senate File as follows:

GENERAL ORDERS		CONSENT CALENDAR		CALENDAR	
H.F. No.	S.F. No.	H.F. No.	S.F. No.	H.F. No.	S.F. No.
3380	3031				

Pursuant to Rule 45, the Committee on Rules and Administration recommends that H.F. No. 3380 be amended as follows:

Delete all the language after the enacting clause of H.F. No. 3380, the second engrossment; and insert the language after the enacting clause of S.F. No. 3031, the first engrossment; further, delete the title of H.F. No. 3380, the second engrossment; and insert the title of S.F. No. 3031, the first engrossment.

And when so amended H.F. No. 3380 will be identical to S.F. No. 3031, and further recommends that H.F. No. 3380 be given its second reading and substituted for S.F. No. 3031, and that the Senate File be indefinitely postponed.

Pursuant to Rule 45, this report was prepared and submitted by the Secretary of the Senate on behalf of the Committee on Rules and Administration. Amendments adopted. Report adopted.

SECOND READING OF HOUSE BILLS

H.F. Nos. 4223 and 3380 were read the second time.

MOTIONS AND RESOLUTIONS

Senators Koering, Dille, Day, Metzen and Vickerman introduced –

Senate Resolution No. 205: A Senate resolution honoring the memory of W.W. "Bill" Thompson of Brainerd.

Referred to the Committee on Rules and Administration.

Senators Moua, Higgins, Sheran, Saltzman and Rosen introduced –

Senate Resolution No. 206: A Senate resolution recognizing May 12, 2008, as National Fibromyalgia Awareness Day.

Referred to the Committee on Rules and Administration.

Without objection, remaining on the Order of Business of Motions and Resolutions, the Senate reverted to the Order of Business of Messages From the House.

MESSAGES FROM THE HOUSE

Mr. President:

I have the honor to announce the passage by the House of the following Senate File, AS AMENDED by the House, in which amendments the concurrence of the Senate is respectfully requested:

S.F. No. 2941: A bill for an act relating to health; changing provisions for prescribing and filing drugs; amending Minnesota Statutes 2006, sections 151.01, subdivision 23; 151.37, subdivision 7; Minnesota Statutes 2007 Supplement, sections 148.235, subdivision 11; 151.37, subdivision 2; 151.56; repealing Minnesota Statutes 2007 Supplement, section 148.235, subdivision 12.

Senate File No. 2941 is herewith returned to the Senate.

Albin A. Mathiowetz, Chief Clerk, House of Representatives

Returned May 8, 2008

CONCURRENCE AND REPASSAGE

Senator Marty moved that the Senate concur in the amendments by the House to S.F. No. 2941 and that the bill be placed on its repassage as amended. The motion prevailed.

S.F. No. 2941 was read the third time, as amended by the House, and placed on its repassage.

The question was taken on the repassage of the bill, as amended.

The roll was called, and there were yeas 61 and nays 1, as follows:

Those who voted in the affirmative were:

Anderson	Erickson Ropes	Kubly	Olson, M.	Sheran
Bakk	Fischbach	Langseth	Pappas	Sieben
Berglin	Foley	Larson	Pariseau	Skoe
Betzold	Frederickson	Latz	Pogemiller	Sparks
Bonoff	Gerlach	Limmer	Prettner Solon	Stumpf
Carlson	Gimse	Lourey	Rest	Tomassoni
Chaudhary	Hann	Lynch	Robling	Torres Ray
Clark	Higgins	Marty	Rosen	Wergin
Cohen	Ingebrigtsen	Metzen	Rummel	Wiger
Dahle	Johnson	Michel	Saltzman	
Day	Jungbauer	Moua	Saxhaug	
Dibble	Koch	Olseen	Scheid	
Doll	Koering	Olson, G.	Senjem	

Those who voted in the negative were:

Vandeveer

So the bill, as amended, was repassed and its title was agreed to.

MOTIONS AND RESOLUTIONS - CONTINUED

Remaining on the Order of Business of Motions and Resolutions, Senator Pogemiller moved that the Senate take up the Calendar. The motion prevailed.

CALENDAR

H.F. No. 3783: A bill for an act relating to commerce; regulating insurance fees, coverages, contracts, filings, and forms; regulating financial planners, motor vehicle retail installment sales, service contracts, real estate appraisers, subdivided lands, domestic mutual insurance companies, and collection agencies; merging certain joint underwriting associations; making technical and clarifying changes; amending Minnesota Statutes 2006, sections 53C.01, subdivision 2; 59B.01; 59B.02, subdivision 11, by adding a subdivision; 59B.05, subdivision 5; 60A.71, subdivision 7; 61A.57; 62A.149, subdivision 1; 62A.152, subdivision 2; 62A.44, by adding a subdivision; 62E.10, subdivision 2; 62F.02, by adding a subdivision; 62M.02, subdivision 21; 62Q.47; 62Q.64; 62S.01, by adding subdivisions; 62S.13, subdivision 4; 62S.15; 62S.18, subdivision 2; 62S.20, subdivision 6, by adding subdivisions; 62S.26, subdivision 2; 62S.266, subdivisions 4, 10; 62S.29, by adding subdivisions; 65A.37; 66A.02, subdivision 4; 66A.07, subdivision 2, by adding a subdivision; 66A.41, subdivision 1; 67A.31, subdivision 2; 72A.51, subdivision 2; 79A.06, subdivision 5; 79A.22, subdivisions 3, 4; 79A.23, subdivision 2; 82B.23, subdivision 1; 83.25, by adding a subdivision; Minnesota Statutes 2007 Supplement, sections 61A.257, subdivision 1; 62A.30, subdivision 2; 62S.23, subdivision 1; 72A.52, subdivision 1; proposing coding for new law in Minnesota Statutes, chapters 62S; 332; repealing Minnesota Statutes 2006, sections 62A.149, subdivision 2; 65B.29; Laws 2006, chapter 255, section 26.

Senator Scheid moved that H.F. No. 3783, No. 1 on the Calendar, be stricken and placed on General Orders. The motion prevailed.

H.F. No. 3955: A bill for an act relating to human services; modifying regulations of certain home care service providers; promoting community-based care for older adults through the

establishment of community consortiums; requiring reports; amending Minnesota Statutes 2006, section 144A.45, subdivision 1, by adding a subdivision; proposing coding for new law in Minnesota Statutes, chapter 256.

Was read the third time and placed on its final passage.

The question was taken on the passage of the bill.

The roll was called, and there were yeas 60 and nays 2, as follows:

Those who voted in the affirmative were:

Anderson	Doll	Koering	Olseen	Saxhaug
Bakk	Erickson Ropes	Kubly	Olson, G.	Scheid
Berglin	Fischbach	Langseth	Olson, M.	Senjem
Betzold	Foley	Larson	Pappas	Sheran
Bonoff	Frederickson	Latz	Pariseau	Sieben
Carlson	Gerlach	Limmer	Pogemiller	Skoe
Chaudhary	Gimse	Lourey	Prettner Solon	Sparks
Clark	Hann	Lynch	Rest	Stumpf
Cohen	Higgins	Marty	Robling	Tomassoni
Dahle	Ingebrigtsen	Metzen	Rosen	Torres Ray
Day	Johnson	Michel	Rummel	Wergin
Dibble	Koch	Moua	Saltzman	Wiger

Those who voted in the negative were:

Jungbauer	Vandeveer

So the bill passed and its title was agreed to.

S.F. No. 3281: A bill for an act relating to state government; creating the Veterans Health Care Advisory Council; proposing coding for new law in Minnesota Statutes, chapter 196.

Was read the third time and placed on its final passage.

The question was taken on the passage of the bill.

The roll was called, and there were yeas 62 and nays 0, as follows:

Those who voted in the affirmative were:

Anderson	Erickson Ropes	Kubly	Olson, M.	Sheran
Bakk	Fischbach	Langseth	Pappas	Sieben
Berglin	Foley	Larson	Pariseau	Skoe
Betzold	Frederickson	Latz	Pogemiller	Sparks
Bonoff	Gerlach	Limmer	Prettner Solon	Stumpf
Carlson	Gimse	Lourey	Rest	Tomassoni
Chaudhary	Hann	Lynch	Robling	Torres Ray
Clark	Higgins	Marty	Rosen	Vandeveer
Cohen	Ingebrigtsen	Metzen	Rummel	Wergin
Dahle	Johnson	Michel	Saltzman	Wiger
Day	Jungbauer	Moua	Saxhaug	
Dibble	Koch	Olseen	Scheid	
Doll	Koering	Olson, G.	Senjem	

So the bill passed and its title was agreed to.

H.F. No. 3420: A bill for an act relating to local government; revising procedures and fees charged by county registrars of title for registering supplemental declarations of common interest communities; amending Minnesota Statutes 2006, sections 508.82, subdivision 1; 515B.1-116.

Was read the third time and placed on its final passage.

The question was taken on the passage of the bill.

The roll was called, and there were yeas 62 and nays 0, as follows:

Those who voted in the affirmative were:

Anderson	Erickson Ropes	Kubly	Olson, M.	Sheran
Bakk	Fischbach	Langseth	Pappas	Sieben
Berglin	Foley	Larson	Pariseau	Skoe
Betzold	Frederickson	Latz	Pogemiller	Sparks
Bonoff	Gerlach	Limmer	Prettner Solon	Stumpf
Carlson	Gimse	Lourey	Rest	Tomassoni
Chaudhary	Hann	Lynch	Robling	Torres Ray
Clark	Higgins	Marty	Rosen	Vandeveer
Cohen	Ingebrigtsen	Metzen	Rummel	Wergin
Dahle	Johnson	Michel	Saltzman	Wiger
Day	Jungbauer	Moua	Saxhaug	
Dibble	Koch	Olseen	Scheid	
Doll	Koering	Olson, G.	Senjem	

So the bill passed and its title was agreed to.

H.F. No. 3699: A bill for an act relating to elections; providing for discretionary partial recounts; specifying certain recount and postelection review procedures; changing certain voting system requirements; amending Minnesota Statutes 2006, sections 204C.35, subdivisions 1, 2; 204C.36, subdivision 2; 206.57, by adding subdivisions; 206.89, subdivision 2; Minnesota Statutes 2007 Supplement, section 206.57, subdivision 5.

Was read the third time and placed on its final passage.

The question was taken on the passage of the bill.

The roll was called, and there were yeas 62 and nays 0, as follows:

Those who voted in the affirmative were:

Anderson	Erickson Ropes	Kubly	Olson, M.	Sheran
Bakk	Fischbach	Langseth	Pappas	Sieben
Berglin	Foley	Larson	Pariseau	Skoe
Betzold	Frederickson	Latz	Pogemiller	Sparks
Bonoff	Gerlach	Limmer	Prettner Solon	Stumpf
Carlson	Gimse	Lourey	Rest	Tomassoni
Chaudhary	Hann	Lynch	Robling	Torres Ray
Clark	Higgins	Marty	Rosen	Vandeveer
Cohen	Ingebrigtsen	Metzen	Rummel	Wergin
Dahle	Johnson	Michel	Saltzman	Wiger
Day	Jungbauer	Moua	Saxhaug	
Dibble	Koch	Olseen	Scheid	
Doll	Koering	Olson, G.	Senjem	

So the bill passed and its title was agreed to.

MOTIONS AND RESOLUTIONS - CONTINUED

Remaining on the Order of Business of Motions and Resolutions, Senator Pogemiller moved that the Senate take up the General Orders Calendar. The motion prevailed.

GENERAL ORDERS

The Senate resolved itself into a Committee of the Whole, with Senator Metzen in the chair.

After some time spent therein, the committee arose, and Senator Metzen reported that the committee had considered the following:

S.F. No. 3787, which the committee recommends to pass, after the following motion:

The question was taken on the recommendation to pass S.F. No. 3787.

The roll was called, and there were yeas 35 and nays 30, as follows:

Those who voted in the affirmative were:

Anderson	Dibble	Latz	Olson, M.	Sieben
Betzold	Erickson Ropes	Lourey	Pappas	Skoe
Bonoff	Foley	Lynch	Pogemiller	Sparks
Carlson	Higgins	Marty	Rest	Stumpf
Clark	Kubly	Metzen	Rummel	Tomassoni
Cohen	Langseth	Murphy	Saltzman	Torres Ray
Dahle	Larson	Olseen	Saxhaug	Wiger

Those who voted in the negative were:

Bakk	Fischbach	Johnson	Moua	Rosen
Berglin	Frederickson	Jungbauer	Olson, G.	Scheid
Chaudhary	Gerlach	Koch	Ortman	Sheran
Day	Gimse	Koering	Pariseau	Skogen
Dille	Hann	Limmer	Prettner Solon	Vandeveer
Doll	Ingebrigtsen	Michel	Robling	Vickerman

The motion prevailed. So S.F. No. 3787 was recommended to pass.

H.F. No. 3783, which the committee recommends to pass with the following amendment offered by Senator Scheid:

Amend H.F. No. 3783, as amended pursuant to Rule 45, adopted by the Senate May 8, 2008, as follows:

(The text of the amended House File is identical to S.F. No. 3467.)

Page 6, after line 10, insert:

"**EFFECTIVE DATE.** This section is effective January 1, 2009."

Page 30, after line 18, insert:

"**EFFECTIVE DATE.** This section is effective January 1, 2009."

Page 31, after line 16, insert:

"**EFFECTIVE DATE.** This section is effective January 1, 2009."

The motion prevailed. So the amendment was adopted.

On motion of Senator Pogemiller, the report of the Committee of the Whole, as kept by the Secretary, was adopted.

RECESS

Senator Pogemiller moved that the Senate do now recess subject to the call of the President. The motion prevailed.

After a brief recess, the President called the Senate to order.

MOTIONS AND RESOLUTIONS - CONTINUED

Without objection, remaining on the Order of Business of Motions and Resolutions, the Senate reverted to the Order of Business of Reports of Committees.

REPORTS OF COMMITTEES

Senator Pogemiller moved that the Committee Report at the Desk be now adopted. The motion prevailed.

Senator Pogemiller from the Committee on Rules and Administration, to which was referred

H.F. No. 3807: A bill for an act relating to state government; providing additional whistleblower protection to state executive branch employees; amending Minnesota Statutes 2007 Supplement, section 181.932, subdivision 1.

Reports the same back with the recommendation that the bill do pass and be re-referred to the Committee on Finance. Report adopted.

RECESS

Senator Pogemiller moved that the Senate do now recess subject to the call of the President. The motion prevailed.

After a brief recess, the President called the Senate to order.

CALL OF THE SENATE

Senator Pogemiller imposed a call of the Senate. The Sergeant at Arms was instructed to bring in the absent members.

MOTIONS AND RESOLUTIONS - CONTINUED

S.F. No. 2876 and the Conference Committee Report thereon were reported to the Senate.

CONFERENCE COMMITTEE REPORT ON S.F. NO. 2876

A bill for an act relating to animals; changing provisions regulating dangerous dogs and dogs at certain establishments; imposing penalties; amending Minnesota Statutes 2006, sections 347.50, by

adding a subdivision; 347.51, subdivisions 2, 2a, 3, 4, 7, 9; 347.52; 347.53; 347.54, subdivisions 1, 3; 347.55; 347.56; proposing coding for new law in Minnesota Statutes, chapters 157; 347.

May 7, 2008

The Honorable James P. Metzen
President of the Senate

The Honorable Margaret Anderson Kelliher
Speaker of the House of Representatives

We, the undersigned conferees for S.F. No. 2876 report that we have agreed upon the items in dispute and recommend as follows:

That the Senate concur in the House amendment and that S.F. No. 2876 be further amended as follows:

Delete everything after the enacting clause and insert:

"Section 1. **[157.175] DOGS; OUTDOOR FOOD AND BEVERAGE SERVICE ESTABLISHMENTS.**

Subdivision 1. **Municipal authorization.** A statutory or home rule charter city may adopt an ordinance to permit food and beverage service establishments to allow dogs to accompany persons patronizing designated outdoor areas of food and beverage establishments.

Subd. 2. **Dangerous and potentially dangerous dogs.** The ordinance must prohibit dangerous and potentially dangerous dogs, as defined in section 347.50, from accompanying patrons to food and beverage establishments.

Subd. 3. **Banning dogs.** The ordinance may not prohibit a food and beverage establishment from banning dogs. A person accompanied by a dog who remains at an establishment knowing that the operator of the establishment or its agent has posted a sign banning dogs or otherwise informed the person that dogs are not permitted in the establishment may be ordered to leave the premises.

Subd. 4. **Permit process.** (a) The ordinance must require participating establishments to apply for and receive a permit from the city before allowing patrons' dogs on their premises. The city shall require from the applicant such information as the local government deems reasonably necessary, but shall require, at a minimum, the following information:

(1) the name, location, and mailing address of the establishment;

(2) the name, mailing address, and telephone contact information of the permit applicant;

(3) a description of the designated outdoor areas in which the permit applicant intends to allow dogs; and

(4) a description of the days of the week and hours of operation that patrons' dogs will be permitted in the designated outdoor areas.

(b) A permit issued pursuant to the authority granted in this section must not be transferred to a subsequent owner upon the sale of a food and beverage establishment but must expire automatically upon the sale of the establishment. The subsequent owner shall be required to reapply for a permit

pursuant to this section if the subsequent owner wishes to continue to accommodate patrons' dogs.

(c) A city may incorporate the permit requirements of this section into a permit or license issued under an existing ordinance if the city ensures that current and future permit and license holders comply with the requirements of this section. A city may exempt current permit and license holders from reapplying for a permit, if the current permit or license holder provides the city with the information required in paragraph (a) and any other information that the city requests.

Subd. 5. **Minimum requirements.** The ordinance must include such regulations and limitations as the local government deems reasonably necessary to protect the health, safety, and general welfare of the public, but must require, at a minimum, the following requirements, which must be clearly printed on a sign or signs posted on premises in a manner and place that are conspicuous to employees and patrons:

(1) employees must be prohibited from touching, petting, or otherwise handling dogs;

(2) employees and patrons must not allow dogs to come into contact with serving dishes, utensils, tableware, linens, paper products, or any other items involved in food service operations;

(3) patrons must keep their dogs on a leash at all times and must keep their dogs under reasonable control;

(4) dogs must not be allowed on chairs, tables, or other furnishings; and

(5) dog waste must be cleaned immediately and the area sanitized.

Subd. 6. **Service animals.** Nothing in this statute, or an ordinance adopted pursuant to this statute, shall be construed to limit:

(1) the right of a person with disabilities to access places of public accommodation while accompanied by a service animal as provided in sections 256C.02 and 363A.19; or

(2) the lawful use of a service animal by a licensed peace officer.

Subd. 7. **Designated outdoor area.** The ordinance must include a definition of "designated outdoor area" that is consistent with applicable rules adopted by the commissioner of health.

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

Sec. 2. Minnesota Statutes 2006, section 347.50, is amended by adding a subdivision to read:

Subd. 8. **Provocation.** "Provocation" means an act that an adult could reasonably expect may cause a dog to attack or bite.

Sec. 3. Minnesota Statutes 2006, section 347.51, subdivision 2, is amended to read:

Subd. 2. **Registration.** An animal control authority shall issue a certificate of registration to the owner of a dangerous dog if the owner presents sufficient evidence that:

(1) a proper enclosure exists for the dangerous dog and a posting on the premises with a clearly visible warning sign that there is a dangerous dog on the property, including a warning symbol to inform children~~, that there is a dangerous dog on the property~~;

(2) a surety bond issued by a surety company authorized to conduct business in this state in a

form acceptable to the animal control authority in the sum of at least ~~$50,000~~ $300,000, payable to any person injured by the dangerous dog, or a policy of liability insurance issued by an insurance company authorized to conduct business in this state in the amount of at least ~~$50,000~~ $300,000, insuring the owner for any personal injuries inflicted by the dangerous dog;

(3) the owner has paid an annual fee of not more than $500, in addition to any regular dog licensing fees, to obtain a certificate of registration for a dangerous dog under this section; and

(4) the owner has had microchip identification implanted in the dangerous dog as required under section 347.515.

Sec. 4. Minnesota Statutes 2006, section 347.51, subdivision 2a, is amended to read:

Subd. 2a. **Warning symbol.** If ~~a county~~ an animal control authority issues a certificate of registration to the owner of a dangerous dog pursuant to subdivision 2, the ~~county~~ animal control authority must provide, for posting on the owner's property, a copy of a warning symbol to inform children that there is a dangerous dog on the property. The ~~design of the~~ warning symbol must be the uniform ~~and specified~~ symbol provided by the commissioner of public safety~~, after consultation with animal control professionals~~. The commissioner shall provide the number of copies of the warning symbol requested by ~~each county~~ the animal control authority and shall charge the ~~county~~ animal control authority the actual cost of the warning symbols received. The ~~county~~ animal control authority may charge the registrant a reasonable fee to cover its administrative costs and the cost of the warning symbol.

Sec. 5. Minnesota Statutes 2006, section 347.51, subdivision 3, is amended to read:

Subd. 3. **Fee.** The ~~county~~ animal control authority may charge the owner an annual fee, in addition to any regular dog licensing fees, to obtain a certificate of registration for a dangerous dog under this section.

Sec. 6. Minnesota Statutes 2006, section 347.51, subdivision 7, is amended to read:

Subd. 7. **Tag.** A dangerous dog registered under this section must have a standardized, easily identifiable tag identifying the dog as dangerous and containing the uniform dangerous dog symbol, affixed to the dog's collar at all times. ~~The commissioner of public safety, after consultation with animal control professionals, shall provide by rule for the design of the tag.~~

Sec. 7. Minnesota Statutes 2006, section 347.51, subdivision 9, is amended to read:

Subd. 9. **Contracted services.** ~~A county~~ An animal control authority may contract with another political subdivision or other person to provide the services required under sections 347.50 to ~~347.54~~ 347.565. Notwithstanding any contract entered into under this subdivision, all fees collected under sections 347.50 to 347.54 shall be paid to the ~~county~~ animal control authority and all certificates of registration must be issued in the name of the ~~county~~ animal control authority.

Sec. 8. Minnesota Statutes 2006, section 347.52, is amended to read:

347.52 DANGEROUS DOGS; REQUIREMENTS.

(a) An owner of a dangerous dog shall keep the dog, while on the owner's property, in a proper enclosure. If the dog is outside the proper enclosure, the dog must be muzzled and restrained by a substantial chain or leash and under the physical restraint of a responsible person. The muzzle must

be made in a manner that will prevent the dog from biting any person or animal but that will not cause injury to the dog or interfere with its vision or respiration.

(b) An owner of a dangerous dog must renew the registration of the dog annually until the dog is deceased. If the dog is removed from the jurisdiction, it must be registered as a dangerous dog in its new jurisdiction.

(c) An owner of a dangerous dog must notify the animal control authority in writing of the death of the dog or its transfer to a new ~~jurisdiction~~ location where the dog will reside within 30 days of the death or transfer, and must, if requested by the animal control authority, execute an affidavit under oath setting forth either the circumstances of the dog's death and disposition or the complete name, address, and telephone number of the person to whom the dog has been transferred or the address where the dog has been relocated.

(d) An animal control authority ~~may~~ shall require a dangerous dog to be sterilized at the owner's expense. If the owner does not have the animal sterilized within 30 days, the animal control authority ~~may~~ shall seize the dog and have ~~the animal~~ it sterilized at the owner's expense.

(e) A person who owns a dangerous dog and who rents property from another where the dog will reside must disclose to the property owner prior to entering the lease agreement and at the time of any lease renewal that the person owns a dangerous dog that will reside at the property.

(f) A person who ~~sells~~ transfers ownership of a dangerous dog must notify the ~~purchaser~~ new owner that the animal control authority has identified the dog as dangerous. The ~~seller~~ current owner must also notify the animal control authority in writing of the ~~sale~~ transfer of ownership and provide the animal control authority with the new owner's name, address, and telephone number.

Sec. 9. Minnesota Statutes 2006, section 347.53, is amended to read:

347.53 POTENTIALLY DANGEROUS AND DANGEROUS DOGS.

Any statutory or home rule charter city, or any county, may regulate potentially dangerous and dangerous dogs. Except as provided in section 347.51, subdivision 8, nothing in sections 347.50 to ~~347.54~~ 347.565 limits any restrictions that the local jurisdictions may place on owners of potentially dangerous or dangerous dogs.

Sec. 10. Minnesota Statutes 2006, section 347.54, subdivision 1, is amended to read:

Subdivision 1. **Seizure.** (a) The animal control authority having jurisdiction shall immediately seize any dangerous dog if:

(1) after 14 days after the owner has notice that the dog is dangerous, the dog is not validly registered under section 347.51;

(2) after 14 days after the owner has notice that the dog is dangerous, the owner does not secure the proper liability insurance or surety coverage as required under section 347.51, subdivision 2;

(3) the dog is not maintained in the proper enclosure; ~~or~~

(4) the dog is outside the proper enclosure and not under physical restraint of a responsible person as required under section 347.52; or

(5) the dog is not sterilized within 30 days, pursuant to section 347.52, paragraph (d).

(b) If an owner of a dog is convicted of a crime for which the dog was originally seized, the court may order that the dog be confiscated and destroyed in a proper and humane manner, and that the owner pay the costs incurred in confiscating, confining, and destroying the dog.

Sec. 11. Minnesota Statutes 2006, section 347.54, subdivision 3, is amended to read:

Subd. 3. **Subsequent offenses; seizure.** If a person has been convicted of a misdemeanor for violating a provision of section 347.51, 347.515, or 347.52, and the person is charged with a subsequent violation relating to the same dog, the dog must be seized by the animal control authority having jurisdiction. If the owner is convicted of the crime for which the dog was seized, the court shall order that the dog be destroyed in a proper and humane manner and the owner pay the cost of confining and destroying the animal. ~~If the person is not convicted of the crime for which the dog was seized, the owner may reclaim the dog upon payment to the animal control authority of a fee for the care and boarding of the dog.~~ If the owner is not convicted and the dog is not reclaimed by the owner within seven days after the owner has been notified that the dog may be reclaimed, the dog may be disposed of as provided under section 35.71, subdivision 3~~, and the owner is liable to the animal control authority for the costs incurred in confining, impounding, and disposing of the dog~~.

Sec. 12. **[347.541] DISPOSITION OF SEIZED ANIMALS.**

Subdivision 1. **Hearing.** The owner of any dog declared dangerous has the right to a hearing by an impartial hearing officer.

Subd. 2. **Security.** A person claiming an interest in a seized dog may prevent disposition of the dog by posting security in an amount sufficient to provide for the dog's actual cost of care and keeping. The security must be posted within seven days of the seizure inclusive of the date of the seizure.

Subd. 3. **Notice.** The authority declaring the dog dangerous shall give notice of this section by delivering or mailing it to the owner of the dog, or by posting a copy of it at the place where the dog is kept, or by delivering it to a person residing on the property, and telephoning, if possible. The notice must include:

(1) a description of the seized dog; the authority for and purpose of the dangerous dog declaration and seizure; the time, place, and circumstances under which the dog was declared dangerous; and the telephone number and contact person where the dog is kept;

(2) a statement that the owner of the dog may request a hearing concerning the dangerous dog declaration and, if applicable, prior potentially dangerous dog declarations for the dog, and that failure to do so within 14 days of the date of the notice will terminate the owner's right to a hearing under this section;

(3) a statement that if an appeal request is made within 14 days of the notice, the owner must immediately comply with the requirements of section 347.52, paragraphs (a) and (c), and until such time as the hearing officer issues an opinion;

(4) a statement that if the hearing officer affirms the dangerous dog declaration, the owner will have 14 days from receipt of that decision to comply with all other requirements of sections 347.51,

347.515, and 347.52;

(5) a form to request a hearing under this subdivision; and

(6) a statement that all actual costs of the care, keeping, and disposition of the dog are the responsibility of the person claiming an interest in the dog, except to the extent that a court or hearing officer finds that the seizure or impoundment was not substantially justified by law.

Subd. 4. **Right to hearing.** Any hearing must be held within 14 days of the request to determine the validity of the dangerous dog declaration. The hearing officer must be an impartial employee of the local government or an impartial person retained by the local government to conduct the hearing. In the event that the dangerous dog declaration is upheld by the hearing officer, actual expenses of the hearing up to a maximum of $1,000 will be the responsibility of the dog's owner. The hearing officer shall issue a decision on the matter within ten days after the hearing. The decision must be delivered to the dog's owner by hand delivery or registered mail as soon as practical and a copy must be provided to the animal control authority.

Sec. 13. **[347.542] RESTRICTIONS.**

Subdivision 1. **Dog ownership prohibited.** Except as provided in subdivision 3, no person may own a dog if the person has:

(1) been convicted of a third or subsequent violation of section 347.51, 347.515, or 347.52;

(2) been convicted of a violation under section 609.205, clause (4);

(3) been convicted of a gross misdemeanor under section 609.226, subdivision 1;

(4) been convicted of a violation under section 609.226, subdivision 2; or

(5) had a dog ordered destroyed under section 347.56 and been convicted of one or more violations of section 347.51, 346.515, 347.52, or 609.226, subdivision 2.

Subd. 2. **Household members.** If any member of a household is prohibited from owning a dog in subdivision 1, unless specifically approved with or without restrictions by an animal control authority, no person in the household is permitted to own a dog.

Subd. 3. **Dog ownership prohibition review.** Beginning three years after a conviction under subdivision 1 that prohibits a person from owning a dog, and annually thereafter, the person may request that the animal control authority review the prohibition. The animal control authority may consider such facts as the seriousness of the violation or violations that led to the prohibition, any criminal convictions, or other facts that the animal control authority deems appropriate. The animal control authority may rescind the prohibition entirely or rescind it with limitations. The animal control authority also may establish conditions a person must meet before the prohibition is rescinded, including, but not limited to, successfully completing dog training or dog handling courses. If the animal control authority rescinds a person's prohibition and the person subsequently fails to comply with any limitations imposed by the animal control authority or the person is convicted of any animal violation involving unprovoked bites or dog attacks, the animal control authority may permanently prohibit the person from owning a dog in this state.

Sec. 14. Minnesota Statutes 2006, section 347.55, is amended to read:

347.55 PENALTY.

(a) ~~Any~~ A person who violates ~~any~~ a provision of section 347.51, 347.515, or 347.52 is guilty of a misdemeanor.

(b) It is a misdemeanor to remove a microchip from a dangerous or potentially dangerous dog, to fail to renew the registration of a dangerous dog, to fail to account for a dangerous dog's death or ~~removal from the jurisdiction~~ change of location where the dog will reside, to sign a false affidavit with respect to a dangerous dog's death or ~~removal from the jurisdiction~~ change of location where the dog will reside, or to fail to disclose ownership of a dangerous dog to a property owner from whom the person rents property.

(c) A person who is convicted of a second or subsequent violation of paragraph (a) or (b) is guilty of a gross misdemeanor.

(d) An owner who violates section 347.542, subdivision 1, is guilty of a gross misdemeanor.

(e) Any household member who knowingly violates section 347.542, subdivision 2, is guilty of a gross misdemeanor.

Sec. 15. Minnesota Statutes 2006, section 347.56, is amended to read:

347.56 DESTRUCTION OF DOG IN CERTAIN CIRCUMSTANCES.

Subdivision 1. **Circumstances.** Notwithstanding sections 347.51 to 347.55, a dog ~~that inflicted substantial or great bodily harm on a human being on public or private property without provocation may be destroyed in a proper and humane manner by the animal control authority. The animal control authority may not destroy the dog until the dog owner has had the opportunity for a hearing before an impartial decision maker.~~ may be destroyed in a proper and humane manner by the animal control authority if the dog:

(1) inflicted substantial or great bodily harm on a human on public or private property without provocation;

(2) inflicted multiple bites on a human on public or private property without provocation;

(3) bit multiple human victims on public or private property in the same attack without provocation; or

(4) bit a human on public or private property without provocation in an attack where more than one dog participated in the attack.

Subd. 2. **Hearing.** The animal control authority may not destroy the dog until the dog owner has had the opportunity for a hearing before an impartial decision maker. The definitions in section 347.50 and the exemptions under section 347.51, subdivision 5, apply to this section.

Sec. 16. **[347.565] APPLICABILITY.**

Sections 347.50 to 347.56 must be enforced by animal control authorities or law enforcement agencies, whether or not these sections have been adopted into local ordinance."

Delete the title and insert:

"A bill for an act relating to animals; changing provisions regulating dangerous dogs; providing for certain cities to authorize certain outdoor food and beverage establishments to allow dogs to accompany patrons; amending Minnesota Statutes 2006, sections 347.50, by adding a subdivision; 347.51, subdivisions 2, 2a, 3, 7, 9; 347.52; 347.53; 347.54, subdivisions 1, 3; 347.55; 347.56; proposing coding for new law in Minnesota Statutes, chapters 157; 347."

We request the adoption of this report and repassage of the bill.

Senate Conferees: (Signed) Ellen R. Anderson, D. Scott Dibble, Steve Dille

House Conferees: (Signed) Michael Paymar, Frank Hornstein, Ron Erhardt

Senator Anderson moved that the foregoing recommendations and Conference Committee Report on S.F. No. 2876 be now adopted, and that the bill be repassed as amended by the Conference Committee. The motion prevailed. So the recommendations and Conference Committee Report were adopted.

S.F. No. 2876 was read the third time, as amended by the Conference Committee, and placed on its repassage.

The question was taken on the repassage of the bill, as amended by the Conference Committee.

The roll was called, and there were yeas 59 and nays 0, as follows:

Those who voted in the affirmative were:

Anderson	Erickson Ropes	Koering	Olson, G.	Sheran
Berglin	Fischbach	Kubly	Olson, M.	Sieben
Betzold	Foley	Langseth	Ortman	Skogen
Bonoff	Frederickson	Larson	Pappas	Sparks
Carlson	Gerlach	Latz	Pogemiller	Stumpf
Chaudhary	Gimse	Lourey	Prettner Solon	Tomassoni
Cohen	Hann	Lynch	Rest	Torres Ray
Dahle	Higgins	Marty	Robling	Vandeveer
Day	Ingebrigtsen	Michel	Rosen	Vickerman
Dibble	Johnson	Moua	Rummel	Wergin
Dille	Jungbauer	Murphy	Saxhaug	Wiger
Doll	Koch	Olseen	Senjem	

So the bill, as amended by the Conference Committee, was repassed and its title was agreed to.

MOTIONS AND RESOLUTIONS - CONTINUED

Pursuant to Rule 26, Senator Pogemiller, Chair of the Committee on Rules and Administration, designated S.F. No. 2720 a Special Order to be heard immediately.

SPECIAL ORDER

S.F. No. 2720: A bill for an act relating to retirement; various retirement plans; adding two employment positions to the correctional state employees retirement plan; including certain departments of the Rice Memorial Hospital in Willmar and the Worthington Regional Hospital in privatized public employee retirement coverage; providing for the potential dissolution of the Minnesota Post Retirement Investment Fund; increasing teacher retirement plan reemployed

annuitant earnings limitations; temporarily exempting Metropolitan Airports Commission police officers from reemployed annuitant earnings limits; mandating joint and survivor optional annuities rather than single life annuities as basic annuity form; making various changes in retirement plan administrative provisions; amending requirements for tribal police officer pension coverage; clarifying general state employee retirement plan alternative coverage elections by certain unclassified state employees retirement program participants; clarifying direct state aid for the teacher retirement associations; clarifying the handling of unclaimed retirement accounts in the individual retirement account plan; providing for a study of certain Minnesota State Colleges and Universities System tenure track faculty members; modifying the manner in which official actuarial work for public pension plans is performed; allowing pension plans greater latitude in setting salary and payroll assumptions; extending amortization target dates for various retirement plans; making the number and identity of tax-sheltered annuity vendors a mandatory bargaining item for school districts and their employees; allowing a certain firefighter relief association certain benefit increases; allowing security broker-dealers to directly hold local pension plan assets; increasing upmost flexible service pension maximum amounts for volunteer firefighters; creating a voluntary statewide volunteer firefighter retirement plan advisory board within the Public Employees Retirement Association; allowing various retirement plans to accept labor union retired member dues deduction authorizations; authorizing various prior service credit purchases; authorizing certain service credit and coverage transfers; authorizing a disability benefit application to be rescinded; authorizing a retirement coverage termination; providing an additional benefit to certain injured Minneapolis bomb squad officers; allowing certain Independent School District No. 625 school board members to make back defined contribution retirement plan contributions; revising post-2009 additional amortization state aid allocations; modifying PERA-P&F duty disability benefit amounts; authorizing a PERA prior military service credit purchase; revising the administrative duties of the board and the executive director of the Minnesota State Retirement System; appropriating money; amending Minnesota Statutes 2006, sections 6.67; 11A.18, subdivision 9, by adding subdivisions; 16A.055, subdivision 5; 43A.346, subdivisions 4, 5, 6, 7; 69.011, subdivision 1; 123B.02, subdivision 15; 352.03, subdivisions 4, 5; 352.12, subdivision 2; 352.22, subdivision 10; 352.931, subdivision 1; 352.97; 352.98, subdivisions 1, 2, 3, 4, 5; 352D.075, subdivision 2a; 353.01, subdivisions 10, 11a, by adding a subdivision; 353.27, by adding a subdivision; 353.30, subdivision 3; 353.33, subdivision 5; 353.64, subdivision 11; 353.656, subdivision 2; 353D.05, subdivision 2; 353D.12, subdivision 4; 353E.07, subdivision 7; 354.05, subdivision 37; 354.33, subdivision 5; 354.44, subdivision 5; 354A.12, subdivision 3a; 354A.31, subdivision 3; 354B.20, by adding a subdivision; 354B.25, subdivision 5, by adding a subdivision; 354C.165; 356.20, subdivisions 1, 2, 3, 4, 4a; 356.214, subdivisions 1, 3, by adding a subdivision; 356.215, subdivisions 1, 2, 3, 8, 11, 18; 356.24, subdivision 1; 356.41; 356.46, as amended; 356.47, subdivision 3; 356.551, subdivision 2; 356.611, subdivision 2, by adding a subdivision; 356A.06, subdivisions 1, 7, 8b; 356B.10, subdivision 3; 363A.36, subdivision 1; 383B.914, subdivision 7; 423A.02, subdivision 1b; 424A.001, subdivision 6, by adding a subdivision; 424A.02, subdivisions 3, 7, 9; 424A.05, subdivision 3; 518.003, subdivision 8; Minnesota Statutes 2007 Supplement, sections 43A.346, subdivisions 1, 2; 352.01, subdivision 2a; 352.017, subdivision 2; 352.91, subdivision 3d; 352.955, subdivisions 3, 5; 352D.02, subdivisions 1, 3; 353.01, subdivision 2b; 353.0161, subdivision 2; 353.27, subdivision 14; 353.32, subdivision 1a; 353.656, subdivision 1; 353.657, subdivision 2a; 353F.02, subdivision 4; 354.096, subdivision 2; 354.72, subdivision 2; 354A.12, subdivision 3c; 354C.12, subdivision 4; 356.96, subdivision 1; 422A.06, subdivision 8; Laws 2002, chapter 392, article 2, section 4; Laws 2006, chapter 271, article 5, section 5; proposing coding for new law in Minnesota Statutes, chapters 11A; 352; 353D; 353F; 354; 354C; 356; 423A;

repealing Minnesota Statutes 2006, sections 352.96; 354.44, subdivision 6a; 354.465; 354.51, subdivision 4; 354.55, subdivisions 2, 3, 6, 12, 15; 354A.091, subdivisions 1a, 1b; 354A.12, subdivision 3a; 355.629; 356.214, subdivision 2; 356.215, subdivision 2a; Minnesota Statutes 2007 Supplement, section 354A.12, subdivisions 3b, 3c; Laws 1965, chapter 592, sections 3, as amended; 4, as amended; Laws 1967, chapter 575, sections 2, as amended; 3; 4; Laws 1969, chapter 352, section 1, subdivisions 3, 4, 5, 6; Laws 1969, chapter 526, sections 3; 4; 5, as amended; 7, as amended; Laws 1971, chapter 140, sections 2, as amended; 3, as amended; 4, as amended; 5, as amended; Laws 1971, chapter 214, section 1, subdivisions 1, 2, 3, 4, 5; Laws 1973, chapter 304, section 1, subdivisions 3, 4, 5, 6, 7, 8, 9; Laws 1973, chapter 472, section 1, as amended; Laws 1975, chapter 185, section 1; Laws 1985, chapter 261, section 37, as amended; Laws 1991, chapter 125, section 1; Laws 1993, chapter 244, article 4, section 1; Laws 2005, First Special Session chapter 8, article 1, section 23; Minnesota Rules, parts 7905.0100; 7905.0200; 7905.0300; 7905.0400; 7905.0500; 7905.0600; 7905.0700; 7905.0800; 7905.0900; 7905.1000; 7905.1100; 7905.1200; 7905.1300; 7905.1400; 7905.1500; 7905.1600; 7905.1700; 7905.1800; 7905.1900; 7905.2000; 7905.2100; 7905.2200; 7905.2300; 7905.2400; 7905.2450; 7905.2500; 7905.2560; 7905.2600; 7905.2700; 7905.2800; 7905.2900.

Senator Betzold moved to amend S.F. No. 2720 as follows:

Page 59, delete article 7

Renumber the articles in sequence and correct the internal references

Amend the title accordingly

The motion prevailed. So the amendment was adopted.

Senator Betzold moved to amend S.F. No. 2720 as follows:

Page 92, line 24, before "At" insert "(a)"

Page 93, after line 5, insert:

"(b) When considering vendors under paragraph (a), the school district and the exclusive representative of the employees shall consider all of the following:

(1) the vendor's ability to comply with all employer requirements imposed by section 403(b) of the Internal Revenue Code of 1986 and its subsequent amendments, other provisions of the Internal Revenue Code of 1986 that apply to section 403(b) of the Internal Revenue Code, and any regulation adopted in relation to these laws;

(2) the vendor's experience in providing 403(b) plans;

(3) the vendor's potential effectiveness in providing client services attendant to its plan and in relation to cost;

(4) the nature and extent of rights and benefits offered under the vendor's plan;

(5) the suitability of the rights and benefits offered under the vendor's plan;

(6) the vendor's ability to provide the rights and benefits offered under its plan; and

(7) the vendor's financial stability."

Amend the title accordingly

The motion prevailed. So the amendment was adopted.

Senator Vandeveer moved to amend S.F. No. 2720 as follows:

Page 92, after line 21, insert:

"Section 1. **[3.0835] DEFERRED COMPENSATION LIMIT.**

No member of the legislature may receive state funds exceeding $500 per calendar year as a contribution to a deferred compensation account established for the benefit of the member."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

CALL OF THE SENATE

Senator Vandeveer imposed a call of the Senate for the balance of the proceedings on S.F. No. 2720. The Sergeant at Arms was instructed to bring in the absent members.

The question was taken on the adoption of the Vandeveer amendment.

Senator Pogemiller moved that those not voting be excused from voting. The motion prevailed.

The roll was called, and there were yeas 16 and nays 44, as follows:

Those who voted in the affirmative were:

Fischbach	Ingebrigtsen	Limmer	Robling
Gerlach	Johnson	Michel	Senjem
Gimse	Jungbauer	Ortman	Vandeveer
Hann	Koch	Pariseau	Wergin

Those who voted in the negative were:

Anderson	Dahle	Kubly	Pappas	Skoe
Bakk	Day	Langseth	Pogemiller	Skogen
Berglin	Dibble	Larson	Prettner Solon	Sparks
Betzold	Dille	Latz	Rest	Stumpf
Bonoff	Doll	Lourey	Rosen	Tomassoni
Carlson	Erickson Ropes	Moua	Rummel	Torres Ray
Chaudhary	Foley	Murphy	Saxhaug	Vickerman
Clark	Frederickson	Olseen	Sheran	Wiger
Cohen	Higgins	Olson, M.	Sieben	

The motion did not prevail. So the amendment was not adopted.

S.F. No. 2720 was read the third time, as amended, and placed on its final passage.

The question was taken on the passage of the bill, as amended.

The roll was called, and there were yeas 46 and nays 16, as follows:

Those who voted in the affirmative were:

Anderson	Betzold	Carlson	Clark	Dahle
Bakk	Bonoff	Chaudhary	Cohen	Day

Dibble	Kubly	Olson, G.	Rummel	Torres Ray
Dille	Langseth	Olson, M.	Saxhaug	Vickerman
Doll	Larson	Pappas	Senjem	Wergin
Frederickson	Latz	Pariseau	Sieben	Wiger
Gimse	Lourey	Pogemiller	Skoe	
Higgins	Moua	Rest	Skogen	
Ingebrigtsen	Murphy	Robling	Sparks	
Koering	Olseen	Rosen	Stumpf	

Those who voted in the negative were:

Berglin	Gerlach	Koch	Prettner Solon
Erickson Ropes	Hann	Limmer	Sheran
Fischbach	Johnson	Michel	Tomassoni
Foley	Jungbauer	Ortman	Vandeveer

So the bill, as amended, was passed and its title was agreed to.

Senator Pogemiller moved that S.F. No. 2720 be laid on the table. The motion prevailed.

MOTIONS AND RESOLUTIONS - CONTINUED

Senator Erickson Ropes moved that S.F. No. 1128 be taken from the table. The motion prevailed.

S.F. No. 1128: A bill for an act relating to employment; modifying use of personal sick leave benefits; amending Minnesota Statutes 2006, section 181.9413.

CONCURRENCE AND REPASSAGE

Senator Erickson Ropes moved that the Senate concur in the amendments by the House to S.F. No. 1128 and that the bill be placed on its repassage as amended. The motion prevailed.

S.F. No. 1128 was read the third time, as amended by the House, and placed on its repassage.

The question was taken on the repassage of the bill, as amended.

The roll was called, and there were yeas 48 and nays 12, as follows:

Those who voted in the affirmative were:

Anderson	Doll	Larson	Pappas	Skoe
Berglin	Erickson Ropes	Latz	Pariseau	Skogen
Betzold	Fischbach	Limmer	Pogemiller	Sparks
Bonoff	Foley	Lourey	Prettner Solon	Stumpf
Carlson	Frederickson	Michel	Rest	Tomassoni
Chaudhary	Gimse	Moua	Rosen	Torres Ray
Clark	Higgins	Murphy	Rummel	Vickerman
Cohen	Koering	Olseen	Saxhaug	Wiger
Dahle	Kubly	Olson, G.	Sheran	
Dille	Langseth	Olson, M.	Sieben	

Those who voted in the negative were:

Day	Hann	Jungbauer	Senjem
Dibble	Ingebrigtsen	Koch	Vandeveer
Gerlach	Johnson	Robling	Wergin

So the bill, as amended, was repassed and its title was agreed to.

RECESS

Senator Pogemiller moved that the Senate do now recess subject to the call of the President. The motion prevailed.

After a brief recess, the President called the Senate to order.

CALL OF THE SENATE

Senator Pogemiller imposed a call of the Senate. The Sergeant at Arms was instructed to bring in the absent members.

MOTIONS AND RESOLUTIONS - CONTINUED

Without objection, remaining on the Order of Business of Motions and Resolutions, the Senate reverted to the Orders of Business of Executive and Official Communications, Messages From the House, First Reading of House Bills, Reports of Committees, Second Reading of Senate Bills and Second Reading of House Bills.

EXECUTIVE AND OFFICIAL COMMUNICATIONS

The following communication was received.

May 12, 2008

The Honorable James P. Metzen
President of the Senate

Dear President Metzen:

I have vetoed and am returning Senate File 651, a bill banning flame retardants and certain other chemicals from products sold in Minnesota.

I am committed to supporting scientifically based processes to ensure that products manufactured and sold in Minnesota provide appropriate protections to public health. However, I am vetoing this bill because the prohibitions in the bill are not based on established science, and banning the use of flame retardants in children's clothing may increase burn injuries to children.

This legislation bans decabromodiphenyl ethers (DECA), a proven fire retardant, effective July 1, 2011. Flame retardants are used in a variety of products including products designed to protect children. Banning an effective flame retardant without assurances that safe and reasonable alternatives are in place is unwise public policy.

Although a recent study completed by the Minnesota Pollution Control Agency identified potential alternative flame retardants to DECA, the report did not conclude that a ban on DECA is sound public policy. Moreover, contrary to claims from the legislative backers of this bill, the DECA ban in this bill in not similar to action taken in Washington. That state has not initiated an outright ban on products with DECA. Rather, a ban is implemented only after suitable alternatives are identified.

Such an approach would have been a wiser course here. I understand this approach was rejected by the bill authors. Even more significantly, the European Union has conducted more than 500 studies over 10 years and concluded that DECA does not pose any significant environmental or human health risk.

The availability and safety of such alternatives is not well known. Further study of DECA and the safety of alternatives to DECA should be conducted before a ban is implemented. This bill recognized the need for further study. However, it implemented an outright ban of an effective flame retardant before even considering the result of the research.

This bill also bans the sale of any children's products containing certain phthalates in a concentration of more than 0.1 percent. Again, the legislative mandate overreaches and goes beyond current scientific research. To my knowledge, no peer reviewed studies have concluded these products pose a significant risk to human health. Indeed, Israel recently repealed its phthalates ban after numerous studies showed that the science did not support the ban. While the European Union has a ban, it recently completed its risk assessment studies and concluded: "The end products containing diisonyl phthalate and the sources of exposure are unlikely to pose a risk for consumers following inhalation, skin contact and ingestion."

The issues of product safety and product availability are important and need to be based on science. I am willing to work with the Legislature that further studies and potentially limits or bans these chemicals, but such steps should be based on sound science.

Sincerely,
Tim Pawlenty, Governor

Senator Pogemiller moved that S.F. No. 651 and the veto message thereon be laid on the table. The motion prevailed.

MESSAGES FROM THE HOUSE

Mr. President:

I have the honor to announce that the House refuses to concur in the Senate amendments to House File No. 3420:

H.F. No. 3420: A bill for an act relating to local government; revising procedures and fees charged by county registrars of title for registering supplemental declarations of common interest communities; amending Minnesota Statutes 2006, sections 508.82, subdivision 1; 515B.1-116.

The House respectfully requests that a Conference Committee of 3 members be appointed thereon.

Hilstrom, Pelowski and Smith have been appointed as such committee on the part of the House.

House File No. 3420 is herewith transmitted to the Senate with the request that the Senate appoint a like committee.

Albin A. Mathiowetz, Chief Clerk, House of Representatives

Transmitted May 12, 2008

Senator Moua moved that the Senate accede to the request of the House for a Conference Committee on H.F. No. 3420, and that a Conference Committee of 3 members be appointed by the Subcommittee on Conference Committees on the part of the Senate, to act with a like Conference Committee appointed on the part of the House. The motion prevailed.

Mr. President:

I have the honor to announce that the House has acceded to the request of the Senate for the appointment of a Conference Committee, consisting of 5 members of the House, on the amendments adopted by the House to the following Senate File:

S.F. No. 2651: A bill for an act relating to natural resources; modifying provisions for sale of surplus state land; creating a Minnesota forests for the future program; establishing a revolving account; providing for alternative recording of state forest roads; providing for certain wetland banking credits; modifying provisions related to aquatic farms; providing for expedited exchanges of public land; providing for consultation on certain unallotments; providing for viral hemorrhagic septicemia and wildlife disease control; providing for a voluntary walleye stamp; creating the Lessard-Heritage Enhancement Council; modifying hunting and fishing licensing and taking provisions; modifying certain fund and account provisions; modifying outdoor recreation system provisions; adding to and deleting from state parks, recreation areas, and forests; providing for public and private sales, conveyances, leases, and exchanges of certain state land; requiring reports and studies; appropriating money; amending Minnesota Statutes 2006, sections 16B.281, subdivision 3; 16B.282; 16B.283; 16B.284; 16B.287, subdivision 2; 17.4985, subdivisions 2, 3, 5; 17.4986, subdivisions 1, 2, 4; 17.4987; 17.4988, subdivision 3; 17.4992, subdivision 2; 17.4993; 84.943, subdivision 5; 84D.03, subdivision 4; 86A.04; 86A.08, subdivision 1; 89.715; 97A.015, subdivisions 32a, 41a, by adding subdivisions; 97A.045, subdivisions 7, 11; 97A.055, subdivision 4b; 97A.075, subdivisions 4, 5, by adding a subdivision; 97A.311, subdivision 5; 97A.431, subdivision 2; 97A.433, subdivision 2; 97A.434, subdivision 2; 97A.473, subdivision 2; 97A.474, subdivision 2; 97A.475, subdivision 5, by adding a subdivision; 97A.485, subdivision 6; 97A.535, subdivision 1; 97B.015, subdivision 5; 97B.041; 97B.071; 97B.081; 97B.106, subdivision 1; 97B.211, subdivision 1; 97B.301, subdivisions 1, 2, 4, 6; 97B.621, subdivision 3; 97B.721; 97C.203; 97C.205; 97C.341; 97C.355, subdivisions 4, 7a; 97C.401, subdivision 2; 97C.505, subdivision 1; 97C.515, subdivisions 2, 4, 5; 97C.821; 325D.55, subdivision 1; Minnesota Statutes 2007 Supplement, sections 17.4984, subdivision 1; 97A.055, subdivision 4; 97A.405, subdivisions 2, 4; 97A.441, subdivision 7; 97A.451, subdivision 3; 97A.473, subdivision 5; 97A.475, subdivisions 2, 3; 97B.031, subdivision 1; 97B.036; 97B.328; 97C.355, subdivision 8; Laws 2005, chapter 161, section 25; Laws 2006, chapter 236, article 1, section 43; proposing coding for new law in Minnesota Statutes, chapters 84; 94; 97A; 97B; 97C; 103G; repealing Minnesota Statutes 2006, sections 16B.281, subdivisions 2, 4, 5; 16B.285; 97A.411, subdivision 2; 97C.515, subdivision 3; Minnesota Statutes 2007 Supplement, section 97B.301, subdivision 7; Minnesota Rules, parts 6232.0200, subpart 4; 6232.0300, subpart 4.

There has been appointed as such committee on the part of the House:

Dill, Wagenius, Thao, Moe and McNamara.

Senate File No. 2651 is herewith returned to the Senate.

Albin A. Mathiowetz, Chief Clerk, House of Representatives

Returned May 12, 2008

Mr. President:

I have the honor to announce that the House has adopted the recommendation and report of the Conference Committee on Senate File No. 2876, and repassed said bill in accordance with the report of the Committee, so adopted.

S.F. No. 2876: A bill for an act relating to animals; changing provisions regulating dangerous dogs and dogs at certain establishments; imposing penalties; amending Minnesota Statutes 2006, sections 347.50, by adding a subdivision; 347.51, subdivisions 2, 2a, 3, 4, 7, 9; 347.52; 347.53; 347.54, subdivisions 1, 3; 347.55; 347.56; proposing coding for new law in Minnesota Statutes, chapters 157; 347.

Senate File No. 2876 is herewith returned to the Senate.

Albin A. Mathiowetz, Chief Clerk, House of Representatives

Returned May 12, 2008

Mr. President:

I have the honor to announce that the House has adopted the recommendation and report of the Conference Committee on Senate File No. 3166, and repassed said bill in accordance with the report of the Committee, so adopted.

S.F. No. 3166: A bill for an act relating to human services; amending child welfare and licensing provisions; adopting a new Interstate Compact for the Placement of Children and repealing the old compact; regulating child and adult adoptions; regulating children in voluntary foster care for treatment; providing targeted case management services to certain children with developmental disabilities; providing for certain data classifications; amending Minnesota Statutes 2006, sections 13.46, by adding subdivisions; 245C.24, subdivision 2; 245C.29, subdivision 2; 256.045, subdivisions 3, 3b; 259.20, subdivision 1; 259.21, by adding a subdivision; 259.22, subdivision 2; 259.23, subdivision 2; 259.43; 259.52, subdivision 2; 259.53, subdivision 3; 259.59, subdivisions 1, 2; 259.67, subdivisions 2, 3, by adding a subdivision; 259.75, subdivision 5; 259.89, subdivisions 1, 2, 4, by adding a subdivision; 260C.001, subdivision 2; 260C.007, subdivisions 5, 6, 13; 260C.101, subdivision 2; 260C.141, subdivision 2; 260C.171, subdivision 2; 260C.178, subdivision 1; 260C.205; 260C.212, subdivisions 7, 8, by adding a subdivision; 260C.325, subdivisions 1, 3; 524.2-114; 626.556, subdivision 7; Minnesota Statutes 2007 Supplement, sections 245C.14, subdivision 1; 245C.15, subdivisions 2, 3, 4; 245C.24, subdivision 3; 245C.27, subdivision 1; 259.41, subdivision 1; 259.57, subdivision 1; 259.67, subdivision 4; 260C.163, subdivision 1; 260C.209, subdivisions 1, 2, by adding a subdivision; 260C.212, subdivisions 1, 4; 626.556, subdivision 10a; Laws 2007, chapter 147, article 2, section 56; proposing coding for new law in Minnesota Statutes, chapters 259; 260; proposing coding for new law as Minnesota Statutes, chapter 260D; repealing Minnesota Statutes 2006, sections 260.851; 260C.141, subdivision 2a; 260C.431; 260C.435; Minnesota Statutes 2007 Supplement, section 260C.212, subdivision 9; Minnesota Rules, part 9560.0609.

Senate File No. 3166 is herewith returned to the Senate.

Albin A. Mathiowetz, Chief Clerk, House of Representatives

Returned May 12, 2008

Mr. President:

I have the honor to announce the passage by the House of the following House Files, herewith transmitted: H.F. Nos. 2748, 1875 and 4072.

Albin A. Mathiowetz, Chief Clerk, House of Representatives

Transmitted May 12, 2008

FIRST READING OF HOUSE BILLS

The following bills were read the first time.

H.F. No. 2748: A bill for an act relating to health; establishing oversight for rural health cooperative; requiring the administrative services unit to apportion the amount necessary to purchase medical professional liability insurance coverage and authorizing fees to be adjusted to compensate for the apportioned amount; appropriating money; amending Minnesota Statutes 2006, section 214.40, by adding a subdivision; proposing coding for new law in Minnesota Statutes, chapter 62R.

Referred to the Committee on Finance.

H.F. No. 1875: A bill for an act relating to health; modifying board of directors for comprehensive health association; amending Minnesota Statutes 2006, section 62E.10, subdivision 2.

Referred to the Committee on Finance.

H.F. No. 4072: A bill for an act relating to capital improvements; appropriating money for asset preservation at the University of Minnesota and Minnesota State Colleges and Universities; authorizing the sale and issuance of state bonds.

Senator Pogemiller moved that H.F. No. 4072 be laid on the table. The motion prevailed.

REPORTS OF COMMITTEES

Senator Pogemiller moved that the Committee Reports at the Desk be now adopted. The motion prevailed.

Senator Cohen from the Committee on Finance, to which was re-referred

H.F. No. 3807: A bill for an act relating to state government; providing additional whistleblower protection to state executive branch employees; amending Minnesota Statutes 2007 Supplement,

section 181.932, subdivision 1.

Reports the same back with the recommendation that the bill be amended as follows:

Delete everything after the enacting clause and insert:

"Section 1. **NONCOMPLIANCE WITH REAL ID ACT.**

The commissioner of public safety is prohibited from taking any action to implement or to plan for the implementation by this state of those sections of Public Law 109-13 known as the Real ID Act.

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

Delete the title and insert:

"A bill for an act relating to public safety; prohibiting implementation of Real ID Act in this state."

And when so amended the bill do pass. Amendments adopted. Report adopted.

Senator Cohen from the Committee on Finance, to which was referred

S.F. No. 3815: A bill for an act relating to capital improvements; appropriating money for asset preservation at the University of Minnesota and Minnesota State Colleges and Universities; authorizing the sale and issuance of state bonds.

Reports the same back with the recommendation that the bill be amended as follows:

Delete everything after the enacting clause and insert:

"Section 1. **CENTRAL CORRIDOR TRANSIT WAY.**

Subdivision 1. **Appropriation.** (a) $70,000,000 is appropriated from the bond proceeds fund to the Metropolitan Council for one or more of the following activities for the Central Corridor light rail transit line that will connect downtown Minneapolis with downtown St. Paul: preliminary engineering, final design, property acquisition, including improvements and betterments of a capital nature, relocation of utilities owned by public entities, and construction. No more than $20,000,000 of the appropriation may be used for preliminary engineering.

(b) Hennepin and Ramsey Counties need not spend their matching money for this project at a rate faster than dollar for dollar with the money from this appropriation.

(c) District heating and district cooling nonprofit corporations organized under Minnesota Statutes, chapter 317A, that are exempt organizations under section 501(c)(3) of the United States Internal Revenue Code and are public right-of-way users under Minnesota Rules, chapter 7819, are eligible to receive grants and federal money for costs of relocating facilities from public rights-of-way to prevent interference with public light rail projects, unless eligibility would impact the project's Federal Transit Authority required cost effectiveness index.

Subd. 2. **Bond sale.** To provide the money appropriated in this act from the bond proceeds fund, the commissioner of finance shall sell and issue bonds of the state in an amount up to $70,000,000 in the manner, upon the terms, and with the effect prescribed by Minnesota Statutes, sections 16A.631

to 16A.675, and by the Minnesota Constitution, article XI, sections 4 to 7.

Sec. 2. **EFFECTIVE DATE.**

This act is effective the day following final enactment."

Delete the title and insert:

"A bill for an act relating to capital improvements; appropriating money for the Central Corridor Transit Way; authorizing the sale and issuance of state bonds."

And when so amended the bill do pass. Amendments adopted. Report adopted.

SECOND READING OF SENATE BILLS

S.F. No. 3815 was read the second time.

SECOND READING OF HOUSE BILLS

H.F. No. 3807 was read the second time.

MOTIONS AND RESOLUTIONS - CONTINUED

Senator Prettner Solon moved that her name be stricken as chief author, and the name of Senator Betzold be added as chief author to S.F. No. 1593. The motion prevailed.

Without objection, remaining on the Order of Business of Motions and Resolutions, the Senate reverted to the Order of Business of Messages From the House.

MESSAGES FROM THE HOUSE

Mr. President:

I have the honor to announce that the House has adopted the recommendation and report of the Conference Committee on House File No. 3222, and repassed said bill in accordance with the report of the Committee, so adopted.

House File No. 3222 is herewith transmitted to the Senate.

Albin A. Mathiowetz, Chief Clerk, House of Representatives

Transmitted May 12, 2008

CONFERENCE COMMITTEE REPORT ON H. F. NO. 3222

A bill for an act relating to human services; amending health care services provisions; making changes to general assistance medical care, medical assistance, and MinnesotaCare;

modifying claims, liens, and treatment of assets; establishing a statewide information exchange; amending Minnesota Statutes 2006, sections 256B.056, subdivisions 2, 4a, 11, by adding a subdivision; 256B.057, subdivision 1; 256B.0571, subdivisions 8, 9, 15, by adding a subdivision; 256B.058; 256B.059, subdivisions 1, 1a; 256B.0594; 256B.0595, subdivisions 1, 2, 3, 4, by adding subdivisions; 256B.0625, subdivision 13g; 256B.075, subdivision 2; 256B.15, subdivision 4; 256B.69, subdivisions 6, 27; 524.3-803; Minnesota Statutes 2007 Supplement, sections 256B.055, subdivision 14; 256B.0625, subdivision 49; 256D.03, subdivision 3; proposing coding for new law in Minnesota Statutes, chapter 256B.

May 7, 2008

The Honorable Margaret Anderson Kelliher
Speaker of the House of Representatives

The Honorable James P. Metzen
President of the Senate

We, the undersigned conferees for H. F. No. 3222 report that we have agreed upon the items in dispute and recommend as follows:

That the Senate recede from its amendments and that H. F. No. 3222 be further amended as follows:

Delete everything after the enacting clause and insert:

"**ARTICLE 1**

HEALTH CARE

Section 1. Minnesota Statutes 2006, section 125A.02, subdivision 1, is amended to read:

Subdivision 1. **Child with a disability.** Every child who has a hearing impairment, blindness, visual disability, speech or language impairment, physical disability, other health impairment, mental disability, emotional/behavioral disorder, specific learning disability, autism, traumatic brain injury, multiple disabilities, or deaf/blind disability and needs special instruction and services, as determined by the standards of the commissioner, is a child with a disability. A licensed physician, an advanced practice nurse, or a licensed psychologist is qualified to make a diagnosis and determination of attention deficit disorder or attention deficit hyperactivity disorder for purposes of identifying a child with a disability. In addition, every child under age three, and at local district discretion from age three to age seven, who needs special instruction and services, as determined by the standards of the commissioner, because the child has a substantial delay or has an identifiable physical or mental condition known to hinder normal development is a child with a disability.

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

Sec. 2. Minnesota Statutes 2006, section 144A.45, subdivision 1, is amended to read:

Subdivision 1. **Rules.** The commissioner shall adopt rules for the regulation of home care providers pursuant to sections 144A.43 to 144A.47. The rules shall include the following:

~~(a)~~ (1) provisions to assure, to the extent possible, the health, safety and well-being, and appropriate treatment of persons who receive home care services;

~~(b)~~ (2) requirements that home care providers furnish the commissioner with specified information necessary to implement sections 144A.43 to 144A.47;

~~(c)~~ (3) standards of training of home care provider personnel, which may vary according to the nature of the services provided or the health status of the consumer;

~~(d)~~ (4) standards for medication management which may vary according to the nature of the services provided, the setting in which the services are provided, or the status of the consumer. Medication management includes the central storage, handling, distribution, and administration of medications;

~~(e)~~ (5) standards for supervision of home care services requiring supervision by a registered nurse or other appropriate health care professional which must occur on site at least every 62 days, or more frequently if indicated by a clinical assessment, and in accordance with sections 148.171 to 148.285 and rules adopted thereunder, except that, notwithstanding the provisions of Minnesota Rules, part 4668.0110, subpart 5, item B, supervision of a person performing home care aide tasks for a class B licensee providing paraprofessional services must occur only every 180 days, or more frequently if indicated by a clinical assessment;

~~(f)~~ (6) standards for client evaluation or assessment which may vary according to the nature of the services provided or the status of the consumer;

~~(g)~~ (7) requirements for the involvement of a consumer's physician, the documentation of physicians' orders, if required, and the consumer's treatment plan, and the maintenance of accurate, current clinical records;

~~(h)~~ (8) the establishment of different classes of licenses for different types of providers and different standards and requirements for different kinds of home care services; and

~~(i)~~ (9) operating procedures required to implement the home care bill of rights.

Sec. 3. Minnesota Statutes 2006, section 144A.45, is amended by adding a subdivision to read:

Subd. 1a. **Home care aide tasks.** Notwithstanding the provisions of Minnesota Rules, part 4668.0110, subpart 1, item E, home care aide tasks also include assisting toileting, transfers, and ambulation if the client is ambulatory and if the client has no serious acute illness or infectious disease.

Sec. 4. **[145.1622] POLICY FOR NOTIFICATION OF DISPOSITION OPTIONS.**

Hospitals, clinics, and medical facilities must have in place by January 15, 2009, a policy for informing a woman of available options for fetal disposition when the woman experiences a miscarriage or is expected to experience a miscarriage.

Sec. 5. Minnesota Statutes 2006, section 150A.06, is amended by adding a subdivision to read:

Subd. 9. **Graduates of nonaccredited dental programs.** A graduate of a nonaccredited dental program who successfully completes the clinical licensure examination, and meets all other applicant requirements of the board shall be licensed to practice dentistry and granted a limited general dentist license by the board. The board shall place limitations on the licensee's authority to practice by requiring the licensee to practice under the general supervision of a Minnesota-licensed dentist approved by the board. A person licensed under this subdivision must practice for three

consecutive years in Minnesota pursuant to a written agreement, approved by the board, between the licensee and a Minnesota-licensed dentist who may limit the types of services authorized. At the conclusion of the three-year period, the board shall grant an unlimited license without further restrictions if all supervising dentists who had entered into written agreements with the licensee during any part of the three-year period recommend unlimited licensure, and if no corrective action or disciplinary action has been taken by the board against the licensee.

Sec. 6. Minnesota Statutes 2006, section 214.40, is amended by adding a subdivision to read:

Subd. 8. **Fee adjustment.** The administrative services unit shall apportion between the Board of Medical Practice, the Board of Dentistry, and the Board of Nursing an amount to be raised through fees by the respective board. The amount apportioned to each board shall be the total amount expended on medical professional liability insurance coverage purchased for the providers regulated by the respective board. The respective board may adjust the fees which the board is required to collect to compensate for the amount apportioned to the board by the administrative services unit.

Sec. 7. Minnesota Statutes 2006, section 256.01, is amended by adding a subdivision to read:

Subd. 27. **Statewide health information exchange.** (a) The commissioner has the authority to join and participate as a member in a legal entity developing and operating a statewide health information exchange that shall meet the following criteria:

(1) the legal entity must meet all constitutional and statutory requirements to allow the commissioner to participate; and

(2) the commissioner or the commissioner's designated representative must have the right to participate in the governance of the legal entity under the same terms and conditions and subject to the same requirements as any other member in the legal entity and in that role shall act to advance state interests and lessen the burdens of government.

(b) Notwithstanding chapter 16C, the commissioner may pay the state's prorated share of development-related expenses of the legal entity retroactively from October 29, 2007, regardless of the date the commissioner joins the legal entity as a member.

Sec. 8. Minnesota Statutes 2007 Supplement, section 256B.055, subdivision 14, is amended to read:

Subd. 14. **Persons detained by law.** (a) Medical assistance may be paid for an inmate of a correctional facility who is conditionally released as authorized under section 241.26, 244.065, or 631.425, if the individual does not require the security of a public detention facility and is housed in a halfway house or community correction center, or under house arrest and monitored by electronic surveillance in a residence approved by the commissioner of corrections, and if the individual meets the other eligibility requirements of this chapter.

(b) An individual who is enrolled in medical assistance, and who is charged with a crime and incarcerated for less than 12 months shall be suspended from eligibility at the time of incarceration until the individual is released. Upon release, medical assistance eligibility is reinstated without reapplication using a reinstatement process and form, if the individual is otherwise eligible.

(c) An individual, regardless of age, who is considered an inmate of a public institution as defined in Code of Federal Regulations, title 42, section ~~435.1009~~ 435.1010, is not eligible for medical

assistance.

Sec. 9. Minnesota Statutes 2006, section 256B.056, subdivision 2, is amended to read:

Subd. 2. **Homestead exclusion ~~and homestead equity limit~~ for ~~institutionalized~~ persons residing in a long-term care facility.** ~~(a)~~ The homestead shall be excluded for the first six calendar months of a person's stay in a long-term care facility and shall continue to be excluded for as long as the recipient can be reasonably expected to return to the homestead. For purposes of this subdivision, "reasonably expected to return to the homestead" means the recipient's attending physician has certified that the expectation is reasonable, and the recipient can show that the cost of care upon returning home will be met through medical assistance or other sources. The homestead shall continue to be excluded for persons residing in a long-term care facility if it is used as a primary residence by one of the following individuals:

(1) the spouse;

(2) a child under age 21;

(3) a child of any age who is blind or permanently and totally disabled as defined in the supplemental security income program;

(4) a sibling who has equity interest in the home and who resided in the home for at least one year immediately before the date of the person's admission to the facility; or

(5) a child of any age~~,~~ or~~, subject to federal approval,~~ a grandchild of any age~~,~~ who resided in the home for at least two years immediately before the date of the person's admission to the facility, and who provided care to the person that permitted the person to reside at home rather than in an institution.

~~(b) Effective for applications filed on or after July 1, 2006, and for renewals after July 1, 2006, for persons who first applied for payment of long-term care services on or after January 2, 2006, the equity interest in the homestead of an individual whose eligibility for long-term care services is determined on or after January 1, 2006, shall not exceed $500,000, unless it is the lawful residence of the individual's spouse or child who is under age 21, blind, or disabled. The amount specified in this paragraph shall be increased beginning in year 2011, from year to year based on the percentage increase in the Consumer Price Index for all urban consumers (all items; United States city average), rounded to the nearest $1,000. This provision may be waived in the case of demonstrated hardship by a process to be determined by the secretary of health and human services pursuant to section 6014 of the Deficit Reduction Act of 2005, Public Law 109-171.~~

Sec. 10. Minnesota Statutes 2006, section 256B.056, is amended by adding a subdivision to read:

Subd. 2a. **Home equity limit for medical assistance payment of long-term care services.** (a) Effective for requests of medical assistance payment of long-term care services filed on or after July 1, 2006, and for renewals on or after July 1, 2006, for persons who received payment of long-term care services under a request filed on or after January 1, 2006, the equity interest in the home of a person whose eligibility for long-term care services is determined on or after January 1, 2006, shall not exceed $500,000, unless it is the lawful residence of the person's spouse or child who is under age 21, or a child of any age who is blind or permanently and totally disabled as defined in the Supplemental Security Income program. The amount specified in this paragraph shall be increased beginning in year 2011, from year to year based on the percentage increase in the Consumer Price

Index for all urban consumers (all items; United States city average), rounded to the nearest $1,000.

(b) For purposes of this subdivision, a "home" means any real or personal property interest, including an interest in an agricultural homestead as defined under section 273.124, subdivision 1, that, at the time of the request for medical assistance payment of long-term care services, is the primary dwelling of the person or was the primary dwelling of the person before receipt of long-term care services began outside of the home.

(c) A person denied or terminated from medical assistance payment of long-term care services because the person's home equity exceeds the home equity limit may seek a waiver based upon a hardship by filing a written request with the county agency. Hardship is an imminent threat to the person's health and well-being that is demonstrated by documentation of no alternatives for payment of long-term care services. The county agency shall make a decision regarding the written request to waive the home equity limit within 30 days if all necessary information has been provided. The county agency shall send the person and the person's representative a written notice of decision on the request for a demonstrated hardship waiver that also advises the person of appeal rights under the fair hearing process of section 256.045.

Sec. 11. Minnesota Statutes 2006, section 256B.056, subdivision 4a, is amended to read:

Subd. 4a. **Asset verification.** For purposes of verification, ~~the value of~~ an individual is not required to make a good faith effort to sell a life estate that is not excluded under subdivision 2 and the life estate shall be ~~considered~~ deemed not salable unless the owner of the remainder interest intends to purchase the life estate, or the owner of the life estate and the owner of the remainder sell the entire property. This subdivision applies only for the purpose of determining eligibility for medical assistance, and does not apply to the valuation of assets owned by either the institutional spouse or the community spouse under section 256B.059, subdivision 2.

Sec. 12. Minnesota Statutes 2006, section 256B.056, subdivision 11, is amended to read:

Subd. 11. **Treatment of annuities.** (a) Any ~~individual applying for or seeking recertification of eligibility for~~ person requesting medical assistance payment of long-term care services shall provide a complete description of any interest either the ~~individual~~ person or the ~~individual's~~ person's spouse has in annuities on a form designated by the department. The form shall include a statement that the state becomes a preferred remainder beneficiary of annuities or similar financial instruments by virtue of the receipt of medical assistance payment of long-term care services. The ~~individual~~ person and the ~~individual's~~ person's spouse shall furnish the agency responsible for determining eligibility with complete current copies of their annuities and related documents ~~for review as part of the application process on disclosure forms provided by the department as part of their application~~ and complete the form designating the state as the preferred remainder beneficiary for each annuity in which the person or the person's spouse has an interest.

(b) ~~The disclosure form shall include a statement that the department becomes the remainder beneficiary under the annuity or similar financial instrument by virtue of the receipt of medical assistance.~~ The ~~disclosure form~~ department shall ~~include a~~ provide notice to the issuer of the department's right under this section as a preferred remainder beneficiary under the annuity or similar financial instrument for medical assistance furnished to the ~~individual~~ person or the ~~individual's~~ person's spouse, and ~~require the issuer to provide confirmation that a remainder beneficiary designation has been made and to notify the county agency when there is a change in the amount of the income or principal being withdrawn from the annuity or other similar financial~~

~~instrument at the time of the most recent disclosure required under this section. The individual and the individual's spouse shall execute separate disclosure forms for each annuity or similar financial instrument that they are required to disclose under this section and in which they have an interest~~ provide notice of the issuer's responsibilities as provided in paragraph (c).

(c) An issuer of an annuity or similar financial instrument who receives notice ~~on a disclosure form~~ of the state's right to be named a preferred remainder beneficiary as described in paragraph (b) shall provide confirmation to the requesting agency that ~~a remainder beneficiary designating~~ the state has been made ~~and~~ a preferred remainder beneficiary. The issuer shall also notify the county agency when ~~there is~~ a change in the amount of income or principal being withdrawn from the annuity or other similar financial instrument or a change in the state's preferred remainder beneficiary designation under the annuity or other similar financial instrument occurs. The county agency shall provide the issuer with the name, address, and telephone number of a unit within the department that the issuer can contact to comply with this paragraph.

(d) "Preferred remainder beneficiary" for purposes of this subdivision and sections 256B.0594 and 256B.0595 means the state is a remainder beneficiary in the first position in an amount equal to the amount of medical assistance paid on behalf of the institutionalized person, or is a remainder beneficiary in the second position if the institutionalized person designates and is survived by a remainder beneficiary who is (1) a spouse who does not reside in a medical institution, (2) a minor child, or (3) a child of any age who is blind or permanently and totally disabled as defined in the Supplemental Security Income program. Notwithstanding this paragraph, the state is the remainder beneficiary in the first position if the spouse or child disposes of the remainder for less than fair market value.

(e) For purposes of this subdivision, "institutionalized person" and "long-term care services" have the meanings given in section 256B.0595, subdivision 1, paragraph (h).

(f) For purposes of this subdivision, "medical institution" means a skilled nursing facility, intermediate care facility, intermediate care facility for persons with developmental disabilities, nursing facility, or inpatient hospital.

Sec. 13. Minnesota Statutes 2006, section 256B.057, subdivision 1, is amended to read:

Subdivision 1. **Infants and pregnant women.** (a)(1) An infant less than one year of age or a pregnant woman who has written verification of a positive pregnancy test from a physician or licensed registered nurse is eligible for medical assistance if countable family income is equal to or less than 275 percent of the federal poverty guideline for the same family size. ~~A pregnant woman who has written verification of a positive pregnancy test from a physician or licensed registered nurse is eligible for medical assistance if countable family income is equal to or less than 200 percent of the federal poverty guideline for the same family size.~~ For purposes of this subdivision, "countable family income" means the amount of income considered available using the methodology of the AFDC program under the state's AFDC plan as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law 104-193, except for the earned income disregard and employment deductions.

(2) For applications processed within one calendar month prior to the effective date, eligibility shall be determined by applying the income standards and methodologies in effect prior to the effective date for any months in the six-month budget period before that date and the income standards and methodologies in effect on the effective date for any months in the six-month budget

period on or after that date. The income standards for each month shall be added together and compared to the applicant's total countable income for the six-month budget period to determine eligibility.

(b)(1) [Expired, 1Sp2003 c 14 art 12 s 19]

(2) For applications processed within one calendar month prior to July 1, 2003, eligibility shall be determined by applying the income standards and methodologies in effect prior to July 1, 2003, for any months in the six-month budget period before July 1, 2003, and the income standards and methodologies in effect on the expiration date for any months in the six-month budget period on or after July 1, 2003. The income standards for each month shall be added together and compared to the applicant's total countable income for the six-month budget period to determine eligibility.

(3) An amount equal to the amount of earned income exceeding 275 percent of the federal poverty guideline, up to a maximum of the amount by which the combined total of 185 percent of the federal poverty guideline plus the earned income disregards and deductions allowed under the state's AFDC plan as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Act of 1996 (PRWORA), Public Law 104-193, exceeds 275 percent of the federal poverty guideline will be deducted for pregnant women and infants less than one year of age.

(c) Dependent care and child support paid under court order shall be deducted from the countable income of pregnant women.

(d) An infant born on or after January 1, 1991, to a woman who was eligible for and receiving medical assistance on the date of the child's birth shall continue to be eligible for medical assistance without redetermination until the child's first birthday, as long as the child remains in the woman's household.

Sec. 14. Minnesota Statutes 2006, section 256B.0571, subdivision 6, is amended to read:

Subd. 6. **Partnership policy.** "Partnership policy" means a long-term care insurance policy that meets the requirements under subdivision 10 and was issued on or after the effective date of the state plan amendment implementing the partnership program in Minnesota. Policies that are exchanged or that have riders or endorsements added on or after the effective date of the state plan amendment as authorized by the commissioner of commerce qualify as a partnership policy.

Sec. 15. Minnesota Statutes 2006, section 256B.0571, subdivision 8, is amended to read:

Subd. 8. **Program established.** (a) The commissioner, in cooperation with the commissioner of commerce, shall establish the Minnesota partnership for long-term care program to provide for the financing of long-term care through a combination of private insurance and medical assistance.

(b) An individual who meets the requirements in this paragraph is eligible to participate in the partnership program. The individual must:

(1) meet one of the following criteria:

(i) be a beneficiary of, and a Minnesota resident at the time coverage first became effective under ~~the~~ a partnership policy~~;~~

~~(2) be a beneficiary of a partnership policy~~ that ~~(i)~~ either is issued on or after the effective date of the state plan amendment implementing the partnership program in Minnesota, or ~~(ii)~~ qualifies

as a partnership policy ~~under the provisions of subdivision 8a~~ as authorized by the commissioner of commerce under subdivision 6; ~~and~~ or

(ii) be a beneficiary of a policy recognized under subdivision 17; and

~~(3)~~ (2) have exhausted all of the benefits under the partnership policy as described in this section. Benefits received under a long-term care insurance policy before July 1, 2006, do not count toward the exhaustion of benefits required in this subdivision.

Sec. 16. Minnesota Statutes 2006, section 256B.0571, subdivision 9, is amended to read:

Subd. 9. **Medical assistance eligibility.** (a) Upon ~~application~~ request for medical assistance program payment of long-term care services by an individual who meets the requirements described in subdivision 8, the commissioner shall determine the individual's eligibility for medical assistance according to paragraphs (b) to (i).

(b) After determining assets subject to the asset limit under section 256B.056, subdivision 3 or 3c, or 256B.057, subdivision 9 or 10, the commissioner shall allow the individual to designate assets to be protected from recovery under subdivisions 13 and 15 up to the dollar amount of the benefits utilized under the partnership policy. Designated assets shall be disregarded for purposes of determining eligibility for payment of long-term care services.

(c) The individual shall identify the designated assets and the full fair market value of those assets and designate them as assets to be protected at the time of initial application for medical assistance. The full fair market value of real property or interests in real property shall be based on the most recent full assessed value for property tax purposes for the real property, unless the individual provides a complete professional appraisal by a licensed appraiser to establish the full fair market value. The extent of a life estate in real property shall be determined using the life estate table in the health care program's manual. Ownership of any asset in joint tenancy shall be treated as ownership as tenants in common for purposes of its designation as a disregarded asset. The unprotected value of any protected asset is subject to estate recovery according to subdivisions 13 and 15.

(d) The right to designate assets to be protected is personal to the individual and ends when the individual dies, except as otherwise provided in subdivisions 13 and 15. It does not include the increase in the value of the protected asset and the income, dividends, or profits from the asset. It may be exercised by the individual or by anyone with the legal authority to do so on the individual's behalf. It shall not be sold, assigned, transferred, or given away.

(e) If the dollar amount of the benefits utilized under a partnership policy is greater than the full fair market value of all assets protected at the time of the application for medical assistance long-term care services, the individual may designate additional assets that become available during the individual's lifetime for protection under this section. The individual must make the designation in writing ~~to the county agency~~ no later than ~~the last date on which the individual must report a change in circumstances to the county agency, as provided for under the medical assistance program~~ ten days from the date the designation is requested by the county agency. Any excess used for this purpose shall not be available to the individual's estate to protect assets in the estate from recovery under section 256B.15 or 524.3-1202, or otherwise.

(f) This section applies only to estate recovery under United States Code, title 42, section 1396p,

subsections (a) and (b), and does not apply to recovery authorized by other provisions of federal law, including, but not limited to, recovery from trusts under United States Code, title 42, section 1396p, subsection (d)(4)(A) and (C), or to recovery from annuities, or similar legal instruments, subject to section 6012, subsections (a) and (b), of the Deficit Reduction Act of 2005, Public Law 109-171.

(g) An individual's protected assets owned by the individual's spouse who applies for payment of medical assistance long-term care services shall not be protected assets or disregarded for purposes of eligibility of the individual's spouse solely because they were protected assets of the individual.

(h) Assets designated under this subdivision shall not be subject to penalty under section 256B.0595.

(i) The commissioner shall otherwise determine the individual's eligibility for payment of long-term care services according to medical assistance eligibility requirements.

Sec. 17. Minnesota Statutes 2006, section 256B.0571, subdivision 15, is amended to read:

Subd. 15. **Limitation on liens.** (a) An individual's interest in real property shall not be subject to a medical assistance lien under sections 514.980 to 514.985 or a ~~notice of potential claim~~ lien arising under section 256B.15 while and to the extent it is protected under subdivision 9. An individual's interest in real property that exceeds the value protected under subdivision 9 is subject to a lien for recovery.

(b) Medical assistance liens under sections 514.980 to 514.985 or liens arising under ~~notices of potential claims~~ section 256B.15 against an individual's interests in real property in the individual's estate that are designated as protected under subdivision 13, paragraph (b), shall be released to the extent of the dollar value of the protection applied to the interest.

(c) If an interest in real property is protected from a lien for recovery of medical assistance paid on behalf of the individual under paragraph (a) or (b), no lien for recovery of medical assistance paid on behalf of that individual shall be filed against the protected interest in real property after it is distributed to the individual's heirs or devisees.

Sec. 18. Minnesota Statutes 2006, section 256B.0571, is amended by adding a subdivision to read:

Subd. 17. **Reciprocal agreements.** The commissioner may enter into an agreement with any other state with a partnership program under United States Code, title 42, section 1396p(b)(1)(C), for reciprocal recognition of qualified long-term care insurance policies purchased under each state's partnership program. The commissioner shall notify the secretary of the United States Department of Health and Human Services if the commissioner declines to enter into a national reciprocal agreement.

Sec. 19. Minnesota Statutes 2006, section 256B.058, is amended to read:

256B.058 TREATMENT OF INCOME OF INSTITUTIONALIZED SPOUSE.

Subdivision 1. **Income not available.** The income described in subdivisions 2 and 3 shall be deducted from an institutionalized spouse's monthly income and is not considered available for payment of the monthly costs of an institutionalized ~~person in the institution~~ spouse after ~~the person has been~~ the institutionalized spouse has been determined eligible for medical assistance.

Subd. 2. **Monthly income allowance for community spouse.** (a) For an institutionalized spouse ~~with a spouse residing in the community~~, monthly income may be allocated to the community spouse as a monthly income allowance for the community spouse. Beginning with the first full calendar month the institutionalized spouse is in the institution, the monthly income allowance is not considered available to the institutionalized spouse for monthly payment of costs of care in the institution as long as the income is made available to the community spouse.

(b) The monthly income allowance is the amount by which the community spouse's monthly maintenance needs allowance under paragraphs (c) and (d) exceeds the amount of monthly income otherwise available to the community spouse.

(c) The community spouse's monthly maintenance needs allowance is the lesser of $1,500 or 122 percent of the monthly federal poverty guideline for a family of two plus an excess shelter allowance. The excess shelter allowance is for the amount of shelter expenses that exceed 30 percent of 122 percent of the federal poverty guideline line for a family of two. Shelter expenses are the community spouse's expenses for rent, mortgage payments including principal and interest, taxes, insurance, required maintenance charges for a cooperative or condominium that is the community spouse's principal residence, and the standard utility allowance under section 5(e) of the federal Food Stamp Act of 1977. If the community spouse has a required maintenance charge for a cooperative or condominium, the standard utility allowance must be reduced by the amount of utility expenses included in the required maintenance charge.

If the community or institutionalized spouse establishes that the community spouse needs income greater than the monthly maintenance needs allowance determined in this paragraph due to exceptional circumstances resulting in significant financial duress, the monthly maintenance needs allowance may be increased to an amount that provides needed additional income.

(d) The percentage of the federal poverty guideline used to determine the monthly maintenance needs allowance in paragraph (c) is increased to 133 percent on July 1, 1991, and to 150 percent on July 1, 1992. Adjustments in the income limits due to annual changes in the federal poverty guidelines shall be implemented the first day of July following publication of the annual changes. The $1,500 maximum must be adjusted January 1, 1990, and every January 1 after that by the same percentage increase in the Consumer Price Index for all urban consumers (all items; United States city average) between the two previous Septembers.

(e) If a court has entered an order against an institutionalized spouse for monthly income for support of the community spouse, the community spouse's monthly income allowance under this subdivision shall not be less than the amount of the monthly income ordered.

Subd. 3. **Family allowance.** (a) A family allowance determined under paragraph (b) is not considered available to the institutionalized spouse for monthly payment of costs of care in the institution.

(b) The family allowance is equal to one-third of the amount by which 122 percent of the monthly federal poverty guideline for a family of two exceeds the monthly income for that family member.

(c) For purposes of this subdivision, the term family member only includes a minor or dependent child as defined in the Internal Revenue Code, dependent parent, or dependent sibling of the institutionalized or community spouse if the sibling resides with the community spouse.

(d) The percentage of the federal poverty guideline used to determine the family allowance in paragraph (b) is increased to 133 percent on July 1, 1991, and to 150 percent on July 1, 1992. Adjustments in the income limits due to annual changes in the federal poverty guidelines shall be implemented the first day of July following publication of the annual changes.

Subd. 4. **Treatment of income.** (a) No income of the community spouse will be considered available to an eligible institutionalized spouse, beginning the first full calendar month of institutionalization, except as provided in this subdivision.

(b) In determining the income of an institutionalized spouse or community spouse, after the institutionalized spouse has been determined eligible for medical assistance, the following rules apply.

(1) For income that is not from a trust, availability is determined according to items (i) to (v), unless the instrument providing the income otherwise specifically provides:

(i) if payment is made solely in the name of one spouse, the income is considered available only to that spouse;

(ii) if payment is made in the names of both spouses, one-half of the income is considered available to each;

(iii) if payment is made in the names of one or both spouses together with one or more other persons, the income is considered available to each spouse according to the spouse's interest, or one-half of the joint interest is considered available to each spouse if each spouse's interest is not specified;

(iv) if there is no instrument that establishes ownership, one-half of the income is considered available to each spouse; and

(v) either spouse may rebut the determination of availability of income by showing by a preponderance of the evidence that ownership interests are different than provided above.

(2) For income from a trust, income is considered available to each spouse as provided in the trust. If the trust does not specify an amount available to either or both spouses, availability will be determined according to items (i) to (iii):

(i) if payment of income is made only to one spouse, the income is considered available only to that spouse;

(ii) if payment of income is made to both spouses, one-half is considered available to each; and

(iii) if payment is made to either or both spouses and one or more other persons, the income is considered available to each spouse in proportion to each spouse's interest, or if no such interest is specified, one-half of the joint interest is considered available to each spouse.

Sec. 20. Minnesota Statutes 2006, section 256B.059, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) For purposes of this section and ~~section~~ sections 256B.058 and 256B.0595, the terms defined in this subdivision have the meanings given them.

(b) "Community spouse" means the spouse of an institutionalized spouse.

(c) "Spousal share" means one-half of the total value of all assets, to the extent that either the institutionalized spouse or the community spouse had an ownership interest at the time of the first continuous period of institutionalization.

(d) "Assets otherwise available to the community spouse" means assets individually or jointly owned by the community spouse, other than assets excluded by subdivision 5, paragraph (c).

(e) "Community spouse asset allowance" is the value of assets that can be transferred under subdivision 3.

(f) "Institutionalized spouse" means a person who is:

(1) in a hospital, nursing facility, or intermediate care facility for persons with developmental disabilities, or receiving home and community-based services under section 256B.0915 ~~or 256B.49~~, and is expected to remain in the facility or institution or receive the home and community-based services for at least 30 consecutive days; and

(2) married to a person who is not in a hospital, nursing facility, or intermediate care facility for persons with developmental disabilities, and is not receiving home and community-based services under section 256B.0915, 256B.092, or 256B.49.

(g) "For the sole benefit of" means no other individual or entity can benefit in any way from the assets or income at the time of a transfer or at any time in the future.

(h) "Continuous period of institutionalization" means a 30-consecutive-day period of time in which a person is expected to stay in a medical or long-term care facility, or receive home and community-based services that would qualify for coverage under the elderly waiver (EW) or alternative care (AC) programs. For a stay in a facility, the 30-consecutive-day period begins on the date of entry into a medical or long-term care facility. For receipt of home and community-based services, the 30-consecutive-day period begins on the date that the following conditions are met:

(1) the person is receiving services that meet the nursing facility level of care determined by a long-term care consultation;

(2) the person has received the long-term care consultation within the past 60 days;

(3) the services are paid by the EW program under section 256B.0915 or the AC program under section 256B.0913 or would qualify for payment under the EW or AC programs if the person were otherwise eligible for either program, and but for the receipt of such services the person would have resided in a nursing facility; and

(4) the services are provided by a licensed provider qualified to provide home and community-based services.

Sec. 21. Minnesota Statutes 2006, section 256B.059, subdivision 1a, is amended to read:

Subd. 1a. **Institutionalized spouse.** The provisions of this section apply only when a spouse ~~is institutionalized for a~~ begins the first continuous period ~~beginning~~ of institutionalization on or after October 1, 1989.

Sec. 22. Minnesota Statutes 2006, section 256B.0594, is amended to read:

256B.0594 PAYMENT OF BENEFITS FROM AN ANNUITY.

When payment becomes due under an annuity that names the department a remainder beneficiary ~~as described in section 256B.056, subdivision 11~~, the issuer shall request and the department shall, within 45 days after receipt of the request, provide a written statement of the total amount of the medical assistance paid or confirmation that any family member designated as a remainder beneficiary meets requirements for qualification as a beneficiary in the first position. Upon timely receipt of the written statement of the amount of medical assistance paid, the issuer shall pay the department an amount equal to the lesser of the amount due the department under the annuity or the total amount of medical assistance paid on behalf of the individual or the individual's spouse. Any amounts remaining after the issuer's payment to the department shall be payable according to the terms of the annuity or similar financial instrument. The county agency or the department shall provide the issuer with the name, address, and telephone number of a unit within the department the issuer can contact to comply with this section. The requirements of section 72A.201, subdivision 4, clause (3), shall not apply to payments made under this section until the issuer has received final payment information from the department, if the issuer has notified the beneficiary of the requirements of this section at the time it initially requests payment information from the department.

Sec. 23. Minnesota Statutes 2006, section 256B.0595, subdivision 1, is amended to read:

Subdivision 1. **Prohibited transfers.** (a) For transfers of assets made on or before August 10, 1993, if ~~a~~ an institutionalized person or the institutionalized person's spouse has given away, sold, or disposed of, for less than fair market value, any asset or interest therein, except assets other than the homestead that are excluded under the supplemental security program, within 30 months before or any time after the date of institutionalization if the person has been determined eligible for medical assistance, or within 30 months before or any time after the date of the first approved application for medical assistance if the person has not yet been determined eligible for medical assistance, the person is ineligible for long-term care services for the period of time determined under subdivision 2.

(b) Effective for transfers made after August 10, 1993, ~~a~~ an institutionalized person, ~~a~~ an institutionalized person's spouse, or any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of the institutionalized person or institutionalized person's spouse, may not give away, sell, or dispose of, for less than fair market value, any asset or interest therein, except assets other than the homestead that are excluded under the supplemental security income program, for the purpose of establishing or maintaining medical assistance eligibility. This applies to all transfers, including those made by a community spouse after the month in which the institutionalized spouse is determined eligible for medical assistance. For purposes of determining eligibility for long-term care services, any transfer of such assets within 36 months before or any time after an institutionalized person ~~applies for~~ requests medical assistance payment of long-term care services, or 36 months before or any time after a medical assistance recipient becomes an institutionalized person, for less than fair market value may be considered. Any such transfer is presumed to have been made for the purpose of establishing or maintaining medical assistance eligibility and the institutionalized person is ineligible for long-term care services for the period of time determined under subdivision 2, unless the institutionalized person furnishes convincing evidence to establish that the transaction was exclusively for another purpose, or unless the transfer is permitted under subdivision 3 or 4. In the

case of payments from a trust or portions of a trust that are considered transfers of assets under federal law, or in the case of any other disposal of assets made on or after February 8, 2006, any transfers made within 60 months before or any time after an institutionalized person ~~applies for~~ requests medical assistance payment of long-term care services and within 60 months before or any time after a medical assistance recipient becomes an institutionalized person, may be considered.

(c) This section applies to transfers, for less than fair market value, of income or assets, including assets that are considered income in the month received, such as inheritances, court settlements, and retroactive benefit payments or income to which the institutionalized person or the institutionalized person's spouse is entitled but does not receive due to action by the institutionalized person, the institutionalized person's spouse, or any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of the institutionalized person or the institutionalized person's spouse.

(d) This section applies to payments for care or personal services provided by a relative, unless the compensation was stipulated in a notarized, written agreement which was in existence when the service was performed, the care or services directly benefited the person, and the payments made represented reasonable compensation for the care or services provided. A notarized written agreement is not required if payment for the services was made within 60 days after the service was provided.

(e) This section applies to the portion of any asset or interest that ~~a~~ an institutionalized person, ~~a~~ an institutionalized person's spouse, or any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of the institutionalized person or the institutionalized person's spouse, transfers to any annuity that exceeds the value of the benefit likely to be returned to the institutionalized person or institutionalized person's spouse while alive, based on estimated life expectancy ~~using the life expectancy tables employed by the supplemental security income program to determine the value of an agreement for services for life~~ as determined according to the current actuarial tables published by the Office of the Chief Actuary of the Social Security Administration. The commissioner may adopt rules reducing life expectancies based on the need for long-term care. This section applies to an annuity ~~described in this paragraph~~ purchased on or after March 1, 2002, that:

(1) is not purchased from an insurance company or financial institution that is subject to licensing or regulation by the Minnesota Department of Commerce or a similar regulatory agency of another state;

(2) does not pay out principal and interest in equal monthly installments; or

(3) does not begin payment at the earliest possible date after annuitization.

(f) Effective for transactions, including the purchase of an annuity, occurring on or after February 8, 2006, ~~the purchase of an annuity~~ by or on behalf of an ~~individual~~ institutionalized person who has applied for or is receiving long-term care services or the ~~individual's~~ institutionalized person's spouse shall be treated as the disposal of an asset for less than fair market value unless the department is named ~~as the~~ a preferred remainder beneficiary ~~in first position for an amount equal to at least the total amount of medical assistance paid on behalf of the individual or the individual's spouse; or the department is named as the remainder beneficiary in second position for an amount equal to at least the total amount of medical assistance paid on behalf of the individual or the individual's spouse after the individual's community spouse or minor or disabled child and is named as the remainder~~

~~beneficiary in the first position if the community spouse or a representative of the minor or disabled child disposes of the remainder for less than fair market value~~ as described in section 256B.056, subdivision 11. Any subsequent change to the designation of the department as a preferred remainder beneficiary shall result in the annuity being treated as a disposal of assets for less than fair market value. The amount of such transfer shall be the maximum amount the ~~individual~~ institutionalized person or the ~~individual's~~ institutionalized person's spouse could receive from the annuity or similar financial instrument. Any change in the amount of the income or principal being withdrawn from the annuity or other similar financial instrument at the time of the most recent disclosure shall be deemed to be a transfer of assets for less than fair market value unless the ~~individual~~ institutionalized person or the ~~individual's~~ institutionalized person's spouse demonstrates that the transaction was for fair market value. In the event a distribution of income or principal has been improperly distributed or disbursed from an annuity or other retirement planning instrument of an institutionalized person or the institutionalized person's spouse, a cause of action exists against the individual receiving the improper distribution for the cost of medical assistance services provided or the amount of the improper distribution, whichever is less.

(g) Effective for transactions, including the purchase of an annuity, occurring on or after February 8, 2006, ~~the purchase of an annuity~~ by or on behalf of an ~~individual~~ institutionalized person applying for or receiving long-term care services shall be treated as a disposal of assets for less than fair market value unless it is:

(i) an annuity described in subsection (b) or (q) of section 408 of the Internal Revenue Code of 1986; or

(ii) purchased with proceeds from:

(A) an account or trust described in subsection (a), (c), or (p) of section 408 of the Internal Revenue Code;

(B) a simplified employee pension within the meaning of section 408(k) of the Internal Revenue Code; or

(C) a Roth IRA described in section 408A of the Internal Revenue Code; or

(iii) an annuity that is irrevocable and nonassignable; is actuarially sound as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration; and provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

(h) For purposes of this section, long-term care services include services in a nursing facility, services that are eligible for payment according to section 256B.0625, subdivision 2, because they are provided in a swing bed, intermediate care facility for persons with developmental disabilities, and home and community-based services provided pursuant to sections 256B.0915, 256B.092, and 256B.49. For purposes of this subdivision and subdivisions 2, 3, and 4, "institutionalized person" includes a person who is an inpatient in a nursing facility or in a swing bed, or intermediate care facility for persons with developmental disabilities or who is receiving home and community-based services under sections 256B.0915, 256B.092, and 256B.49.

(i) This section applies to funds used to purchase a promissory note, loan, or mortgage unless the note, loan, or mortgage:

(1) has a repayment term that is actuarially sound;

(2) provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and

(3) prohibits the cancellation of the balance upon the death of the lender.

In the case of a promissory note, loan, or mortgage that does not meet an exception in clauses (1) to (3), the value of such note, loan, or mortgage shall be the outstanding balance due as of the date of the ~~individual's application~~ institutionalized person's request for medical assistance payment of long-term care services.

(j) This section applies to the purchase of a life estate interest in another ~~individual's~~ person's home unless the purchaser resides in the home for a period of at least one year after the date of purchase.

Sec. 24. Minnesota Statutes 2006, section 256B.0595, subdivision 2, is amended to read:

Subd. 2. **Period of ineligibility.** (a) For any uncompensated transfer occurring on or before August 10, 1993, the number of months of ineligibility for long-term care services shall be the lesser of 30 months, or the uncompensated transfer amount divided by the average medical assistance rate for nursing facility services in the state in effect on the date of application. The amount used to calculate the average medical assistance payment rate shall be adjusted each July 1 to reflect payment rates for the previous calendar year. The period of ineligibility begins with the month in which the assets were transferred. If the transfer was not reported to the local agency at the time of application, and the applicant received long-term care services during what would have been the period of ineligibility if the transfer had been reported, a cause of action exists against the transferee for the cost of long-term care services provided during the period of ineligibility, or for the uncompensated amount of the transfer, whichever is less. ~~The action may be brought by the state or the local agency responsible for providing medical assistance under chapter 256G.~~ The uncompensated transfer amount is the fair market value of the asset at the time it was given away, sold, or disposed of, less the amount of compensation received.

(b) For uncompensated transfers made after August 10, 1993, the number of months of ineligibility for long-term care services shall be the total uncompensated value of the resources transferred divided by the average medical assistance rate for nursing facility services in the state in effect on the date of application. The amount used to calculate the average medical assistance payment rate shall be adjusted each July 1 to reflect payment rates for the previous calendar year. The period of ineligibility begins with the first day of the month after the month in which the assets were transferred except that if one or more uncompensated transfers are made during a period of ineligibility, the total assets transferred during the ineligibility period shall be combined and a penalty period calculated to begin on the first day of the month after the month in which the first uncompensated transfer was made. If the transfer was reported to the local agency after the date that advance notice of a period of ineligibility that affects the next month could be provided to the recipient and the recipient received medical assistance services or the transfer was not reported to the local agency, and the applicant or recipient received medical assistance services during what would have been the period of ineligibility if the transfer had been reported, a cause of action exists against the transferee for ~~the cost of medical assistance~~ that portion of long-term care services provided during the period of ineligibility, or for the uncompensated amount of the transfer, whichever is less. ~~The action may be brought by the state or the local agency responsible~~

~~for providing medical assistance under chapter 256G.~~ The uncompensated transfer amount is the fair market value of the asset at the time it was given away, sold, or disposed of, less the amount of compensation received. Effective for transfers made on or after March 1, 1996, involving persons who apply for medical assistance on or after April 13, 1996, no cause of action exists for a transfer unless:

(1) the transferee knew or should have known that the transfer was being made by a person who was a resident of a long-term care facility or was receiving that level of care in the community at the time of the transfer;

(2) the transferee knew or should have known that the transfer was being made to assist the person to qualify for or retain medical assistance eligibility; or

(3) the transferee actively solicited the transfer with intent to assist the person to qualify for or retain eligibility for medical assistance.

(c) For uncompensated transfers made on or after February 8, 2006, the period of ineligibility:

(1) for uncompensated transfers by or on behalf of individuals receiving medical assistance payment of long-term care services, begins ~~on~~ the first day of the month ~~in which~~ following advance notice ~~can be given following~~ of the penalty period, but no later than the first day of the month ~~in which assets have been transferred for less than fair market value,~~ that follows three full calendar months from the date of the report or discovery of the transfer; or

(2) for uncompensated transfers by individuals requesting medical assistance payment of long-term care services, begins the date on which the individual is eligible for medical assistance under the Medicaid state plan and would otherwise be receiving long-term care services based on an approved application for such care but for the application of the penalty period~~, whichever is later,~~; and ~~which does not occur~~

(3) cannot begin during any other period of ineligibility.

(d) If a calculation of a penalty period results in a partial month, payments for long-term care services shall be reduced in an amount equal to the fraction.

(e) In the case of multiple fractional transfers of assets in more than one month for less than fair market value on or after February 8, 2006, the period of ineligibility is calculated by treating the total, cumulative, uncompensated value of all assets transferred during all months on or after February 8, 2006, as one transfer.

Sec. 25. Minnesota Statutes 2006, section 256B.0595, subdivision 3, is amended to read:

Subd. 3. **Homestead exception to transfer prohibition.** (a) An institutionalized person is not ineligible for long-term care services due to a transfer of assets for less than fair market value if the asset transferred was a homestead and:

(1) title to the homestead was transferred to the individual's:

(i) spouse;

(ii) child who is under age 21;

(iii) blind or permanently and totally disabled child as defined in the supplemental security income program;

(iv) sibling who has equity interest in the home and who was residing in the home for a period of at least one year immediately before the date of the individual's admission to the facility; or

(v) son or daughter who was residing in the individual's home for a period of at least two years immediately before the date ~~of the individual's admission to the facility~~ the individual became an institutionalized person, and who provided care to the individual that, as certified by the individual's attending physician, permitted the individual to reside at home rather than receive care in an institution or facility;

(2) a satisfactory showing is made that the individual intended to dispose of the homestead at fair market value or for other valuable consideration; or

(3) the local agency grants a waiver of a penalty resulting from a transfer for less than fair market value because denial of eligibility would cause undue hardship for the individual, based on imminent threat to the individual's health and well-being. Whenever an applicant or recipient is denied eligibility because of a transfer for less than fair market value, the local agency shall notify the applicant or recipient that the applicant or recipient may request a waiver of the penalty if the denial of eligibility will cause undue hardship. With the written consent of the individual or the personal representative of the individual, a long-term care facility in which an individual is residing may file an undue hardship waiver request, on behalf of the individual who is denied eligibility for long-term care services on or after July 1, 2006, due to a period of ineligibility resulting from a transfer on or after February 8, 2006. In evaluating a waiver, the local agency shall take into account whether the individual was the victim of financial exploitation, whether the individual has made reasonable efforts to recover the transferred property or resource, and other factors relevant to a determination of hardship. If the local agency does not approve a hardship waiver, the local agency shall issue a written notice to the individual stating the reasons for the denial and the process for appealing the local agency's decision.

(b) When a waiver is granted under paragraph (a), clause (3), a cause of action exists against the person to whom the homestead was transferred for that portion of long-term care services ~~granted~~ provided within:

(1) 30 months of a transfer made on or before August 10, 1993;

(2) 60 months if the homestead was transferred after August 10, 1993, to a trust or portion of a trust that is considered a transfer of assets under federal law;

(3) 36 months if transferred in any other manner after August 10, 1993, but prior to February 8, 2006; or

(4) 60 months if the homestead was transferred on or after February 8, 2006,

or the amount of the uncompensated transfer, whichever is less, together with the costs incurred due to the action. ~~The action shall be brought by the state unless the state delegates this responsibility to the local agency responsible for providing medical assistance under chapter 256G.~~

Sec. 26. Minnesota Statutes 2006, section 256B.0595, subdivision 4, is amended to read:

Subd. 4. **Other exceptions to transfer prohibition.** An institutionalized person who has made, or whose spouse has made a transfer prohibited by subdivision 1, is not ineligible for long-term care services if one of the following conditions applies:

(1) the assets were transferred to the individual's spouse or to another for the sole benefit of the spouse; or

(2) the institutionalized spouse, prior to being institutionalized, transferred assets to a spouse, provided that the spouse to whom the assets were transferred does not then transfer those assets to another person for less than fair market value. (At the time when one spouse is institutionalized, assets must be allocated between the spouses as provided under section 256B.059); or

(3) the assets were transferred to the individual's child who is blind or permanently and totally disabled as determined in the supplemental security income program; or

(4) a satisfactory showing is made that the individual intended to dispose of the assets either at fair market value or for other valuable consideration; or

(5) the local agency determines that denial of eligibility for long-term care services would work an undue hardship and grants a waiver of a penalty resulting from a transfer for less than fair market value based on an imminent threat to the individual's health and well-being. Whenever an applicant or recipient is denied eligibility because of a transfer for less than fair market value, the local agency shall notify the applicant or recipient that the applicant or recipient may request a waiver of the penalty if the denial of eligibility will cause undue hardship. With the written consent of the individual or the personal representative of the individual, a long-term care facility in which an individual is residing may file an undue hardship waiver request, on behalf of the individual who is denied eligibility for long-term care services on or after July 1, 2006, due to a period of ineligibility resulting from a transfer on or after February 8, 2006. In evaluating a waiver, the local agency shall take into account whether the individual was the victim of financial exploitation, whether the individual has made reasonable efforts to recover the transferred property or resource, whether the individual has taken any action to prevent the designation of the department as a remainder beneficiary on an annuity as described in section 256B.056, subdivision 11, and other factors relevant to a determination of hardship. The local agency shall make a determination within 30 days of the receipt of all necessary information needed to make such a determination. If the local agency does not approve a hardship waiver, the local agency shall issue a written notice to the individual stating the reasons for the denial and the process for appealing the local agency's decision. When a waiver is granted, a cause of action exists against the person to whom the assets were transferred for that portion of long-term care services ~~granted~~ provided within:

(i) 30 months of a transfer made on or before August 10, 1993;

(ii) 60 months of a transfer if the assets were transferred after August 30, 1993, to a trust or portion of a trust that is considered a transfer of assets under federal law;

(iii) 36 months of a transfer if transferred in any other manner after August 10, 1993, but prior to February 8, 2006; or

(iv) 60 months of any transfer made on or after February 8, 2006,

or the amount of the uncompensated transfer, whichever is less, together with the costs incurred due to the action~~. The action shall be brought by the state unless the state delegates this responsibility~~

~~to the local agency responsible for providing medical assistance under this chapter;~~ or

(6) for transfers occurring after August 10, 1993, the assets were transferred by the person or person's spouse: (i) into a trust established for the sole benefit of a son or daughter of any age who is blind or disabled as defined by the Supplemental Security Income program; or (ii) into a trust established for the sole benefit of an individual who is under 65 years of age who is disabled as defined by the Supplemental Security Income program.

"For the sole benefit of" has the meaning found in section 256B.059, subdivision 1.

Sec. 27. Minnesota Statutes 2006, section 256B.0595, is amended by adding a subdivision to read:

Subd. 8. **Cause of action; transfer prior to death.** (a) A cause of action exists against a transferee who receives assets for less than fair market value, either:

(1) from a person who was a recipient of medical assistance and who made an uncompensated transfer that was known to the county agency but a penalty period could not be implemented under this section due to the death of the person; or

(2) from a person who was a recipient of medical assistance who made an uncompensated transfer that was not known to the county agency and the transfer was made with the intent to hinder, delay, or defraud the state or local agency from recovering as allowed under section 256B.15. In determining intent under this clause consideration may be given, among other factors, to whether:

(i) the transfer was to a family member;

(ii) the transferor retained possession or control of the property after the transfer;

(iii) the transfer was concealed;

(iv) the transfer included the majority of the transferor's assets;

(v) the value of the consideration received was not reasonably equivalent to the fair market value of the property; and

(vi) the transfer occurred shortly before the death of the transferor.

(b) No cause of action exists under this subdivision unless:

(1) the transferee knew or should have known that the transfer was being made by a person who was receiving medical assistance as described in section 256B.15, subdivision 1, paragraph (b); and

(2) the transferee received the asset without providing a reasonable equivalent fair market value in exchange for the transfer.

(c) The cause of action is for the uncompensated amount of the transfer or the amount of medical assistance paid on behalf of the person, whichever is less. The uncompensated transfer amount is the fair market value of the asset at the time it was given away, sold, or disposed of, less the amount of the compensation received.

Sec. 28. Minnesota Statutes 2006, section 256B.0595, is amended by adding a subdivision to read:

Subd. 9. **Filing cause of action; limitation.** (a) The county of financial responsibility under chapter 256G may bring a cause of action under any or all of the following:

(1) subdivision 1, paragraph (f);

(2) subdivision 2, paragraphs (a) and (b);

(3) subdivision 3, paragraph (b);

(4) subdivision 4, clause (5); and

(5) subdivision 8

on behalf of the claimant who must be the commissioner.

(b) Notwithstanding any other law to the contrary, a cause of action under subdivision 2, paragraph (a) or (b), or 8, must be commenced within six years of the date the local agency determines that a transfer was made for less than fair market value. Notwithstanding any other law to the contrary, a cause of action under subdivision 3, paragraph (b), or 4, clause (5), must be commenced within six years of the date of approval of a waiver of the penalty period for a transfer for less than fair market value based on undue hardship.

Sec. 29. Minnesota Statutes 2006, section 256B.0625, subdivision 3c, is amended to read:

Subd. 3c. **Health Services Policy Committee.** The commissioner, after receiving recommendations from professional physician associations, professional associations representing licensed nonphysician health care professionals, and consumer groups, shall establish a 13-member Health Services Policy Committee, which consists of 12 voting members and one nonvoting member. The Health Services Policy Committee shall advise the commissioner regarding health services pertaining to the administration of health care benefits covered under the medical assistance, general assistance medical care, and MinnesotaCare programs. The Health Services Policy Committee shall meet at least quarterly. The Health Services Policy Committee shall annually elect a physician chair from among its members, who shall work directly with the commissioner's medical director, to establish the agenda for each meeting. The Health Services Policy Committee shall also recommend criteria for verifying centers of excellence for specific aspects of medical care where a specific set of combined services, a volume of patients necessary to maintain a high level of competency, or a specific level of technical capacity is associated with improved health outcomes.

Sec. 30. Minnesota Statutes 2006, section 256B.0625, subdivision 13g, is amended to read:

Subd. 13g. **Preferred drug list.** (a) The commissioner shall adopt and implement a preferred drug list by January 1, 2004. The commissioner may enter into a contract with a vendor ~~or one or more states~~ for the purpose of participating in a ~~multistate~~ preferred drug list and supplemental rebate program. The commissioner shall ensure that any contract meets all federal requirements and maximizes federal financial participation. The commissioner shall publish the preferred drug list annually in the State Register and shall maintain an accurate and up-to-date list on the agency Web site.

(b) The commissioner may add to, delete from, and otherwise modify the preferred drug list, after consulting with the Formulary Committee and appropriate medical specialists and providing

public notice and the opportunity for public comment.

(c) The commissioner shall adopt and administer the preferred drug list as part of the administration of the supplemental drug rebate program. Reimbursement for prescription drugs not on the preferred drug list may be subject to prior authorization, unless the drug manufacturer signs a supplemental rebate contract.

(d) For purposes of this subdivision, "preferred drug list" means a list of prescription drugs within designated therapeutic classes selected by the commissioner, for which prior authorization based on the identity of the drug or class is not required.

(e) The commissioner shall seek any federal waivers or approvals necessary to implement this subdivision.

Sec. 31. Minnesota Statutes 2006, section 256B.0625, subdivision 13h, is amended to read:

Subd. 13h. **Medication therapy management services.** (a) Medical assistance and general assistance medical care cover medication therapy management services for a recipient taking four or more prescriptions to treat or prevent two or more chronic medical conditions, or a recipient with a drug therapy problem that is identified or prior authorized by the commissioner that has resulted or is likely to result in significant nondrug program costs. The commissioner may cover medical therapy management services under MinnesotaCare if the commissioner determines this is cost-effective. For purposes of this subdivision, "medication therapy management" means the provision of the following pharmaceutical care services by a licensed pharmacist to optimize the therapeutic outcomes of the patient's medications:

(1) performing or obtaining necessary assessments of the patient's health status;

(2) formulating a medication treatment plan;

(3) monitoring and evaluating the patient's response to therapy, including safety and effectiveness;

(4) performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events;

(5) documenting the care delivered and communicating essential information to the patient's other primary care providers;

(6) providing verbal education and training designed to enhance patient understanding and appropriate use of the patient's medications;

(7) providing information, support services, and resources designed to enhance patient adherence with the patient's therapeutic regimens; and

(8) coordinating and integrating medication therapy management services within the broader health care management services being provided to the patient.

Nothing in this subdivision shall be construed to expand or modify the scope of practice of the pharmacist as defined in section 151.01, subdivision 27.

(b) To be eligible for reimbursement for services under this subdivision, a pharmacist must meet

the following requirements:

(1) have a valid license issued under chapter 151;

(2) have graduated from an accredited college of pharmacy on or after May 1996, or completed a structured and comprehensive education program approved by the Board of Pharmacy and the American Council of Pharmaceutical Education for the provision and documentation of pharmaceutical care management services that has both clinical and didactic elements;

(3) be practicing in an ambulatory care setting as part of a multidisciplinary team or have developed a structured patient care process that is offered in a private or semiprivate patient care area that is separate from the commercial business that also occurs in the setting, or in home settings, excluding long-term care and group homes, if the service is ordered by the provider-directed care coordination team; and

(4) make use of an electronic patient record system that meets state standards.

(c) For purposes of reimbursement for medication therapy management services, the commissioner may enroll individual pharmacists as medical assistance and general assistance medical care providers. The commissioner may also establish contact requirements between the pharmacist and recipient, including limiting the number of reimbursable consultations per recipient.

(d) The commissioner, after receiving recommendations from professional medical associations, professional pharmacy associations, and consumer groups, shall convene an 11-member Medication Therapy Management Advisory Committee to advise the commissioner on the implementation and administration of medication therapy management services. The committee shall be comprised of: two licensed physicians; two licensed pharmacists; two consumer representatives; two health plan company representatives; and three members with expertise in the area of medication therapy management, who may be licensed physicians or licensed pharmacists. The committee is governed by section 15.059, except that committee members do not receive compensation or reimbursement for expenses. The advisory committee expires on June 30, 2007.

(e) The commissioner shall evaluate the effect of medication therapy management on quality of care, patient outcomes, and program costs, and shall include a description of any savings generated in the medical assistance and general assistance medical care programs that can be attributable to this coverage. The evaluation shall be submitted to the legislature by December 15, 2007. The commissioner may contract with a vendor or an academic institution that has expertise in evaluating health care outcomes for the purpose of completing the evaluation.

Sec. 32. Minnesota Statutes 2007 Supplement, section 256B.0625, subdivision 49, is amended to read:

Subd. 49. **Community health worker.** (a) Medical assistance covers the care coordination and patient education services provided by a community health worker if the community health worker has:

(1) received a certificate from the Minnesota State Colleges and Universities System approved community health worker curriculum; or

(2) at least five years of supervised experience with an enrolled physician, registered nurse, ~~or~~ advanced practice registered nurse, or dentist, or at least five years of supervised experience by a

certified public health nurse operating under the direct authority of an enrolled unit of government.

Community health workers eligible for payment under clause (2) must complete the certification program by January 1, 2010, to continue to be eligible for payment.

(b) Community health workers must work under the supervision of a medical assistance enrolled physician, registered nurse, ~~or~~ advanced practice registered nurse, or dentist, or work under the supervision of a certified public health nurse operating under the direct authority of an enrolled unit of government.

(c) Care coordination and patient education services covered under this subdivision include, but are not limited to, services relating to oral health and dental care.

Sec. 33. Minnesota Statutes 2006, section 256B.075, subdivision 2, is amended to read:

Subd. 2. **Fee-for-service.** (a) The commissioner shall develop and implement a disease management program for medical assistance and general assistance medical care recipients who are not enrolled in the prepaid medical assistance or prepaid general assistance medical care programs and who are receiving services on a fee-for-service basis. The commissioner may contract with an outside organization to provide these services.

(b) The commissioner shall seek any federal approval necessary to implement this section and to obtain federal matching funds.

(c) The commissioner shall develop and implement a pilot intensive care management program for medical assistance 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~~.

Sec. 34. Minnesota Statutes 2006, section 256B.15, subdivision 4, is amended to read:

Subd. 4. **Other survivors.** (a) If the decedent who was single or the surviving spouse of a married couple is survived by one of the following persons, a claim exists against the estate payable first from the value of the nonhomestead property included in the estate and the personal representative shall make, execute, and deliver to the county agency a lien against the homestead property in the estate for any unpaid balance of the claim to the claimant as provided under this section:

~~(a)~~ (1) a sibling who resided in the decedent medical assistance recipient's home at least one year before the decedent's institutionalization and continuously since the date of institutionalization; or

~~(b)~~ (2) a son or daughter or a grandchild who resided in the decedent medical assistance recipient's home for at least two years immediately before the parent's or grandparent's institutionalization and continuously since the date of institutionalization, and who establishes by a preponderance of the evidence having provided care to the parent or grandparent who received medical assistance, that the care was provided before institutionalization, and that the care permitted the parent or grandparent to reside at home rather than in an institution.

(b) For purposes of this subdivision, "institutionalization" means receiving care:

(1) in a nursing facility or swing bed, or intermediate care facility for persons with developmental disabilities; or

(2) through home and community-based services under section 256B.0915, 256B.092, or

256B.49.

Sec. 35. Minnesota Statutes 2006, section 256B.69, subdivision 3a, is amended to read:

Subd. 3a. **County authority.** (a) The commissioner, when implementing the general assistance medical care, or medical assistance prepayment program within a county, must include the county board in the process of development, approval, and issuance of the request for proposals to provide services to eligible individuals within the proposed county. County boards must be given reasonable opportunity to make recommendations regarding the development, issuance, review of responses, and changes needed in the request for proposals. The commissioner must provide county boards the opportunity to review each proposal based on the identification of community needs under chapters 145A and 256E and county advocacy activities. If a county board finds that a proposal does not address certain community needs, the county board and commissioner shall continue efforts for improving the proposal and network prior to the approval of the contract. The county board shall make recommendations regarding the approval of local networks and their operations to ensure adequate availability and access to covered services. The provider or health plan must respond directly to county advocates and the state prepaid medical assistance ombudsperson regarding service delivery and must be accountable to the state regarding contracts with medical assistance and general assistance medical care funds. The county board may recommend a maximum number of participating health plans after considering the size of the enrolling population; ensuring adequate access and capacity; considering the client and county administrative complexity; and considering the need to promote the viability of locally developed health plans. The county board or a single entity representing a group of county boards and the commissioner shall mutually select health plans for participation at the time of initial implementation of the prepaid medical assistance program in that county or group of counties and at the time of contract renewal. The commissioner shall also seek input for contract requirements from the county or single entity representing a group of county boards at each contract renewal and incorporate those recommendations into the contract negotiation process. ~~The commissioner, in conjunction with the county board, shall actively seek to develop a mutually agreeable timetable prior to the development of the request for proposal, but counties must agree to initial enrollment beginning on or before January 1, 1999, in either the prepaid medical assistance and general assistance medical care programs or county-based purchasing under section 256B.692. At least 90 days before enrollment in the medical assistance and general assistance medical care prepaid programs begins in a county in which the prepaid programs have not been established, the commissioner shall provide a report to the chairs of senate and house committees having jurisdiction over state health care programs which verifies that the commissioner complied with the requirements for county involvement that are specified in this subdivision.~~

(b) At the option of the county board, the board may develop contract requirements related to the achievement of local public health goals to meet the health needs of medical assistance and general assistance medical care enrollees. These requirements must be reasonably related to the performance of health plan functions and within the scope of the medical assistance and general assistance medical care benefit sets. If the county board and the commissioner mutually agree to such requirements, the department shall include such requirements in all health plan contracts governing the prepaid medical assistance and general assistance medical care programs in that county at initial implementation of the program in that county and at the time of contract renewal. The county board may participate in the enforcement of the contract provisions related to local public health goals.

(c) For counties in which prepaid medical assistance and general assistance medical care programs have not been established, the commissioner shall not implement those programs if a county board submits acceptable and timely preliminary and final proposals under section 256B.692, until county-based purchasing is no longer operational in that county. For counties in which prepaid medical assistance and general assistance medical care programs are in existence on or after September 1, 1997, the commissioner must terminate contracts with health plans according to section 256B.692, subdivision 5, if the county board submits and the commissioner accepts preliminary and final proposals according to that subdivision. The commissioner is not required to terminate contracts that begin on or after September 1, 1997, according to section 256B.692 until two years have elapsed from the date of initial enrollment.

(d) In the event that a county board or a single entity representing a group of county boards and the commissioner cannot reach agreement regarding: (i) the selection of participating health plans in that county; (ii) contract requirements; or (iii) implementation and enforcement of county requirements including provisions regarding local public health goals, the commissioner shall resolve all disputes after taking into account the recommendations of a three-person mediation panel. The panel shall be composed of one designee of the president of the association of Minnesota counties, one designee of the commissioner of human services, and one ~~designee of the commissioner of health~~ person selected jointly by the designee of the commissioner of human services and the designee of the Association of Minnesota Counties. Within a reasonable period of time before the hearing, the panelists must be provided all documents and information relevant to the mediation. The parties to the mediation must be given 30 days' notice of a hearing before the mediation panel.

(e) If a county which elects to implement county-based purchasing ceases to implement county-based purchasing, it is prohibited from assuming the responsibility of county-based purchasing for a period of five years from the date it discontinues purchasing.

~~(f) Notwithstanding the requirement in this subdivision that a county must agree to initial enrollment on or before January 1, 1999, the commissioner shall grant a delay in the implementation of the county-based purchasing authorized in section 256B.692 until federal waiver authority and approval has been granted, if the county or group of counties has submitted a preliminary proposal for county-based purchasing by September 1, 1997, has not already implemented the prepaid medical assistance program before January 1, 1998, and has submitted a written request for the delay to the commissioner by July 1, 1998. In order for the delay to be continued, the county or group of counties must also submit to the commissioner the following information by December 1, 1998. The information must:~~

~~(1) identify the proposed date of implementation, as determined under section 256B.692, subdivision 5;~~

~~(2) include copies of the county board resolutions which demonstrate the continued commitment to the implementation of county-based purchasing by the proposed date. County board authorization may remain contingent on the submission of a final proposal which meets the requirements of section 256B.692, subdivision 5, paragraph (b);~~

~~(3) demonstrate actions taken for the establishment of a governance structure between the participating counties and describe how the fiduciary responsibilities of county-based purchasing will be allocated between the counties, if more than one county is involved in the proposal;~~

~~(4) describe how the risk of a deficit will be managed in the event expenditures are greater than total capitation payments. This description must identify how any of the following strategies will be used:~~

~~(i) risk contracts with licensed health plans;~~

~~(ii) risk arrangements with providers who are not licensed health plans;~~

~~(iii) risk arrangements with other licensed insurance entities; and~~

~~(iv) funding from other county resources;~~

~~(5) include, if county-based purchasing will not contract with licensed health plans or provider networks, letters of interest from local providers in at least the categories of hospital, physician, mental health, and pharmacy which express interest in contracting for services. These letters must recognize any risk transfer identified in clause (4), item (ii); and~~

~~(6) describe the options being considered to obtain the administrative services required in section 256B.692, subdivision 3, clauses (3) and (5).~~

~~(g) For counties which receive a delay under this subdivision, the final proposals required under section 256B.692, subdivision 5, paragraph (b), must be submitted at least six months prior to the requested implementation date. Authority to implement county-based purchasing remains contingent on approval of the final proposal as required under section 256B.692.~~

~~(h) If the commissioner is unable to provide county-specific, individual-level fee-for-service claims to counties by June 4, 1998, the commissioner shall grant a delay under paragraph (f) of up to 12 months in the implementation of county-based purchasing, and shall require implementation not later than January 1, 2000. In order to receive an extension of the proposed date of implementation under this paragraph, a county or group of counties must submit a written request for the extension to the commissioner by August 1, 1998, must submit the information required under paragraph (f) by December 1, 1998, and must submit a final proposal as provided under paragraph (g).~~

~~(i) Notwithstanding other requirements of this subdivision, the commissioner shall not require the implementation of the county-based purchasing authorized in section 256B.692 until six months after federal waiver approval has been obtained for county-based purchasing, if the county or counties have submitted the final plan as required in section 256B.692, subdivision 5. The commissioner shall allow the county or counties which submitted information under section 256B.692, subdivision 5, to submit supplemental or additional information which was not possible to submit by April 1, 1999. A county or counties shall continue to submit the required information and substantive detail necessary to obtain a prompt response and waiver approval. If amendments to the final plan are necessary due to the terms and conditions of the waiver approval, the commissioner shall allow the county or group of counties 60 days to make the necessary amendments to the final plan and shall not require implementation of the county-based purchasing until six months after the revised final plan has been submitted.~~

(f) The commissioner shall not require that contractual disputes between county-based purchasing entities and the commissioner be mediated by a panel that includes a representative of the Minnesota Council of Health Plans.

(g) At the request of a county-purchasing entity, the commissioner shall adopt a contract

reprocurement or renewal schedule under which all counties included in the entity's service area are reprocured or renewed at the same time.

(h) The commissioner shall provide a written report under section 3.195 to the chairs of the legislative committees having jurisdiction over human services in the senate and the house of representatives describing in detail the activities undertaken by the commissioner to ensure full compliance with this section. The report must also provide an explanation for any decisions of the commissioner not to accept the recommendations of a county or group of counties required to be consulted under this section. The report must be provided at least 30 days prior to the effective date of a new or renewed prepaid or managed care contract in a county.

Sec. 36. Minnesota Statutes 2006, section 256B.69, subdivision 6, is amended to read:

Subd. 6. **Service delivery.** (a) Each demonstration provider shall be responsible for the health care coordination for eligible individuals. Demonstration providers:

(1) shall authorize and arrange for the provision of all needed health services including but not limited to the full range of services listed in sections 256B.02, subdivision 8, and 256B.0625 in order to ensure appropriate health care is delivered to enrollees; notwithstanding section 256B.0621, demonstration providers that provide nursing home and community-based services under this section shall provide relocation service coordination to enrolled persons age 65 and over;

(2) shall accept the prospective, per capita payment from the commissioner in return for the provision of comprehensive and coordinated health care services for eligible individuals enrolled in the program;

(3) may contract with other health care and social service practitioners to provide services to enrollees; and

(4) shall institute recipient grievance procedures according to the method established by the project, utilizing applicable requirements of chapter 62D. Disputes not resolved through this process shall be appealable to the commissioner as provided in subdivision 11.

(b) Demonstration providers must comply with the standards for claims settlement under section 72A.201, subdivisions 4, 5, 7, and 8, when contracting with other health care and social service practitioners to provide services to enrollees. A demonstration provider must pay a clean claim, as defined in Code of Federal Regulations, title 42, section 447.45(b), within 30 business days of the date of acceptance of the claim.

Sec. 37. Minnesota Statutes 2006, section 256B.69, subdivision 27, is amended to read:

Subd. 27. **Information for persons with limited English-language proficiency.** Managed care contracts entered into under this section and sections 256D.03, subdivision 4, paragraph (c), and 256L.12 must require demonstration providers to ~~inform enrollees that upon request the enrollee can obtain a certificate of coverage in the following languages: Spanish, Hmong, Laotian, Russian, Somali, Vietnamese, or Cambodian. Upon request, the demonstration provider must provide the enrollee with a certificate of coverage in the specified language of preference~~ provide language assistance to enrollees that ensures meaningful access to its programs and services according to Title VI of the Civil Rights Act and federal regulations adopted under that law or any guidance from the United States Department of Health and Human Services.

Sec. 38. Minnesota Statutes 2006, section 256B.69, subdivision 28, is amended to read:

Subd. 28. **Medicare special needs plans; medical assistance basic health care.** (a) The commissioner may contract with qualified Medicare-approved special needs plans to provide medical assistance basic health care services to persons with disabilities, including those with developmental disabilities. Basic health care services include:

(1) those services covered by the medical assistance state plan except for ICF/MR services, home and community-based waiver services, case management for persons with developmental disabilities under section 256B.0625, subdivision 20a, and personal care and certain home care services defined by the commissioner in consultation with the stakeholder group established under paragraph (d); and

(2) basic health care services may also include risk for up to 100 days of nursing facility services for persons who reside in a noninstitutional setting and home health services related to rehabilitation as defined by the commissioner after consultation with the stakeholder group.

The commissioner may exclude other medical assistance services from the basic health care benefit set. Enrollees in these plans can access any excluded services on the same basis as other medical assistance recipients who have not enrolled.

Unless a person is otherwise required to enroll in managed care, enrollment in these plans for Medicaid services must be voluntary. For purposes of this subdivision, automatic enrollment with an option to opt out is not voluntary enrollment.

(b) Beginning January 1, 2007, the commissioner may contract with qualified Medicare special needs plans to provide basic health care services under medical assistance to persons who are dually eligible for both Medicare and Medicaid and those Social Security beneficiaries eligible for Medicaid but in the waiting period for Medicare. The commissioner shall consult with the stakeholder group under paragraph (d) in developing program specifications for these services. The commissioner shall report to the chairs of the house and senate committees with jurisdiction over health and human services policy and finance by February 1, 2007, on implementation of these programs and the need for increased funding for the ombudsman for managed care and other consumer assistance and protections needed due to enrollment in managed care of persons with disabilities. Payment for Medicaid services provided under this subdivision for the months of May and June will be made no earlier than July 1 of the same calendar year.

(c) Beginning January 1, 2008, the commissioner may expand contracting under this subdivision to all persons with disabilities not otherwise required to enroll in managed care.

(d) The commissioner shall establish a state-level stakeholder group to provide advice on managed care programs for persons with disabilities, including both MnDHO and contracts with special needs plans that provide basic health care services as described in paragraphs (a) and (b). The stakeholder group shall provide advice on program expansions under this subdivision and subdivision 23, including:

(1) implementation efforts;

(2) consumer protections; and

(3) program specifications such as quality assurance measures, data collection and reporting,

and evaluation of costs, quality, and results.

(e) Each plan under contract to provide medical assistance basic health care services shall establish a local or regional stakeholder group, including representatives of the counties covered by the plan, members, consumer advocates, and providers, for advice on issues that arise in the local or regional area.

(f) The commissioner is prohibited from providing the names of potential enrollees to health plans for marketing purposes. The commissioner may mail marketing materials to potential enrollees on behalf of health plans, in which case the health plans shall cover any costs incurred by the commissioner for mailing marketing materials.

Sec. 39. Minnesota Statutes 2006, section 256B.692, subdivision 7, is amended to read:

Subd. 7. **Dispute resolution.** In the event the commissioner rejects a proposal under subdivision 6, the county board may request the recommendation of a three-person mediation panel. The commissioner shall resolve all disputes after taking into account the recommendations of the mediation panel. The panel shall be composed of one designee of the president of the Association of Minnesota Counties, one designee of the commissioner of human services, and one ~~designee of the commissioner of health~~ person selected jointly by the designee of the commissioner of human services and the designee of the Association of Minnesota Counties. Within a reasonable period of time before the hearing, the panelists must be provided all documents and information relevant to the mediation. The parties to the mediation must be given 30 days' notice of a hearing before the mediation panel.

Sec. 40. Minnesota Statutes 2007 Supplement, section 256D.03, subdivision 3, is amended to read:

Subd. 3. **General assistance medical care; eligibility.** (a) General assistance medical care may be paid for any person who is not eligible for medical assistance under chapter 256B, including eligibility for medical assistance based on a spenddown of excess income according to section 256B.056, subdivision 5, or MinnesotaCare as defined in paragraph (b), except as provided in paragraph (c), and:

(1) who is receiving assistance under section 256D.05, except for families with children who are eligible under Minnesota family investment program (MFIP), or who is having a payment made on the person's behalf under sections 256I.01 to 256I.06; or

(2) who is a resident of Minnesota; and

(i) who has gross countable income not in excess of 75 percent of the federal poverty guidelines for the family size, using a six-month budget period and whose equity in assets is not in excess of $1,000 per assistance unit. General assistance medical care is not available for applicants or enrollees who are otherwise eligible for medical assistance but fail to verify their assets. Enrollees who become eligible for medical assistance shall be terminated and transferred to medical assistance. Exempt assets, the reduction of excess assets, and the waiver of excess assets must conform to the medical assistance program in section 256B.056, subdivision 3, with the following exception: the maximum amount of undistributed funds in a trust that could be distributed to or on behalf of the beneficiary by the trustee, assuming the full exercise of the trustee's discretion under the terms of the trust, must be applied toward the asset maximum;

(ii) who has gross countable income above 75 percent of the federal poverty guidelines but not in excess of 175 percent of the federal poverty guidelines for the family size, using a six-month budget period, whose equity in assets is not in excess of the limits in section 256B.056, subdivision 3c, and who applies during an inpatient hospitalization; or

(iii) the commissioner shall adjust the income standards under this section each July 1 by the annual update of the federal poverty guidelines following publication by the United States Department of Health and Human Services.

(b) Effective for applications and renewals processed on or after September 1, 2006, general assistance medical care may not be paid for applicants or recipients who are adults with dependent children under 21 whose gross family income is equal to or less than 275 percent of the federal poverty guidelines who are not described in paragraph (e).

(c) Effective for applications and renewals processed on or after September 1, 2006, general assistance medical care may be paid for applicants and recipients who meet all eligibility requirements of paragraph (a), clause (2), item (i), for a temporary period beginning the date of application. Immediately following approval of general assistance medical care, enrollees shall be enrolled in MinnesotaCare under section 256L.04, subdivision 7, with covered services as provided in section 256L.03 for the rest of the six-month general assistance medical care eligibility period, until their six-month renewal.

(d) To be eligible for general assistance medical care following enrollment in MinnesotaCare as required by paragraph (c), an individual must complete a new application.

(e) Applicants and recipients eligible under paragraph (a), clause (1)~~; who~~, are exempt from the MinnesotaCare enrollment requirements in this subdivision if they:

(1) have applied for and are awaiting a determination of blindness or disability by the state medical review team or a determination of eligibility for Supplemental Security Income or Social Security Disability Insurance by the Social Security Administration; ~~who~~

(2) fail to meet the requirements of section 256L.09, subdivision 2; ~~who~~

(3) are homeless as defined by United States Code, title 42, section 11301, et seq.; ~~who~~

(4) are classified as end-stage renal disease beneficiaries in the Medicare program; ~~who~~

(5) are enrolled in private health care coverage as defined in section 256B.02, subdivision 9; ~~who~~

(6) are eligible under paragraph (j); ~~or who~~

(7) receive treatment funded pursuant to section 254B.02 ~~are exempt from the MinnesotaCare enrollment requirements of this subdivision~~; or

(8) reside in the Minnesota sex offender program defined in chapter 246B.

(f) For applications received on or after October 1, 2003, eligibility may begin no earlier than the date of application. For individuals eligible under paragraph (a), clause (2), item (i), a redetermination of eligibility must occur every 12 months. Individuals are eligible under paragraph (a), clause (2), item (ii), only during inpatient hospitalization but may reapply if there is

a subsequent period of inpatient hospitalization.

(g) Beginning September 1, 2006, Minnesota health care program applications and renewals completed by recipients and applicants who are persons described in paragraph (c) and submitted to the county agency shall be determined for MinnesotaCare eligibility by the county agency. If all other eligibility requirements of this subdivision are met, eligibility for general assistance medical care shall be available in any month during which MinnesotaCare enrollment is pending. Upon notification of eligibility for MinnesotaCare, notice of termination for eligibility for general assistance medical care shall be sent to an applicant or recipient. If all other eligibility requirements of this subdivision are met, eligibility for general assistance medical care shall be available until enrollment in MinnesotaCare subject to the provisions of paragraphs (c), (e), and (f).

(h) The date of an initial Minnesota health care program application necessary to begin a determination of eligibility shall be the date the applicant has provided a name, address, and Social Security number, signed and dated, to the county agency or the Department of Human Services. If the applicant is unable to provide a name, address, Social Security number, and signature when health care is delivered due to a medical condition or disability, a health care provider may act on an applicant's behalf to establish the date of an initial Minnesota health care program application by providing the county agency or Department of Human Services with provider identification and a temporary unique identifier for the applicant. The applicant must complete the remainder of the application and provide necessary verification before eligibility can be determined. The county agency must assist the applicant in obtaining verification if necessary.

(i) County agencies are authorized to use all automated databases containing information regarding recipients' or applicants' income in order to determine eligibility for general assistance medical care or MinnesotaCare. Such use shall be considered sufficient in order to determine eligibility and premium payments by the county agency.

(j) General assistance medical care is not available for a person in a correctional facility unless the person is detained by law for less than one year in a county correctional or detention facility as a person accused or convicted of a crime, or admitted as an inpatient to a hospital on a criminal hold order, and the person is a recipient of general assistance medical care at the time the person is detained by law or admitted on a criminal hold order and as long as the person continues to meet other eligibility requirements of this subdivision.

(k) General assistance medical care is not available for applicants or recipients who do not cooperate with the county agency to meet the requirements of medical assistance.

(l) In determining the amount of assets of an individual eligible under paragraph (a), clause (2), item (i), there shall be included any asset or interest in an asset, including an asset excluded under paragraph (a), that was given away, sold, or disposed of for less than fair market value within the 60 months preceding application for general assistance medical care or during the period of eligibility. Any transfer described in this paragraph shall be presumed to have been for the purpose of establishing eligibility for general assistance medical care, unless the individual furnishes convincing evidence to establish that the transaction was exclusively for another purpose. For purposes of this paragraph, the value of the asset or interest shall be the fair market value at the time it was given away, sold, or disposed of, less the amount of compensation received. For any uncompensated transfer, the number of months of ineligibility, including partial months, shall be calculated by dividing the uncompensated transfer amount by the average monthly per person

payment made by the medical assistance program to skilled nursing facilities for the previous calendar year. The individual shall remain ineligible until this fixed period has expired. The period of ineligibility may exceed 30 months, and a reapplication for benefits after 30 months from the date of the transfer shall not result in eligibility unless and until the period of ineligibility has expired. The period of ineligibility begins in the month the transfer was reported to the county agency, or if the transfer was not reported, the month in which the county agency discovered the transfer, whichever comes first. For applicants, the period of ineligibility begins on the date of the first approved application.

(m) When determining eligibility for any state benefits under this subdivision, the income and resources of all noncitizens shall be deemed to include their sponsor's income and resources as defined in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, title IV, Public Law 104-193, sections 421 and 422, and subsequently set out in federal rules.

(n) Undocumented noncitizens and nonimmigrants are ineligible for general assistance medical care. For purposes of this subdivision, a nonimmigrant is an individual in one or more of the classes listed in United States Code, title 8, section 1101(a)(15), and an undocumented noncitizen is an individual who resides in the United States without the approval or acquiescence of the United States Citizenship and Immigration Services.

(o) Notwithstanding any other provision of law, a noncitizen who is ineligible for medical assistance due to the deeming of a sponsor's income and resources, is ineligible for general assistance medical care.

(p) Effective July 1, 2003, general assistance medical care emergency services end.

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

Sec. 41. Minnesota Statutes 2006, section 524.3-803, is amended to read:

524.3-803 LIMITATIONS ON PRESENTATION OF CLAIMS.

(a) All claims as defined in section 524.1-201(6), against a decedent's estate which arose before the death of the decedent, including claims of the state and any subdivision thereof, whether due or to become due, absolute or contingent, liquidated or unliquidated, if not barred earlier by other statute of limitations, are barred against the estate, the personal representative, and the heirs and devisees of the decedent, unless presented as follows:

(1) in the case of a creditor who is only entitled, under the United States Constitution and under the Minnesota Constitution, to notice by publication under section 524.3-801, within four months after the date of the court administrator's notice to creditors which is subsequently published pursuant to section 524.3-801;

(2) in the case of a creditor who was served with notice under section 524.3-801(c), within the later to expire of four months after the date of the first publication of notice to creditors or one month after the service;

(3) within the later to expire of one year after the decedent's death, or one year after June 16, 1989, whether or not notice to creditors has been published or served under section 524.3-801, provided, however, that in the case of a decedent who died before June 16, 1989, no claim which was then barred by any provision of law may be deemed to have been revived by the amendment

of this section. Claims authorized by section 246.53, 256B.15, or 256D.16 must not be barred after one year as provided in this clause.

(b) All claims against a decedent's estate which arise at or after the death of the decedent, including claims of the state and any subdivision thereof, whether due or to become due, absolute or contingent, liquidated or unliquidated, are barred against the estate, the personal representative, and the heirs and devisees of the decedent, unless presented as follows:

(1) a claim based on a contract with the personal representative, within four months after performance by the personal representative is due;

(2) any other claim, within four months after it arises.

(c) Nothing in this section affects or prevents:

(1) any proceeding to enforce any mortgage, pledge, or other lien upon property of the estate;

(2) any proceeding to establish liability of the decedent or the personal representative for which there is protection by liability insurance, to the limits of the insurance protection only;

(3) the presentment and payment at any time within one year after the decedent's death of any claim arising before the death of the decedent that is referred to in section 524.3-715, clause (18), although the same may be otherwise barred under this section; or

(4) the presentment and payment at any time before a petition is filed in compliance with section 524.3-1001 or 524.3-1002 or a closing statement is filed under section 524.3-1003, of:

(i) any claim arising after the death of the decedent that is referred to in section 524.3-715, clause (18), although the same may be otherwise barred hereunder;

(ii) any other claim, including claims subject to clause (3), which would otherwise be barred hereunder, upon allowance by the court upon petition of the personal representative or the claimant for cause shown on notice and hearing as the court may direct.

Sec. 42. **NURSING FACILITY PENSION COSTS.**

The commissioner of human services shall evaluate the extent to which the alternative payment system reimbursement methodology for pension costs leads to funding shortfalls for nursing facilities that convert from public to private ownership. The commissioner shall report to the legislature by January 15, 2009, recommendations for any changes to the alternative payment system reimbursement methodology for pension costs necessary to ensure the financial viability of nursing facilities. The commissioner shall pay for any costs related to this study using existing resources.

Sec. 43. **NURSING FACILITY RATE DISPARITY REPORT.**

The commissioner of human services shall study and make a report to the legislature by January 15, 2009, with recommendations to reduce rate disparities between nursing facilities in various regions of the state. The recommendations shall include cost estimates and may include a phase-in schedule. The study shall be accomplished using existing resources.

Sec. 44. **HOME MODIFICATIONS.**

Effective upon federal approval, the costs associated with home modifications that add to the square footage of an unlicensed private residence when necessary to complete a modification to configure a bathroom to accommodate a wheelchair may be allowed expenses for home and community-based waiver services provided under Minnesota Statutes, sections 256B.0916 and 256B.49, for persons with disabilities when the following conditions are met:

(1) the annual cost of the care and modifications for the waiver recipient does not exceed the cost of care that would otherwise be incurred for the recipient without the modification, as determined by the local lead agency;

(2) the modification is based on the assessed needs, goals, and best interest of the recipient as identified in the plan of care;

(3) the modification has been found to be the least costly appropriate alternative after other alternatives have been explored through an evaluation by the local lead agency; and

(4) the modification is reasonable given the value and size of the home.

Sec. 45. **WAIVER AMENDMENT.**

The commissioner of human services shall submit an amendment to the Centers for Medicare and Medicaid Services consistent with section 44 by October 1, 2008.

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

Sec. 46. **APPROPRIATION.**

$65,000 is appropriated in the fiscal year beginning July 1, 2008, from the state government special revenue fund to the administrative services unit to pay for medical professional liability insurance coverage required under Minnesota Statutes, section 214.40. This appropriation shall become part of the base appropriation for the administrative services unit and shall be annually adjusted based on the cost of the coverage purchased to comply with Minnesota Statutes, section 214.40.

Sec. 47. **REPEALER.**

(a) Minnesota Statutes 2006, section 256B.0571, subdivision 8a, is repealed.

(b) Laws 2003, First Special Session chapter 5, section 11, is repealed.

ARTICLE 2

SEX OFFENDER PROGRAM

Section 1. Minnesota Statutes 2006, section 13.851, is amended by adding a subdivision to read:

Subd. 9. **Civil commitment of sexual offenders.** Data relating to the preparation of a petition to commit an individual as a sexual psychopathic personality or sexually dangerous person is governed by section 253B.185, subdivision 1b.

Sec. 2. Minnesota Statutes 2006, section 246B.02, is amended to read:

246B.02 ESTABLISHMENT OF MINNESOTA SEX OFFENDER PROGRAM.

The commissioner of human services shall establish and maintain a secure facility located in Moose Lake. The facility shall be operated by the Minnesota sex offender program. The program shall provide care and treatment in secure treatment facilities to persons on a court-hold order and residing in a secure treatment facility or program pending commitment or committed by the courts as sexual psychopathic personalities or sexually dangerous persons~~, or persons admitted there with the consent of the commissioner of human services~~.

Sec. 3. **[246B.06] ESTABLISHMENT OF MINNESOTA STATE INDUSTRIES.**

Subdivision 1. **Establishment; purpose.** (a) The commissioner of human services may establish, equip, maintain, and operate the Minnesota State Industries at any Minnesota sex offender program facility under this chapter. The commissioner may establish industrial and commercial activities for sex offender treatment patients as the commissioner deems necessary and suitable to the profitable employment, educational training, and development of proper work habits of patients consistent with the requirements in section 246B.05. The industrial and commercial activities authorized by this section are designated Minnesota State Industries and must be for the primary purpose of sustaining and ensuring Minnesota State Industries' self-sufficiency, providing educational training, meaningful employment, and the teaching of proper work habits to the patients of the Minnesota sex offender program under this chapter, and not solely as competitive business ventures.

(b) The net profits from Minnesota State Industries must be used for the benefit of the patients as it relates to building education and self-sufficiency skills. Prior to the establishment of any industrial and commercial activity, the commissioner of human services shall consult with stakeholders including representatives of business, industry, organized labor, the commissioner of education, the state Apprenticeship Council, the commissioner of labor and industry, the commissioner of employment and economic development, the commissioner of administration, and other stakeholders the commissioner deems qualified. The purpose of the stakeholder consultation is to determine the quantity and nature of the goods, wares, merchandise, and services to be made or provided, and the types of processes to be used in their manufacture, processing, repair, and production consistent with the greatest opportunity for the reform and educational training of the patients, and with the best interests of the state, business, industry, and labor.

(c) The commissioner of human services shall, at all times in the conduct of any industrial or commercial activity authorized by this section, utilize patient labor to the greatest extent feasible, provided that the commissioner may employ all administrative, supervisory, and other skilled workers necessary to the proper instruction of the patients and the profitable and efficient operation of the industrial and commercial activities authorized by this section.

(d) The commissioner of human services may authorize the director of any Minnesota sex offender treatment facility under the commissioner's control to accept work projects from outside sources for processing, fabrication, or repair, provided that preference is given to the performance of work projects for state departments and agencies.

Subd. 2. **Revolving fund.** As described in section 246B.05, subdivision 2, there is established a Minnesota State Industries revolving fund under the control of the commissioner of human services. The revolving fund must be used for Minnesota State Industries authorized under this section, including, but not limited to, the purchase of equipment and raw materials, the payment of salaries and wages, and other necessary expenses as determined by the commissioner of

human services. The purchase of services, materials, and commodities used in and held for resale are not subject to the competitive bidding procedures of section 16C.06, but are subject to all other provisions of chapters 16B and 16C. When practical, purchases must be made from small targeted group businesses designated under section 16C.16. Additionally, the expenses of patient educational training and self-sufficiency skills may be financed from the revolving fund in an amount to be determined by the commissioner or designee. The proceeds and income from all Minnesota State Industries conducted at the Minnesota sex offender treatment facilities must be deposited in the revolving fund subject to disbursement under subdivision 3. The commissioner of human services may request that money in the fund be invested pursuant to section 11A.25. Proceeds from the investment not currently needed must be accounted for separately and credited to the revolving fund.

Subd. 3. **Disbursement from fund.** The Minnesota State Industries revolving fund must be deposited in the state treasury and paid out only on proper vouchers as authorized and approved by the commissioner of human services, and in the same manner and under the same restrictions as are now provided by law for the disbursement of funds by the commissioner. An amount deposited in the state treasury equal to six months of net operating cash as determined by the prior 12 months of revenue and cash flow statements must be restricted for use only by Minnesota State Industries as described under subdivision 2. For purposes of this subdivision, "net operating cash" means net income, minus sales, plus cost of goods sold. Cost of goods sold include all direct costs of industry products attributable to the goods' production.

Subd. 4. **Revolving fund; borrowing.** The commissioner of human services is authorized to borrow sums of money as the commissioner deems necessary to meet current demands on the Minnesota State Industries revolving fund. The sums borrowed must not exceed, in any calendar year, six months of net operating cash as determined by the previous 12 months of the industries' revenue and cash flow statements. If the commissioner of human services determines that borrowing of funds is necessary, the commissioner of human services shall certify this need to the commissioner of finance. Funds may be borrowed from general fund appropriations to the Minnesota sex offender program with the authorization of the commissioner of finance. Upon authorization of the commissioner of finance, the transfer must be made and credited to the Minnesota State Industries revolving fund. The sum transferred to the Minnesota State Industries revolving fund must be repaid by the commissioner of human services from the revolving fund to the fund from which it was transferred in a time period specified by the commissioner of finance, but by no later than the end of the biennium, as defined in section 16A.011, in which the loan is made. When any transfer is made to the Minnesota State Industries revolving fund, the commissioner of finance shall notify the commissioner of human services of the amount transferred to the fund and the date the transfer is to be repaid.

Subd. 5. **Federal grant fund transfers.** Grants received by the commissioner of human services from the federal government for any vocational training program or for administration by the commissioner of human services must (1) be credited to a federal grant fund and then (2) be transferred from the federal grant fund to the credit of the commissioner of human services in the appropriate account upon certification by the commissioner of human services that the amounts requested to be transferred have been earned or are required for the purposes of this section. Funds received by the federal grant fund need not be budgeted as such, provided transfers from the fund are budgeted for allotment purposes in the appropriate appropriation.

Subd. 6. **Wages.** Notwithstanding section 177.24 or any other law to the contrary, wages paid to patients working within this program are at the discretion of the commissioner of human services.

Sec. 4. Minnesota Statutes 2006, section 253B.045, subdivision 1, is amended to read:

Subdivision 1. **Restriction.** Except when ordered by the court pursuant to a finding of necessity to protect the life of the proposed patient or others, or as provided under subdivision 1a, no person subject to the provisions of this chapter shall be confined in a jail or correctional institution, except pursuant to chapter 242 or 244.

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

Sec. 5. Minnesota Statutes 2006, section 253B.045, is amended by adding a subdivision to read:

Subd. 1a. **Exception.** A person who is being petitioned for commitment under section 253B.185 and who is placed under a judicial hold order under section 253B.07, subdivision 2b or 7, may be confined at a Department of Corrections or a county correctional or detention facility, rather than a secure treatment facility, until a determination of the commitment petition as specified in this subdivision.

(a) A court may order that a person who is being petitioned for commitment under section 253B.185 be confined in a Department of Corrections facility pursuant to the judicial hold order under the following circumstances and conditions:

(1) The person is currently serving a sentence in a Department of Corrections facility and the court determines that the person has made a knowing and voluntary (i) waiver of the right to be held in a secure treatment facility and (ii) election to be held in a Department of Corrections facility. The order confining the person in the Department of Corrections facility shall remain in effect until the court vacates the order or the person's criminal sentence and conditional release term expire.

In no case may the person be held in a Department of Corrections facility pursuant only to this subdivision, and not pursuant to any separate correctional authority, for more than 210 days.

(2) A person who has elected to be confined in a Department of Corrections facility under this subdivision may revoke the election by filing a written notice of intent to revoke the election with the court and serving the notice upon the Department of Corrections and the county attorney. The court shall order the person transferred to a secure treatment facility within 15 days of the date that the notice of revocation was filed with the court, except that, if the person has additional time to serve in prison at the end of the 15-day period, the person shall not be transferred to a secure treatment facility until the person's prison term expires. After a person has revoked an election to remain in a Department of Corrections facility under this subdivision, the court may not adopt another election to remain in a Department of Corrections facility without the agreement of both parties and the Department of Corrections.

(3) Upon petition by the commissioner of corrections, after notice to the parties and opportunity for hearing and for good cause shown, the court may order that the person's place of confinement be changed from the Department of Corrections to a secure treatment facility.

(4) While at a Department of Corrections facility pursuant to this subdivision, the person shall remain subject to all rules and practices applicable to correctional inmates in the facility in which the person is placed including, but not limited to, the powers and duties of the commissioner of

corrections under section 241.01, powers relating to use of force under section 243.52, and the right of the commissioner of corrections to determine the place of confinement in a prison, reformatory, or other facility.

(5) A person may not be confined in a Department of Corrections facility under this provision beyond the end of the person's executed sentence or the end of any applicable conditional release period, whichever is later. If a person confined in a Department of Corrections facility pursuant to this provision reaches the person's supervised release date and is subject to a period of conditional release, the period of conditional release shall commence on the supervised release date even though the person remains in the Department of Corrections facility pursuant to this provision. At the end of the later of the executed sentence or any applicable conditional release period, the person shall be transferred to a secure treatment facility.

(6) Nothing in this section may be construed to establish a right of an inmate in a state correctional facility to participate in sex offender treatment. This section must be construed in a manner consistent with the provisions of section 244.03.

(b) The committing county may offer a person who is being petitioned for commitment under section 253B.185 and who is placed under a judicial hold order under section 253B.07, subdivision 2b or 7, the option to be held in a county correctional or detention facility rather than a secure treatment facility, under such terms as may be agreed to by the county, the commitment petitioner, and the commitment respondent. If a person makes such an election under this paragraph, the court hold order shall specify the terms of the agreement, including the conditions for revoking the election.

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

Sec. 6. Minnesota Statutes 2006, section 253B.045, subdivision 2, is amended to read:

Subd. 2. **Facilities.** Each county or a group of counties shall maintain or provide by contract a facility for confinement of persons held temporarily for observation, evaluation, diagnosis, treatment, and care. When the temporary confinement is provided at a regional treatment center, the commissioner shall charge the county of financial responsibility for the costs of confinement of persons hospitalized under section 253B.05, subdivisions 1 and 2, and section 253B.07, subdivision 2b, except that the commissioner shall bill the responsible health plan first. If the person has health plan coverage, but the hospitalization does not meet the criteria in subdivision 6 or section 62M.07, 62Q.53, or 62Q.535, the county is responsible. When a person is temporarily confined in a Department of Corrections facility solely under subdivision 1a, and not based on any separate correctional authority:

(1) the commissioner of corrections may charge the county of financial responsibility for the costs of confinement; and

(2) the Department of Human Services shall use existing appropriations to fund all remaining nonconfinement costs. The funds received by the commissioner for the confinement and nonconfinement costs are appropriated to the department for these purposes.

"County of financial responsibility" means the county in which the person resides at the time of confinement or, if the person has no residence in this state, the county which initiated the confinement. The charge for confinement in a facility operated by the commissioner of human

services shall be based on the commissioner's determination of the cost of care pursuant to section 246.50, subdivision 5. When there is a dispute as to which county is the county of financial responsibility, the county charged for the costs of confinement shall pay for them pending final determination of the dispute over financial responsibility. Disputes about the county of financial responsibility shall be submitted to the commissioner to be settled in the manner prescribed in section 256G.09.

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

Sec. 7. Minnesota Statutes 2006, section 253B.18, subdivision 4c, is amended to read:

Subd. 4c. **Special review board.** (a) The commissioner shall establish one or more panels of a special review board ~~for persons committed as mentally ill and dangerous to the public~~. The board shall consist of three members experienced in the field of mental illness. One member of each special review board panel shall be a psychiatrist and one member shall be an attorney. No member shall be affiliated with the Department of Human Services. The special review board shall meet at least every six months and at the call of the commissioner. It shall hear and consider all petitions for a reduction in custody or to appeal a revocation of provisional discharge. A "reduction in custody" means transfer from a secure treatment facility~~; all petitions for~~, discharge, and provisional discharge~~, and revocation of provisional discharge; and make recommendations to the commissioner concerning them~~. Patients may be transferred by the commissioner between secure treatment facilities without a special review board hearing.

~~(b)~~ Members of the special review board shall receive compensation and reimbursement for expenses as established by the commissioner.

(b) A petition filed by a person committed as mentally ill and dangerous to the public under this section must be heard as provided in subdivision 5 and, as applicable, subdivision 13. A petition filed by a person committed as a sexual psychopathic personality or as a sexually dangerous person under section 253B.185, or committed as both mentally ill and dangerous to the public under this section and as a sexual psychopathic personality or as a sexually dangerous person must be heard as provided in section 253B.185, subdivision 9.

Sec. 8. Minnesota Statutes 2006, section 253B.18, subdivision 5, is amended to read:

Subd. 5. **Petition; notice of hearing; attendance; order.** (a) A petition for ~~an order of transfer, discharge, provisional discharge,~~ a reduction in custody or revocation of provisional discharge shall be filed with the commissioner and may be filed by the patient or by the head of the treatment facility. A patient may not petition the special review board for six months following commitment under subdivision 3 or following the final disposition of any previous petition and subsequent appeal by the patient. The medical director may petition at any time.

(b) Fourteen days prior to the hearing, the committing court, the county attorney of the county of commitment, the designated agency, interested person, the petitioner, and the petitioner's counsel shall be given written notice by the commissioner of the time and place of the hearing before the special review board. Only those entitled to statutory notice of the hearing or those administratively required to attend may be present at the hearing. The patient may designate interested persons to receive notice by providing the names and addresses to the commissioner at least 21 days before the hearing. The board shall provide the commissioner with written findings of fact and recommendations within 21 days of the hearing. The commissioner shall issue an order no later

than 14 days after receiving the recommendation of the special review board. A copy of the order shall be ~~sent by certified mail~~ mailed to every person entitled to statutory notice of the hearing within five days after it is signed. No order by the commissioner shall be effective sooner than 30 days after the order is signed, unless the county attorney, the patient, and the commissioner agree that it may become effective sooner.

(c) The special review board shall hold a hearing on each petition prior to making its recommendation to the commissioner. The special review board proceedings are not contested cases as defined in chapter 14. Any person or agency receiving notice that submits documentary evidence to the special review board prior to the hearing shall also provide copies to the patient, the patient's counsel, the county attorney of the county of commitment, the case manager, and the commissioner.

(d) Prior to the final decision by the commissioner, the special review board may be reconvened to consider events or circumstances that occurred subsequent to the hearing.

(e) In making their recommendations and order, the special review board and commissioner must consider any statements received from victims under subdivision 5a.

Sec. 9. Minnesota Statutes 2006, section 253B.18, subdivision 5a, is amended to read:

Subd. 5a. **Victim notification of petition and release; right to submit statement.** (a) As used in this subdivision:

(1) "crime" has the meaning given to "violent crime" in section 609.1095, and includes criminal sexual conduct in the fifth degree and offenses within the definition of "crime against the person" in section 253B.02, subdivision 4a, and also includes offenses listed in section 253B.02, subdivision 7a, paragraph (b), regardless of whether they are sexually motivated;

(2) "victim" means a person who has incurred loss or harm as a result of a crime the behavior for which forms the basis for a commitment under this section or section 253B.185; and

(3) "convicted" and "conviction" have the meanings given in section 609.02, subdivision 5, and also include juvenile court adjudications, findings under Minnesota Rules of Criminal Procedure, Rule 20.02, that the elements of a crime have been proved, and findings in commitment cases under this section or section 253B.185 that an act or acts constituting a crime occurred.

(b) A county attorney who files a petition to commit a person under this section or section 253B.185 shall make a reasonable effort to provide prompt notice of filing the petition to any victim of a crime for which the person was convicted. In addition, the county attorney shall make a reasonable effort to promptly notify the victim of the resolution of the petition.

(c) Before provisionally discharging, discharging, granting pass-eligible status, approving a pass plan, or otherwise permanently or temporarily releasing a person committed under this section or section 253B.185 from a treatment facility, the head of the treatment facility shall make a reasonable effort to notify any victim of a crime for which the person was convicted that the person may be discharged or released and that the victim has a right to submit a written statement regarding decisions of the medical director, special review board, or commissioner with respect to the person. To the extent possible, the notice must be provided at least 14 days before any special review board hearing or before a determination on a pass plan. Notwithstanding section 611A.06, subdivision 4, the commissioner shall provide the judicial appeal panel with victim information in order to comply

with the provisions of this section. The judicial appeal panel shall ensure that the data on victims remains private as provided for in section 611A.06, subdivision 4.

(d) This subdivision applies only to victims who have requested notification by contacting, in writing, the county attorney in the county where the conviction for the crime occurred. A county attorney who receives a request for notification under this paragraph shall promptly forward the request to the commissioner of human services.

(e) The rights under this subdivision are in addition to rights available to a victim under chapter 611A. This provision does not give a victim all the rights of a "notified person" or a person "entitled to statutory notice" under subdivision 4a, 4b, or 5.

Sec. 10. Minnesota Statutes 2007 Supplement, section 253B.185, subdivision 1b, is amended to read:

Subd. 1b. **County attorney access to data.** Notwithstanding sections 144.291 to 144.298; 245.467, subdivision 6; 245.4876, subdivision 7; 260B.171; 260B.235, subdivision 8; 260C.171; and 609.749, subdivision 6, or any provision of chapter 13 or other state law, prior to filing a petition for commitment as a sexual psychopathic personality or as a sexually dangerous person, and upon notice to the proposed patient, the county attorney or the county attorney's designee may move the court for an order granting access to any records or data, to the extent it relates to the proposed patient, for the purpose of determining whether good cause exists to file a petition and, if a petition is filed, to support the allegations set forth in the petition.

The court may grant the motion if: (1) the Department of Corrections refers the case for commitment as a sexual psychopathic personality or a sexually dangerous person; or (2) upon a showing that the requested category of data or records may be relevant to the determination by the county attorney or designee. The court shall decide a motion under this subdivision within 48 hours after a hearing on the motion. Notice to the proposed patient need not be given upon a showing that such notice may result in harm or harassment of interested persons or potential witnesses.

Notwithstanding any provision of chapter 13 or other state law, a county attorney considering the civil commitment of a person under this section may obtain records and data from the Department of Corrections or any probation or parole agency in this state upon request, without a court order, for the purpose of determining whether good cause exists to file a petition and, if a petition is filed, to support the allegations set forth in the petition. At the time of the request for the records, the county attorney shall provide notice of the request to the person who is the subject of the records.

Data collected pursuant to this subdivision shall retain their original status and, if not public, are inadmissible in any court proceeding unrelated to civil commitment, unless otherwise permitted.

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

Sec. 11. Minnesota Statutes 2006, section 253B.185, subdivision 5, is amended to read:

Subd. 5. **Financial responsibility.** (a) For purposes of this subdivision, "state facility" has the meaning given in section 246.50 and also includes a Department of Corrections facility when the proposed patient is confined in such a facility pursuant to section 253B.045, subdivision 1a.

(b) Notwithstanding sections 246.54, 253B.045, and any other law to the contrary, when a petition is filed for commitment under this section pursuant to the notice required in section 244.05,

subdivision 7, the state and county are each responsible for 50 percent of the cost of the person's confinement at a state facility or county jail, prior to commitment.

(c) The county shall submit an invoice to the state court administrator for reimbursement of the state's share of the cost of confinement.

(d) Notwithstanding paragraph (b), the state's responsibility for reimbursement is limited to the amount appropriated for this purpose.

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

Sec. 12. Minnesota Statutes 2006, section 253B.185, is amended by adding a subdivision to read:

Subd. 9. **Petition for reduction in custody.** (a) This subdivision applies only to committed persons as defined in paragraph (b). The procedures in section 253B.18, subdivision 5a, for victim notification and right to submit a statement under section 253B.18 apply to petitions filed and reductions in custody recommended under this subdivision.

(b) As used in this subdivision:

(1) "committed person" means an individual committed under this section, or under this section and under section 253B.18, as mentally ill and dangerous. It does not include persons committed only as mentally ill and dangerous under section 253B.18; and

(2) "reduction in custody" means transfer out of a secure treatment facility, a provisional discharge, or a discharge from commitment. A reduction in custody is considered to be a commitment proceeding under section 8.01.

(c) A petition for a reduction in custody or an appeal of a revocation of provisional discharge may be filed by either the committed person or by the head of the treatment facility and must be filed with and considered by the special review board. A committed person may not petition the special review board any sooner than six months following either:

(1) the entry of judgment in the district court of the order for commitment issued under section 253B.18, subdivision 3, or upon the exhaustion of all related appeal rights in state court relating to that order, whichever is later; or

(2) any recommendation of the special review board or order of the judicial appeal panel, or upon the exhaustion of all appeal rights in state court, whichever is later. The medical director may petition at any time. The special review board proceedings are not contested cases as defined in chapter 14.

(d) The special review board shall hold a hearing on each petition before issuing a recommendation under paragraph (f). Fourteen days before the hearing, the committing court, the county attorney of the county of commitment, the designated agency, an interested person, the petitioner and the petitioner's counsel, and the committed person and the committed person's counsel must be given written notice by the commissioner of the time and place of the hearing before the special review board. Only those entitled to statutory notice of the hearing or those administratively required to attend may be present at the hearing. The patient may designate interested persons to receive notice by providing the names and addresses to the commissioner at least 21 days before the hearing.

(e) A person or agency receiving notice that submits documentary evidence to the special review board before the hearing must also provide copies to the committed person, the committed person's counsel, the county attorney of the county of commitment, the case manager, and the commissioner. The special review board must consider any statements received from victims under section 253B.18, subdivision 5a.

(f) Within 30 days of the hearing, the special review board shall issue written findings of fact and shall recommend denial or approval of the petition to the judicial appeal panel established under section 253B.19. The commissioner shall forward the recommendation of the special review board to the judicial appeal panel and to every person entitled to statutory notice. No reduction in custody or reversal of a revocation of provisional discharge recommended by the special review board is effective until it has been reviewed by the judicial appeal panel and until 15 days after an order from the judicial appeal panel affirming, modifying, or denying the recommendation.

Sec. 13. Minnesota Statutes 2006, section 253B.19, subdivision 2, is amended to read:

Subd. 2. **Petition; hearing.** ~~The committed person or the county attorney of the county from which a patient was committed as a person who is mentally ill and dangerous to the public, or as a sexual psychopathic personality or as a sexually dangerous person may petition the appeal panel for a rehearing and reconsideration of a decision by the commissioner. The petition shall be filed with the Supreme Court within 30 days after the decision of the commissioner is signed. The Supreme Court shall refer the petition to the chief judge of the appeal panel.~~ (a) A person committed as mentally ill and dangerous to the public under section 253B.18, or the county attorney of the county from which the person was committed or the county of financial responsibility, may petition the judicial appeal panel for a rehearing and reconsideration of a decision by the commissioner under section 253B.18, subdivision 5. The judicial appeal panel must not consider petitions for relief other than those considered by the commissioner from which the appeal is taken. The petition must be filed with the Supreme Court within 30 days after the decision of the commissioner is signed. The hearing must be held within 45 days of the filing of the petition unless an extension is granted for good cause.

(b) A person committed as a sexual psychopathic personality or as a sexually dangerous person under section 253B.185, or committed as both mentally ill and dangerous to the public under section 253B.18 and as a sexual psychopathic personality or as a sexually dangerous person under section 253B.185; the county attorney of the county from which the person was committed or the county of financial responsibility; or the commissioner may petition the judicial appeal panel for a rehearing and reconsideration of a decision of the special review board under section 253B.185, subdivision 9. The petition must be filed with the Supreme Court within 30 days after the decision is mailed by the commissioner as required in section 253B.185, subdivision 9, paragraph (f). The hearing must be held within 180 days of the filing of the petition unless an extension is granted for good cause. If no party petitions the judicial appeal panel for a rehearing or reconsideration within 30 days, the judicial appeal panel shall either issue an order adopting the recommendations of the special review board or set the matter on for a hearing pursuant to this paragraph.

(c) For an appeal under paragraph (a) or (b), the Supreme Court shall refer the petition to the chief judge of the judicial appeal panel. The chief judge shall notify the patient, the county attorney of the county of commitment, the designated agency, the commissioner, the head of the treatment facility, any interested person, and other persons the chief judge designates, of the time and place of the hearing on the petition. The notice shall be given at least 14 days prior to the date of the hearing.

~~The hearing shall be within 45 days of the filing of the petition unless an extension is granted for good cause.~~

(d) Any person may oppose the petition. The patient, the patient's counsel, the county attorney of the committing county or the county of financial responsibility, and the commissioner shall participate as parties to the proceeding pending before the judicial appeal panel and shall, no later than 20 days before the hearing on the petition, inform the judicial appeal panel and the opposing party in writing whether they support or oppose the petition and provide a summary of facts in support of their position. The judicial appeal panel may appoint examiners and may adjourn the hearing from time to time. It shall hear and receive all relevant testimony and evidence and make a record of all proceedings. The patient, the patient's counsel, and the county attorney of the committing county ~~may~~ or the county of financial responsibility have the right to be present and may present and cross-examine all witnesses and offer a factual and legal basis in support of their positions. The petitioning party bears the burden of going forward with the evidence. The party opposing discharge bears the burden of proof by clear and convincing evidence that the respondent is in need of commitment.

Sec. 14. Minnesota Statutes 2006, section 253B.19, subdivision 3, is amended to read:

Subd. 3. **Decision.** A majority of the judicial appeal panel shall rule upon the petition. The panel shall consider the petition de novo. The order of the judicial appeal panel shall supersede ~~the~~ an order of the commissioner ~~in the cases~~ under section 253B.18, subdivision 5. No order of the judicial appeal panel granting a transfer, discharge or provisional discharge shall be made effective sooner than 15 days after it is issued. The panel may not consider petitions for relief other than those considered by the commissioner or special review board from which the appeal is taken. The judicial appeal panel may not grant a transfer or provisional discharge on terms or conditions that were not presented to the commissioner or the special review board.

Sec. 15. Minnesota Statutes 2006, section 626.5572, subdivision 21, is amended to read:

Subd. 21. **Vulnerable adult.** "Vulnerable adult" means any person 18 years of age or older who:

(1) is a resident or inpatient of a facility;

(2) receives services at or from a facility required to be licensed to serve adults under sections 245A.01 to 245A.15, except that a person receiving outpatient services for treatment of chemical dependency or mental illness, or one who is served in the Minnesota sex offender program on a court-hold order for commitment, or is committed as a sexual psychopathic personality or as a sexually dangerous person under chapter 253B, is not considered a vulnerable adult unless the person meets the requirements of clause (4);

(3) receives services from a home care provider required to be licensed under section 144A.46; or from a person or organization that exclusively offers, provides, or arranges for personal care assistant services under the medical assistance program as authorized under sections 256B.04, subdivision 16, 256B.0625, subdivision 19a, 256B.0651, and 256B.0653 to 256B.0656; or

(4) regardless of residence or whether any type of service is received, possesses a physical or mental infirmity or other physical, mental, or emotional dysfunction:

(i) that impairs the individual's ability to provide adequately for the individual's own care without assistance, including the provision of food, shelter, clothing, health care, or supervision; and

(ii) because of the dysfunction or infirmity and the need for assistance, the individual has an impaired ability to protect the individual from maltreatment.

Sec. 16. **MINNESOTA SEX OFFENDER PROGRAM; OPERATING STANDARDS.**

The commissioner of human services shall convene a working group of interested parties to develop standards and guidelines for the operations of the Minnesota sex offender program. The standards and guidelines shall include, but not be limited to:

(1) criteria to establish a sex offender treatment advisory board;

(2) criteria to ensure the necessary provision of health and dental care for patients;

(3) criteria to ensure the necessary provision of mental health care; and

(4) fire and safety criteria.

The standards and guidelines shall be developed by the commissioner in consultation with the working group members by February 1, 2009, and presented to the chairs of the policy and finance committees having jurisdiction over the Minnesota sex offender program for review.

ARTICLE 3

MFIP

Section 1. Minnesota Statutes 2007 Supplement, section 256J.49, subdivision 13, is amended to read:

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

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

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

(3) unpaid work experience, including community service, volunteer work, the community work experience program as specified in section 256J.67, unpaid apprenticeships or internships, and supported work when a wage subsidy is not provided. Unpaid work experience is only an option if the participant has been unable to obtain or maintain paid employment in the competitive labor market, and no paid work experience programs are available to the participant. Prior to placing a participant in unpaid work, the county must inform the participant that the participant will be notified if a paid work experience or supported work position becomes available. Unless a participant consents in writing to ~~participating~~ participate in unpaid work experience, the participant's employment plan may only include unpaid work experience if including the unpaid work experience in the plan will meet the following criteria:

(i) the unpaid work experience will provide the participant specific skills or experience that

cannot be obtained through other work activity options where the participant resides or is willing to reside; and

(ii) the skills or experience gained through the unpaid work experience will result in higher wages for the participant than the participant could earn without the unpaid work experience;

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

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

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

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

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

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

ARTICLE 4

MANAGED CARE CONTRACT

Section 1. Laws 2005, First Special Session chapter 4, article 8, section 84, as amended by Laws 2006, chapter 264, section 15, is amended to read:

Sec. 84. **SOLE-SOURCE OR SINGLE-PLAN MANAGED CARE CONTRACT.**

(a) Notwithstanding Minnesota Statutes, section 256B.692, subdivision 6, clause (1), paragraph (c), the commissioner of human services shall approve a county-based purchasing health plan proposal, submitted on behalf of Cass, Crow Wing, Morrison, Todd, and Wadena Counties, that requires county-based purchasing on a single-plan basis contract if the implementation of the single-plan purchasing proposal does not limit an enrollee's provider choice or access to services and all other requirements applicable to health plan purchasing are satisfied. ~~The commissioner shall continue single-health plan purchasing arrangements with county-based purchasing entities in the service areas in existence on May 1, 2006, including arrangements for which a proposal was submitted by May 1, 2006, on behalf of Cass, Crow Wing, Morrison, Todd, and Wadena Counties, in response to a request for proposals issued by the commissioner.~~ The commissioner shall continue to use single-health plan, county-based purchasing arrangements for medical assistance and general assistance medical care programs and products for the counties that were in single-health plan, county-based purchasing arrangements on March 1, 2008. This paragraph does not require the commissioner to terminate an existing contract with a noncounty-based purchasing plan that had enrollment in a medical assistance program or product in these counties on March 1, 2008. This paragraph expires on December 31, 2010, or the effective date of a new contract for

medical assistance and general assistance medical care managed care programs entered into at the conclusion of the commissioner's next scheduled reprocurement process for the county-based purchasing entities covered by this paragraph, whichever is later.

(b) The commissioner shall consider, and may approve, contracting on a single-health plan basis with other county-based purchasing plans, or with other qualified health plans that have coordination arrangements with counties, to serve persons with a disability who voluntarily enroll, in order to promote better coordination or integration of health care services, social services and other community-based services, provided that all requirements applicable to health plan purchasing, including those in Minnesota Statutes, section 256B.69, subdivision 23, are satisfied. ~~By January 15, 2007, the commissioner shall report to the chairs of the appropriate legislative committees in the house and senate an analysis of the advantages and disadvantages of using single-health plan purchasing to serve persons with a disability who are eligible for health care programs. The report shall include consideration of the impact of federal health care programs and policies for persons who are eligible for both federal and state health care programs and shall consider strategies to improve coordination between federal and state health care programs for those persons.~~ Nothing in this paragraph supersedes or modifies the requirements in paragraph (a)."

Delete the title and insert:

"A bill for an act relating to human services; amending health care services provisions; making changes to a managed care contract provision; increasing a HMO renewal fee; changing provisions relating to sex offender program; changing a work activity provision under MFIP; requiring a report; appropriating money; amending Minnesota Statutes 2006, sections 13.851, by adding a subdivision; 125A.02, subdivision 1; 144A.45, subdivision 1, by adding a subdivision; 150A.06, by adding a subdivision; 214.40, by adding a subdivision; 246B.02; 253B.045, subdivisions 1, 2, by adding a subdivision; 253B.18, subdivisions 4c, 5, 5a; 253B.185, subdivision 5, by adding a subdivision; 253B.19, subdivisions 2, 3; 256.01, by adding a subdivision; 256B.056, subdivisions 2, 4a, 11, by adding a subdivision; 256B.057, subdivision 1; 256B.0571, subdivisions 6, 8, 9, 15, by adding a subdivision; 256B.058; 256B.059, subdivisions 1, 1a; 256B.0594; 256B.0595, subdivisions 1, 2, 3, 4, by adding subdivisions; 256B.0625, subdivisions 3c, 13g, 13h; 256B.075, subdivision 2; 256B.15, subdivision 4; 256B.69, subdivisions 3a, 6, 27, 28; 256B.692, subdivision 7; 524.3-803; 626.5572, subdivision 21; Minnesota Statutes 2007 Supplement, sections 253B.185, subdivision 1b; 256B.055, subdivision 14; 256B.0625, subdivision 49; 256D.03, subdivision 3; 256J.49, subdivision 13; Laws 2005, First Special Session chapter 4, article 8, section 84, as amended; proposing coding for new law in Minnesota Statutes, chapters 145; 246B; repealing Minnesota Statutes 2006, section 256B.0571, subdivision 8a; Laws 2003, First Special Session chapter 5, section 11."

We request the adoption of this report and repassage of the bill.

House Conferees: (Signed) Thomas Huntley, Erin Murphy, Ron Erhardt

Senate Conferees: (Signed) Linda Berglin, Tony Lourey, Paul E. Koering

Senator Berglin moved that the foregoing recommendations and Conference Committee Report on H.F. No. 3222 be now adopted, and that the bill be repassed as amended by the Conference Committee. The motion prevailed. So the recommendations and Conference Committee Report were adopted.

H.F. No. 3222 was read the third time, as amended by the Conference Committee, and placed

on its repassage.

The question was taken on the repassage of the bill, as amended by the Conference Committee.

The roll was called, and there were yeas 45 and nays 6, as follows:

Those who voted in the affirmative were:

Anderson	Dibble	Koering	Olson, M.	Saxhaug
Berglin	Dille	Kubly	Pappas	Senjem
Betzold	Doll	Lourey	Pariseau	Sheran
Bonoff	Erickson Ropes	Lynch	Pogemiller	Skoe
Carlson	Foley	Marty	Prettner Solon	Skogen
Chaudhary	Frederickson	Metzen	Robling	Torres Ray
Clark	Gimse	Moua	Rosen	Vickerman
Dahle	Higgins	Murphy	Rummel	Wergin
Day	Ingebrigtsen	Olseen	Saltzman	Wiger

Those who voted in the negative were:

Hann	Koch	Michel
Jungbauer	Limmer	Vandeveer

So the bill, as amended by the Conference Committee, was repassed and its title was agreed to.

MESSAGES FROM THE HOUSE - CONTINUED

Mr. President:

I have the honor to announce that the House refuses to adopt the report of the Conference Committee on Senate File No. 3138 and requests that the bill be returned to the Conference Committee for further consideration.

S.F. No. 3138: A bill for an act relating to health; changing provisions for handling genetic information; amending Minnesota Statutes 2006, sections 13.386, subdivision 3; 144.05, by adding a subdivision; Minnesota Statutes 2007 Supplement, section 144.125, subdivision 3.

Senate File No. 3138 is herewith returned to the Senate.

Albin A. Mathiowetz, Chief Clerk, House of Representatives

Returned May 12, 2008

Senator Lynch moved that the Senate accede to the request of the House to return S.F. No. 3138 to the Conference Committee as formerly constituted for further consideration. The motion prevailed.

RECONSIDERATION

Senator Lynch moved that the vote whereby S.F. No. 3138 was repassed by the Senate on May 1, 2008, be now reconsidered. The motion prevailed. So the vote was reconsidered.

RECONSIDERATION

Senator Lynch then moved that the vote whereby the Conference Committee Report on S.F. No. 3138 was adopted by the Senate on May 1, 2008, be now reconsidered. The motion prevailed. So the vote was reconsidered.

Senator Lynch moved that S.F. No. 3138 be returned to the Conference Committee as formerly constituted for further consideration. The motion prevailed.

RECESS

Senator Pogemiller moved that the Senate do now recess subject to the call of the President. The motion prevailed.

After a brief recess, the President called the Senate to order.

CALL OF THE SENATE

Senator Pogemiller imposed a call of the Senate. The Sergeant at Arms was instructed to bring in the absent members.

MOTIONS AND RESOLUTIONS - CONTINUED

Without objection, remaining on the Order of Business of Motions and Resolutions, the Senate reverted to the Order of Business of Messages From the House.

MESSAGES FROM THE HOUSE

Mr. President:

I have the honor to announce the passage by the House of the following Senate File, AS AMENDED by the House, in which amendments the concurrence of the Senate is respectfully requested:

S.F. No. 2833: A bill for an act relating to health; requiring public pools and spas to be equipped with anti-entrapment devices or systems; appropriating money; amending Minnesota Statutes 2006, sections 144.1222, subdivision 1a, by adding subdivisions; 157.16, as amended; 157.20, subdivisions 1, 2a.

Senate File No. 2833 is herewith returned to the Senate.

Albin A. Mathiowetz, Chief Clerk, House of Representatives

Returned May 12, 2008

CONCURRENCE AND REPASSAGE

Senator Michel moved that the Senate concur in the amendments by the House to S.F. No. 2833 and that the bill be placed on its repassage as amended. The motion prevailed.

S.F. No. 2833 was read the third time, as amended by the House, and placed on its repassage.

The question was taken on the repassage of the bill, as amended.

The roll was called, and there were yeas 60 and nays 0, as follows:

Those who voted in the affirmative were:

Anderson	Erickson Ropes	Kubly	Olseen	Senjem
Berglin	Fischbach	Langseth	Olson, M.	Sheran
Betzold	Foley	Larson	Ortman	Sieben
Bonoff	Frederickson	Latz	Pappas	Skogen
Carlson	Gimse	Limmer	Pariseau	Sparks
Clark	Hann	Lourey	Pogemiller	Stumpf
Cohen	Higgins	Lynch	Prettner Solon	Tomassoni
Dahle	Ingebrigtsen	Marty	Robling	Torres Ray
Day	Johnson	Metzen	Rosen	Vandeveer
Dibble	Jungbauer	Michel	Rummel	Vickerman
Dille	Koch	Moua	Saltzman	Wergin
Doll	Koering	Murphy	Scheid	Wiger

So the bill, as amended, was repassed and its title was agreed to.

MESSAGES FROM THE HOUSE - CONTINUED

Mr. President:

I have the honor to announce that the House has adopted the recommendation and report of the Conference Committee on House File No. 3391, and repassed said bill in accordance with the report of the Committee, so adopted.

House File No. 3391 is herewith transmitted to the Senate.

Albin A. Mathiowetz, Chief Clerk, House of Representatives

Transmitted May 12, 2008

CONFERENCE COMMITTEE REPORT ON H. F. NO. 3391

A bill for an act relating to health care reform; increasing affordability and continuity of care for state health care programs; modifying health care provisions; providing subsidies for employee share of employer-subsidized insurance in certain cases; establishing the Health Care Transformation Commission; creating an affordability standard; implementing a statewide health improvement program; requiring an evaluation of mandated health benefits; requiring a payment system to encourage provider innovation; requiring studies and reports; appropriating money; amending Minnesota Statutes 2006, sections 62Q.025, by adding a subdivision; 256.01, subdivision 18; 256B.056, by adding a subdivision; 256B.057, subdivision 8; 256B.69, by adding

a subdivision; 256L.05, by adding a subdivision; 256L.06, subdivision 3; 256L.07, subdivision 3, by adding a subdivision; 256L.15, by adding a subdivision; Minnesota Statutes 2007 Supplement, sections 256.01, subdivision 2b; 256B.056, subdivision 10; 256L.03, subdivisions 3, 5; 256L.04, subdivisions 1, 7; 256L.05, subdivision 3a; 256L.07, subdivision 1; 256L.15, subdivision 2; proposing coding for new law in Minnesota Statutes, chapters 145; 256B; proposing coding for new law as Minnesota Statutes, chapter 62U; repealing Minnesota Statutes 2006, section 256L.15, subdivision 3.

May 11, 2008

The Honorable Margaret Anderson Kelliher
Speaker of the House of Representatives

The Honorable James P. Metzen
President of the Senate

We, the undersigned conferees for H. F. No. 3391 report that we have agreed upon the items in dispute and recommend as follows:

That the Senate recede from its amendment and that H. F. No. 3391 be further amended as follows:

Delete everything after the enacting clause and insert:

"**ARTICLE 1**

PUBLIC HEALTH

Section 1. **[145.986] STATEWIDE HEALTH IMPROVEMENT PROGRAM.**

Subdivision 1. **Goals.** It is the goal of the state to substantially reduce the percentage of Minnesotans who are obese or overweight, and to reduce the use of tobacco.

Subd. 2. **Grants to local communities.** (a) Beginning July 1, 2009, the commissioner of health shall award grants to community health boards established pursuant to section 145A.09, and tribal governments to convene, coordinate, and implement evidence-based strategies targeted at reducing the percentage of Minnesotans who are obese or overweight and to reduce the use of tobacco.

(b) Grantee activities shall:

(1) be based on scientific evidence;

(2) be based on community input;

(3) address behavior change at the individual, community, and systems levels;

(4) occur in community, school, worksite, and health care settings; and

(5) be focused on policy, systems, and environmental changes that support healthy behaviors.

(c) To receive a grant under this section, community health boards and tribal governments must submit proposals to the commissioner. A local match of ten percent of the total funding allocation is required. This local match may include funds donated by community partners.

(d) In order to receive a grant, community health boards and tribal governments must submit a health improvement plan to the commissioner of health for approval. The commissioner may require the plan to identify a community leadership team, community partners, and a community action plan that includes an assessment of area strengths and needs, proposed action strategies, technical assistance needs, and a staffing plan.

(e) The grant recipient must implement the health improvement plan, evaluate the effectiveness of the interventions, and modify or discontinue interventions found to be ineffective.

(f) Grant recipients shall receive the standard base amount and a standard per capita amount to be established by the commissioner.

(g) By January 15, 2011, the commissioner of health shall recommend whether any funding should be distributed to community health boards and tribal governments based on health disparities demonstrated in the populations served.

(h) Grant recipients shall report their activities and their progress towards the outcomes established under subdivision 3 to the commissioner in a format and at a time specified by the commissioner.

(i) All grant recipients shall be held accountable for making progress toward the measurable outcomes established in subdivision 3. The commissioner shall require a corrective action plan and may reduce the funding level of grant recipients that do not make adequate progress toward the measurable outcomes.

Subd. 3. **Outcomes.** (a) The commissioner shall set measurable outcomes to meet the goals specified in subdivision 1, and annually review the progress of grant recipients in meeting the outcomes.

(b) The commissioner shall measure current public health status, using existing measures and data collection systems when available, to determine baseline data against which progress shall be monitored.

Subd. 4. **Technical assistance and oversight.** The commissioner shall provide content expertise, technical expertise, and training to grant recipients and advice on evidence-based strategies, including those based on populations and types of communities served. The commissioner shall ensure that the statewide health improvement program meets the outcomes established under subdivision 3 by conducting a comprehensive statewide evaluation and assisting grant recipients to modify or discontinue interventions found to be ineffective.

Subd. 5. **Evaluation.** Using the outcome measures established in subdivision 3, the commissioner shall conduct a biennial evaluation of the statewide health improvement program funded under this section. Grant recipients shall cooperate with the commissioner in the evaluation and provide the commissioner with the information necessary to conduct the evaluation.

Subd. 6. **Report.** The commissioner shall submit a biennial report to the legislature on the statewide health improvement program funded under this section. These reports must include information on grant recipients, activities that were conducted using grant funds, evaluation data, and outcome measures, if available. In addition, the commissioner shall provide recommendations on future areas of focus for health improvement. These reports are due by January 15 of every other year, beginning in 2010. In the report due on January 15, 2010, the commissioner shall include

recommendations on a sustainable funding source for the statewide health improvement program other than the health care access fund.

Subd. 7. **Supplantation of existing funds.** Community health boards and tribal governments must use funds received under this section to develop new programs, expand current programs that work to reduce the percentage of Minnesotans who are obese or overweight, or who use tobacco, or replace discontinued state or federal funds previously used to reduce the percentage of Minnesotans who are obese or overweight, or who use tobacco. Funds must not be used to supplant current state or local funding to community health boards or tribal governments used to reduce the percentage of Minnesotans who are obese or overweight or to reduce tobacco use.

ARTICLE 2

HEALTH CARE HOMES

Section 1. **[256B.0751] HEALTH CARE HOMES.**

Subdivision 1. **Definitions.** (a) For purposes of sections 256B.0751 to 256B.0753, the following definitions apply.

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

(c) "Commissioners" means the commissioner of humans services and the commissioner of health, acting jointly.

(d) "Health plan company" has the meaning provided in section 62Q.01, subdivision 4.

(e) "Personal clinician" means a physician licensed under chapter 147, a physician assistant registered and practicing under chapter 147A, an advanced practice nurse licensed and registered to practice under chapter 148, and other health care providers as determined by the commissioner of health.

(f) "State health care program" means the medical assistance, MinnesotaCare, and general assistance medical care programs.

Subd. 2. **Development and implementation of standards.** (a) By July 1, 2009, the commissioners of health and human services shall develop and implement standards of certification for health care homes for state health care programs. In developing these standards, the commissioners shall consider existing standards developed by national independent accrediting and medical home organizations. The standards developed by the commissioners must meet the following criteria:

(1) emphasize, enhance, and encourage the use of primary care, and include the use of primary care physicians, advanced practice nurses, and physician assistants as personal clinicians, as well as appropriate specialists if they provide care according to these standards;

(2) focus on delivering high-quality, efficient, and effective health care services, enhancing the experience of patients and their families, and appropriately engaging patients and their families in the decision-making process;

(3) encourage patient-centered care, including active participation by the patient and family or a legal guardian, or a health care agent as defined in chapter 145C, as appropriate in decision making,

care plan development, and include patient representation on practice level quality improvement teams;

(4) provide patients with a consistent, ongoing contact with a personal clinician to ensure continuous and appropriate care for the patient's condition;

(5) ensure that health care homes develop and maintain appropriate comprehensive care plans for their patients with complex or chronic conditions, including the provision of an initial health assessment in order to identify all of the patient's complex or chronic health conditions;

(6) enable and encourage utilization of a range of qualified health care professionals to provide care, including dedicated care coordinators, in a manner that enables providers to practice to the fullest extent of their license;

(7) focus initially on patients who have or are at risk of developing chronic health conditions;

(8) provide care that is appropriate to the patient's race, ethnicity, and language;

(9) incorporate measures of quality and cost of care;

(10) ensure the use of health information technology and systematic follow-up through the use of patient registries; and

(11) encourage the use of evidence-based health care, patient decision-making aids that provide patients with information about treatment options and their associated benefits, risks, costs, and comparative outcomes, and other clinical decision support tools.

(b) In developing these standards, the commissioners shall consult with national and local organizations working on health care home models, health care providers, relevant state agencies, health plans, and hospitals. The commissioners may satisfy this requirement by continuing the provider directed care coordination advisory committee.

(c) For the purposes of developing and implementing these standards, the commissioners are exempt from the provisions of chapter 14, including the specific provisions in section 14.386.

Subd. 3. **Requirements for clinicians certified as health care homes.** (a) A personal clinician or a primary care clinic may be certified as a health care home. If a primary care clinic is certified, all of the primary care clinics' clinicians must meet the criteria of a health care home. In order to be certified as a health care home, a clinician or clinic must meet the standards set by the commissioners in accordance with this section. Certification as a health care home is voluntary. In order to maintain their status as health care homes, clinicians or clinics must renew their certification annually.

(b) Clinicians or clinics certified as health care homes must offer their health care home services to all their patients with complex or chronic health conditions who are interested in participation.

(c) Health care homes must participate in the health care home learning collaborative established under subdivision 5.

Subd. 4. **Alternative models.** Nothing in this section shall preclude the continued development of existing medical or health care home projects currently operating or under development by the commissioner of human services or preclude the commissioner from establishing alternative models and payment mechanisms for persons who are enrolled in integrated Medicare and

Medicaid programs under section 256B.69, subdivisions 23 and 28, are enrolled in managed care long-term care programs under section 256B.69, subdivision 6, paragraph (b), are dually eligible for Medicare and medical assistance, are in the waiting period for Medicare, or who have other primary coverage.

Subd. 5. **Health care home collaborative.** By July 1, 2009, the commissioners shall establish a health care home collaborative to provide an opportunity for health care homes and state agencies to exchange information related to quality improvement and best practices.

Subd. 6. **Evaluation and continued development.** (a) For continued certification under this section, health care homes must meet process, outcome, and quality standards as developed and specified by the commissioners. The commissioners shall collect data from health care homes necessary for monitoring compliance with certification standards and for evaluating the impact of health care homes on health care quality, cost, and outcomes.

(b) The commissioners may contract with a private entity to perform an evaluation of the effectiveness of health care homes. Data collected under this subdivision is classified as nonpublic data under chapter 13.

Subd. 7. **Outreach.** Upon implementation of the certification process and standards under subdivision 1, the commissioner shall encourage state health care program enrollees who have a complex or chronic condition to select a primary care clinic with clinicians who have been certified as health care homes.

Sec. 2. **[256B.0752] CARE COORDINATION FEE.**

Subdivision 1. **Development.** The commissioner of human services shall develop a payment system that provides per-person care coordination payments to health care providers for providing care coordination services and directly managing onsite or employing care coordinators. In order to be eligible for a care coordination payment, a health care provider must be certified as a health care home by the commissioners of human services and health based on the certification standards for health care homes established under section 256B.0751. The care coordination payment system must vary the fees paid by thresholds of care complexity, with the highest fees being paid for care provided to individuals requiring the most intensive care coordination and those who face racial, ethnic, or language barriers. The commissioner may determine a schedule for phasing-in care coordination fees such that the fees will be applied first to individuals who have, or are at risk of developing, complex or chronic health conditions and coordinate with the implementation of the provider-directed care coordination payments under section 256B.0625, subdivision 51. Development of the payment system must be completed by January 1, 2010.

Subd. 2. **Payment of care coordination fee.** By July 1, 2010, the commissioner of human services shall pay each certified health care home a per-person care coordination fee for providing care coordination services for each state health care program enrollee served under the fee-for-service system. The care coordination fee must be determined by the commissioner in contracts with certified health care homes. Payment of the care coordination fee is contingent on the health care home meeting the certification standards for health care homes described in section 256B.0751. The care coordination fee is in addition to reimbursement received by a health care home under the medical assistance fee-for-service payment system for health care services.

Subd. 3. **Managed care and county-based purchasing.** By July 1, 2010, the commissioner

of human services shall require managed care and county-based purchasing plans serving state health care program enrollees under sections 256B.69 and 256B.692, and chapters 256D and 256L to implement a care coordination payment system for state health care program enrollees who are provided care coordination services in health care homes certified under section 256B.0751. The payment system shall be designed in accordance with section 62U.05.

Subd. 4. **Cost neutrality.** If initial savings from implementation of health care homes are not sufficient to allow implementation of the care coordination fee in a cost-neutral manner, the commissioner may make recommendations to the legislature on reallocating costs within the health care system.

EFFECTIVE DATE. This section is effective July 1, 2010, or upon federal approval, whichever is later.

Sec. 3. **[256B.0753] HEALTH CARE HOME REPORTING REQUIREMENTS.**

Subdivision 1. **Standards and criteria review.** Prior to implementation, the commissioners shall report the certification standards and evaluation criteria established in sections 256B.0751 and 256B.0752 to the Legislative Commission on Health Care Access. These standards are not subject to chapter 14, and the specific provisions in section 14.386 do not apply.

Subd. 2. **Annual reports on implementation and administration.** The commissioners shall report annually to the legislature on the implementation and administration of the health care home model for state health care program enrollees in the fee-for-service, managed care, and county-based purchasing sectors, beginning January 15, 2011, and each January 15 thereafter. The annual report must include the cost benefit analysis of the implementation of the health care home model for the state public health care programs.

Subd. 3. **Evaluation reports.** The commissioners shall provide to the legislature comprehensive evaluations of the health care home model three years and five years after implementation. The report must include:

(1) the number of state health care program enrollees in health care homes, the number and characteristics of enrollees with complex or chronic conditions, identified by income, race, ethnicity, and language;

(2) the number and geographic distribution of health care home providers;

(3) the performance and quality of care of health care homes;

(4) measures of preventive care;

(5) health care home payment arrangements, and costs related to implementation and payment of care coordination fees; and

(6) the estimated impact of health care homes on health disparities.

Sec. 4. **[256B.766] PRIMARY CARE PHYSICIAN REIMBURSEMENT RATE INCREASE.**

(a) Effective for physician services rendered on or after January 1, 2009, the commissioner shall increase reimbursements to primary care physicians deemed by the commissioner to meet the

requirements in paragraph (b). Reimbursement may be increased by not more than 50 percent above the reimbursement rate that would otherwise be paid to the primary care provider. Payments to health plan companies shall be adjusted to reflect increased reimbursement to primary care physicians as approved by the commissioner.

(b) The commissioner, in collaboration with the Office of Rural Health, shall determine areas of the state in need of primary care physicians. By September 1 of each year, beginning September 1, 2008, the commissioner shall accept applications from primary care physicians who agree to practice in a designated underserved area for a period of no less than five years. The commissioner shall determine participant eligibility based on their suitability for practice serving a designated geographic area.

(c) The commissioner may reconsider the designated areas, as necessary. A primary care physician who agrees to practice in an area designated as underserved shall receive the increased reimbursement rates for at least a period of five years, unless the physician discontinues practicing in the designated area during the five-year period.

(d) A health care clinic or medical group may submit applications under this section for primary care physicians who will be hired to fill vacancies, prior to filling the vacant position.

Sec. 5. **WORKFORCE SHORTAGE STUDY.**

To address health care workforce shortages, the commissioner of health, in consultation with the health licensing boards and professional associations, shall study changes necessary in health professional licensure and regulation to ensure full utilization of advanced practice registered nurses, physician assistants, and other licensed health care professionals in the health care home and primary delivery system. The commissioner shall make recommendations to the legislature by January 15, 2009.

ARTICLE 3

INCREASING ACCESS; CONTINUITY OF CARE

Section 1. **[124D.1115] FREE AND REDUCED SCHOOL LUNCH PROGRAM DATA SHARING.**

(a) Each school participating in the federal school lunch program shall electronically send to the Department of Education the eligibility information on each child who is eligible for the free and reduced lunch program, unless the child's parent or legal guardian after being notified of the potential disclosure of this information for the limited purpose stated in paragraph (b), elects not to have the information disclosed.

(b) Pursuant to United States Code, title 42, section 1758(b)(6)(A), the Department of Education shall enter into an agreement with the Department of Human Services to share the eligibility information provided by each school in paragraph (a) for the limited purpose of identifying children who may be eligible for medical assistance or MinnesotaCare. The Department of Human Services must ensure that this information remains confidential and shall only be used for this purpose. Any unauthorized disclosure shall be subject to a penalty.

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

Subd. 27. **Automation and coordination for state health care programs.** (a) For purposes of this subdivision, "state health care program" means the medical assistance, MinnesotaCare, or general assistance medical care programs.

(b) By July 1, 2009, the commissioner shall improve coordination between state health care programs and social service programs including, but not limited to WIC, free and reduced school lunch programs, and food stamps, and shall develop and use automated systems to identify persons served by social service programs who may be eligible for, but are not enrolled in, a state health care program. By January 15, 2009, the commissioner shall, as necessary, identify and recommend to the legislature statutory changes to state health care and social service programs necessary to improve coordination and automation of outreach and enrollment efforts.

(c) By January 15, 2009, the commissioner shall establish and implement an automated process to send out state health care program renewal forms in the most common foreign languages, to those state health care program enrollees who request renewal forms in those foreign languages. The commissioner, as part of the initial enrollment process, shall inform applicants of the availability of this option.

(d) Beginning July 1, 2008, the commissioner, county social service agencies, and health care providers shall update state health care program enrollee addresses and related contact information, at the time of each enrollee contact.

EFFECTIVE DATE. This section is effective July 1, 2008.

Sec. 3. Minnesota Statutes 2007 Supplement, section 256.962, subdivision 5, is amended to read:

Subd. 5. **Incentive program.** Beginning January 1, 2008, the commissioner shall establish an incentive program for organizations that directly identify and assist potential enrollees in filling out and submitting an application. For each applicant who is successfully enrolled in MinnesotaCare, medical assistance, or general assistance medical care, the commissioner, within the available appropriation, shall pay the organization a ~~$20~~ $25 application assistance bonus. The organization may provide an applicant a gift certificate or other incentive upon enrollment.

Sec. 4. Minnesota Statutes 2007 Supplement, section 256.962, subdivision 6, is amended to read:

Subd. 6. **School districts.** (a) At the beginning of each school year, a school district shall provide information to each student on the availability of health care coverage through the Minnesota health care programs.

(b) For each child who is determined to be eligible for ~~a~~ the free ~~or~~ and reduced ~~priced~~ school lunch program, the district shall provide the child's family with ~~an application for the Minnesota health care programs and~~ information on how to obtain an application for the Minnesota health care programs and application assistance.

(c) A district shall also ensure that applications and information on application assistance are available at early childhood education sites and public schools located within the district's jurisdiction.

(d) Each district shall designate an enrollment specialist to provide application assistance and follow-up services with families ~~who are eligible for the reduced or free lunch program or~~ who have indicated an interest in receiving information or an application for the Minnesota health care

program. A district is eligible for the application assistance bonus described in subdivision 5.

(e) Each school district shall provide on their Web site a link to information on how to obtain an application and application assistance.

Sec. 5. Minnesota Statutes 2006, section 256B.057, subdivision 8, is amended to read:

Subd. 8. **Children under age two.** Medical assistance may be paid for a child under two years of age whose countable family income is above 275 percent of the federal poverty guidelines for the same size family but less than or equal to ~~280~~ 305 percent of the federal poverty guidelines for the same size family.

EFFECTIVE DATE. This section is effective July 1, 2010, or upon federal approval, whichever is later.

Sec. 6. Minnesota Statutes 2007 Supplement, section 256L.04, subdivision 1, is amended to read:

Subdivision 1. **Families with children.** (a) Families with children with family income equal to or less than ~~275~~ 300 percent of the federal poverty guidelines for the applicable family size shall be eligible for MinnesotaCare according to this section. All other provisions of sections 256L.01 to 256L.18, including the insurance-related barriers to enrollment under section 256L.07, shall apply unless otherwise specified.

(b) Parents who enroll in the MinnesotaCare program must also enroll their children, if the children are eligible. Children may be enrolled separately without enrollment by parents. However, if one parent in the household enrolls, both parents must enroll, unless other insurance is available. If one child from a family is enrolled, all children must be enrolled, unless other insurance is available. If one spouse in a household enrolls, the other spouse in the household must also enroll, unless other insurance is available. Families cannot choose to enroll only certain uninsured members.

(c) Beginning October 1, 2003, the dependent sibling definition no longer applies to the MinnesotaCare program. These persons are no longer counted in the parental household and may apply as a separate household.

(d) ~~Beginning July 1, 2003, or upon federal approval, whichever is later, parents are not eligible for MinnesotaCare if their gross income exceeds $50,000.~~

~~(e)~~ Children formerly enrolled in medical assistance and automatically deemed eligible for MinnesotaCare according to section 256B.057, subdivision 2c, are exempt from the requirements of this section until renewal.

EFFECTIVE DATE. This section is effective July 1, 2010, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 7. Minnesota Statutes 2007 Supplement, section 256L.04, subdivision 7, is amended to read:

Subd. 7. **Single adults and households with no children.** (a) The definition of eligible persons includes all individuals and households with no children who have gross family incomes that are equal to or less than 200 percent of the federal poverty guidelines.

(b) Effective July 1, 2009, the definition of eligible persons includes all individuals and households with no children who have gross family incomes that are equal to or less than 215 percent of the federal poverty guidelines.

(c) Effective July 1, 2010, the definition of eligible persons includes all individuals and households with no children who have gross family incomes that are equal to or less than 300 percent of the federal poverty guidelines.

Sec. 8. Minnesota Statutes 2007 Supplement, section 256L.05, subdivision 3a, is amended to read:

Subd. 3a. **Renewal of eligibility.** (a) Beginning July 1, 2007, an enrollee's eligibility must be renewed every 12 months. The 12-month period begins in the month after the month the application is approved.

(b) Each new period of eligibility must take into account any changes in circumstances that impact eligibility and premium amount. An enrollee must provide all the information needed to redetermine eligibility by the first day of the month that ends the eligibility period. If there is no change in circumstances, the enrollee may renew eligibility at designated locations that include community clinics and health care providers' offices. The designated sites shall forward the renewal forms to the commissioner. The premium for the new period of eligibility must be received as provided in section 256L.06 in order for eligibility to continue.

(c) For single adults and households with no children formerly enrolled in general assistance medical care and enrolled in MinnesotaCare according to section 256D.03, subdivision 3, the first period of eligibility begins the month the enrollee submitted the application or renewal for general assistance medical care.

(d) An enrollee who fails to submit renewal forms and related documentation necessary for verification of continued eligibility in a timely manner shall remain eligible for one additional month beyond the end of the current eligibility period, before being disenrolled. The enrollee remains responsible for MinnesotaCare premiums for the additional month.

EFFECTIVE DATE. This section is effective January 1, 2009, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 9. Minnesota Statutes 2006, section 256L.05, is amended by adding a subdivision to read:

Subd. 6. **Delayed verification.** On the basis of information provided on the completed application, an applicant whose gross income is less than 90 percent of the applicable income standard and meets all other eligibility requirements, including compliance at the time of application with citizenship or nationality documentation requirements under section 256L.04, subdivision 10, must be determined eligible and enrolled upon payment of premiums according to subdivision 3. The applicant shall provide all required verifications within 60 days' notice of the eligibility determination, or eligibility shall be denied or canceled. Applicants who are denied or canceled for failure to provide all required verifications are not eligible for coverage using the delayed verification procedures specified in this subdivision for 12 months.

EFFECTIVE DATE. This section is effective January 1, 2009, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when

federal approval is obtained.

Sec. 10. Minnesota Statutes 2006, section 256L.06, subdivision 3, is amended to read:

Subd. 3. **Commissioner's duties and payment.** (a) Premiums are dedicated to the commissioner for MinnesotaCare.

(b) The commissioner shall develop and implement procedures to: (1) require enrollees to report changes in income; (2) adjust sliding scale premium payments, based upon both increases and decreases in enrollee income, at the time the change in income is reported; and (3) disenroll enrollees from MinnesotaCare for failure to pay required premiums. Failure to pay includes payment with a dishonored check, a returned automatic bank withdrawal, or a refused credit card or debit card payment. The commissioner may demand a guaranteed form of payment, including a cashier's check or a money order, as the only means to replace a dishonored, returned, or refused payment.

(c) Premiums are calculated on a calendar month basis and may be paid on a monthly, quarterly, or semiannual basis, with the first payment due upon notice from the commissioner of the premium amount required. The commissioner shall inform applicants and enrollees of these premium payment options. Premium payment is required before enrollment is complete and to maintain eligibility in MinnesotaCare. Premium payments received before noon are credited the same day. Premium payments received after noon are credited on the next working day.

(d) Nonpayment of the premium will result in disenrollment from the plan effective ~~for~~ the first day of the calendar month following the calendar month for which the premium was due. Persons disenrolled for nonpayment or who voluntarily terminate coverage from the program may not reenroll until four calendar months have elapsed. ~~Persons disenrolled for nonpayment who pay all past due premiums as well as current premiums due, including premiums due for the period of disenrollment, within 20 days of disenrollment, shall be reenrolled retroactively to the first day of disenrollment~~ The commissioner shall waive premiums for coverage provided under this paragraph to persons disenrolled for nonpayment who reapply under section 256L.05, subdivision 3b. Persons disenrolled for nonpayment or who voluntarily terminate coverage from the program may not reenroll for four calendar months unless the person demonstrates good cause for nonpayment. Good cause does not exist if a person chooses to pay other family expenses instead of the premium. The commissioner shall define good cause in rule.

EFFECTIVE DATE. This section is effective January 1, 2009, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 11. Minnesota Statutes 2007 Supplement, section 256L.07, subdivision 1, is amended to read:

Subdivision 1. **General requirements.** (a) Children enrolled in the original children's health plan as of September 30, 1992, children who enrolled in the MinnesotaCare program after September 30, 1992, pursuant to Laws 1992, chapter 549, article 4, section 17, and children who have family gross incomes that are equal to or less than 150 percent of the federal poverty guidelines are eligible without meeting the requirements of subdivision 2 ~~and the four-month requirement in subdivision 3~~, as long as they maintain continuous coverage in the MinnesotaCare program or medical assistance. Children who apply for MinnesotaCare on or after the implementation date of the employer-subsidized health coverage program as described in Laws 1998, chapter 407, article

5, section 45, who have family gross incomes that are equal to or less than 150 percent of the federal poverty guidelines, must meet the requirements of subdivision 2 to be eligible for MinnesotaCare.

Families enrolled in MinnesotaCare under section 256L.04, subdivision 1, whose income increases above ~~275~~ 300 percent of the federal poverty guidelines, are no longer eligible for the program and shall be disenrolled by the commissioner. Beginning January 1, 2008, individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose income increases above 200 percent of the federal poverty guidelines or 215 percent of the federal poverty guidelines on or after July 1, 2009, or 300 percent of federal poverty guidelines on or after July 1, 2010, are no longer eligible for the program and shall be disenrolled by the commissioner. For persons disenrolled under this subdivision, MinnesotaCare coverage terminates the last day of the calendar month following the month in which the commissioner determines that the income of a family or individual exceeds program income limits.

(b) Notwithstanding paragraph (a), children may remain enrolled in MinnesotaCare if ten percent of their gross individual or gross family income as defined in section 256L.01, subdivision 4, is less than the annual premium for a policy with a $500 deductible available through the Minnesota Comprehensive Health Association. Children who are no longer eligible for MinnesotaCare under this clause shall be given a 12-month notice period from the date that ineligibility is determined before disenrollment. The premium for children remaining eligible under this clause shall be the maximum premium determined under section 256L.15, subdivision 2, paragraph (b).

~~(c) Notwithstanding paragraphs (a) and (b), parents are not eligible for MinnesotaCare if gross household income exceeds $50,000 for the 12-month period of eligibility.~~

EFFECTIVE DATE. The effective date for the amendment to paragraph (a) related to the four-month requirement is effective January 1, 2009, or upon federal approval, whichever is later. The effective date for the amendment of paragraph (a) related to the expansion in eligibility to 300 percent of federal poverty guidelines, and the amendment to paragraph (c), are effective July 1, 2010.

Sec. 12. Minnesota Statutes 2006, section 256L.07, subdivision 3, is amended to read:

Subd. 3. **Other health coverage.** (a) Families and individuals enrolled in the MinnesotaCare program must have no health coverage while enrolled ~~or for at least four months prior to application and renewal.~~ Children enrolled in the original children's health plan and children in families with income equal to or less than 150 percent of the federal poverty guidelines, who have other health insurance, are eligible if the coverage:

(1) lacks two or more of the following:

(i) basic hospital insurance;

(ii) medical-surgical insurance;

(iii) prescription drug coverage;

(iv) dental coverage; or

(v) vision coverage;

(2) requires a deductible of $100 or more per person per year; or

(3) lacks coverage because the child has exceeded the maximum coverage for a particular diagnosis or the policy excludes a particular diagnosis.

The commissioner may change this eligibility criterion for sliding scale premiums in order to remain within the limits of available appropriations. The requirement of no health coverage does not apply to newborns.

(b) Medical assistance, general assistance medical care, and the Civilian Health and Medical Program of the Uniformed Service, CHAMPUS, or other coverage provided under United States Code, title 10, subtitle A, part II, chapter 55, are not considered insurance or health coverage for purposes of ~~the four-month requirement described in~~ this subdivision.

~~(c)~~ For purposes of this subdivision, an applicant or enrollee who is entitled to Medicare Part A or enrolled in Medicare Part B coverage under title XVIII of the Social Security Act, United States Code, title 42, sections 1395c to 1395w-152, is considered to have health coverage. An applicant or enrollee who is entitled to premium-free Medicare Part A may not refuse to apply for or enroll in Medicare coverage to establish eligibility for MinnesotaCare.

~~(d)~~ (c) Applicants who were recipients of medical assistance or general assistance medical care within one month of application must meet the provisions of this subdivision and subdivision 2.

~~(e) Cost-effective health insurance that was paid for by medical assistance is not considered health coverage for purposes of the four-month requirement under this section, except if the insurance continued after medical assistance no longer considered it cost-effective or after medical assistance closed.~~

EFFECTIVE DATE. This section is effective January 1, 2009, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 13. Minnesota Statutes 2007 Supplement, section 256L.15, subdivision 2, is amended to read:

Subd. 2. **Sliding fee scale; monthly gross individual or family income.** (a) The commissioner shall establish a sliding fee scale to determine the percentage of monthly gross individual or family income that households at different income levels must pay to obtain coverage through the MinnesotaCare program. The sliding fee scale must be based on the enrollee's monthly gross individual or family income. The sliding fee scale must contain separate tables based on enrollment of one, two, or three or more persons. Until June 30, 2009, the sliding fee scale begins with a premium of 1.5 percent of monthly gross individual or family income for individuals or families with incomes below the limits for the medical assistance program for families and children in effect on January 1, 1999, and proceeds through the following evenly spaced steps: 1.8, 2.3, 3.1, 3.8, 4.8, 5.9, 7.4, and 8.8 percent. These percentages are matched to evenly spaced income steps ranging from the medical assistance income limit for families and children in effect on January 1, 1999, to 275 percent of the federal poverty guidelines for the applicable family size, up to a family size of five. The sliding fee scale for a family of five must be used for families of more than five. The sliding fee scale and percentages are not subject to the provisions of chapter 14. If a family or individual reports increased income after enrollment, premiums shall be adjusted at the time the change in income is reported.

(b) ~~Families~~ Children in families whose gross income is above ~~275~~ 300 percent of the federal poverty guidelines shall pay the maximum premium. The maximum premium is defined as a base charge for one, two, or three or more enrollees so that if all MinnesotaCare cases paid the maximum premium, the total revenue would equal the total cost of MinnesotaCare medical coverage and administration. In this calculation, administrative costs shall be assumed to equal ten percent of the total. The costs of medical coverage for pregnant women and children under age two and the enrollees in these groups shall be excluded from the total. The maximum premium for two enrollees shall be twice the maximum premium for one, and the maximum premium for three or more enrollees shall be three times the maximum premium for one.

(c) Beginning July 1, 2009, MinnesotaCare enrollees shall pay premiums according to the affordability scale established in section 62U.08 with the exception that children in families with income at or below 150 percent of the federal poverty guidelines shall pay a monthly premium of $4. For purposes of this paragraph, and the affordability standard under section 62U.09, "minimum" means a monthly premium of $4.

EFFECTIVE DATE. This section is effective January 1, 2009, or upon federal approval, whichever is later, except that the amendment to paragraph (b) related to the expansion in eligibility to 300 percent of federal poverty guidelines is effective July 1, 2010, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 14. Laws 2007, chapter 147, article 5, section 19, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective July 1, ~~2007, or upon federal approval, whichever is later~~ 2008.

Sec. 15. **REPEALER.**

Minnesota Statutes 2006, section 256L.15, subdivision 3, is repealed.

EFFECTIVE DATE. This section is effective January 1, 2009, or upon federal approval of the amendments to Minnesota Statutes, section 256L.15, subdivision 2, paragraph (c), whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

ARTICLE 4

HEALTH INSURANCE PURCHASING AND AFFORDABILITY REFORM

Section 1. Minnesota Statutes 2007 Supplement, section 62J.495, is amended by adding a subdivision to read:

Subd. 3. **Interoperable electronic health record requirements.** To meet the requirements of subdivision 1, hospitals and health care providers must meet the following criteria when implementing an interoperable electronic health records system within their hospital system or clinical practice setting.

(a) The electronic health record must be certified by the Certification Commission for Healthcare Information Technology, or its successor. This criterion only applies to hospitals and health care providers whose practice setting is a practice setting covered by Certification Commission for

Healthcare Information Technology certifications. This criterion shall be considered met if a hospital or health care provider is using an electronic health records system that has been certified within the last three years, even if a more current version of the system has been certified within the three-year period.

(b) A health care provider who is a prescriber or dispenser of controlled substances must have an electronic health record system that meets the requirements of section 62J.497.

Sec. 2. **[62J.497] ELECTRONIC PRESCRIPTION DRUG PROGRAM.**

Subdivision 1. **Definitions.** For the purposes of this section, the following terms have the meanings given.

(a) "Dispense" or "dispensing" has the meaning given in section 151.01, subdivision 30. Dispensing does not include the direct administering of a controlled substance to a patient by a licensed health care professional.

(b) "Dispenser" means a person authorized by law to dispense a controlled substance, pursuant to a valid prescription.

(c) "Electronic media" has the same meaning given this term under Code of Federal Regulations, title 45, part 160.103.

(d) "E-prescribing" means the transmission using electronic media, of prescription or prescription-related information between a prescriber, dispenser, pharmacy benefit manager, or group purchaser, either directly or through an intermediary, including an e-prescribing network. E-prescribing includes, but is not limited to, two-way transmissions between the point of care and the dispenser.

(e) "Electronic prescription drug program" means a program that provides for e-prescribing.

(f) "Group purchaser" has the meaning given in section 62J.03, subdivision 6.

(g) "HL7 messages" means a standard approved by the standards development organization known as Health Level Seven.

(h) "National Provider Identifier" or "NPI" means the identifier described under Code of Federal Regulations, title 45, part 162.406.

(i) "NCPDP" means the National Council for Prescription Drug Programs, Inc.

(j) "NCPDP Formulary and Benefits Standard" means the National Council for Prescription Drug Programs Formulary and Benefits Standard, Implementation Guide, Version 1, Release 0, October 2005.

(k) "NCPDP SCRIPT Standard" means the National Council for Prescription Drug Programs Prescriber/Pharmacist Interface SCRIPT Standard, Implementation Guide Version 8, Release 1 (Version 8.1), October 2005.

(l) "Pharmacy" has the meaning given in section 151.01, subdivision 2.

(m) "Prescriber" means a licensed health care professional who is authorized to prescribe a controlled substance under section 152.12, subdivision 1.

(n) "Prescription-related information" means information regarding eligibility for drug benefits, medication history, or related health or drug information.

(o) "Provider" or "health care provider" has the meaning given in section 62J.03, subdivision 8.

Subd. 2. **Requirements for electronic prescribing.** (a) Effective January 1, 2011, all providers, group purchasers, prescribers, and dispensers must establish and maintain an electronic prescription drug program that complies with the applicable standards in this section for transmitting, directly or through an intermediary, prescriptions and prescription-related information using electronic media.

(b) Nothing in this section requires providers, group purchasers, prescribers, or dispensers to conduct the transactions described in this section. If transactions described in this section are conducted, they must be done electronically using the standards described in this section. Nothing in this section requires providers, group purchasers, prescribers, or dispensers to electronically conduct transactions that are expressly prohibited by other sections or federal law.

(c) Providers, group purchasers, prescribers, and dispensers must use either HL7 messages or the NCPDP SCRIPT Standard to transmit prescriptions or prescription-related information internally when the sender and the recipient are part of the same legal entity. If an entity sends prescriptions outside the entity, it must use the NCPDP SCRIPT Standard or other applicable standards required by this section. Any pharmacy within an entity must be able to receive electronic prescription transmittals from outside the entity using the adopted NCPDP SCRIPT Standard. This exemption does not supersede any Health Insurance Portability and Accountability Act (HIPAA) requirement that may require the use of a HIPAA transaction standard within an organization.

(d) Entities transmitting prescriptions or prescription-related information where the prescriber is required by law to issue a prescription for a patient to a nonprescribing provider that in turn forwards the prescription to a dispenser are exempt from the requirement to use the NCPDP SCRIPT Standard when transmitting prescriptions or prescription-related information.

Subd. 3. **Standards for electronic prescribing.** (a) Prescribers and dispensers must use the NCPDP SCRIPT Standard for the communication of a prescription or prescription-related information. The NCPDP SCRIPT Standard shall be used to conduct the following transactions:

(1) get message transaction;

(2) status response transaction;

(3) error response transaction;

(4) new prescription transaction;

(5) prescription change request transaction;

(6) prescription change response transaction;

(7) refill prescription request transaction;

(8) refill prescription response transaction;

(9) verification transaction;

(10) password change transaction;

(11) cancel prescription request transaction; and

(12) cancel prescription response transaction.

(b) Providers, group purchasers, prescribers, and dispensers must use the NCPDP SCRIPT Standard for communicating and transmitting medication history information.

(c) Providers, group purchasers, prescribers, and dispensers must use the NCPDP Formulary and Benefits Standard for communicating and transmitting formulary and benefit information.

(d) Providers, group purchasers, prescribers, and dispensers must use the national provider identifier to identify a health care provider in e-prescribing or prescription related transactions when a health care provider's identifier is required.

(e) Providers, group purchasers, prescribers, and dispensers must communicate eligibility information and conduct health care eligibility benefit inquiry and response transactions according to the requirements of section 62J.536.

Sec. 3. **[62U.01] DEFINITIONS.**

Subdivision 1. **Applicability.** For purposes of this chapter, the terms defined in this section have the meanings given, unless otherwise specified.

Subd. 2. **Basket or baskets of care.** "Basket" or "baskets of care" means a collection of health care services that are paid separately under a fee-for-service system, but which are ordinarily combined by a provider in delivering a full diagnostic or treatment procedure to a patient.

Subd. 3. **Clinically effective.** "Clinically effective" means that the use of a particular health technology or service improves or prevents a decline in patient clinical status, as measured by medical condition, survival rates, and other variables, and that the use of the particular technology or service demonstrates a clinical or outcome advantage over alternative technologies or services. This definition shall not be used to exclude or deny technology or treatment necessary to preserve life on the basis of an individual's age or expected length of life or of the individual's present or predicted disability, degree of medical dependency, or quality of life.

Subd. 4. **Cost-effective.** "Cost-effective" means that the economic costs of using a particular service, device, or health technology to achieve improvement or prevent a decline in a patient's health outcome are justified given the comparison to both the economic costs and the improvement or prevention of decline in patient health outcome resulting from the use of an alternative service, device, or technology, or from not providing the service, device, or technology.

Subd. 5. **Group purchaser.** "Group purchaser" has the meaning provided in section 62J.03.

Subd. 6. **Health plan.** "Health plan" means a health plan as defined in section 62A.011.

Subd. 7. **Health plan company.** "Health plan company" has the meaning provided in section 62Q.01, subdivision 4.

Subd. 8. **Participating provider.** "Participating provider" means a provider who has entered into a service agreement with a health plan company.

Subd. 9. **Provider or health care provider.** "Provider" or "health care provider" means a health

care provider as defined in section 62J.03, subdivision 8.

Subd. 10. **Service agreement.** "Service agreement" means an agreement, contract, or other arrangement between a health plan company and a provider under which the provider agrees that when health services are provided for an enrollee, the provider shall not make a direct charge against the enrollee for those services or parts of services that are covered by the enrollee's contract, but shall look to the service plan corporation for the payment for covered services, to the extent they are covered.

Subd. 11. **State health care program.** "State health care program" means the medical assistance, MinnesotaCare, and general assistance medical care programs.

Subd. 12. **Third-party administrator.** "Third-party administrator" means a vendor of risk-management services or an entity administering a self-insurance or health insurance plan under section 60A.23.

Sec. 4. **[62U.02] VALUE-BASED BENEFIT SET AND DESIGN.**

Subdivision 1. **Creation.** By October 15, 2009, the commissioner of health shall make recommendations to the legislature on the components and design of a value-based set of health benefits. The commissioner shall convene an advisory committee to assist in preparing recommendations. Prior to recommending the value-based benefit set and design, the commissioner and advisory committee shall convene public hearings throughout the state.

Subd. 2. **Operations of advisory committee.** The advisory committee shall consist of no more than 11 members. The members shall be appointed by the commissioner and must have expertise in benefit design and development in terms of outcomes, actuarial health care analysis, or knowledge relating to the analysis of the cost impact of coverage of specified benefits. The commissioner shall convene the first meeting on or before September 1, 2008, upon the appointment of the initial committee and must meet at least once a year, and at other times as necessary. The commissioner shall provide office space, equipment and supplies, and technical support to the advisory committee. In establishing the benefit set, the committee shall consult with organizations with expertise in formulating scientifically based practice standards. The advisory committee shall be governed by section 15.059, except the committee shall not expire.

Subd. 3. **Immunity of liability.** No member of the advisory committee shall be held civilly liable for an act or omission by that member if the act or omission was in good faith and within the scope of the member's responsibilities under this chapter.

Subd. 4. **Benefit set design.** (a) The value-based set of health benefits must provide individuals and families with access to a broad range of health care services, including preventive health care, without incurring severe financial loss as a result of serious illness or injury. The benefit set must include health care services, procedures, and diagnostic tests that are scientifically proven to be both clinically effective and cost effective. The benefit set may require differentiated co-pays and deductibles based upon the clinical effectiveness and cost effectiveness of a particular health care service. The advisory committee must consider including cost effective and clinically effective dental care, mental health services, chemical dependency treatment, vision care, language interpreter services, emergency transportation, and prescription drugs. The committee shall consider cultural, ethnic, and religious values and beliefs to ensure that the health care needs of all Minnesota residents are addressed in the benefit set.

(b) The benefit set must identify and include the following services with minimal or no cost-sharing requirements, if the committee determines that the savings and health quality improvements associated with broad access are equal to or greater than the cost of providing the services: preventive services, chronic care coordination, early diagnostic tests, and outpatient care for asthma, heart disease, diabetes, and depression.

(c) The benefit set shall, to the extent possible, be designed to be affordable to Minnesotans consistent with the affordability standard established in section 62U.09.

(d) The benefit design must establish a limited number of maximum cost-sharing variations based upon deductibles and maximum out-of-pocket costs. There must be no maximum lifetime benefit.

(e) The commissioners of human services and finance shall, to the extent possible, consider incorporating the benefit design into the state public health care programs and the state employee group insurance program.

(f) The commissioners of health and commerce shall report to the legislature on necessary changes needed to current mandated benefit sets to incorporate the benefit design developed under this section.

Subd. 5. **Continued review.** The commissioner and the committee shall review the benefit set and design on an ongoing periodic basis and shall adjust the benefit set and design as necessary, to ensure that the benefit set and design continues to be safe, effective, and scientifically based.

Sec. 5. **[62U.03] HEALTH TECHNOLOGY ASSESSMENT REVIEW.**

The commissioner of health, in consultation with the Health Advisory Council, the Institute for Clinical Systems, and practicing health care providers who either use health technology in their scope of practice or have an expertise in health technology, shall review the health technology assessments of new and existing health technologies that have been conducted by existing programs, including but not limited to, the state of Washington's health technology assessment program and the Medicaid Evidence-Based Decisions Project for inclusion to the value-based benefit set and design under section 62U.02.

Sec. 6. **[62U.04] PAYMENT RESTRUCTURING; INCENTIVE PAYMENTS BASED ON QUALITY OF CARE.**

Subdivision 1. **Development.** (a) The commissioner of health shall develop a standardized set of measures by which to assess the quality of health care services offered by health care providers, including health care providers certified as health care homes under section 256B.0751. Quality measures must be based on medical evidence and be developed through a process in which providers participate. The measures shall be used for the quality incentive payment system developed in subdivision 2 and must:

(1) include uniform definitions, measures, and forms for submission of data, to the greatest extent possible;

(2) seek to avoid increasing the administrative burden on health care providers;

(3) be initially based on existing quality indicators for physician and hospital services, which

are measured and reported publicly by quality measurement organizations including Minnesota Community Measurement and specialty societies;

(4) place a priority on measures of health care outcomes, rather than process measures, wherever possible; and

(5) incorporate measures for primary care, including preventive services, coronary artery and heart disease, diabetes, asthma, depression, and other measures as determined by the commissioner.

(b) The measures shall be reviewed at least annually by the commissioner.

Subd. 2. **Quality incentive payments.** (a) By July 1, 2009, the commissioner shall develop a system of quality incentive payments under which providers are eligible for quality-based payments that are in addition to existing payment levels, based upon a comparison of provider performance against specified targets, including improvement over time. The targets must be based upon and consistent with the quality measures established under subdivision 1.

(b) To the extent possible, the payment system must adjust for variations in patient population, in order to reduce incentives to health care providers to avoid high-risk patients or populations.

(c) The requirements of section 62Q.101 do not apply under this incentive payment system.

Subd. 3. **Quality transparency.** The commissioner shall establish standards for measuring health outcomes, establish a system for risk adjusting quality measures, and issue annual public reports on provider quality beginning July 1, 2010. By January 1, 2010, physician clinics and hospitals shall submit standardized electronic information on the outcomes and processes associated with patient care to the commissioner or the commissioner's designee. In addition to measures of care processes and outcomes, the report may include other measures designated by the commissioner, including, but not limited to, care infrastructure and patient satisfaction. The commissioner shall ensure that any quality data reporting requirements established under this subdivision are not duplicative of publicly reported, community-wide quality reporting activities currently under way in Minnesota. Nothing in this subdivision is intended to replace or duplicate current privately supported activities related to quality measurement and reporting in Minnesota.

Subd. 4. **Contracting.** The commissioner may contract with a private entity or consortium of private entities to complete the tasks in subdivisions 1, 2, and 3. The private entity or consortium must be nonprofit and have governance that includes representatives from the following stakeholder groups: health care providers, health plan companies, consumers, employers or other health care purchasers, and state government. No one stakeholder group shall have a majority of the votes on any issue or hold extraordinary powers not granted to any other governance stakeholder.

Subd. 5. **Implementation.** (a) By January 1, 2010, health plan companies shall use the standardized quality measures established under this section and shall not require providers to use and report health plan company-specific quality and outcome measures.

(b) By July 1, 2010, the commissioner of human services shall implement this incentive payment system for all enrollees in state health care programs consistent with relevant state and federal statute and rule.

(c) By July 1, 2010, the commissioner of finance shall implement this incentive payment system for all participants in the state employee group insurance program.

(d) By July 1, 2010, all health plan company incentive based performance payment systems shall comply with subdivision 2 for all participating providers.

Sec. 7. **[62U.05] PAYMENT RESTRUCTURING; CARE COORDINATION PAYMENTS.**

By July 1, 2010, health plan companies shall integrate health care homes into their provider networks and shall develop a payment system that provides per-person care coordination payments to health care providers for providing care coordination services and directly managing onsite or employing care coordinators for their members who choose to enroll in health care homes certified by the commissioners of health and human services under section 256B.0751. Health plan companies shall develop payment conditions and terms for the care coordination fee for health care homes participating in their network in a manner that is consistent with the system developed under section 256B.0751. Nothing in this section shall restrict the ability of health plan companies to selectively contract with health care providers, including health care homes.

Sec. 8. **[62U.06] PAYMENT REFORM TO REDUCE HEALTH CARE COSTS AND IMPROVE QUALITY.**

Subdivision 1. **Development of uniform standards.** The commissioner of health shall develop the uniform standards identified in this section needed to implement on a broad scale innovative payment reform that rewards quality and efficiency. The development of the standards must be completed by January 1, 2010.

Subd. 2. **Calculation of health care costs and quality.** The commissioner shall develop a method of calculating providers' relative cost of care, defined as a measure of health care spending including resource use and unit prices, and relative quality of care. In developing this method, the commissioner must address the following issues:

(1) provider attribution of costs and quality;

(2) appropriate adjustment for outlier or catastrophic cases;

(3) appropriate risk adjustment to reflect differences in the demographics and health status across provider patient populations, using generally accepted and transparent risk adjustment methodologies;

(4) specific types of providers that should be included in the calculation;

(5) specific types of services that should be included in the calculation;

(6) appropriate adjustment for variation in payment rates;

(7) the appropriate provider level for analysis;

(8) payer mix adjustments, including variation across providers in the percentage of revenue received from government programs; and

(9) other factors that the commissioner determines are needed to ensure validity and comparability of the analysis.

Subd. 3. **Provider peer grouping.** (a) The commissioner shall develop a peer grouping system for providers based on a measure that incorporates both provider risk-adjusted cost of care and

quality of care for specific conditions as determined by the commissioner. In developing this system, the commissioner shall consult and coordinate with health care providers, health plan companies, state agencies, and organizations that work to improve health care quality in Minnesota. However, in the final development of this peer grouping system, the commissioner shall not contract with any private entity, organization, or consortium of entities that has or will have a direct financial interest in the outcome of this system.

(b) Beginning June 1, 2010, the commissioner shall disseminate information to providers on their cost of care, resource use, quality of care, and the results of the grouping developed under this subdivision in comparison to an appropriate peer group. Any analyses or reports that identify providers may only be published after the provider has been provided the opportunity by the commissioner to review the underlying data and submit comments. The provider shall have 21 days to review the data for accuracy.

(c) The commissioner shall establish an appeals process to resolve disputes from providers regarding the accuracy of the data used to develop analyses or reports.

(d) Beginning September 1, 2010, the commissioner shall, no less than annually, publish information on providers' cost, quality, and the results of the peer grouping process. The results that are published must be on a risk-adjusted basis.

Subd. 4. **Encounter data.** (a) Beginning July 1, 2009, and every six months thereafter, all health plan companies and third-party administrators shall submit encounter data to a private entity designated by the commissioner of health. The data shall be submitted in a form and manner specified by the commissioner subject to the following requirements:

(1) the data must be de-identified data as described under the Code of Federal Regulations, title 45, section 164.514;

(2) the data for each encounter must include an identifier for the patient's health care home if the patient has selected a health care home; and

(3) except for the identifier described in clause (2), the data must not include information that is not included in a health care claim or equivalent encounter information transaction that is required under section 62J.536.

(b) The commissioner, or the commissioner's designee, shall only use the data submitted under paragraph (a) for the purpose of carrying out its responsibilities in this section, and must maintain the data that it receives according to the provisions of this section.

(c) Data on providers collected under this subdivision are private data on individuals or nonpublic data, as defined in section 13.02. Notwithstanding the definition of summary data in section 13.02, subdivision 19, summary data prepared under this subdivision may be derived from nonpublic data. The commissioner shall establish procedures and safeguards to protect the integrity and confidentiality of any data that it maintains.

(d) The commissioner, or the commissioner's designee, shall not publish analyses or reports that identify, or could potentially identify, individual patients.

Subd. 5. **Pricing data.** (a) Beginning July 1, 2009, and annually on January 1 thereafter, all health plan companies and third-party administrators shall submit data on their contracted prices

with health care providers to a private entity designated by the commissioner of health for the purposes of performing the analyses required under this subdivision. The data shall be submitted in the form and manner specified by the commissioner of health.

(b) The commissioner shall only use the data submitted under this subdivision for the purpose of carrying out its responsibilities under this section.

(c) Data collected under this subdivision are nonpublic data as defined in section 13.02. Notwithstanding the definition of summary data in section 13.02, subdivision 19, summary data prepared under this section may be derived from nonpublic data. The commissioner shall establish procedures and safeguards to protect the integrity and confidentiality of any data that it maintains.

Subd. 6. **Contracting.** The commissioner may contract with a private entity or consortium of entities to develop the standards. The private entity or consortium must be nonprofit and have governance that includes representatives from the following stakeholder groups: health care providers, health plans, hospitals, consumers, employers or other health care purchasers, and state government. The entity or consortium must ensure that the representatives of stakeholder groups in the aggregate reflect all geographic areas of the state. No one stakeholder group shall have a majority of the votes on any issue or hold extraordinary powers not granted to any other governance stakeholder.

Subd. 7. **Provider innovation to reduce health care costs and improve quality.** (a) Nothing in this section shall prohibit group purchasers and health care providers, upon mutual agreement, from entering into arrangements that establish package prices for a comprehensive set of services or separately for the cost of care for specific health conditions in addition to the baskets of care established in section 62U.07, in order to give providers the flexibility to innovate on ways to reduce health care costs while improving overall quality of care and health outcomes.

(b) The commissioner of health may convene working groups of private sector payers and health care providers to discuss and develop new strategies for reforming health care payment systems to promote innovative care delivery that reduces health care costs and improves quality.

Subd. 8. **Uses of information.** (a) By January 1, 2011:

(1) the commissioner of finance shall use the information and methods developed under subdivision 3 to strengthen incentives for members of the state employee group insurance program to use high-quality, low-cost providers;

(2) the commissioner of human services shall use the information and methods developed under subdivision 3 to establish a payment system that:

(i) rewards high-quality, low-cost providers;

(ii) creates enrollee incentives to receive care from high-quality, low-cost providers; and

(iii) fosters collaboration among providers to reduce cost shifting from one part of the health continuum to another;

(3) all political subdivisions, as defined in section 13.02, subdivision 11, that offer health benefits to their employees must offer plans that differentiate providers on their cost and quality performance and create incentives for members to use better-performing providers;

(4) all health plan companies shall use the information and methods developed under subdivision 3 to develop products that encourage consumers to use high-quality, low-cost providers; and

(5) health plan companies that issue health plans in the individual market or the small employer market must offer at least one health plan that uses the information developed under subdivision 3 to establish financial incentives for consumers to choose high-quality, low-cost providers through enrollee cost-sharing or selective provider networks.

(b) By January 1, 2011, the commissioner of health shall report to the governor and the legislature on recommendations to encourage health plan companies to promote widespread adoption of products that encourage the use of high-quality, low-cost providers. The commissioner's recommendations may include tax incentives, public reporting of health plan performance, regulatory incentives or changes, and other strategies.

(c) The commissioner of health shall consult with an advisory group comprised of employers and consumers to utilize the cost and provider quality information developed under subdivision 3 to identify ways to improve overall health care costs and quality for residents of Minnesota.

Sec. 9. **[62U.07] PROVIDER PRICING FOR BASKETS OF CARE.**

Subdivision 1. **Establishment of definitions.** (a) The commissioner of health shall establish uniform definitions for baskets of care beginning with a minimum of 15 baskets of care. In selecting health conditions for which baskets of care should be defined, the commissioner shall consider coronary artery and heart disease, diabetes, asthma, and depression. In selecting health conditions, the commissioner shall also consider the prevalence of the health conditions, the cost of treating the health conditions, and the potential for innovations to reduce cost and improve quality resulting from establishing a basket of care for a specific health condition.

(b) The commissioner shall convene one or more work groups to assist in establishing these definitions. Each work group shall include members appointed by statewide associations representing relevant health care providers and health plan companies, and organizations that work to improve health care quality in Minnesota.

(c) The baskets of care shall incorporate a patient-directed, decision-making support model.

(d) The commissioner shall submit recommendations to the Legislative Commission on Health Care Access on establishing a uniform definition of a basket of total cost of care.

Subd. 2. **Package prices.** (a) Beginning January 1, 2010, health care providers may establish package prices for the baskets of care defined under subdivision 1.

(b) Beginning January 1, 2010, no health care provider or group of providers that has established a package price for a basket of care under this section shall vary the payment amount that the provider accepts as full payment for a health care service based upon the identity of the payer, upon a contractual relationship with a payer, upon the identity of the patient, or upon whether the patient has coverage through a group purchaser. This paragraph applies only to health care services provided to Minnesota residents or to non-Minnesota residents who obtain health insurance through a Minnesota employer. This paragraph does not apply to a variation based upon a payer being a governmental entity, to workers' compensation, or no-fault automobile insurance payments. This paragraph does not affect the right of a provider to provide charity care or care for a reduced price due to financial hardship of the patient or due to the patient being a relative or friend of the provider.

Subd. 3. **Quality measurements for baskets of care.** (a) The commissioner shall establish quality measurements for the defined baskets of care by December 31, 2009. The commissioner may contract with an organization that works to improve health care quality to make recommendations about the use of existing measures or establishing new measures where no measures currently exist.

(b) Beginning July 1, 2010, the commissioner shall publish comparative price and quality information on the baskets of care in a manner that is easily accessible and understandable to the public, as this information becomes available.

Sec. 10. **[62U.08] COORDINATION; LEGISLATIVE OVERSIGHT ON PAYMENT RESTRUCTURING.**

Subdivision 1. **Coordination.** In carrying out the responsibilities of this chapter, the commissioner of health shall ensure that the activities and data collection are implemented in an integrated and coordinated manner that avoids unnecessary duplication of effort. To the extent possible, the commissioner shall use existing data sources and implement methods to streamline data collection in order to reduce public and private sector administrative costs.

Subd. 2. **Legislative oversight.** Beginning December 1, 2008, the commissioner of health shall submit to the Legislative Commission on Health Care Access periodic progress reports on the implementation of this chapter and sections 256B.0751 to 256B.0753 that includes, but is not limited to, the following:

(1) the standardized set of measures that are to be used to access the quality of health care services offered by health care providers developed under section 62U.04;

(2) the identification of the evidence supporting each measure developed under section 62U.04 as an effective method of improving the quality of patient care;

(3) the contract terms and the identity of the consortium if the commissioner contracts with a private entity or consortium of private entities as permitted under sections 62U.04 and 62U.06;

(4) methodology for peer grouping of providers under section 62U.06, subdivision 3;

(5) methodology for calculating providers' relative cost of care under section 62U.06, subdivision 2; and

(6) the uniform definitions of baskets of care under section 62U.07.

Sec. 11. **[62U.09] AFFORDABILITY STANDARD.**

Subdivision 1. **Definition of affordability.** For purposes of this section, coverage is "affordable" if the sum of premiums, deductibles, and other out-of-pocket costs paid by an individual or family for health coverage does not exceed the applicable percentage of the individual or family's gross monthly income specified in subdivision 2.

Subd. 2. **Affordability standard.** The following affordability standard is established for individuals and households with gross family incomes of 400 percent of the federal poverty guidelines or less:

Federal Poverty Guideline Range	**Percent of Average Gross Monthly Income**

0-45%	minimum
46-54%	1.1%
55-81%	1.4%
82-109%	1.9%
110-136%	2.6%
137-164%	3.4%
165-191%	4.4%
192-219%	5.2%
220-248%	5.9%
249-274%	6.5%
275-300%	7.0%
301-325%	7.7%
326-350%	8.4%
351-375%	9.2%
376-400%	10.0%

Subd. 3. **Application.** The affordability standard in this section shall apply only to subsidies under the MinnesotaCare program and the employee subsidy program established under section 62U.10. Nothing in this section shall be construed to limit or restrict the percentage of premiums, deductibles, and other out-of-pocket costs paid by an individual or family in the private commercial health care coverage market.

Sec. 12. **[62U.10] EMPLOYEE SUBSIDIES FOR HEALTH COVERAGE.**

Subdivision 1. **Development of subsidy program.** The commissioner of health, in coordination with the commissioner of human services, shall develop a plan and submit recommendations to the legislature by January 15, 2010, for a subsidy program for eligible individuals and employees with access to employer-subsidized health coverage. The plan may include direct subsidies or tax credits and deductions, including refundable tax credits, or a combination. For purposes of this section, employer-subsidized health coverage has the meaning provided in section 256L.07, subdivision 2, paragraph (c).

Subd. 2. **Eligible employees and dependents; incomes not exceeding 300 percent of federal poverty guidelines.** In order to be eligible for a subsidy under this plan, an employee or dependent with a gross household income that does not exceed 300 percent of the federal poverty guidelines must:

(1) be covered by employer-subsidized health coverage, as defined in section 256L.07, subdivision 2, paragraph (c), that meets the value-based benefit set and design requirements established under section 62U.02; and

(2) meet all eligibility criteria for the MinnesotaCare program established under chapter 256L, except for the requirements related to:

(i) no access to employer-subsidized coverage under section 256L.07, subdivision 2; and

(ii) no other health coverage under section 256L.07, subdivision 3.

Subd. 3. **Eligible individuals, employees and dependents; incomes greater than 300 percent but not exceeding 400 percent of federal poverty guidelines.** In order to be eligible for a subsidy under this plan, an individual, employee, or dependent with a gross household income that is greater than 300 percent but does not exceed 400 percent of the federal poverty guidelines must:

(1) purchase or be covered by health coverage that meets the value-based benefit set and design requirements established under section 62U.02; and

(2) meet all eligibility criteria for the MinnesotaCare program established under chapter 256L, except for the requirements related to:

(i) no access to employer-subsidized coverage under section 256L.07, subdivision 2;

(ii) no other health coverage under section 256L.07, subdivision 3; and

(iii) gross household income under section 256L.04, subdivisions 1 and 7.

Subd. 4. **Amount of subsidy.** The subsidy included in this plan must equal the amount the individual or employee is required to pay for health coverage for the employee and any dependents, including premiums, deductibles, and other cost sharing, minus an amount based on the affordability standard specified in section 62U.09. The maximum subsidy must not exceed the amount of the subsidy that would have been provided under the MinnesotaCare program, if the individual or employee and any dependents were eligible for that program.

Subd. 5. **Payment of subsidy.** The subsidy amount under this plan for an individual or employee and any dependents to the individual's or employee's health plan company, shall be credited toward the individual's or employee's share of premium. Any additional amount paid to the individual's or employee's health plan company that exceeds the individual's or employee's share of premium must be credited first toward the individual's or employee's deductible and then toward any other cost-sharing obligation.

Sec. 13. **[62U.11] PROJECTED AND ACTUAL HEALTH CARE SPENDING.**

Subdivision 1. **Projected spending baseline.** (a) The commissioner of health shall calculate the annual projected total health care spending for the state and establish a health care spending baseline beginning for the calendar year 2008 and for the next ten years based on the annual projected growth in spending.

(b) In establishing the health care spending baseline, the commissioner shall use the Center for Medicare and Medicaid Services forecast for total growth in national health care expenditures, and adjust this forecast to reflect the demographics, health status, and other factors deemed necessary by the commissioner. The commissioner shall contract with an actuarial consultant to make recommendations as to the adjustments needed to specifically reflect projected spending for Minnesota residents.

(c) On an annual basis, the commissioner may adjust the projected baseline as necessary to reflect any updated federal projections or account for unanticipated changes in federal policy.

(d) Medicare and long-term care spending must not be included in the calculations required under this section.

Subd. 2. **Actual spending.** By February 15 of each year, beginning February 15, 2010, the commissioner shall determine the actual private and public health care expenditures for the calendar year two years prior to the current calendar year based on data collected under chapter 62J and shall determine the difference between the projected spending as determined under subdivision 1 and the actual spending for that year. The actual spending must be certified by an independent actuarial consultant.

Subd. 3. **Publication of spending.** By February 15 of each year, beginning February 15, 2010, the commissioner shall publish in the State Register the projected spending baseline, including any adjustments, and the actual spending for the calendar year two years prior to the current calendar year.

Sec. 14. **[62U.12] HEALTH CARE REFORM REVIEW COUNCIL.**

Subdivision 1. **Establishment.** The Health Care Reform Review Council is established for the purpose of periodically reviewing the progress of implementation of this chapter and sections 256B.0751 to 256B.0753.

Subd. 2. **Members.** (a) The Health Care Reform Review Council shall consist of ten members who are appointed as follows:

(1) two members appointed by the Minnesota Medical Association, at least one of whom must represent rural physicians;

(2) one member appointed by the Minnesota Nurses Association;

(3) two members appointed by the Minnesota Hospital Association, at least one of whom must be a rural hospital administrator;

(4) one member appointed by the Minnesota Academy of Physician Assistants;

(5) one member appointed by the Minnesota Business Partnership;

(6) one member appointed by the Minnesota Chamber of Commerce;

(7) one member appointed by the SEIU Minnesota State Council; and

(8) one member appointed by the AFL-CIO.

(b) If a member is no longer able or eligible to participate, a new member shall be appointed by the entity that appointed the outgoing member.

Subd. 3. **Operations of council.** (a) The commissioner of health shall convene the first meeting of the council on or before January 15, 2009, following the initial appointment of the members and the advisory council must meet at least quarterly thereafter.

(b) The council is governed by section 15.059, except that members shall not receive per diems and the council does not expire.

(c) The commissioner of health shall provide staff, administrative support, and office space to

the council.

Subd. 4. **Responsibilities of council.** The council shall periodically review the implementation of this chapter and sections 256B.0571 to 256B.0573, including but not limited to:

(1) the development and implementation of certification, process, outcome, and quality standards for health care homes;

(2) development and implementation of payment restructuring and payment reform under sections 62U.04, 62U.05, 62U.06, and 62U.07; and

(3) development of the plan and recommendations for providing subsidies to employees for health coverage under section 62U.10.

Sec. 15. **[62U.13] SECTION 125 PLANS.**

Subdivision 1. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Employee" means an employee currently on an employer's payroll other than a retiree or disabled former employee.

(b) "Employer" means a person, firm, corporation, partnership, association, business trust, or other entity employing one or more persons, including a political subdivision of the state, filing payroll tax information on the employed person or persons.

(c) "Section 125 Plan" means a cafeteria or premium-only plan under section 125 of the Internal Revenue Code that allows employees to pay for health coverage premiums with pretax dollars.

Subd. 2. **Section 125 Plan requirement.** (a) Effective July 1, 2009, all employers with 11 or more current full-time equivalent employees in this state shall establish and maintain a Section 125 Plan to allow their employees to purchase individual market or employer-based health coverage with pretax dollars. Nothing in this section requires employers to offer or purchase group health coverage for their employees. The following employers are exempt from the Section 125 Plan requirement:

(1) employers that offer a health plan as defined in section 62A.011, subdivision 3, that is group coverage;

(2) employers that provide self-insurance as defined in section 62E.02; or

(3) employers that have no employees who are eligible to participate in a Section 125 Plan.

(b) Notwithstanding paragraph (a), an employer that has been certified by a licensed insurance producer as having received education and information on the benefits and advantages of offering Section 125 Plans is not required to establish a Section 125 Plan and may opt out of the requirement to establish a Section 125 Plan by sending a form to the commissioner of commerce. The commissioner of commerce shall create a simple check-box form for employers to opt out. The commissioner of commerce shall make the form available through their Web site by April 1, 2009.

Subd. 3. **Employer requirements.** (a) Employers that do not offer a health plan as defined in section 62A.011, subdivision 3, that is group coverage and are required to offer or choose to offer a Section 125 Plan shall:

(1) allow employees to purchase an individual market health plan for themselves and their dependents;

(2) allow employees to choose any insurance producer licensed in accident and health insurance under chapter 60K to assist them in purchasing an individual market health plan;

(3) upon an employee's request, deduct premium amounts on a pretax basis in an amount not to exceed an employee's wages, and remit these employee payments to the health plan; and

(4) provide written notice to employees that individual market health plans purchased by employees through payroll deduction are not employer-sponsored or administered.

(b) Employers shall be held harmless from any and all claims related to the individual market health plans purchased by employees under a Section 125 Plan.

Sec. 16. **[256B.0751] PAYMENT REFORM.**

Subdivision 1. **Quality incentive payments.** The commissioner of human services shall implement quality incentive payments as required under section 62U.04. This does not limit the ability of the commissioner of human services to establish by contract and monitor, as part of its quality assurance obligations for state health care programs, outcome and performance measures for nonmedical services and health issues likely to occur in low-income populations or racial or cultural groups disproportionately represented in state health care program enrollment, that would likely be underrepresented when using traditional measures that are based on longer-term enrollment.

Subd. 2. **Payment reform.** The commissioner of human services shall establish a payment system to reduce health care costs and improve quality as required under section 62U.06.

Sec. 17. **HIGH-DEDUCTIBLE HEALTH PLAN OPTION.**

The commissioner of finance shall consider including an option that is compatible with the definition of a high-deductible health plan in section 223 of the Internal Revenue Code in the health insurance benefit plans offered under the managerial plan in Minnesota Statutes, section 43A.18, subdivision 3.

Sec. 18. **STUDY OF UNIFORM CLAIMS REVIEW PROCESS.**

The commissioner of health shall establish a work group including representatives of the Minnesota Hospital Association, Minnesota Medical Association, and Minnesota Council of Health Plans to make recommendations on the potential for reducing claims adjudication costs of health care providers and health plan companies by adopting more uniform payment methods, and the potential impact of establishing uniform prices that would replace current prices negotiated individually by providers with separate payers. The work group shall make its recommendations to the commissioner by January 1, 2010, and shall identify specific action steps needed to achieve the recommendations.

ARTICLE 5

APPROPRIATIONS

Section 1. **SUMMARY OF APPROPRIATIONS.**

The amounts shown in this section summarize direct appropriations, by fund, made in this article.

	2009	Total
General Fund	$ 403,000	$ 403,000
Health Care Access Fund	12,883,000	12,883,000
Total	**$ 13,286,000**	**$ 13,286,000**

Sec. 2. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are added to or, if shown in parentheses, subtracted from the appropriations in Laws 2007, chapter 147, article 19, or other law to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal year indicated for each purpose. The figure "2009" used in this article means that the addition to or subtraction from the appropriation listed under it is available for the fiscal year ending June 30, 2009.

	APPROPRIATIONS Available for the Year Ending June 30 2009
Sec. 3. **HUMAN SERVICES**	
Subdivision 1. **Total Appropriation**	**$ 6,175,000**

Appropriations by Fund

	2009
General	1,227,000
Health Care Access	4,948,000

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Children and Economic Assistance Management**

Health Care Access	6,000

This is a onetime appropriation.

Subd. 3. **Basic Health Care Grants**

The amounts that may be spent from the appropriation for each purpose are as follows:

(a) **MinnesotaCare Grants**

Health Care Access	1,301,000

(b) **Other Health Care Grants**

Health Care Access	200,000

Primary Care Physician Rate Increases. (1) Of the general fund appropriation, $200,000 is to the commissioner for the medical assistance reimbursement rate increase described in Minnesota Statutes, section 256B.766.

(2) Notwithstanding Minnesota Statutes, section 295.581, the commissioner of finance shall reimburse the medical assistance general fund account from the health care access fund the amount of general fund expenditures for this activity. The amount reimbursed under this paragraph is appropriated to the commissioner.

Subsidies for Employer-Subsidized Health Coverage. For the biennium beginning July 1, 2009, base level funding for the subsidy program described in Minnesota Statutes, section 62U.10, shall be $20,000,000 from the health care access fund for the first year and $35,000,000 from the health care access fund for the second year.

Base Adjustment. The health care access fund base is increased by $3,000,000 in fiscal year 2010 and increased by $5,000,000 in fiscal year 2011.

Subd. 4. **Health Care Management**

The amounts that may be spent from the appropriation for each purpose are as follows:

(a) **Health Care Policy Administration**

General	1,008,000
Health Care Access	282,000

Base Adjustment. The health care access fund

is decreased by $89,000 in fiscal year 2010 and decreased by $272,000 in fiscal year 2011.

Base Adjustment. The general fund base is decreased by $80,000 in both fiscal years 2010 and 2011.

Department of Education Computer System. $50,000 is from the health care access fund for the commissioner to enter into an agreement with the Department of Education for the modification of the department's computer system to implement Minnesota Statutes, section 124D.1115. This is a onetime appropriation.

Public dental coverage program study. (1) Of the health care access fund appropriation, $50,000 in fiscal year 2009 is for the commissioner of human services to undertake a study to determine whether alternative approaches to offering dental coverage to public program enrollees would result in:

(i) improved access to dental care;

(ii) cost savings to providers and the department; and

(iii) improved quality and outcomes of care.

Alternatives considered must include moving to a single dental plan administrator, retaining the current model, and other innovative approaches. Issues relating to chronic disease management, medical and dental interface, plan payment approaches, and provider payment should also be addressed. The report must make a recommendation on whether to alter the current approach to contracting for dental services, and include a detailed plan on how to implement any changes. The commissioner shall consult with dentists, safety net dental providers, dental plans, health plans and county-based purchasing organizations, patients and advocates, and other interested parties in developing their findings and recommendations.

(2) By December 15, 2008, the commissioner of human services shall report findings and recommendations to the chairs of the house of representatives and senate committees having jurisdiction over health and human services policy and finance.

(b) **Health Care Operations**

General	219,000
Health Care Access	2,355,000

This is a onetime appropriation.

Incentive Program and Outreach Grants. Of the appropriation for the Minnesota health care outreach program in Laws 2007, chapter 147, article 19, section 3, subdivision 7, paragraph (b):

(1) $400,000 in fiscal year 2009 from the general fund and $200,000 in fiscal year 2009 from the health care access fund are for the incentive program under Minnesota Statutes, section 256.962, subdivision 5. For the biennium beginning July 1, 2009, base level funding for this activity shall be $360,000 from the general fund and $160,000 from the health care access fund; and

(2) $100,000 in fiscal year 2009 from the general fund and $50,000 in fiscal year 2009 from the health care access fund are for the outreach grants under Minnesota Statutes, section 256.962, subdivision 2. For the biennium beginning July 1, 2009, base level funding for this activity shall be $90,000 from the general fund and $40,000 from the health care access fund.

Outreach Funding. (1) Of the health care access fund appropriation, $100,000 is for the incentive program under Minnesota Statutes, section 256.962, subdivision 5. This is in addition to the base level fund for the biennium beginning July 1, 2009. For the fiscal year beginning July 1, 2011, appropriations for this activity shall be from

the health savings reinvestment fund.

(2) Notwithstanding Minnesota Statutes, section 295.581, the commissioner of finance shall reimburse the medical assistance general fund account from the health care access fund by $701,000 in fiscal year 2010 and $1,527,000 in fiscal year 2011 for the cost to the general fund for the increase in enrollment to the medical assistance program for families with children due to the outreach efforts.

Base Adjustment. The health care access fund base is decreased by $387,000 in fiscal year 2010 and increased by $642,000 in fiscal year 2011.

Subd. 5. **Continuing Care Management**

Health Care Access 804,000

Long-Term Care Worker Health Coverage Study. (a) Of the health care access fund appropriation, $804,000 is for the commissioner to study and report to the legislature by December 15, 2008, with recommendations for a rate increase to long-term care employers dedicated to the purchase of employee health insurance in the private market. The commissioner shall collect necessary actuarial data, employment data, current coverage data, and other needed information.

(b) The commissioner shall develop cost estimates for three levels of insurance coverage for long-term care workers:

(1) the coverage provided to state employees;

(2) the coverage provided to MinnesotaCare enrollees; and

(3) the benefits provided under an "average" private market insurance product, but with a deductible limited to $100 per person.

Premium cost sharing, waiting periods for eligibility, definitions of full- and part-time employment, and other parameters under the

three options must be identical to those under the state employees' health plan.

(c) For purposes of this section, a long-term care worker is a person employed by a nursing facility, an intermediate care facility for persons with developmental disabilities, or a service provider that:

(1) is eligible under Laws 2007, chapter 147, article 7, section 71; and

(2) provides long-term care services.

The commissioner may recommend a different definition of long-term care worker if this definition presents insurmountable implementation issues.

(d) The recommendations must include measures to:

(1) ensure equitable treatment between employers that currently have different levels of expenditure for employee health insurance costs; and

(2) enforce the requirement that the rate increase be expended for the intended purpose.

This is a onetime appropriation.

Sec. 4. **COMMISSIONER OF HEALTH**

Subdivision 1. **Total Appropriation** **$** **7,111,000**

Appropriations by Fund

	2009
Health Care Access	7,935,000
General	(824,000)

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Community and Family Health Promotion**

Health Care Access	152,000

$152,000 in fiscal year 2009 is for statewide health saving research and measurement.

Statewide Health Improvement Program. The health care access fund base shall be increased by $19,587,000 in fiscal year 2010 and $26,175,000 in fiscal year 2011 for grants to local communities in accordance with Minnesota Statutes, section 145.986, subdivision 2; $205,000 in fiscal year 2010 and $424,000 in fiscal year 2011 is for staffing; $22,000 in fiscal year 2010 and $42,000 in fiscal year 2011 is for operating costs; $150,000 in fiscal year 2010 and $300,000 in fiscal year 2011 is for contracts for evaluation; and $36,000 in fiscal year 2010 and $60,000 in fiscal year 2011 is for administrative costs. The base for this program in fiscal year 2012 is $0.

Subd. 3. **Policy, Quality, and Compliance**

Health Care Access	7,783,000
General	(824,000)

Open Door Health Center. Of the health care access fund appropriation, $350,000 is to be awarded as a grant to the Open Door Health Center to act as bridge funding to meet the demand for health care services in medically underserved areas. This is a onetime appropriation.

Of this appropriation, $84,000 is for the commissioner to make recommendations to the legislature on community benefit standards to be required of nonprofit health plan companies doing business in the state. The expectations of the community benefits provided and reported should be related to the statutory expectations in Minnesota Statutes, sections 62C.01 and 62D.01, and focus on supporting public health, improving the art and science of medical care, and addressing the need for financial assistance to access ongoing coverage, and not related to general philanthropic endeavors. The commissioner shall seek public input regarding the range of

options to be explored and the accountability measures.

The recommendations must include a procedure by which each nonprofit health plan company would periodically and uniformly report to the state and to the public regarding the company's compliance with the requirements.

The commissioner shall recommend a fair and effective enforcement and remediation mechanism. This is a onetime appropriation.

Federally Qualified Health Centers. Of the health care access fund appropriation, $2,824,000 is for subsidies to federally qualified health centers under Minnesota Statutes, section 145.9269. The health care access fund base shall be $3,500,000 for fiscal years 2010 and 2011.

The general fund appropriation for this program shall be reduced by $824,000 for fiscal year 2009, and by $1,500,000 in both fiscal years 2010 and 2011.

Base Adjustment. The health care access fund base shall be further reduced by $4,104,000 in fiscal year 2010 and $4,323,000 in fiscal year 2011.

Sec. 5. **SUNSET OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2009, unless a different expiration date is specified.

Sec. 6. **EFFECTIVE DATE.**

The provisions in this article are effective July 1, 2008, unless a different effective date is specified."

Delete the title and insert:

"A bill for an act relating to health care; establishing a statewide health improvement program; establishing health care homes and reporting requirements; establishing a care coordination payment; increasing reimbursements to primary care physicians in certain areas; requiring a workforce shortage study; establishing requirements for interoperable health records; establishing electronic prescription drug program; establishing a value-based benefit set and design for health benefits; providing for health care payment restructuring; requiring uniform standards; establishing an affordability standard; requiring development of employee subsidies for health

coverage; requiring a health care spending baseline be developed; establishing a health care reform review council; establishing Section 125 Plan; providing for fees; requiring reports; authorizing rulemaking; appropriating money; amending Minnesota Statutes 2006, sections 256.01, by adding a subdivision; 256B.057, subdivision 8; 256L.05, by adding a subdivision; 256L.06, subdivision 3; 256L.07, subdivision 3; Minnesota Statutes 2007 Supplement, sections 62J.495, by adding a subdivision; 256.962, subdivisions 5, 6; 256L.04, subdivisions 1, 7; 256L.05, subdivision 3a; 256L.07, subdivision 1; 256L.15, subdivision 2; Laws 2007, chapter 147, article 5, section 19; proposing coding for new law in Minnesota Statutes, chapters 62J; 124D; 145; 256B; proposing coding for new law as Minnesota Statutes, chapter 62U; repealing Minnesota Statutes 2006, section 256L.15, subdivision 3."

We request the adoption of this report and repassage of the bill.

House Conferees: (Signed) Thomas Huntley, Paul Thissen, Diane Loeffler, Kim Norton

Senate Conferees: (Signed) Linda Berglin, Ann Lynch, Tony Lourey, Kathy Sheran, Julie A. Rosen

CALL OF THE SENATE

Senator Berglin imposed a call of the Senate for the balance of the proceedings on H.F. No. 3391. The Sergeant at Arms was instructed to bring in the absent members.

Senator Berglin moved that the foregoing recommendations and Conference Committee Report on H.F. No. 3391 be now adopted, and that the bill be repassed as amended by the Conference Committee. The motion prevailed. So the recommendations and Conference Committee Report were adopted.

H.F. No. 3391 was read the third time, as amended by the Conference Committee, and placed on its repassage.

The question was taken on the repassage of the bill, as amended by the Conference Committee.

The roll was called, and there were yeas 53 and nays 13, as follows:

Those who voted in the affirmative were:

Anderson	Dibble	Langseth	Pappas	Sieben
Bakk	Dille	Larson	Pogemiller	Skoe
Berglin	Doll	Latz	Prettner Solon	Skogen
Betzold	Erickson Ropes	Lourey	Rest	Sparks
Bonoff	Fischbach	Lynch	Robling	Stumpf
Carlson	Foley	Marty	Rosen	Tomassoni
Chaudhary	Frederickson	Metzen	Rummel	Torres Ray
Clark	Gimse	Moua	Saltzman	Vickerman
Cohen	Higgins	Murphy	Saxhaug	Wiger
Dahle	Koering	Olseen	Scheid	
Day	Kubly	Olson, M.	Sheran	

Those who voted in the negative were:

Gerlach	Johnson	Limmer	Pariseau	Wergin
Hann	Jungbauer	Michel	Senjem	
Ingebrigtsen	Koch	Ortman	Vandeveer	

So the bill, as amended by the Conference Committee, was repassed and its title was agreed to.

RECESS

Senator Pogemiller moved that the Senate do now recess subject to the call of the President. The motion prevailed.

After a brief recess, the President called the Senate to order.

APPOINTMENTS

Senator Pogemiller from the Subcommittee on Conference Committees recommends that the following Senators be and they hereby are appointed as a Conference Committee on:

H.F. No. 3420: Senators Moua, Scheid and Limmer.

Senator Pogemiller moved that the foregoing appointments be approved. The motion prevailed.

MEMBERS EXCUSED

Senator Ortman was excused from the Session of today from 11:00 a.m. to 12:05 p.m. and from 7:15 to 7:45 p.m. Senators Dille and Vickerman were excused from the Session of today from 11:00 a.m. to 12:15 p.m. Senator Skogen was excused from the Session of today from 11:30 a.m. to 12:00 noon. Senators Senjem and Wergin were excused from the Session of today from 12:00 noon to 12:20 p.m. Senators Metzen and Saltzman were excused from the Session of today from 2:15 to 3:15 p.m. Senator Scheid was excused from the Session of today from 2:15 to 10:20 p.m. Senator Lynch was excused from the Session of today from 2:35 to 3:15 p.m. Senator Olson, G. was excused from the Session of today at 7:15 p.m. Senator Johnson was excused from the Session of today from 7:15 to 7:40 p.m. Senators Fischbach, Sieben and Tomassoni were excused from the Session of today from 7:15 to 7:45 p.m. Senators Latz and Rest were excused from the Session of today from 7:15 to 9:30 p.m. Senator Gerlach was excused from the Session of today from 7:15 to 10:45 p.m. Senator Saxhaug was excused from the Session of today from 9:20 to 10:45 p.m.

ADJOURNMENT

Senator Pogemiller moved that the Senate do now adjourn until 10:30 a.m., Tuesday, May 13, 2008. The motion prevailed.

Patrick E. Flahaven, Secretary of the Senate

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